Book Reviews

An Unusual View Of Health Economics

BY BRYAN DOWD

The Economics of Health Reconsidered
by Thomas Rice
(Chicago: Health Administration Press, April 1998), 251 pp., $50 (cloth), $40 (paper)

In The Economics of Health Reconsidered, Tom Rice has provided a highly critical review of health economics and its application to health policy. The book builds on Rice’s April 1997 article in the Journal of Health Politics, Policy and Law, which was named the 1998 Article of the Year by the Association for Health Services Research. Although I do not agree with all of Rice’s analysis, I found it thought-provoking, and many of his points deserve more attention than they typically receive in a standard health economics course.

The organization of the book is unusual. Standard microeconomics texts usually present the theory of consumers, the theory of firms, the intersection of the two (general equilibrium theory), market pathologies, and welfare economics, in that order. Rice’s book begins with general equilibrium theory, thus requiring discussion of consumer and firm behavior without any background in demand and supply. The reason for the odd ordering is that the purpose of the book is to undermine the reader’s trust in the efficiency of perfectly competitive markets. Rice does not argue that the standard result is wrong but, rather, that the entire competitive model is inapplicable to the health care industry.

Rice points out several ways in which health care markets fail to meet the requirements of perfect competition. Some of these ways are the usual suspects, such as poor information and distorted prices, while others (envy and altruism) may be less familiar. Rice also argues against using welfare analysis, in general, and consumer preferences in particular, as the basis for evaluating health policy proposals. I simultaneously suggest a different organization of the material and comment on Rice’s analysis.

I would recommend starting the book with Rice’s chapters 3 and 4 (demand and supply theory) but would limit the discussion to the standard results. Next I would cover the general equilibrium results in chapter 2, making sure that the standard results were fully appreciated. Following presentation of the standard theory, I would begin the discussion of market failure, starting with two most serious forms of “natural” market failure: decreasing marginal costs and pure public goods.

Causes of market failure. Rice’s discussion of decreasing marginal costs (pp. 119–120) is incomplete, mixes results on quality with results on costs, deals only with hospitals, and unjustifiably generalizes results to the entire “health care area.”

I found no reference to pure public goods per se. The omission may be due to the fact that neither health insurance nor health care services are pure public goods, but if we are to have a balanced analysis of the role of government based on a standard economic framework, it is necessary to discuss the findings that do not support our position, as well as those that do.

Even if we agree that health care markets pass the first hurdle of decreasing marginal costs and pure public goods, we still must ask how likely competitive markets are to produce efficient equilibria. Four possible problems stand in the way: poor information, restricted entry to and exit from the market, distorted prices, and externalities (spillover costs and benefits).
Rice references the long-standing debate in the health economics literature over the degree of consumer information required to support a competitive market. He quotes Frank Sloan, Roger Feldman, and Mark Pauly’s opinion that a few well-informed consumers may be able to discipline a market (p. 69) and then counters with a quote from Uwe Reinhardt, who argues that experts lack adequate information on consumers’ specific needs, and vendors have ulterior motives. Ironically, Reinhardt (who wrote the book’s foreword) identifies precisely the information flaw in full-blown national health insurance systems, since in those systems the government is both the expert that allocates resources and the vendor that supplies them.

Rice devotes very little discussion to restricted entry (for example, physician licensure). Restricted entry in health care markets, for the most part, is not a natural problem. It often is the result of government policy, used to counter the problem of poor consumer information. The proper question is whether government restrictions on market entry are efficiency-enhancing.

Rice appropriately devotes most of his discussion of distorted prices to the effect of moral hazard on the estimated welfare loss of “excess” health insurance. An analysis I did with Roger Feldman found that consumers purchased “excess” private insurance (beyond the point at which marginal benefits equal marginal cost), and the resultant welfare loss could be more than $100 billion a year (in 1984 dollars). Rice argues that our estimates are inflated because consumers are unable to judge the quality or effects of medical treatment. We believe that poor consumer information would make our estimates conservative.

Externalities are a crucial part of Rice’s analysis. Rice argues that allocating resources on the basis of individual demand for health care services will lead to inefficiency because lavish consumption of health care services by the wealthy creates a negative externality in the form of envy on the part of lower-income people. Although no one can deny the existence of envy, I object to Rice’s appeal to envy as a justification for forced, uniform consumption of health care services, for several reasons.

First, the welfare losses resulting from envy may be offset, or even more than offset, by welfare gains by pretentious consumers who enjoy maximizing the distance between their consumption and that of others. Second, in the absence of a clever mechanism designed to elicit honest appraisals of envy, self-reported levels would be a foolish and dangerous basis for public policy. Third, Rice’s discussion contains no mention of moral justification, liberty, or rights, and envy in the form of “coveting” is expressly prohibited by the moral code to which most Americans at least nominally subscribe. Rice argues that moral distinctions have no place in economic assessments (p. 31). Even if I agreed, which I do not, I still would insist that seizure of property or property rights be justified on the grounds of economic efficiency as well as morality.

Altruism, on the other hand, not only is affirmed in the moral code, but its presence and extent are empirically verifiable: We observe people voluntarily transferring their income to others. Rice acknowledges the importance of “participation” altruism in explaining behavior such as voting and recycling (p. 156), but he fails to note that there is no market failure associated with participation altruism. He points out that altruism based on the income, welfare, consumption, or health status of others can suffer from collective-action and public-good problems. This is an important part of the book. However, Rice’s position would be better served if the discussion were not scattered throughout the book (pp. 33–34, 79–81, and 155–163). Also, there is no discussion of private solutions to externalities; collective-action problems and public-good problems are discussed at length (pp. 78–79 and 155), but they never are referred to by those names; and there is no reference to the primary sources on this topic, including Mancur Olsen’s seminal analysis, The Logic of Collective Action (Harvard University Press, 1965). My own opinion is that neither consumption externalities nor the collective-action or pure public-good problems associated with envy are as important as Rice and others claim.
with charity provide a compelling case for either public financing or public provision of health care services to the general population purely on efficiency grounds.

Rice also objects to using consumer preferences, as embedded in standard welfare analysis, as a foundation for judging the efficiency of alternative health care reform proposals. It is important for advocates of national health insurance to discredit consumer preferences because, as Rice reports, only 23 percent of the U.S. population agrees with the statement: “It is the responsibility of the government to take care of the very poor people who can’t take care of themselves” (p. 163). Taken at face value (albeit a dangerous exercise with surveys), that means that 77 percent of the U.S. population doesn’t even support the current Medicaid program, much less further government-based redistribution.

- **Fairness.** The discussion of fairness bring us to what I think is the main point of the book. In standard economic theory there is no necessary relationship between competitive markets and the fairness of the distribution of resources. In contrast, Rice thinks that competition has contributed to unfairness by increasing the financial pressure on providers so that they no longer can afford to provide charity care. This topic needs additional empirical work. I could agree that increased competition might necessitate more explicit mechanisms for charity. But reduced prices resulting from competition also may reduce the need for charity.

Market failure, as found throughout the health care industry, results in competitive equilibria that are inefficient, but society nonetheless may judge those inefficient equilibria to be fair. Thus, imperfect competition does not preclude attainment of a fair final distribution.

Fairness has a value to consumers, just as efficiency does. In some cases, correcting intrinsic sources of market failure, such as poor consumer information, may cost more than the improvement in efficiency is worth to consumers. The same is true of fairness. “Fairness at all cost” may be seductive rhetoric, but from a purely economic viewpoint, it is as nonsensical as “efficiency at all cost.”

Rice believes that both the current method of distributing health care resources and the distribution itself are unfair. Many health economists would agree. He argues for an allocation system based on determination of need and a distribution of health care services that is equal across all members of society, after adjusting for “need” (pp. 160–162). Contrasting this system with one that provides a minimal floor of services to those who otherwise could not afford it reveals the crucial role of envy in Rice’s analysis. A minimal floor might satisfy the altruistic desires of consumers, but only equality of consumption can eliminate envy. Rice makes a plea for putting fairness issues first, followed by efficiency concerns, but I am left with the feeling that I am being asked to put envy first, followed by efficiency. I also am concerned that while Rice is quick to question the reliability of consumers’ preferences over their own consumption, he seems quite sanguine about converting consumers’ preferences regarding the consumption of others directly into public policy.

Rice also favors national health insurance proposals that address fairness through the use of in-kind transfers (in the form of health care services) rather than cash transfers, because donors prefer them to cash transfers (pp. 157–158). Donors’ preferences are defensible criteria, but I wonder if Rice would be equally enthusiastic about donors’ preferences if they included conditions on recipients’ behavior, such as refraining from having children out of wedlock.

Rice favors comprehensive coverage in NHI systems, rather than point-of-purchase cost sharing (pp. 81–101 and 129–135).
fairness argument against point-of-purchase cost sharing is that poor people can’t afford it. The standard reply is that there is no reason to impose the inefficiency of first-dollar coverage on the whole health care system to address the fairness concerns of poor people. Meas- 

ured waivers of coinsurance, deductibles, and out-of-pocket premiums, like those already in place in the Medicare program, provide a solution. Of course, Rice does not believe that zero cost sharing increases inefficiency, but he and I disagree about that.

■ Summary. The central question, as Pauly notes, is whether our current system is optimally efficient or fair. The central question is whether the efficiency and fairness problems that exist are addressed best by imperfect government or by imperfect markets.

Rice’s objective is to have national health insurance proposals begin on an equal footing with market-based proposals for health care reform (p. 168). Before I could agree to that, someone would have to go further than pointing out market imperfections that are, for the most part, well recognized by health econom- 

ists and common to many sectors of the economy that seem to function well enough. I would have to be shown that the problems of regulatory capture, self-serving and self-per- 

petuating bureaucracies, homogeneity restrictions (imposed on government charity but not private charity), and a host of other sources of “government failure” are less problematic than market failure is. I also would have to understand why the outcome of a national health insurance proposal would differ from Medicare—the best example we have of our government’s inability to run a nationalized health insurance system. Medicare ap- 

pears to have taken up permanent residency on the brink of fiscal insolvency; has been blocked politically from implementing even the simplest efficiency-improving competitive-bidding arrangements; would not be able to provide its beneficiaries with anything approaching the benefits enjoyed by the privately insured population were it not for an irrational HMO payment system and con- 

tracts with private-sector health plans; and transfers income from the poor to the wealthy.

The U.S. health care system is by no means ideal, but neither is it adrift. Rather, it is the aggregate of hundreds of tradeoffs. Restricted market entry counters poor information. Risk protection is traded against moral hazard. Moral hazard also is countered by the restric- 

tions of managed care. The awkwardness of employment-based health insurance counters adverse selection. Any of these decisions could be wrong. All constantly are being called into question, mostly by U.S. health economists. The same is true of our decisions regarding fairness. The working poor pay taxes to subsidize the health insurance premiums of aged multimillionaires. Our Medicare HMO payment policy allocates the most generous benefits to the healthiest beneficiaries, while the old and poor remain in a bare-bones fee-for-service system. These decisions provide the best evidence of our government’s inability to allocate health care resources fairly and efficiently, and I do not find in them any encouragement for the national health insurance position.

As Pauly noted in 1997, “[Economic] theory tells us that, at best, the ideal market can tie an ideal government, not that it can do better.” The reverse also is true. But the ideal government can tie the ideal market only if consum- 

ers are indifferent between bundles of goods that they are assigned and bundles of goods that they freely choose. As Rice reminds us twice (pp. 81 and 155), “It does not take much introspection to realize that the latter may indeed result in higher utility.” We need more such introspection, and if Tom Rice’s work can inspire it, his work will deserve even more awards than it has already received.

NOTES
3. Ibid.