



## Commentary

Thomas Stratmann

Len Nichols identifies a number of problems in the current health care system. They include the rising cost of health care, the poor quality of services in the United States relative to some other countries, the possibility that employer-provided health insurance puts American employers at a competitive disadvantage in the global economy, and that many individuals are uninsured. I will discuss these issues in turn. I will then make some suggestions for improving the current health care system. Contrary to Len's proposal, I suggest making only *some* coverage compulsory—namely, catastrophic health insurance—and to not rely on extra taxes to finance health care services.

Currently the United States spends \$2 trillion on health care. The fraction of gross domestic product spent on health services has increased over many years, totaling now one-seventh of gross domestic product. Health care spending has risen because, on the supply side, quality of care has increased and often higher quality is associated with higher prices. But demand for health care services has also increased because of improved quality of health services and longevity. People live longer and thus demand more health care to maintain a high quality of life. Further, technological advances have given people more options for high-quality care. Treatment for ailments in the health care sector has a large discretionary component. Some people opt to be treated for mild depression, decreased mobility, cosmetic concerns, etc., others do not. As the quality of life-improvement services

increases, more people take advantage of these new options, as expected when quality of services rises faster than its price. This sum of circumstances can explain much of the increase in health care spending. At the same time, it would be interesting to know what would happen to demand if more patients were paying out of pocket.

To spend more on medical services and less on food or housing is an individual's choice, and from an economic perspective this is no problem if choices are not distorted, as for example through public subsidies. As we get richer as a nation, we may decide to devote more and more resources to health care, because our basic needs for food and housing are fulfilled, to further improve our quality of life.

An economist always thinks about so-called opportunity cost, that is, the value of a resource in an alternative use. Thus, from an economist's perspective, the question is not whether we spend too much on health care, but whether we can find some better ways to spend the \$2 trillion, either in the health care sector or in some other way.

Many of the improvements in longevity over the past century are attributable to improvements in health care. A recent article in the *Journal of Political Economy* by Kevin Murphy and Robert Topel (2006) has put a number on the value of this increased longevity: Between 1970 and 2000, the added value of increased longevity, after subtracting out the \$35 trillion in health care spending in this 30-year span, is over \$60 trillion. This shows

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that, at least in an absolute sense, our health care sector performs well.<sup>1</sup>

But do we fare well when we compare the performance of our health care sector with that for other countries? It may be the case that other countries that have comparable or higher rates of longevity, and at the same time spend less on health care, have a more efficient health care system. But there are several reasons that this is not necessarily the case. First, many other countries ration quality-of-life improvements, such as knee replacement, preventive angioplasty, back surgery, and breast reconstruction after breast cancer, and this rationing involves significant costs because patients have to wait for a long time for treatment, as for example in Great Britain. Longevity is only one part of measuring the performance of health care systems, and when it comes to quality-of-life improvements, it is not obvious that other countries do better than the United States. Second, another indicator that the quality of U.S. health care services is high comes from the fact that the United States is a leader in medical research. In fact, many citizens from other countries come to the United States seeking medical treatment. Finally, cross-country comparisons are difficult to make because individuals change their behavior in response to medical progress. In my own studies, I have shown that individuals engage in more risky behavior when they expect to be treated for diabetes and drug abuse (Klick and Stratmann, 2006 and forthcoming). So if there are medical advances in some countries that treat the consequences of obesity (such as diabetes), some people in this country will be less vigilant in their diets because they know that they can take advantage of the treatment options if they gain weight and become diabetic. The resulting increase in obesity will therefore somewhat offset the benefits of technological progress. Because technological progress changes people's behavior and because countries differ in their medical progress, sometimes meaningful cross-country comparisons of health indicators are difficult to make.

Is employer-based health insurance making U.S. firms less competitive in the global market?

Employer contributions to workers' health insurance premiums increase the total cost of labor. The fact that employers pay some of workers' health insurance does not mean that they pay the premiums on top of wages. Employers pay workers less than they would have if employers had not paid the workers' health insurance premiums. So, in the end, workers pay for health insurance premiums through lower wages. Some may argue that this occurs only in the long run, but in this case, the long run is probably not so long. Clearly, when health insurance premiums increase, employers may not be able to reduce workers' wages immediately. But it may be enough to pay for the increased premiums by giving workers a lower increase in wages. Wages have been fairly flat over the past decades, suggesting that employers might have paid for the increased premiums by not increasing wages. So, the time lag to pass on premiums is not necessarily very long. And this means that the argument that employer contributions make employers less competitive in the market place is incorrect, as workers bear the burden through lower earnings.

Clearly, many CEOs complain about high health insurance premiums, but that does not mean that this is the true underlying cause of their failure to successfully compete. For example, the Detroit car manufacturers do not have competitive problems because of health insurance premiums. Foreign car manufactures in the United States are also paying health insurance premiums and are doing quite well in the United States. The problem for the Detroit car manufacturers can be traced to past promises they have made to their workers, not their current payments of health insurance premiums.

What are the economic reasons for the concern that 16 percent of the current U.S. population is uninsured, besides possible humanitarian concerns? The uninsured are primarily healthy and young. So it is possible to view their decision not to take up medical insurance as their free and legitimate choice. The argument most often advanced against this view is that this is not their free and legitimate choice because the uninsured impose costs on the insured. This is because emergency rooms are required to treat every person, and if the uninsured do not pay their bills, then hospitals,

<sup>1</sup> In these comments I draw on [www.becker-posner-blog.com/](http://www.becker-posner-blog.com/), as well as the works cited at the end of this article.

taxpayers, or other insured people will pay for the costs of treatment. So, some individuals may decide not to become insured, because they know of the “free” emergency room treatment option. However, an article by Weber et al. (2005) in *Annals of Emergency Medicine* found no evidence that the uninsured are disproportionately visiting the emergency room. This study was based on interviews of 50,000 individuals who had visited the emergency room. The findings in this study may be due to the fact that the uninsured tend to be the young and healthy who have fewer reasons to visit the emergency room than the insured unhealthy individuals. Further, the incentive to visit the emergency room is not so strong, given that going to the emergency room is not particularly enjoyable, nor always the most appropriate treatment option for ailments.

Currently, those with employer-based insurance are subsidized by the government because workers do not have to declare the portion of the health insurance premium paid by the employer as taxable income. One problem with this arrangement is that it encourages workers to take, and employers to offer, more elaborate and expensive plans just because workers do not pay the full cost, for the tax deductibility benefits. Another problem is that this arrangement distorts the playing field between those who purchase insurance as individuals as opposed to through employers. One way to address this issue is to eliminate the tax exemption of employer-based plans. But if the goal is to get more people insured, it would make sense to extend the tax deductibility, up to a cap (to reduce the incentive to purchase expensive plans that offer little extra health benefits but are purchased only because they are subsidized) for individual plans. This tax deductibility would reduce the cost of individual plans, encouraging some of the currently 46 million uninsured to purchase health insurance.

Finally, it would make sense to mandate catastrophic health insurance. Catastrophic insurance covers events such as long-term illnesses that would deplete an individual’s or family’s resources. Compulsory catastrophic health insurance would reduce the likelihood that the uninsured free ride and push their costs of treatment off onto the insured and taxpayers. The cost of this policy would be low, because catastrophic events do not occur often. No additional subsidy would be required to help lower-income people to pay for this insurance, because they are already covered through Medicaid.

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