

Too Much of a Good Thing?

By Max Borders

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Max Borders: Joining us today is Arnold Kling, author of the new book [Crisis of Abundance: Rethinking How We Pay for Healthcare](#). Our guest received his PhD in economics from MIT, is an adjunct scholar of the Cato Institute, and you probably know him as a TCS columnist and contributing editor. As always we're happy to have him.

Welcome Arnold.

Arnold Kling: Thank you.

Borders: As Americans we spend a large percentage of our GDP on healthcare. In your book you write that there are three primary explanatory narratives for why we spend so much. What are they?

Kling: Let's see if I can remember what I wrote. One of them, which is the one I believe the most, is the narrative that I call "premium medicine" -- that we have developed lots of procedures that involve specialists and involve expensive equipment and that have very high cost, but not always very high benefits. Another narrative is: people blame the insurance industry -- that it's somehow more expensive compared to the alleged efficiency of socialized insurance. And the third narrative is that prices are too high in general. That somehow our doctors and our pharmaceutical companies and other providers charge us more than comparable providers charge elsewhere.

Borders: And you think the most plausible explanation is the first. That is, diagnostic and medical technologies have emerged in the last 30 years. How have these wonders changed our healthcare expectations?

Kling: Well, it's not just diagnostic technologies. It's also specialists. There are about four times the number of gastroenterologists and about seven times the number of diagnostic radiologists, and so on. So we've got many more specialists. It's created just a lot more opportunities for doctors to take precautions. And there is a general cultural expectation that, when you want it, walk into the doctor's office and the doctor's going to completely diagnose your problem and launch a quick treatment. The reality is, even with all these procedures they often can't identify the exact problem, and often treatment is the same regardless of what they choose.

Borders: I remember reading something in the book about what you might expect to receive in terms of care in 1975 and what you might expect today. And there is a big difference in what's offered in all this new technology and with all the specialists. But the fact is, we're not living all that much longer.

Kling: I would say we are. The increase in longevity is progressive. It seems to be a quarter year per year...but it's not clear that it's due to healthcare. A lot of it is just due to better lifestyle. Your main determinants of health are probably things like genetics, the conditions at the time you were born, not having lots of infectious diseases when you're young, and so on. Healthcare comes in pretty low on the list of the things that affect longevity. So most of what we're seeing now is greater precautionary medicine. You know, last year about 50 million CAT-scans were done; about 25 million MRIs. If you go back to 1975 you might have a couple million CAT-scans and no MRIs, yet the overall quality of diagnosis has not gone up nearly as rapidly.

Borders: Let's say if the average consumer had a better handle on the economics of healthcare -- particularly with regard to risks and benefits -- could we make wiser choices and lower our costs?

Kling: I believe that's true. It's something that has to be nailed down on a case-by-case basis. I describe the three most expensive healthcare procedures I've been through in the last 10 years, all of which could be questioned, and none of them affected my treatment. All of them involved specialists and expensive diagnostic procedures. I'll tell you: the classic example is hurting my back moving furniture. I got sent for an MRI. If, knowing what I know now about what MRIs typically do for people who have a specific back injury (as opposed to something that they can't attribute the symptoms to), I would say: if you have to pay for it, you shouldn't go get your own MRI. You shouldn't get an MRI when you hurt your back. It rarely affects the treatment plan.

Borders: So how can the average person get this kind of information, particularly since doctors and specialists are primary authorities and they're the ones recommending this stuff?

Kling: I think our system insulates the consumers from having to worry about that information. 85 percent of our healthcare is paid for either by government-paid insurance or by employer-provided health insurance, or what have you. So no one really has the incentive to pay attention to it. If you wanted to find out the economic information, tell the doctor that you're not going to get insurance; or that it probably won't pay for the procedure. Then the doctor will probably give you a more straight-forward assessment of the costs and benefits. But why would you care? If you've got the employer insurance going for you, why not just go ahead and get the procedure?

Borders: Right. But on the aggregate these costs add up for everyone. These are isolated choices we make, and we're insulated from the effect of these decisions,

because third-party payments -- whether that would be a socialized form or private insurance -- we're still sort of insulated from the incentive systems. I guess you could say this causes aggregate market distortions. Is that a fair assessment?

Kling: Yes. That would be my biggest concern about the US healthcare system. We have all these resources available and all these incentives to use them. In everything else, the incentive is to compare the benefit to the cost. So my Cato colleague Mike Tanner says "well, you know Americans are richer. They're spending more money on shoes and they're spending more money on healthcare. What's the big deal?" Well, the difference is that when they spend money on shoes, they're paying attention to the cost when they make that decision. And they know if they're paying the price when they make a mistake. With healthcare, 85 percent of the time it's not your nickel. So the incentive is to consume as long as there's some benefit, rather than consume only with the benefit and not the direct cost.

Borders: So if we were to move to a system that built in these incentives -- where the individual consumers of healthcare feel these incentives, or feel the pain -- what would it look like? What would be the policy prescription?

Kling: That's what I go into with length in the book. I think healthcare would mostly consist of long-term catastrophic coverage, so that you would have to accumulate 10-, 20- or \$30 thousand worth of cost over a period of several years before insurance would kick in. So that would make health insurance more like other forms of insurance that pay off rarely, but pay off when you need it most. You don't make claims on your fire insurance every year. You don't make claims on your car insurance every year. But people who have health insurance typically make claims on their health insurance every year. So you would start with this -- some kind of long-term catastrophic health insurance so that people would be paying much more like 50 percent of their overall health costs instead of a lot of these small-dollar health costs. That has its pluses and minuses which we can go into.

Borders: Let's suppose you created this incentive system where I might opt as an individual to forego the MRI, say, when I hurt my back. Or let's suppose that I'm a woman and because I hurt my back I get an MRI. I find through this MRI that I have a certain kind of ovarian cancer that had caused me some back pain. Now this is one of those cases where it's very rare that the diagnostic tool, the highly expensive diagnostic tool involved actually discovered something that had saved a person's life. On aggregate we're not going to see this pay off, but as an individual we are. And yet these are the cases that are going to be in the newspapers, and that people are going to point to when we start talking about it in terms of public policy.

Kling: Yes. I think you're getting to an important point, which is: if people are just faced with the cost but they don't have knowledge, then there's at least a good

of chance that they'll forego useful and necessary care as they'll forego unnecessary precautions. So I want to be careful. Like on this case of your back pain and your MRI. If you're having back pain that you can not attribute to any specific event and it's been going on for a while, that's a very different symptom than if you moving a piece of furniture and hurt your back. If you move a piece of furniture and hurt your back, that's probably not ovarian cancer. So you can have this specific event that caused it. If you have this back pain that you don't know where it came from, how it started and what makes it come and go, then you've got more of a reason to investigate.

Borders: This is more a situation of weighing risks and benefits and allowing people to make certain kinds of cost decisions based on more accurate risk/benefit assessments.

Kling: Right.

Borders: You want to be armed with information.

Kling: Yes. And one of the recommendations in the book -- and this is probably unusual from a libertarian perspective -- is that the government charter some kind of commission analogous to what the UK has called their "National Institute for Clinical Excellence". Such an entity would study cost and benefits and do good analysis. In my book, I argued people would have not just medical knowledge, but statistical knowledge and economic knowledge, based on a set of standard recommendations that consumers could use. So a consumer could say "OK well, this is what's standard here, do I want something that's more expensive that takes more precautions, or am I willing to take something less expensive than the standard?" But they would have some kind of benchmark to go by. Because I think right now if you dumped the decisions into the hands of consumers with today's levels of information, it's a reasonable criticism that you would see a lot more mistakes being made.

Borders: Switching gears here momentarily: how concerned should we be about the growth of Medicare spending based on your analysis?

Kling: Well, the growth of Medicare spending is, I think, the number one concern in the whole healthcare area because we have no way of financing the spending going forward. I think within a few years, Medicare's going to start running deficits, and then those deficits just progressively accumulate over time to trillions of dollars. It's a problem no one wants to address, but it's by far the biggest problem in medical care. Because when you have the private sector's spending money, there are just natural limits on what people will spend; so there's some process for controlling it. But with Medicare there's no process for controlling it.

Borders: So would Medicare be the single policy change that you would make if you could? Or what would it be?

Kling: Yes, I think the biggest elephant in the room is Medicare. What I propose there is again a form of long term catastrophic insurance. Right now, if you're about to hit 65 -- on average -- you're spending between now and the end of your life would be \$100,000. We don't tell people to save a \$100,000 by the time they're age 65. But we should be telling them to do that. That would be the biggest policy change I would make. I would make changes that are designed to encourage people to save that \$100,000 between the time they're 30 and the time they're 60, rather than relying on Medicare.

Borders: You may have touched on this a little bit, and this is the final question, but the title of the book is 'Crisis of Abundance'. So what is the abundance to which you refer and how can abundance lead to crisis?

Kling: The abundance is the abundance of technology and specialization. It only leads to a crisis if you have incentives to over-utilize it and particularly incentives to over-utilize it that put the burden of paying for it on the government (that is, taxpayers). Unfortunately, particularly with Medicare, that's the situation we're in.

Borders: Is there anything else you would like to touch on here at the end?

Kling: Well, I think one thing. There are various views on the right. Mine is probably a bit unusual. But the right is often put in the position of trying to defend our existing so-called private insurance system. I prefer to think of our insurance system as not being very private and being sort of more corporatist in the sense of designed by government and implemented by private firms. Then it seems clear that what politicians are looking for is a free lunch that lets people get the same healthcare services they get now, lets providers be paid the same amount for these services they're paid now, and somehow for costs to fall. The politicians all want these free-lunch solutions. But the economics doesn't support any of them.

Borders: Arnold Kling, thank you very much.

Kling: Thank you, Max.