Unmaking the Myths

By Glenn Oakley

The health-care system is rooted in misconceptions and myth, says BSU economist Larry Reynolds

Feeling exhausted and worn out by all those health-care reform proposals? Got that tired, achy feeling from reading articles on universal health-care coverage and Hillary Rodham Clinton's give-and-take with the American Medical Association?

Then try Larry Reynolds' cure for the uncommon economy: question all your assumptions.

Boise State economics professor Reynolds has been studying and presenting papers on the economics of health care for the past decade. Before leaving for an international conference on the subject in Scotland, Reynolds noted that the reason he got interested in health care is because "it juxtaposes economics and ethics."

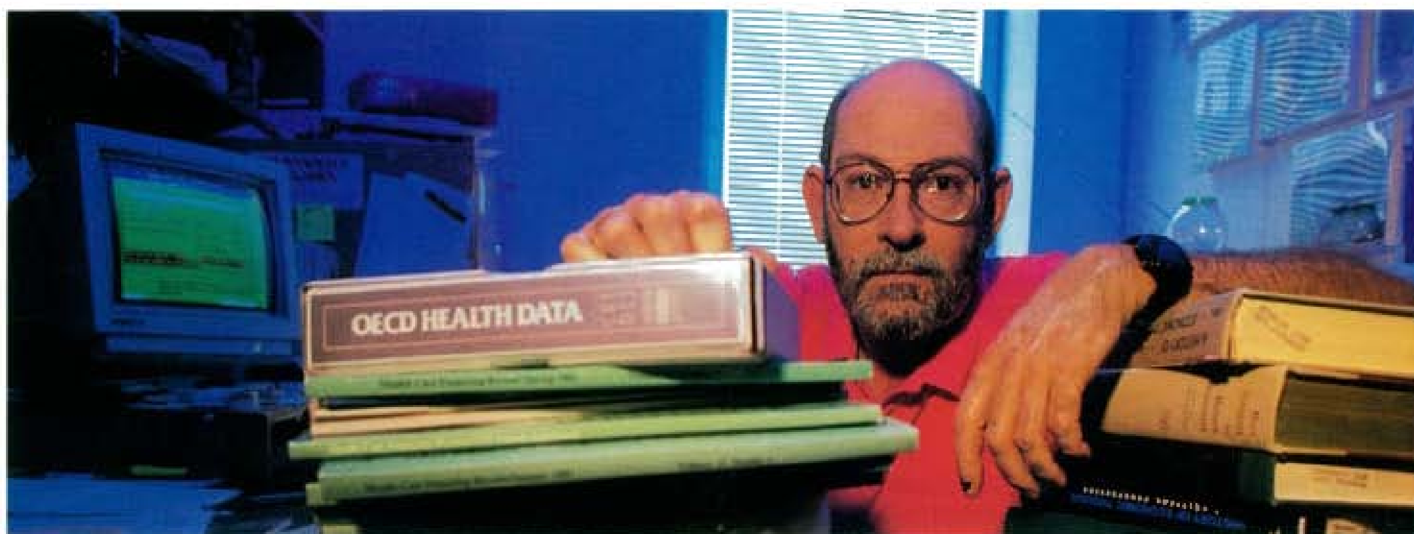
Reynolds maintains that the nation's health-care objectives have not been defined, and that current health policy is based largely on myths and misinformation.

The basic — yet largely unasked — question, says Reynolds, is: What is the health-care policy objective? Should everyone in America be entitled to health care? If so, does that mean everyone should be entitled to bypass surgery or transplants? Just exactly what does health care entail?

Reynolds is quick to interject that, "What we really want is health. Health care is not the same as health." Reynolds poses a hypothetical question: If the government has a limited amount of money to spend on health care, should it choose a new improved trauma center or highway improvements?

Of course this is a trick question to illustrate a point. Improving roads, Reynolds argues, may eliminate a certain percentage of highway accidents and thus might eliminate the need for the improved trauma center. It also spares the crash victims a certain amount of pain and suffering. The point is, says Reynolds, that health is a social, not a technological, problem, and requires a broader perspective.

If the nation decides that everyone in America is entitled to a certain amount of health-care coverage, then what is the best way to achieve that? Reynolds says we must start by acknowledging that much of our current understanding of health care in America is in fact based on myths.



GLENN OAKLEY PHOTO

Volumes of data prove that the health-care system is not part of the free market economy, says Reynolds.

A critical myth followed by physicians is the admonition that they should proceed with medical care as long as they *do no harm*, says Reynolds. Under this philosophy Americans incur their main health-care costs during the last six months of their lives. Aside from the ethical debate over heroic — and perhaps futile — efforts to prolong someone's life, Reynolds says there are hidden costs involved. Resources are finite and health care provided to the terminally ill is denied to someone else. "We may spend $300,000 to give you six months of life," he states. "But you may have cost the life of six neonatal infants. It's an allocation problem."

The statistics seem to support Reynolds. The United States spends 14 percent of its gross national product on health care, yet suffers from a higher infant mortality rate than England, Germany, Canada, Sweden and Japan, all of which spend far less on health care. The infant mortality statistics look a lot better for the United States if one looks solely at white Americans.

This leads to another myth: National health care will lead to health-care rationing.

Well, yes, says Reynolds, national health care would result in rationing. But, he says, "People talk like we're not rationing now. Rationing is based on some reasonable criteria. Discrimination is based on unreasonable criteria. Health care in America is discriminatory because it's based on whether you've got insurance and how much money you've got. ... If you're wealthy and have good health-care insurance you're going to love our system. You'll get the best health care in the world." But there remain 37 million Americans without health insurance, and even for those covered by health insurance, the extraordinary amount of money in America devoted to health care is a drain on the economy. U.S. automakers estimate health care costs add $1,000 to the cost of every car sold, for example.

Still, health-care reform will require tinkering with the free market, right? As Reynolds sees it, the American health-care system currently has nothing in common with a free market. There are characteristics inherent in health care that remove it from the free market, such as the irregular and unpredictable demand for health care, the uncertainty of recovery following treatment, and the imbalance in power and information between seller and buyer (physician and patient). Even more importantly, says Reynolds, "Since the doctor not only demands the care for patients but supplies it as well, there is a financial incentive to supply excessive amounts."

Reynolds says he switched doctors after his physician ordered a battery of X-rays. His doctor had recently purchased a new X-ray machine, which Reynolds found more than coincidental.

Reynolds believes competition in the health-care business may actually work to increase health costs. As an example he cites the proliferation of magnetic resonance imaging (MRI) machines. A 1986 study of 69 institutions in five states reported, "Several hospitals intend to use MRI as a loss leader. They lose money on MRI operations, if necessary, in hopes of increasing revenues from other services. The idea is that patients will be attracted to the hospital or referred there by their physicians because the MRI scanner enhances the hospital's reputation as an up-to-date, full-service hospital — a technology leader."

Still, aren't doctors always going to act in the best interest of their patitents? Reynolds argues that, "People have this mistaken belief that doctors are different than other people." When it comes to money, he says, "Doctors are no different than salesmen or anybody." The fear of lawsuits and the desire to provide maximum care for the patient may also contribute to what some view as overuse of X-rays, MRIs and other tests. But the end result is that the doctors make more money with every test, says Reynolds. "The incentives are to do really bizarre things."

Similarly, the promise of higher fees and greater prestige have led to a dearth of general physicians and an abundance — 30 percent of all physicians — of specialists, says Reynolds.

The patients contribute to the soaring costs of health care by overusing health-care services when covered by insurance. Since the insurance fees are already paid, says Reynolds, "Insurance is like going to a smorgasbord — you're going to eat all you can."

Even some supporters of health-care reform have reservations about government red tape further escalating costs while decreasing services. Former President Bush derided the idea of national health care as producing a government agency with the efficiency of the Postal Service and the compassion of the IRS.

Reynolds says that needn't be the case, and cites a study in the journal *Health Affairs* which showed administrative costs of private U.S. health-care insurance accounting for up to 24 percent of total health care expenditures, while administrative costs in Canada are 11 percent. Canada has a national health insurance system.

"You have to distinguish between micro-regulation and macro-regulation," says Reynolds, citing Medicare as an example of micro-regulation. "That kind of regulation I don't think will work."

Reynolds believes that despite the misinformation and mythinformation clouding health care, reforms will be made. But he doesn't expect a speedy recovery. "No matter what President Clinton does, it won't solve the problem. He's trying to redo one-seventh of the American economy in one year." ◻