

# Regulation

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## The Price Is Wrong

REVIEWED BY DAVID R. HENDERSON

### Priceless: Curing the Healthcare Crisis

By John C. Goodman

370 pages; Independent Institute, 2012

Whether Mitt Romney wins the presidency or President Obama is re-elected, they and Congress would be well advised to read and digest John Goodman's book *Priceless*. The reason is that whoever is president will soon find himself facing unintended, but often predictable, consequences of the new health care law and also of previous laws. Goodman, a health economist and president of the National Center for Policy Analysis, has a lot to say about the Patient Protection and Affordable Care Act (often called "ACA" or "Obamacare") and about many other pressing issues in the economics of health care and health insurance.

Goodman has been studying health economics for over 30 years, and it shows in the wide range of issues he addresses in the book. Whether the issue is Medicare or

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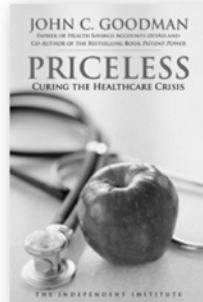
Medicaid, health savings accounts, the tax treatment of health insurance, the costs and effects of preventive health care, the wastefulness of "single payer" health care systems, or the perverse effects of Obamacare, Goodman brings an encyclopedic knowledge to the issue. A reader who is skeptical of his claims can check one of the literally hundreds of studies and government documents that he footnotes. Goodman alternates between being an idealist who wants to get government out of health care, and being a policy analyst who takes certain goals as given—such as having government give health care aid to low-income people—and considers more efficient ways of achieving them. So, whether you want to make a case for complete separation of health care and state (as I do), or you're a legislator who wants to make incremental improvements away from current dysfunctional health care policy, much in this book will inform and help you.

**Engineering vs. prices** | The book's title, *Priceless*, is a play on words. On the one hand, we often use the word "priceless" to suggest that something is very valuable. On the other hand, as Goodman shows

again and again throughout the book, much of health care is priceless in a narrower sense: When we buy health care, we usually don't know the price until after we buy it. Moreover, someone else—the government, say, or an insurance company—pays a large part of the price. Those two facts mean that we can't let the prices of health care guide us in our use of this scarce resource the way we can use the price of, say, ground beef or airline flights to guide our purchases of hamburgers and seats on airplanes. Specifically, we overuse artificially low-priced health care. One of Goodman's main goals is to introduce prices into the health care system in a meaningful way and to do so mainly by deregulating and getting rid of the many regulatory distortions that distort the health care system.

Strong evidence for Goodman's view that there are good effects from having consumers face real prices for health care comes from the area of cosmetic surgery. Such surgery, he notes, is rarely covered by insurance. He points out that, unlike in most areas covered by insurance, patients can typically find a package price that includes all services and facilities and compare prices prior to surgery. Moreover, he notes, prices adjusted for inflation have fallen over time as technology has improved. He notes that for the kinds of surgery covered by insurance, improvements in technology are blamed for rising prices.

A dominant theme in health care reform is what Goodman calls "the engineering approach." This is the idea that all we need to do is figure out what works in health care and then have everyone do it. That engineering approach is an example of Hayek's "fatal conceit," the idea that government officials can design a plan better than the various plans that the market spontaneously creates. The ACA is chock full of such conceit. One instance in the new law is Accountable Care Organizations (ACOs) in which, as Goodman puts it, "a federal bureaucracy will virtually dictate the way medicine is practiced." He lays out the ways in which the ACA will muscle doctors into this federal straightjacket.



Goodman uses his understanding of how actual markets work to point out the flaws in the engineering approach. The basic flaw is that there's no single, specific solution to each problem in health care. He even gives a name to his critique: Goodman's Nonreplicability Theorem. He writes:

Scholars associated with the Brookings Institution identified ten of the best hospital regions in the country and then tried to identify common characteristics that could be replicated. There were almost none. Some regions had doctors on staff. Others paid fee-for-service. Some had electronic medical records. Others did not. A separate study of physicians' practices found the same thing.

Much positive change in the rest of the economy happens because of entrepreneurship, notes Goodman. Why should medical care be any different?

Because both governments and insurers keep the prices of health care artificially low, writes Goodman, we use too much of it. We were already doing that before the ACA. The U.S. tax code gives employers an incentive to provide overly generous health insurance, with low deductibles and low co-payments, as a way of paying tax-free compensation to their employees. This fact, which virtually every American economist who studies health care is aware of, is not given as much prominence in Goodman's book as I had expected. Possibly that's because he and co-author Gerald L. Musgrave dealt with the tax law at great length in their 1992 book *Patient Power*. Obamacare will make the overuse problem worse. Goodman points out that under the new law, insurers will not be able to charge their customers specific fees for a number of "preventive care" services such as annual prostate cancer tests for men and annual mammograms for women in their 40s—tests whose medical value is now questioned.

Goodman's solution on the tax side is to make employers' contributions to their employees' health insurance taxable, but then to have the government give a \$2,000 tax credit per person to be used toward health insurance. Families with many children would get huge tax credits. His plan has some additional complexities. For instance,

if people in a geographical area don't claim the whole tax credit, then the local government in that area would get the unused part of the credit as a block grant from the federal government to be used for indigent care. I'm skeptical about how well this would work. First, the local government doesn't have a strong incentive under Goodman's scheme to use the money well. Second, one can imagine a city government fighting a county government over who gets how much of the block grant. My own view is that a better way to end the distortion is simply to make all employer contributions to employees' health insurance taxable, but then make the change revenue-neutral by dropping marginal tax rates by a few percentage points.

Goodman's other solution to the overuse problem is Health Savings Accounts (HSAs). In fact, he is often called the "father" of HSAs. The idea is that an employer gets to deposit up to a few thousand dollars per year in an employee's HSA, modeled on a Roth IRA, and the employee can use that money for various health care expenditures. Any unused funds in a year would simply accrue and employees would have an incentive to economize on health expenditures in order to amass funds for future expenditures.

**Right to health care?** | One nonstarter that Goodman does an excellent job of criticizing is single-payer health care. He notes that there are only three countries in the world with single payer: Canada, Cuba, and North Korea. It is literally illegal in those countries for an individual to pay for health care. (There are some exceptions in Canada, mainly for services that Canada's single-payer system does not cover.) Under single payer, the government sets a zero price to the patient and then pays the providers. With a zero price, he notes, there is rationing by waiting. Goodman constructs a plausible example to show that such rationing by waiting can add dramatically to the cost. People pay twice: patients with their time and taxpayers with their money.

Goodman also has some striking tables showing that, for some services, uninsured people in the United States get the same or more health care than people in single-

payer Canada. For example, 65 percent of uninsured American women aged 40 to 64 have had a mammogram within five years; in Canada, it's the same percent. Some 31 percent of uninsured American men have been tested for prostate cancer versus only 16 percent of Canadian men. Moreover, in Canada only 5 percent of women and 5 percent of men have ever had a colonoscopy, versus 30 percent of American women and 29 percent of American men.

These data, plus the fact that Canadians wait so long to see a doctor and to get surgery, help to make another point that Goodman discusses: the supposed "right to health care." When I hear people say that people have a right to health care, I take on the moral issue with moral reasoning, questioning whether health care is something that a person can truly have a moral right to. Goodman does it differently—and effectively. He points out that Canadians don't have a right to health care. How can you say it's a right if people aren't guaranteed to actually receive the health care service they need? The right to get in line for care, which is really all that Canadians are guaranteed, is not much of a right. And nothing in the Obamacare legislation makes health care into a right for Americans. Goodman writes, "[A] lot of knowledgeable people (not just conservative critics) predict that access to care is going to be more difficult for our most vulnerable populations." He argues that under the Massachusetts health care law adopted under then-governor Mitt Romney, which served as a template for the ACA, that has happened. "The waiting time to see a new family practice doctor in Boston," he writes, "is longer than in any other major U.S. city."

We often hear that one way to judge a health care system is to look at life expectancy, and that by that standard the U.S. system does substantially worse than other systems that cost less. But Goodman has a table showing that if you take out fatalities due to injury, which presumably are not much affected by health care, the U.S. life expectancy is the highest in the world. One troubling fact, though, is that in his table showing various countries' life expectancies, taking out fatal injuries actually reduces life expectancy in Japan, Canada,

Sweden, and a few other countries. It seems implausible that stripping out fatal injuries for any country *reduces* life expectancy.

**Health care spending** | Goodman has always been a critic of managed-care organizations and scores a number of points against them. Interestingly, though, he does not mention health economist David Dranove's finding, in his book *The Economic Evolution of American Health Care*, that managed care "bent the curve" on health care spending for most of the 1990s. In 1990, health expenditures were 12.5 percent of GDP and grew to 13.8 percent of GDP by 1993. In 2000, they were still "only" 13.8 percent of GDP. Part of this was due, of course, to strong eco-

nommic growth during that period, making the denominator, GDP, grow. But it's also true, as Dranove shows, that managed care restrained the growth of the numerator, health care expenditures.

What should be done about Medicare and Medicaid, two programs whose growth, if unchecked, would likely drive federal spending as a percent of GDP close to European levels by the middle of this century? Goodman considers various proposals too numerous to mention here, many of which seem promising. They range from health care "stamps," similar to food stamps, to Health Insurance Retirement Accounts (HIRAs).

Unfortunately, Goodman recommends that to fund the HIRAs, the federal gov-

ernment require employers and employees each to cough up 2 percent of pay annually. This is essentially a 4 percentage point tax increase, with the difference between this tax and the usual tax being that the employee gets to keep it. One problem with that policy is that, if implemented, it would cause Medicare to last longer. A better solution is for the government, and for free-market economists like Goodman, to start telling people under age 45 that Medicare is unlikely to be around in 20 years and that they had better plan for that fact. The result, if I'm right about the future of Medicare, would likely be a renaissance in health care for the elderly—one that, as Goodman shows throughout his book, is bursting to break out. The price would then be right. **R**