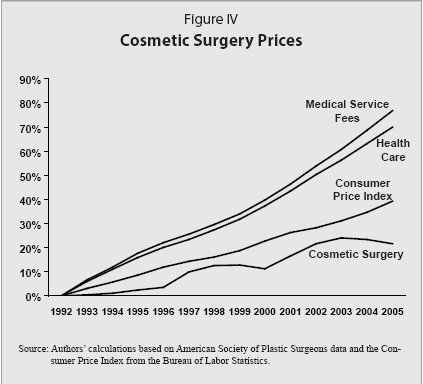
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**Lecture 08: The Economics of Healthcare**

1. Why insurance is nice
   1. We talked in intermediate about why insurance makes sense if you are risk averse. People pool their money to pool their risk.
   2. Since only a small number of people will ever actually have a problem, paying into the pool buys peace of mind.
2. Some strange observations
   1. There are a lot of strange things about healthcare and to highlight them, it’s useful to compare it to another type of insurance: car insurance. This type of insurance functions as one would expect.
      1. You can pick any number of insurance companies to buy from. If anything changes in your life, you don’t have to change your insurance.
      2. You pay for routine maintenance, things you can predict (gas, oil change, new tires). The insurance pays for unforeseen circumstances such as accidents.
      3. Those with different risks pay different amounts: men pay more than women, previous accidents increase your rate, etc. Values differ by companies because they offer different levels of coverage.
      4. Even for things that aren’t your fault, you pay a deductible to help incentivize you to be careful. Mine is a few hundred dollars.
   2. For health insurance, it’s very different.
      1. Your insurance is tied to your job. If you lose your job, you lose insurance.
      2. Insurance pays for everything, including routine maintenance: checkups, physicals, etc.
      3. Everyone pays the same amount (because it’s all done through the employer). What insurance covers is determined *by law*. (Imagine, by law, grocery stores had to offer carrots or organic peanut butter.)
      4. You pay a deductible for insurance, called a co-pay, which is about the only thing healthcare insurance has in common with conventional insurance.
   3. So health insurance is really expensive. It’s hard to tell, though, because you don’t pay for it explicitly. Your employer pays it.
      1. As a side note, this is a big reason why it appears middle-class wages have stagnated. Those numbers don’t include benefits.
      2. If you add benefits, middle-class wages notably improve. Healthcare is about 7.7% of compensation. Add other benefits (retirement, paid leave) and you’re looking at 29.7% of total compensation (these are September 2012 numbers).[[1]](#footnote-1)
3. So how did we get here?
   1. Like so many things, let’s blame Nazis.[[2]](#footnote-2)
   2. Seriously. During WWII, Congress capped salaries (likely to combat war profiteering). There was quite the labor shortage, as expected with a price control. Then three things happened:
      1. During the war, the War Labor Board ruled the price control doesn’t apply to fringe benefits. You can thus correct the shortage by padding pay with paid leave and health insurance.
      2. In the late 1940s, the National Labor Relations Board ruled fringe benefits were subject to collective bargaining; even though the wage controls were gone, inertia and expectations kept them around and now unions were picking them up.
      3. In 1954, the IRS ruled that health insurance premiums were exempt from taxes. Firms can pay a little less, you can get a little more, and we can cut the government out. Of course, this causes health insurance prices for non-firms to rise. So now not only is your health insurance tied to your job, it’s expensive to get health insurance without a job.
4. Why you *need* insurance
   1. If you were to get a bill from the hospital for the full cost of your service, you’d probably die right there. The costs are enormous, and not just because it’s expensive to provide. The charges are just silly.
      1. Example: Columnist David Lazarus’s cat bit him on the hand once; the total bill was $55,000, including four nights in a hospital (at $4,000 per night) and a $16 pill…of generic Tylenol.[[3]](#footnote-3)
      2. Example: Economist Russ Roberts look at his bill from when his wife delivered a baby. The orange juice was about $500.[[4]](#footnote-4)
   2. Of course, you don’t pay these bills; your insurance does. Insurance can afford these because hospitals, before charging insurance, apply deep discounts. One reason the prices are outrageous is so the hospital can cover costs after the discount. Of course, if you don’t have insurance, you don’t get the discount…
   3. Another reason is that you, or rather your insurance, subsidizes the healthcare for the uninsured that can’t pay on their own.
   4. Yet another reason is that some hospitals are teaching hospitals. When you purchase their services, you are also paying the hospital to train nurses and other medical workers.[[5]](#footnote-5)
   5. But of course a major story in this is asymmetric information.
      1. People consume more healthcare because of insurance (remember the RAND study?).
      2. And big government players, such as Medicare, don’t perform oversight. Fraud is common. In January of 2013, Medicare realized it was paying too much for kidney dialysis…to the tune of $880 million, *annually*.[[6]](#footnote-6)
5. Monopoly
   1. It’s not just asymmetric information which leads to high prices; good old fashion monopoly power plays a role, too.
   2. Hospitals restrict entry through the law. To open a venue which performs medical services, other local providers must agree that there is a need for it. These certificates of need (CONs) have a notably appropriate acronym; their main purpose isn’t to improve care but restrict entry.[[7]](#footnote-7)
   3. The Liaison Committee on Medical Education accredits new medical schools, a process which takes an average of eight years.[[8]](#footnote-8)
      1. We even see this anti-competitiveness in dentistry. Do I really need a dentist to get my teeth clean? Can’t I just go see him in emergencies and see the hygienist for routine cleaning? Not legally. Dental hygienists can’t be self-employed. They must be employed by a licensed dentist.[[9]](#footnote-9)
6. End of life care
   1. To top it all off, some costs are inevitable. As people live longer, health complications naturally multiply. This stuff is hard to treat and really hard to treat because there are so many variables to consider and they interact in so many ways.
   2. Treating these complex patients lead to fragmentation and confusion. A patient gets a problem and sees expert 1 who treats the problem. But the treatment creates a problem with a condition expert 1 didn’t know about so the patient goes to expert 2, who then might go to expert 3, and so on.
      1. This is made worse by the fact that many doctors don’t wash their hands between patients. Hospitals struggle to get them to wash their hands. Take a moment and consider the irony.
   3. So not only are you paying these really expensive experts, you employ more than you might otherwise because they keep making problems for one another.[[10]](#footnote-10)
   4. Add in the aging baby boomers, and you have skyrocketing costs (hey, we’re blaming Nazis again!).
7. Cosmetic surgery
   1. How big of an issue is this asymmetric information problem? We can compare conventional healthcare to something that’s like healthcare but the consumer pays 100% of the costs.
   2. Cosmetic surgery gets us really close. While sometimes insurance will cover it (say, skin grafts for a burn victim), most of the time it’s a surgery that’s completely paid for by the consumer.
   3. Economists Devon Herrick and John Goodman looked at the costs of healthcare and of cosmetic surgery between 1992 and 2005.[[11]](#footnote-11) Here’s a chart summarizing what they found.
      1. Healthcare costs have risen, far outpacing inflation. Cosmetic surgery prices have grown less quickly than inflation. In real terms, those prices fell. Asymmetric information is a really powerful influence.
8. There’s so much more!
   1. The economics of healthcare (health economics) is a big topic, with entire classes devoted to it. Some economists specialize in it. Naturally, there’s a lot we can’t get to, such as disability, pharmaceuticals, litigation and malpractice, the FDA, etc.
   2. I direct you EconTalk’s page for health-themed podcasts which provides a wider sampling: <http://www.econtalk.org/archives/health/>

1. <http://www.bls.gov/news.release/ecec.nr0.htm> [↑](#footnote-ref-1)
2. <http://www.nber.org/aginghealth/2009no2/w14839.html> [↑](#footnote-ref-2)
3. <http://articles.latimes.com/2013/jan/15/business/la-fi-lazarus-20130115> [↑](#footnote-ref-3)
4. <http://www.econtalk.org/archives/2012/11/cochrane_on_hea.html> [↑](#footnote-ref-4)
5. <http://www.econtalk.org/archives/2008/12/lipstein_on_hos.html> [↑](#footnote-ref-5)
6. <http://www.washingtonpost.com/business/economy/medicare-to-adjust-payment-for-dialysis-drugs-after-overspending-millions/2013/01/30/136fc7ba-6b06-11e2-95b3-272d604a10a3_story.html> [↑](#footnote-ref-6)
7. <http://faculty.chicagobooth.edu/john.cochrane/research/papers/after_aca.pdf> [↑](#footnote-ref-7)
8. <http://www.washingtonpolicy.org/publications/notes/looming-doctor-shortage> [↑](#footnote-ref-8)
9. <http://thinkprogress.org/yglesias/2011/05/26/201125/legalize-self-employed-dental-hygenists/> [↑](#footnote-ref-9)
10. <http://www.american.com/archive/2008/june-06-08/how-to-fix-healthcare-delivery> [↑](#footnote-ref-10)
11. <http://www.ncpa.org/pdfs/st296.pdf> [↑](#footnote-ref-11)