On the Use of Knowledge in the U.S. Health Care System

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As I sit down to write this essay, the shutdown of the U.S. Government enters its third week. The shutdown has been caused by the Republicans' effort to defund the Patient Protection and Affordable Care Act (PPACA). The GOP has opposed the health care reform because, according to its main strategist, "ObamaCare is going to be the end of the American free-enterprise health-care system" (Moore 2013). Democrats fight back, arguing that the reform is necessary because the existing health care system is inequitable and leaves many individuals without the necessary care. In the words of the late Democratic Senator Ted Kennedy, "what we face is above all a moral issue; that at stake are not just the details of policy, but fundamental principles of social justice and the character of our country" (Kennedy 2009).

Both sides of this highly politicized debate would benefit from studying Friedrich Hayek's exposition of the coordinating role of prices (Hayek 1937; Hayek 1945). In fact, Hayek's insights have a broader application: they illuminate many aspects of the health care conundrum ignored in the partisan talking points. For example, despite what Republicans seem to believe, the third-party payment system, along with the countless layers of contradictory regulations embedded of the pre-reform structure, render it unfit to the definition of a free enterprise. Nevertheless, ObamaCare does little, if anything, to address these problems. In this essay, I address the inefficiencies of the U.S. health care, in particular third-party payments, from the perspective of Hayek's contributions to the economic calculation debate.

COORDINATION PROBLEM IN THE THIRD-PARTY PAYMENT SYSTEM

One of the main issues in the health care debate is growing expenditure. According to the data gathered by Centers for Medicare & Medicaid Services (CMS), in the United States, health care expenditure has increased 40 fold since 1965. However, not the entire increase is contentious (Feldstein 2011). A small portion is attributed to the growth of income: wealthy people spend more on health care than poor people. Another fraction is attributed to technological innovation. More medical services are available now than in the 1960s; the health care of today offers a much richer bundle of products. There were no carbon prosthetics in the 1960s and no ventricular assist devices. And since the fact that Millennials spend more on personal computers and cell phones than Baby Boomers did, is not a policy dilemma, neither should be health care innovation.

This being said, majority of the expenditure growth, is not an outcome of innovation but rather is an indication of inefficiencies that pollute the system. Researchers agree that institutional matters, i.e. benefit levels and payment methods are the predominant reason behind the expenditure growth (Gerdtham et al. 1992; Hagist and Kotlikoff 2005). In this regard, 1954 brought the first major change when the Internal Revenue Service ruled that compensation in the form of health insurance is tax exempt. This policy lead to a dramatic expansion of the employment-based group health insurance and laid a founding stone under the third-party payment system (Thomasson 2003). The second change came in 1965 when government insurance for the elderly and the impoverished was established. These two changes generated third-party payment system under which insured patients are not financially responsible for their health care choices. As a result, since 1965, out-of pocket expenditure on health services has fallen from 79.5 to 52.6 percent (Feldstein 2011).

In the light of growing expenditure, government, hospitals, and private insurers experimented with a variety of cost containment measures. Among them were Medicare utilization reviews, restrictions on hospital investment, limits on physician fee increases, expansion of Health Management Organizations (HMOs), and introduction of Pay for Performance (P4P) programs. However, with an exception of HMOs, other measures had a negligible or even counterproductive effect on the growth of health care expenditure, contributing more to cost shifting than to cost containment (Fuchs 1993; Mays, Claxton, and White 2004; Orentlicher 2010).

THIRD-PARTY PAYMENT SYSTEM FROM A HAYEKIAN PERSPECTIVE

Would Hayek be puzzled by the ineffectiveness of cost containment efforts? Unlikely. Rather, he would attribute it to the poor utilization of knowledge in the third-party payment system. To Hayek, the economic problem that society faces is "how to secure the best use of resources known to any of the members of society, for ends whose relative importance only these individuals know" (Hayek 1945 p.520). In order to allocate resources to their most valuable uses, individuals need to know profitability of alternative applications. This knowledge, though, is dispersed throughout the economy. As a result, individuals require navigational aids and prices play fulfil this function by aggregating all relevant knowledge into a single index. It is because of prices that "without an order being issued, without more than perhaps a handful of people knowing the cause, tens of thousands of people whose identity could not be ascertained by months of investigation, are made to use the material or its products more sparingly; i.e., they move in the right direction" (Hayek 1945 p.527)

Prices, however, are meaningful only in the environment of private property rights. In the absence of private property, prices are meaningless; they contain no useful information pertaining to relative scarcity. As a result, they are of no help to decision-makers (Mises 1920; Boettke 1998). Viewed from the Hayekian perspective, the ineffectiveness of cost containment efforts is an unavoidable outcome of the poor utilization of knowledge due to the lack of private property rights. The third-party payment system is incapable of aggregating information, necessary for the efficient allocation of resources, because it operates in the commons.

For the same reason, Hayek would not be surprised by the results of the recent study that examined unwillingness of insured patients to consider health care costs in selection of medical treatments (Sommers et al. 2013). The study focused on patients who suffered from a prolonged headache. Observed patients were told, during an office visit, that Computerized Tomography (CT scan) would identify nearly all of the problems for a fraction of the cost of a Magnetic Resonance Imaging (MRI). For majority of the patients this information was of no consequence—predominantly, patients refused to limit their consumption to the less expensive option.

Interestingly, the researchers responsible for the study were taken aback by the findings. In the interview for a medical newsletter, one of the authors admitted that the team was surprised by "how firmly and frequently people talked about not wanting cost considerations to factor into decision-making at all" (Andrews 2013). This sense of surprise is foreign to anyone familiar with Hayek's elucidation of the coordinating role of prices: once private property rights and market prices are understood as the key elements in the process of knowledge utilization, there is nothing unusual about patients' immunity to changes in collective health care expenditure. Inefficiencies are an expected outcome of central planning, only individuals can judge the relative importance of different ends, it is the individuals that must be in charge of planning.

As if in a twisted response to Hayek, Obama administration now requires that hospitals reveal prices, or more accurately, the amount billed for an item or service. While the policy is supposed to help patients economize on health care, it is highly unlikely that Hayek would be satisfied with this move. The published database does nothing to improve the way in which knowledge is utilized in the system because published prices are not related to what the patients pay for the treatment. They are not even much related to what the insurance

companies pay. Rather, the list documents from what amount hospitals start to negotiate with an insurance companies.

Prices play their coordinating role by telling individuals how much of one good they would need to give up in order to obtain a different good or service. The mandated publication of hospital charges is of no consequence in this regard. The published prices have no impact on the trade-offs that patients face, they contain no information of how much of other resources to give up in order to get an additional medical exam. Instead, as can be concluded from Hayek's treatment of prices, what would make a difference is paying for the exam from one's own pocket. For example, it is reasonable to presume that, if the above survey was altered so that patients were offered a choice between an additional exam and $1,000, the findings would be significantly different (Cochrane 2013).

CONCLUSIONS

Hayek was not an anarcho-capitalist; he did not deny that there was a role for the government in a free society (for a fascinating overview see Caldwell 2003). This role however, in Hayek's view, should be minimized so that prices can play their coordinating role. As he argued in *The Road to Serfdom*, the more of the planning is done centrally, the more challenging planning becomes for the individual (Hayek 2009 [1944]). If Hayek could participate in the health care policy debate today, he would be in favour of proposals for a consumer–driven health care (Goodman 2012; Cochrane 2013; Topol 2012), with well-defined private property rights and little room for arbitrary intervention. Given his more specific policy recommendations, as outlined in the Constitution of Liberty (Hayek 1960), there would still be a collective element in the system. But its extent would be negligible compared to the current state of affairs and it would operate within laws predictable and equally applied laws.

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