National Review

July 18, 2011

Haves and Have-Mores - A two-tiered health-care system is inevitable

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LENGTH: 2089 words

Is health care a normal economic good, subject to limitations and tradeoffs? Economist Paul Krugman says that it is: "We have to do something about health care costs, which means that we have to find a way to start saying no. In particular, given continuing medical innovation, we can't maintain a system in which Medicare essentially pays for anything a doctor recommends."

However, there are those who disagree. For example, economist Paul Krugman writes:How did it become normal, or for that matter even acceptable, to refer to medical patients as "consumers"? The relationship between patient and doctor used to be considered something special, almost sacred. Now politicians and supposed reformers talk about the act of receiving care as if it were no different from a commercial transaction, like buying a car -- and their only complaint is that it isn't commercial enough. What has gone wrong with us? Thus, in the same column, Krugman occupies both sides of the divide. On one hand, he derides the notion that we cannot put a price on health care; on the other hand, he derides the notion that health care is a "commercial transaction."

All of us wrestle with these sorts of mixed feelings. When we think of health care as a matter of life or death, we cannot imagine applying spending limits, accepting trade-offs, or employing other economic concepts. When we remember that the United States spends about twice as much per capita on health care as other advanced nations without enjoying obviously superior health outcomes, and when we confront the budget outlook for Medicaid and Medicare, we cannot imagine continuing to make an open-ended commitment to pay for any and all medical procedures.

What we want is unlimited access to medical services without having to pay for them. But to the extent that health care is paid for collectively, our access will have to be limited by the institutions doing the paying, whether government or private insurance companies. On the other hand, to the extent that responsibility is given to individuals to share in the cost of our medical care, we will have to make decisions based in part on cost.

Krugman would resolve our conundrum by having a panel of government experts set policies determining which procedures are to be covered. He assumes that the experts will approve reimbursements for procedures that clearly extend or improve life but will not approve reimbursements for procedures that have high costs and low benefits. Individuals who want such discretionary procedures would have to find their own funds

to pay for them. This approach, which also is favored by the Obama administration, implies a two-tiered health-care system. One tier consists of necessary medical procedures. The government guarantees that everyone has access to this tier. The other tier consists of discretionary medical procedures, available only to people who can afford them.

The market-oriented alternative to the rationing-by-experts approach is for individuals to choose health plans and medical procedures on their own. Even if most people are able to obtain health care in a market-oriented system, voters are unlikely to want to see people denied necessary procedures because of lack of wealth. Accordingly, we are likely to see some form of government insurance so that everyone will be able to undergo necessary procedures.

This approach also implies a two-tiered health-care system. One tier consists of necessary medical procedures. For poor households, a voucher or other form of government support guarantees that everyone has access to this tier. The other tier consists of discretionary procedures, available only to those who can afford them.

Assigning key decisions to government experts will lead to a two-tiered health-care system. Using vouchers to give the choice to consumers will also lead to a two-tiered health-care system. We will end up with a two-tiered health-care system either way.

This reflects the reality of health care. Only some procedures are clearly necessary for longer or better life. Many procedures, perhaps most, offer benefits that are far less certain. These procedures, which range from routine diagnostic screening to heroic late-stage treatments, have some potential value. For the majority of patients on whom they are performed, the outcome is no better, and sometimes worse, than it would have been without the procedure.

Pundits speak about the health-care budget in misleading ways. One example is the phrase "bend the cost curve." To identify health-care costs as the problem places the issue entirely on the supply side. The implication is that services are delivered inefficiently and/or that providers are paid excessively.

No one can deny that American health care has inefficiencies or that doctors earn high incomes. But the relentless growth of health-care spending does not reflect increasing inefficiency or rising provider compensation. Instead, it mostly results from more extensive use of medical services, particularly those that require specialists and sophisticated equipment.

Experts raise the level of debate when they focus on this trend rather than on "costs." Even in discussing utilization, however, they can be misleading. For example, in an op-ed in the Financial Times during the debate over Obamacare, budget director Peter Orszag wrote:Based on estimates by Dartmouth College and others, the US spends about $700bn a year on healthcare that does nothing to improve Americans' health outcomes.

Reducing the number of tests, procedures and other medical costs that do not improve health presents an enormous opportunity. What is misleading about this is that it suggests that one can easily identify hundreds of billions of dollars of procedures that provide no benefit. Unfortunately, the problem is considerably more subtle. The high rate of spending on health care in this country is due mostly to procedures that provide at least some benefit in at least some cases. On average, the benefits are low, but they are not zero. This makes cutbacks much more problematic than they would be if the procedures truly had no benefit.

Consider the following:

* In the United States, the number of MRI and CT exams per capita is more than double the average for OECD countries. The benefit of these scans for aggregate health outcomes has not been demonstrated. MRI and CT exams provide real benefits in particular cases, but their extensive use means that, on average, they provide no documentable benefit.

* Screening for colon cancer is recommended for all Americans over the age of 50 at least once every ten years, and more frequently for those with risk factors. However, about 90 percent of these procedures are likely to turn up nothing. In Canada and in other countries, routine colonoscopy is not practiced.

* In December of 2007, my father was diagnosed with terminal esophageal cancer. In January of 2008, he had a fall and broke his hip. In many other countries, he would have been placed in a queue, and he probably would have died before obtaining surgical treatment. Instead, he was operated on the next day. But he was never able to walk or to leave the hospital before he died in April, and thus he is an example of how tens of thousands of dollars can be spent in the last few months of life.

* In January of 2011, my mother-in-law was given a relatively new procedure to treat partial blockage of her aorta. The procedure was successful, but she immediately contracted an infection and died. Although doctors had good intentions, the outcome probably was worse than it would have been if she had never undergone the procedure.

* On a more positive note, a friend in his 50s was successfully treated for kidney cancer by means of a therapy that the doctors said works in less than 5 percent of patients. Given the low success rate, the cost per life saved may be in the millions of dollars, but when you are close to the person, it seems worth it.

It is not known in advance how any procedure will affect an outcome, and so the individual always has an incentive to receive treatment if there is some possible benefit, particularly if the cost is paid by insurance. Yet on average, the benefits may be low relative to the costs -- and Americans choose to undergo so many procedures with high average costs and low average benefits that the budgets of Medicare and Medicaid are under severe stress, while private health insurance is difficult to afford. This is not sustainable.

Given the foregoing, I think that America's health-care system is likely to evolve along the following lines:

The government will draw a boundary between necessary care and discretionary care. This process is going to be imperfect. It ought to involve comparative-effectiveness research, but that in itself cannot and should not supply all of the answers. There are inevitable ethical questions involved. Which is necessary: an operation that successfully cures tennis elbow in 99 percent of cases? An operation that successfully treats cancer in 2 percent of cases?

The process also is going to be politicized and lobbied. Some constituents will insist that fertility treatment is necessary, while others will view it as discretionary. The makers of drugs that treat erectile dysfunction will argue that their products are a vital necessity.

Private health-insurance companies also will draw a line between what they will cover and what they will not cover. But government will have to be especially selective in its definition of "necessary care" in order to get control of its budget.

A taxpayer-funded system will ensure that households have the funds to receive necessary care. This would be true whether poor households were given complete freedom of choice or were limited to a single health plan. They could be enrolled in a government-run program along the lines of the Veterans' Affairs system. Alternatively, they could be given vouchers that would allow them to purchase any health plan, provided that it met certain government-specified criteria.

The instinct of market-oriented policy proponents is to fight for vouchers for low-income households and oppose a government-run program. For poor households, a more paternalistic system, closely managed by government officials, might be inevitable, and in fact might provide better service. The important policy objective is to ensure that middle-class households retain choices and a fair share of responsibility for their health care.

Americans will have the freedom to choose discretionary care. In the United States, it is highly unlikely that an ideological commitment to egalitarianism will prove so strong as to convince voters to restrict health-care services that people may obtain with their own funds. Krugman clearly does not envision such a scenario.

Affluent and middle-class households will be able to consume more health-care services than poor households. These additional services will consist, however, of discretionary care, and the effect on average health outcomes will be minimal. The main benefit may be to offer reassurance (scans that show nothing) or hope (procedures that rarely succeed).

Government health-care programs will cease to be open-ended. Medicare is currently structured to reimburse health-care providers for a potentially limitless number of procedures. Medicaid is a similarly open-ended commitment on the part of the federal government to subsidize state programs.

Such arrangements will end as the line between necessary and unnecessary care is drawn. In order to control spending, government must have mechanisms in place to enforce a fixed budget. The obvious alternatives are vouchers and rationing. Vouchers can be allocated in fixed-dollar amounts, giving the government a precise handle on its budget. Under a more socialized system, government can fix the total compensation it will pay to various health-care providers, leaving it up to doctors to ration the use of available resources, including their own time.

Eventually, our health-care policy will have to limit the amount of taxpayer funding for discretionary care. By narrowing the policy focus to necessary care, the government can avoid the ineluctable escalation of spending that is a property of our current programs. But access to discretionary care will remain for those who can afford it -- meaning that our choice is between two kinds of two tiers.

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