SNG-health care-3-23-15

The opportunity costs of health care

By Jim Nowlan

When I was a boy in the 1950s, health care was simple. If you got sick, you went to the family doctor. I you were really sick, you went to the local hospital and stayed until you got better, or died. If you could afford it, you might go to Mayo's for the latest in care. Most costs came out of a family's pocketbook.

Today, especially as one ages, health care involves a cavalcade of trips to specialists, hands full of daily pills and robotic-driven surgeries to exorcise diseased growths. As relatively little of the costs now come directly out of our pockets, we insist on the latest and best care and technologies, and right away.

As a result, health care costs have gone through the roof and are expected to keep climbing.

According to the Center for American Progress, health care spending in the U.S., adjusted for inflation, increased by 818 percent between 1960 and 2010 while wages were going up just 16 percent. Per capita spending on health care is about $8,000 per year.

Economist William Baumol contends that we can afford the high costs of health care because of productivity increases elsewhere that bring the costs of other goods and services down.

Yet because about half of all health care costs are now borne by government via Medicare, Medicaid and government employee health plans, the costs to government of health

care have been squeezing spending for other programs such as education, social services and, especially in Illinois, pensions.

Economists call these "opportunity costs"—if you spend lots more on one program, the opportunity to spend those same dollars elsewhere is foregone.

I took a look at old Illinois budget books and found that between 1989 and 2009, state spending for education in Illinois did increase, even in inflation-adjusted terms, but spending for Medicaid increased four times as fast as that for the schools and universities.

In that period, spending Illinois Medicaid went from two-thirds of that for K-12 education to much more than for the school kids.

I also recall that in the same 20 year period, the state was socking away less than it should have been for its pension obligations.

Can anything be done to slow spending on the state's Medicaid program significantly? Robert Kaestner, an economist at the University of Illinois at Chicago who focuses on health care, is not optimistic.

First, the Illinois program is relatively low cost. According to data gathered by the Kaiser Foundation, in 2011 Illinois spent $4,477 per Medicaid enrollee, far less than the $5,790 average for the states, and among the lowest in the nation.

Kaestner says costs could be lowered by having patients pay something, by paying doctors less, and by using health care services less.

"The people in the program are poor by definition," observes Kaestner, "and cannot pay much."

Some states are, however, experimenting with requiring small co-pays by Medicaid patients, which could reduce use of services.

Doctors in Illinois are already paid much less by Medicaid than by Medicare and private insurers, so Kaestner doesn't see much potential here, as many doctors would simply stop seeing Medicaid patients if their reimbursements were cut.

Kaestner does see potential in moving more enrollees to risk-based managed, or coordinated, care. At present, much spending goes to pay a fee for each individual service provided, without coordination of care among providers that might reduce costs.

This could save up to 5 percent per enrollee, says Kaestner. As about half of Illinois's 3 million Medicaid enrollees are still not on managed care, this could potentially generate $300 million or so in savings.

Yet there is "no way," says Kaestner, that the Rauner Administration will be able to achieve the $1 billion in savings projected in the state budget for the coming year.

[Kaestner does think significant money could be saved in the state's expensive health care program for its own employees and retirees, which costs almost $3 billion a year, all state money.

[The economist says a high deductible, consumer-driven health care program as in Indiana could save much. But Kaestner doesn't expect the change to be made because of opposition to the idea from strong public employee unions in Illinois.]

Across the nation, health care costs are expected to continue to outpace the rate of growth in gross domestic product. These increases will be driven largely by technological advances and the aging of the Baby Boom generation.

Serious demands to constrain health care costs will only come when we in the body politic come to realize that the opportunity costs of ever more spending on health care are greater than the benefits. But that is the subject of another column.