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NOTES ON HEALTH CARE FINANCING AND FREE MARKETS

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Abstract

This article applies economic theory to the financing of health care. The authors point out that rent-seeking and government intervention into the health care market raise the cost of health care and reduce its quality. The authors call for health care to be financed privately without government intervention.

National politicians are claiming credit for a model of bipartisan cooperation in crafting a balanced budget for the year 2002. The Federal "budget" is the presentation of two opposite flows of money--Federal revenue collections (mainly taxes) and Federal spending. But the supposed "balance" of inflows and outflows is like a mirage in the desert--in the distance it may appear real, but as we get closer to it (that is, to the year 2002), it vanishes. One of the main reasons the "balance" will vanish will be the growth of Medicare spending. Medicare is part of the insurance scheme, called "third-party payment," which pays for our health care. One of the fatal flaws of Medicare is that it is treated as a "free lunch."

The popular saying, "There is no such thing as a free lunch," is a variation of the fundamental idea in economics that anything which is free or priced below market level will be over-consumed (Butler, 1989, Dolan and Goodman, 1995, National Center, 1994, Robbins, et.al, 1994). Any government program which subsidizes purchases or which causes them to appear to cost less than they in fact do, will encourage consumption beyond that which can reasonably be provided at the artificially low price. In the end, consumers as a group, or taxpayers as a group, will wind up paying the true, higher cost. Thus, "there is no such thing as a free lunch." Somebody always pays (Dolan, 1969). True, if a private payment arrangement were to shield consumers from the true costs of their expenditures, it, too, would have similar deleterious effects. But there is one fundamental difference between governments and market participants which must always be kept in mind: when the former engages in such activities, it can do so in the long run, and with impunity. Any losses created by such uneconomic acts can be made up for with tax revenues. In contrast, when private parties such as employers or insurance companies do so, this must of necessity be a short run phenomenon, which can only last as long as bankruptcy can be staved off.[4]

Consumers of health care, unlike consumers of other goods and services, are often not confronted with the true cost of the material and human resources devoted to this end. In freely competitive markets, the interplay of supply and demand, unfettered by interference from external players, communicates to

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[4] This holds only if government does not bail out or subsidize such private misallocative behavior. If the state does support it, then, again, we arrive at that institution, not the market, as the real explanation for the shielding of the consumers from the true costs of their choices.

buyers the true costs are of what they consume and permits them to make informed decisions. In contrast, through the advent of Medicare in 1965, and more generally through the tax-subsidized provision of private health insurance programs by employers since World War II, individual consumers have not been confronted with the real cost of treatment, nor has this information been available to individual care-givers at the point of making treatment decisions (Santerre and Neun, 1996).

In other words, we get the services now at a direct price to the consumer that is very low relative to actual costs, and, presumably, worry about increases in the insurance premiums later. Those who are insured will ultimately pay the full bill through higher premiums, but the group, as individuals, is not faced with those costs at the point of service. A government-sponsored financing mechanism--Medicare and tax-subsidized employer-sponsored insurance[5]--has been put into place which does not allow the usual economizing incentives to work (Manning, et. al., 1987; O'Grady, et al., 1985). The recent "reform" of third-party insurance through the advent of "health maintenance organizations"--HMOs--is supposed to ameliorate adverse demand-side effects by interposing a third party in the decision chain for medical care (Wholey, et al., 1997; Mark and Mueller, 1996). Certainly HMOs have squeezed the margins of providers and notched down the rising trend line of costs. But recent data indicating increasing health plan premiums puts at question whether HMOs are the panacea they are often portrayed to be (Ginsburg and Pickreign, 1996, 1997).

How did we get into this mess, and what are the chances of extricating ourselves from it?

Some writers maintain that the difficulties in health care stem to a great degree from the fact that the goods and services provided are

so expensive and are continually rising in cost. In addition, insurance companies have been placed between the providers of health care and the consumer who pays for the services. The increases in costs are spread over large groups of consumers and the charges incurred by individual consumers are not viewed as directly linked to the insurance premiums. Were this not so, the difficulties of balancing budgets, providing a provision for the poor, pricing the middle class out of the market, would all be far more tractable.

These explanations, while not totally irrelevant, are only superficial. For, as we have seen, only the state can maintain artificially low prices for medical goods and services over the long haul. No insurance company could make profits under such a scheme, and without profits would eventually have to declare bankruptcy. However, high and rising prices do play a role, for they drive a large and increasing sized wedge in between market and controlled prices. That is, if government is going to artificially lower prices, the lower costs are the less disruption it will cause.

Why, then, are physicians services (a large part of the total medical bill) so exorbitant in price? For the answer to this question we must resort to the fundamental economic analysis of supply and demand. Let us take them up in that order--supply, then demand. Doctors' earnings are high and increasing because the American Medical Association (A.M.A.) has been able to impose cartel-like restrictions on entry into the medical profession (Benham, 1978; Friedman, 1970; Gellhorn, 1956; Goodman and Musgrave, 1993; Goodman, 1980; Hamowy, 1979, 1984; Hyde, et. al., 1954; Kessel, 1958; Kett, 1968; Lindsay and Buchanan, 1974; Rayack, 1968). When the supply of any good, service or commodity is artificially limited, and there is an unchanging and downward sloping demand, it necessarily follows that price will rise. Doctors' services constitute no exception to this rule. Hamowy (1984, pp. 285-290) reports physician's salaries far in

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[5] Not only is employer sponsored health insurance supported by tax policy, the entire practice owes its inception to government action. See footnote 9, below.