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Our climbing health care costs

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It is common knowledge with respect to the American health care system that prices communicate relatively little information. In other areas of the economy, the price system works wonders when it comes to coordinating an unfathomable number of goods, resources and consumer desires across space and time, while at the same time adapting from moment to moment to changes in these and other underlying fundamentals. As consumers of health care, though, most of us would probably say that whenever we do see a price—a rare occurrence in American medicine today—just about the only thing we can say for sure about it is that it's unrealistically high. As early as 1992, libertarian health policy analyst and economist John Goodman explained that "most patients in the hospital marketplace cannot find out what the cost will be prior to admission and cannot read the hospital bill upon discharge." More recently, New York Times writer Elisabeth Rosenthal has maintained an ongoing series entitled "Paying Till It Hurts," which details the exorbitant and widely varying fees for a range of procedures in the American health care system.

The "Paying Till It Hurts" series is valuable for the insight it seemingly unintentionally provides into the effect that the lack of a true, market-based price system has had on American health care. Rosenthal, however, seems to believe these errors are endogenous to unrestricted markets for health care in general. "Hospitals are the most powerful players in a health care system that has little or no price regulation in the private market," she explains in a recent installment. Elsewhere, she argues that "hospitals, drug companies, device makers, physicians and other providers can benefit by charging inflated prices, favoring the most costly treatment options and curbing competition that could give patients more, and cheaper, prices." These observations may not be wrong, but ultimately they represent an oversimplified and unsatisfactory explanation of a complex problem.

Although it's possible that "price regulation" is the answer, almost any other area of the economy would emphatically suggest that a lack of price controls does not produce runaway costs. (And, as libertarian think tank the Cato Institute points out, it's worth noting that the health care sector is actually one of the most highly regulated sectors of the economy in the first place.) Everything, from food to automobiles to personal electronic devices, is priced free of government regulations, and yet the prices of these goods generally tend to fall rather than spiraling and skyrocketing out of control. Are grocers, auto dealerships and electronic manufacturers any more immune to the drive to inflate prices, favor costly options and curb competition than their counterparts who ostensibly succumb in the health care sector? Or are there alternative explanations for this phenomenon that resonate a little better with

what we know to generally be true about the tendency of prices of goods (in real terms) to fall over time?

One way of developing an alternative theory would be to look for areas of the medical sector that have been relatively resistant to medical cost inflation, and then compare and contrast them with the broader trend of rapidly climbing prices in American medicine. Such areas, according to John Goodman, include Lasik surgery, cosmetic surgery, independent laboratory and diagnostic testing, independent drug purchases via major retailers or over the Internet, retail clinics, telephone-based medical consultation services and concierge medical practices, not to mention an entire range of services available to pets via veterinarians that are analogous to their human equivalents in everything but the reasonableness of the price tags. Goodman notes, for instance, that a human knee replacement in Dallas, Texas can run anywhere between $21,000 and $75,000 for private insurers and between $16,000 and $30,000 for Medicare, while a canine knee replacement falls within the $3,500 to $5,000 range—a difference that costs associated with surgeon's fees, nurse's fees, hospital stays and other obvious culprits do not come close to explaining.

What do these areas have in common that also sets them apart from most other goods and services in the medical sector? As Devon M. Herrick, a senior fellow at the National Center for Policy Analysis, explains in a December 2008 policy report, these areas represent markets in which patients—rather than third parties like private insurers and government programs—are responsible for shouldering most (if not all) of the cost of the goods or services being delivered. In other words, they are constructed more along the lines of free markets for groceries, automobiles and cell phones than other areas of the health care sector. Although that may sound unappealing, it often induces providers to compete far more aggressively for patients on both price and quality than they do otherwise, and thereby places a downward pressure on prices. "In these markets," Herrick writes, "entrepreneurs compete for patients' business by offering greater convenience, lower prices and innovative services unavailable in traditional clinical settings." He also argues that transparency follows naturally from this, and the success of organizations such as the Surgical Center of Oklahoma, which has forced down average local surgical fees by openly advertising their own prices for procedures, serves as a real world testament to that point.

Of course, there are common objections to the idea that price transparency and consumer-driven health care can help solve the problem of medical cost inflation. A critic might argue, for instance, that Herrick and Goodman aren't making an apples-to-apples comparison when they try to apply their conclusions concerning elective procedures to life-saving emergency interventions. Patients have the luxury of time to shop around for the best price on a facelift or nose job, the argument goes, but demand for emergency interventions is relatively inelastic by comparison. In other words, nobody shops around for prices when they are racing to the nearest hospital with a life-threatening injury. Although this is a valid objection, and one which deserves to be taken quite seriously, the results of the Rand Health Insurance Experiment of the late 1970s and early 1980s suggest that a direct payment relation between patients and providers could reduce the cost of primary care by as much as 30 percent with little to no negative effect on health outcomes (with a very significant exception being sick members of low-income populations, where government aid would clearly be most justified). Another substantive

counterargument stems from the fact that about half of all health care spending in the United States comes from just 5 percent of the population, which is made up of people who are so sick and whose medical bills are so high that they cannot reasonably be expected to cost-share at all, much less discriminate on the basis of price. Finally, in the realm of the abstract, some critics might recognize that so few patients and providers view health care as a market that consumer-driven health care requires a cultural adjustment so substantial that it would be difficult to predict how successful it might be, or what sort of consequences it might hold. These are all thoughtful considerations; in addition to the objections that they raise, they also serve as potent reminders that, when it comes the American health care system, there really are no easy fixes.

To be fair to Elisabeth Rosenthal, her exhaustive “Paying Till It Hurts” pieces do acknowledge in places that consumers have difficulty controlling costs because they are almost never exposed to the prices of the treatments that they seek. With such a wealth of compelling points for and against consumer-driven health care practices, however, we may all do better to generally abandon the old canard of the greedy capitalist pig in American health care, and to focus instead on clarifying what it is that we can and cannot learn from price systems in consumer-driven health markets today.

After the financial crisis of 2008, a common rejoinder to critics of corporate greed was that blaming financial crises on greed is like blaming airplane crashes on gravity. So it is in health care, too: Both greed and gravity will always be with us, and it is up to us to design the systems we use in such a way so as to take account of, rather than merely ignore, these realities.