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From Bismarck to Woodcock: The "Irrational" Pursuit of National Health Insurance: Comment

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COMMENT

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Professor Fuchs identifies three alleged irrationalities in the purchase of health insurance. The first is the widespread and growing tendency of governments to mandate or subsidize health insurance, encouraging an overutilization of health care. The second is the propensity of individuals to purchase first dollar insurance coverage even in the private market. The third is Leonard Woodcock's support of National Health Insurance (NHI). These are all supposedly evidence of a persistent overindulgence in the purchase of health insurance.[1]

The second piece of "evidence," irrational behavior in the private purchase of health insurance, may be disposed of quickly by demonstrating its nonexistence. Theory predicts that the degree of insurance coverage purchased by risk averse consumers will be positively related to the mean and variance of the distribution of expected losses. The degree of coverage of health care expenditures may be crudely measured by either out-of-pocket expense as a per cent of total expense (the coinsurance rate) or the reduction in variance achieved by insurance. The measure used by Professor Fuchs, that is, the number of privately held hospital insurance policies covering first-day hospitalization relative to the number covering long-term stays, is not appropriate because it ignores non-hospital items of health expenditure. Data from a 1970 national survey of medical expenditures shows that, for persons with annual medical expenses under $150, only 7 per cent was paid by insurance, and this percentage rises monotonically to 76 per cent for persons with annual expenses over $1,500.[2] Similarly, insurance covers a larger fraction of hospital expenses than expenses for doctor office visits, where the average total expense is lower. The per cent of variability (measured by the standard deviation of total expense) removed by insurance is greater for hospital expenses (59 per cent) than for doctor office visits (42 per cent).[3] Thus, the evidence is entirely consistent with economic theory.

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[1] Victor R. Fuchs, From Bismarck to Woodcock: The "Irrational" Pursuit of National Health Insurance, 19 J. Law & Econ. 347 (1976).

[2] These estimates are drawn from the analysis by Charles E. Phelps of data from household interview surveys, conducted in 1970 by the University of Chicago's Center for Health Administration Studies, reprinted in Charles E. Phelps, Private Health Insurance: A Special Report, 6 AMA Update (1974).

[3] These figures are for those with group insurance. The same pattern, at lower levels, emerges for those with nongroup insurance.

Turning now to the first point, which is the primary focus of the paper: it is asserted that insurance reduces the price the consumer faces at the time of purchase of medical care and, therefore, induces excessive demand. In the absence of perfect experience rating, this applies equally to private insurance for medical care and for any insured activity or event with a nonzero price elasticity of demand. People buy insurance voluntarily because insurance buys reduction in risk, in addition to medical care. The value of this risk reduction is presumably equal at the margin to the discrepancy between costs and benefits of medical care consumed plus the loading charge.

Thus NHI need not entail a welfare loss. The potential for a welfare loss arises only if the level of coverage under NHI exceeds that which would be purchased in the private market. Even in that case, the resulting level of consumption of medical care is not necessarily excessive. It is not inconceivable that in the absence of a subsidy the amount purchased would be suboptimal, due to monopoly pricing by physicians and other factors of production. Subsidizing health insurance would then induce a movement in the right direction, if not by the right amount or by the cheapest means.

Let us assume, however, that NHI does typically lead to an excessive consumption of medical care as defined by the private demand curves of individual consumers of medical care. Professor Fuchs then tries to identify sources of social gain, that is, gain to members of society other than the direct consumer, to offset this welfare loss. A basic problem with this approach to explaining the survival of NHI is that it presupposes a model of political decision-making that is probably unrealistic. It is only valid if political outcomes reflect the same weighting of preferences as do market outcomes. Given a one-man-one-vote endowment in the political sector, this will hold only if it is costless to buy and sell votes. One of the major contributions of George Stigler has been to focus attention on imperfections in the political market as a source of political decisions that are not necessarily Pareto optimal, and hence are apparently irrational by the Pareto optimality calculus.[4]

Eschewing this approach, Professor Fuchs identifies several potential sources of social gain from NHI. One is to control provider prices. If this were the main goal, surely it would be infinitely cheaper to abolish the government-created supports to monopoly in the medical sector. More plausible is the argument that medical care may have some public-good aspects which make its consumption valuable to others besides the immediate consumer. If this indirect demand is sufficiently widespread, then it may be efficient to fund the additional consumption by taxation rather than voluntary philanthropy. The public-good aspects need not be confined to the contagiousness of disease or the desire to equalize life expectancy, and are

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[4] For example, see George J. Stigler, The Theory of Economic Regulation, 2 Bell J. of Econ. & Man. Sci. 3 (1971).

not proved nonexistent by demonstrating that most of modern medical care is not related to these particular concerns. It is well known that health affects productivity in the market as well as the nonmarket sector. It is also not hard to believe that medical care enhances health, at least at the low levels of consumption of heath care by those whose consumption would be stimulated most by a move to compulsory coverage. Thus, it is invalid to look at the mean marginal product of medical care for the population as a whole in looking for the gain in moving to compulsory universal coverage. Consumption will be stimulated, and the potential for welfare loss exists only for those who consume more under mandatory coverage than they would purchase voluntarily. The marginal product of medical care for these individuals is likely to be well above the average for society as a whole. Thus, if a society accepts responsibility for some minimum level of economic well-being for its members, subsidizing health care may be an efficient form of welfare.[5]

The alleged increase in the level of this subsidy over time does not require that altruism be income-elastic. In the absence of a subsidy, the relative access of some groups in society to medical care may become increasingly unfavorable. The reason for this is that as insurance coverage becomes more widespread, the demand for medical care by those with insurance becomes more inelastic. Optimum prices charged by monopolistic physicians then increase.[6] In the absence of perfect price discrimination, prices faced by the uninsured will also tend to increase and their consumption of medical care fall. It is also likely that those with low income will be disproportionately represented among the uninsured. This is because the cost of insurance is higher for those without regular employment, even in the absence of any subsidy to employer-purchased insurance such as currently exists in the U.S. Group insurance enjoys cost advantages, in addition to any administrative economies of scale, because of saving on the costs of identifying the risk status of each individual in the group. If the group is formed for purchases other than the purchase of health insurance, it can be assumed to constitute a random sample from the population of that social status, so its expected expenditures on medical care are cheap to estimate. The loading fee will, therefore, be small relative to that charged on individual policies or to groups formed specifically for the purchase of health insurance, where there is a possibility of adverse selection. One of the advantages of compulsory national coverage is the savings due to eliminating the need to check the risk status of each individual by eliminating the possibility of adverse selection.

Thus, in the absence of NHI it is possible that the consumption of medical

[5] The question of whether the subsidy in kind achieves this goal more efficiently than would a simple income transfer remains unanswered.

[6] Martin S. Feldstein, The Welfare Loss of Excess Health Insurance, 81 J. Pol. Econ. 251 (1973).

care by low income groups in society will fall in relative and even absolute terms. For them, the marginal product of health care may be very high, and subsidizing their consumption may be an efficient alternative to other welfare programs. However, at least in the U.S., subsidization of health insurance is not confined to low income groups. The tax deductible status of health insurance premiums constitutes a regressive subsidy since the subsidy rate rises with the marginal tax rate. This requires some explanation other than altruism.

Finally, let me turn briefly to the other puzzles mentioned by Professor Fuchs. In assessing the rationality, in terms of self-interest, of United Automobile Workers' (UAW) support of NHI, it is surely necessary to look at the changes in costs as well as benefits under the particular proposal they support relative to the pre-NHI position. The various NHI proposals currently under consideration differ not only in the extent of the benefits, but also in the incidence of the taxes used to finance them. It is possible that the burden of costs might be shifted sufficiently to offset any loss in value of benefits to members of a group such as the UAW.

However, while redistributive gains might explain why a particular group supports a particular NHI scheme, if we adhere to the assumption that political markets function perfectly, this cannot explain a political decision in which the redistributive effects sum to a negative net outcome, as a general subsidy to health insurance seems likely to do. As suggested previously, an alternative explanation is that the political market does not function like the free market. This assumption usually prompts one to look for concentrated producer interests that dominate dispersed consumer interests. One reason Professor Fuchs rejects this model is that physicians opposed Medicare and Medicaid although their income subsequently rose relative to wages in general, and oppose NHI although it would increase the demand for medical care. But the model predicts that producer support for a stimulus to demand for their product will depend on their ability to capture the value of the increased demand. If government health care budgets are set at a level which does not cover the cost of the unconstrained increase in demand generated by NHI, producers will be unable to capture the potential rent.[7] It will be dissipated in nonprice rationing devices such as higher time costs of patients. It is, therefore, not surprising that physicians would support a general subsidy to health insurance such as that implied by the tax deductible status of premiums, but oppose a form of subsidy constrained by a line item in the federal budget, such as is likely for NHI. Second, producer support for government intervention is predicted to be inversely related to

[7] For international comparisons of physician earnings and expenditures on health care, see Joseph P. Newhouse & George A. Goldberg, Allocation of Resources in Medical Care from an Economic Viewpoint: Remarks to the XXIX World Assembly of the World Medical Association and Commentary (Rand Corp. P-5590, Feb. 1976).

their ability to restrict entry and set monopoly prices in the absence of government intervention. Medical providers seem quite able to maintain noncompetitive prices under existing arrangements. Their demand for a regulatory body to enforce cartel prices is, therefore, not surprisingly, low.