15e The Economics of Medical Care

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The purpose of this chapter is to explain to physicians how economists think about physicians' decision-making with regard to the treatment of patients. Economists' mode of thinking has shaped health care policy and institutions and thus the environment in which physicians practice, not only in the United States but in many other countries as well. It may prove useful for physicians to understand some aspects of the economists' way of thinking, even if it sometimes seems foreign or uncongenial.

Physicians see themselves as professionals and as healers, assisting their patients with their health care needs. When economists are patients, they probably see physicians the same way, but when they view doctors through the lens of economics as a discipline, they see physicians—and their patients as well—as economic agents. In other words, economists are interested in the degree to which physicians and patients respond to various incentives in deciding how to deploy the resources over which they exercise choice. Examples of issues that would concern an economist include how much time physicians devote to seeing a patient; which tests they order; what drugs, if any, they prescribe; whether they recommend a procedure; whether they refer a patient; and whether they admit a patient to the hospital. In addition, patients consider the cost when they make a decision about whether to seek care.

To say that economists view physicians and patients as economic agents is not to say that economists consider financial incentives the predominant factor in the decisions that either physicians or patients make about treatment; it is to say only that these incentives have some influence on these decisions. In fact, the role played by financial incentives in medical decision-making may often be dwarfed by the roles played by scientific knowledge, by professional norms and ethics, and by the influence of peers. However, economic policy greatly influences financial incentives, and economists tend to focus on this domain. Their interest stems from fundamental economic questions: What goods and services are produced and consumed? In particular, how much medical care is available, and how much of other goods and services? How is medical care produced? For example, what mix of specific services is used in treating a particular episode of illness? Who receives particular treatments?

Physicians in all societies live and function in economic markets, although those markets differ greatly both from the simple competitive markets depicted in introductory economics textbooks and from country to country, depending on national institutions. Many of the differences between actual medical markets and textbook competitive markets cause what economists term *market failure*, a condition in which some individuals can be made better off without making anyone else worse off.

This chapter explains two features of health care financing that cause market failure: selection and moral hazard. A common response to market failure in medical care is what economists refer to as *administered prices*, which this chapter also describes. Unfortunately, administered prices exact a cost, leading to what economists call *regulatory or government failure*. All societies seek a balance between market failure and regulatory failure, a topic addressed in this chapter's conclusion.

SELECTION

In the idealized competitive market found in economic textbooks, buyers and sellers have the same knowledge about the goods or services they are buying and selling. When one party knows more—or when goods of different quality are being sold at the same price, which is analytically similar—markets can break down in the following sense: There may be a price at which an equally well informed buyer and seller could make a transaction that would make them both better off, but that transaction does not occur because one party knows more than the other. Hence, both the potential buyer and the potential seller are worse off.

The used car market is a classic example of differential information. Owners of used cars (potential sellers) know more about the quality of their cars than do potential buyers. At any specific market price for a certain make and model of car, the only used cars offered will be those whose sellers value them at less than that price. Assuming that quality varies among used cars, those that are offered for sale will differentially be of low quality ("lemons") relative to the given price. Owners of higher-quality cars may simply hold on to them. If, however, a potential buyer knew that the car was of higher quality, the buyer might be willing to pay enough so that the owner of the higher-quality car would sell. It is for this reason that sellers may offer warranties and guarantees, although these are uncommon (but not unknown) in medical care.

The same thing happens when goods of different quality are sold at the supermarket at the same price. Shoppers are happy to take any box of a particular brand of breakfast cereal or any bottle of a particular soft drink on the shelf because the quality of the contents of any box or bottle is the same; however, that is not the case in the produce section, where shoppers will inspect the fruit they pick up to ensure that the apple is not bruised or the banana overly ripe. At the end of the day, it is the bruised apples and overly ripe bananas that are left in the store. In effect, the seller has not used all the available information in pricing the produce, and buyers exploit that information differential.

Selection affects markets for individual—and, to some degree, small-group—health insurance in a fashion similar to that seen in the used car market and at the produce stand, but in this case it is the buyer of insurance who has more knowledge than the seller. Individuals who use above-average amounts of care—for example, those with a chronic disease or a strong proclivity to seek care for a symptom—will value health insurance more than will those who are healthy or who for various reasons shun medical care even if they are symptomatic. However, the insurer does not necessarily know the risk of those it insures, and so it gears insurance premiums to an average risk, which in some instances is conditional on certain observable characteristics, such as age. Just as shoppers do not want the bruised apples and used car buyers do not want lemons, many healthy people will not want to buy insurance voluntarily if its price mainly reflects its use by those who are sick. (Healthy but very risk-averse individuals still may be willing to pay premiums well above their expected use.) In an extreme case, healthy people drop out of the insurance pool, premiums rise because the average person left in the pool is sicker, that rise causes still more people to drop out of the pool, premiums rise further, and so forth, until few people remain to buy insurance.

For this reason, no developed country relies primarily on voluntary individual insurance to finance health care, although many countries use it in the supplemental insurance market, and selection is, in fact, often a feature of that market. Instead, governments and/or employers provide or heavily subsidize the purchase of either mandated or voluntary health insurance (e.g., in Canada or Germany, the Medicare and Medicaid programs in the United States and the purchase of insurance in exchanges by lower-income persons) or provide health services directly (e.g., the United Kingdom and the U.S. Veterans Health Administration). In addition, governments or third parties administering individual insurance markets with competing insurers may "risk-adjust" payments to insurers; that is, transfer monies from insurers who enroll better risks (as measured by observable features, such as diagnoses that are not used to rate premiums) to insurers who enroll worse risks. This feature is found in the American Medicare Advantage program and American insurance exchanges as well as in Germany and the Netherlands. The idea is to reduce insurers' incentives to structure their products in order to appeal to good risks, especially when insurers are making choices about networks and formularies.

Moreover, countries that rely on employment-based health insurance, such as the United States and Germany, either mandate taxes to finance that insurance or provide large tax subsidies for its purchase; otherwise, many healthy employees would prefer that the employer give them the money the employer uses to subsidize the insurance as cash wages. Because an employer that offers health insurance will pay lower cash wages than an otherwise equivalent employer that does