

P E R S P E C T I V E

What Is Consumer-Directed Health Care?

Comparing patient power with other decision mechanisms.

by **John C. Goodman**

ABSTRACT: To control health care costs, someone must choose between health care and other uses of money. The value of most health care is experienced subjectively, as is the value of other goods and services. No one is in a better position to make these subjective trade-offs than patients themselves. The current system not only systematically denies patients the opportunity to make such choices, it distorts the incentives of providers in the process. Chronic patients in particular would be much better off if they could manage more of their own health care dollars and if providers were free to compete to meet their needs. [*Health Affairs* 25 (2006): w540–w543 (published online 24 October 2006; 10.1377/hlthaff.25.w540)]

CONSUMER-DIRECTED health care (CDHC) is a potential solution to two perplexing problems: (1) how to choose between health care and other uses of money, and (2) how to allocate resources in an industry where normal market forces have been systemically suppressed. Unfortunately, the paper by Melinda Beeuwkes Buntin and colleagues does not discuss the problems that CDHC advocates set out to solve.¹ Because they do not acknowledge that health care has to be rationed, the authors do not compare patient power with other decision mechanisms. Because they do not acknowledge that scarce resources must be allocated among unlimited wants, they do not compare price rationing with other rationing schemes. I promise to be more direct.

The Need To Ration Health Care

One of the cardinal beliefs of advocates of single-payer health insurance (and one that is shared by many advocates of the health maintenance organization, or HMO, form of health care delivery) is that health care should be free

at the point of consumption, regardless of willingness or ability to pay. But if health care really were free (and easily accessible), people would have at least an economic incentive to use health care until its value at the margin approaches zero. That would imply an enormous amount of waste.

Granted, the current system of third-party payment discourages many expenditures by failing to cover them (even if useful) and by erecting barriers such as waiting for care. But even the current payment system is unsustainable. Christian Hagist and Laurence Kotlikoff have shown that if health care spending grows at the rate of the past thirty years, it will equal one-third of national income by mid-century, when today's college students reach retirement age.² If private spending on health care keeps up with public spending, the nation will devote about two-thirds of its income to health care by 2050—roughly equal to total consumption of all goods and services today.

■ **Patients as choosers.** To avoid this disastrous scenario, someone must choose between health care and other uses of money.

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The question is: Who will that someone be?

Critics of CDHC are fond of pointing out that there are times when patient choice is not desirable or appropriate. They are, of course, correct. We do not want a parent to choose not to have her child vaccinated; or an at-risk expectant mother to avoid prenatal care; or a heart patient to eschew aspirin or beta-blockers. The reason: There is overwhelming evidence that the social benefits of such care exceed its social costs.³ Yet instances where we are sure that we know which alternative is best are rarer than one might suppose. At the other extreme, in thousands of cases, only the patient can make the right choice.

Take arthritic pain relief. The annual cost of brand-name drugs runs about \$800 more than over-the-counter (OTC) substitutes, and they are riskier (Vioxx and Bextra, for example, have been removed from the market). Is the extra cost and risk worth the marginal improvement in pain relief offered by the prescription drug? Since drugs affect different people differently, we cannot determine for someone else which is more valuable. So it is appropriate and desirable for people to make these decisions themselves—to reap the full benefits and bear the full costs of their decisions.

■ **Mechanisms for choosing.** Buntin and her colleagues define *consumer-directed health care* as high-deductible health plans. This is unfortunate.⁴ Although there is no doubt that high deductibles reduce spending, the question is: Why? Patients who are liquidity-constrained might forgo care—not because it is less valuable than other uses of money, but because (living paycheck to paycheck) they might not have the cash. This is why virtually all CDHC advocates endorse individual self-insurance through a funded account.

With a properly designed health savings account (HSA), people will not spend a dollar on health care services unless they get a dollar's worth of value.⁵ With a properly designed insurance plan, people will self-insure for expenses for which individual choice is appropriate and desirable.⁶ The HSA design required by federal law falls short of these ideals.⁷

The law also requires employers to make

the same deposit to every employee's account—despite the fact that actual health care costs vary radically among employees. Additionally, the law virtually forces employees to use their HSAs in a way that piggybacks on the current payment system rather than fundamentally challenging it. For example, even if the patient saves money by buying an OTC drug rather than a prescription drug, his or her spending does not count toward the deductible unless the OTC drug is covered by the plan (which is typically not the case).

Despite these defects, HSAs are a small but important step in the direction of a health care system in which individuals ration their own health care, instead of having those decisions made by impersonal bureaucracies or doctors who answer to those bureaucracies.

The Need To Allocate Resources

On average, every time Americans spend a dollar on physician services, only ten cents is paid for out of pocket; the remainder is paid by a third party—an employer, insurance company, or government.⁸ From a purely economic perspective, then, our incentive is to consume physician services until their value to us is only ten cents on the dollar. Clearly, we are not rationing health care on the basis of price.

In general, the physician's time is rationed based on patients' willingness and ability to pay for care with time rather than money. Physicians, by contrast, are paid by task. This suppression of the price system has been bad for patients in a number of ways.

■ **Lack of telephone and e-mail consultations.** Whereas lawyers and other professionals routinely communicate with their clients by phone and e-mail, it is very rare for physicians to communicate that way, even for routine prescriptions.⁹ Why? The short answer: They do not get paid for these types of consultations.¹⁰ Medicare does not pay for them, nor does Medicaid or most private insurance.

The fact that patients cannot conveniently consult with physicians leads to two bad consequences. First, the unnecessary office visitors (say, patients who have a cold) expect at least a prescription in return for their invest-

ment of waiting time, and all too often the drug will be an antibiotic. Were telephone consultations possible, the physician might recommend an OTC remedy, thus avoiding the cost of waiting for the patient and the cost of degrading the effectiveness of antibiotics for society as a whole.

At the same time, rationing by waiting imposes disproportionate costs on patients who need more contact with physicians: the chronically ill. This might be one reason why so many are not getting what they most need from primary care physicians and what is most likely to prevent more costly problems later on: prescription drugs.¹¹ The ability to consult with doctors by phone or e-mail could be a boon to chronic care. Face-to-face meetings with physicians would be less frequent, especially if patients learned how to monitor their own conditions and manage their own care.

■ **Lack of electronic health records.**

Whereas the computer is ubiquitous in our society and studies show that electronic health record (EHR) systems have the capacity to improve quality and greatly reduce medical errors, no more than one in five physicians or one in four hospitals have such systems.¹² Why are most medical records still stored on paper? Again, the short answer is this: There is no financial incentive not to do so. For the most part, we collect, manage, and distribute most medical information by means of “pen, paper, telephone, fax, and Post-It note” because doctors cannot get compensated for making an investment in computer technology.¹³

■ **Inadequate advice about drugs and other therapies.** Why do doctors so often prescribe brand-name drugs and fail to tell patients about generic, therapeutic, and OTC substitutes? Why do they typically not know the price of the drugs they prescribe or the costs of alternatives? Once again, the short answer is this: They do not get paid to know these things. Knowing the current best price, knowing where the patient can obtain that price, and knowing all the prices and availabilities of all of the alternatives is demanding and time-consuming. For the doctor, it is time that is not compensated.

■ **Inadequate patient education.** Numerous studies have shown that chronic patients can often manage their own care, with lower costs and as good or better health outcomes than with traditional care. Diabetics, for example, can monitor their own glucose levels, alter their medications when needed, and reduce the number of trips to the emergency room (ER).¹⁴ Similarly, asthmatics can monitor their peak airflows, adjust their medications, and also reduce ER visits.¹⁵

The problem is, to take full advantage of these opportunities, patients need training, which they rarely receive. ER doctors could save themselves and future doctors the necessity of a lot of future ER care if they take the time to educate the mother of a diabetic or asthmatic child about how to monitor and manage the child’s health care. But time spent on such education is not billable.

■ **Lack of competition for patients.** One consequence of rationing by waiting is that doctors have little incentive to compete for patients the way other professionals compete for clients. Unless a primary care physician is starting a new practice or working in a rural area, his or her time is usually fully booked. As a result, neither a loss of some existing patients nor a gain of a few new patients has much effect on the doctor’s income. Loss of some existing patients, for example, would tend to reduce the average waiting time for the remaining patients. But with shorter waiting times, those patients would be encouraged to make more visits. Conversely, a gain of new patients would tend to lengthen waiting times, causing some patients to reduce their number of visits. Because time, not money, is the currency we use to pay for care, the physician doesn’t benefit (very much) from patient-pleasing improvements and is not harmed (very much) by an increase in patient irritations.

Rationing By Waiting Versus Rationing By Price

Virtually all of the features of our health care system discussed above are the direct result of the way in which we pay for health care. We compensate physicians in ways that are

different from the way we pay for other professional services, and those differences create problems in the medical marketplace that do not arise (at least to the same degree) in other markets. The principal payment methods, moreover, are not the natural result of free market forces. They are instead the product of distortions created by public policies.

Would physicians practice medicine differently if they were paid differently? There is ample evidence that the answer is yes. Unlike other forms of surgery, the typical cosmetic surgery patient can (1) find a package price in advance covering all services and facilities, (2) compare prices prior to the surgery, and (3) pay a price that is lower in real terms than the price charged a decade ago for comparable procedures—despite considerable technological innovations in the interim.¹⁶

Ironically, many physicians who perform cosmetic surgery also perform other types of surgery. The difference in behavior is apparently related to how they are paid. A cosmetic surgery transaction has all of the characteristics of a normal market transaction in which the seller has a financial interest in how all aspects of the transaction affect the buyer. In more typical doctor-patient interactions, doctors are not paid to be concerned about all aspects of care and therefore typically ignore the effects on the patient of the cost of time, the cost of drugs, and other ancillary costs. And what is true for U.S. doctors in general is also true of doctors who practice in the government-run health systems of other developed countries.

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NOTES

1. M.B. Buntin et al., "Consumer-directed Health Care: Early Evidence about Effects on Cost and Quality," *Health Affairs* 25 (2006): w516-w530 (published online 24 October 2006; 10.1377/hlthaff.25.w516).
2. C. Hagist and L.J. Kotlikoff, "Health Care Spending: What the Future Will Look Like," Policy Report no. 286 (Dallas: National Center for Policy Analysis, 28 June 2006).
3. See T.O. Tengs et al., "Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness," *Risk Analysis* 15, no. 3 (1995): 369-390.
4. An irritating feature of Buntin and colleagues' paper is that the authors appear not to have read anything that CDHC proponents have written, even while commenting on their goals and objectives. The term was introduced by Harvard Business School professor Regina Herzlinger. See R.E. Herzlinger, ed., *Consumer-driven Health Care: Implications for Providers, Payers, and Policymakers* (San Francisco: Jossey-Bass, 2004); and R.E. Herzlinger, *Market-driven Health Care* (Reading, Mass.: Addison-Wesley, 1996). The concept of the health savings account was first introduced in J.C. Goodman and G.L. Musgrave, *Patient Power* (Washington: Cato Institute, 1993).
5. M.V. Pauly and J.C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs* 14, no. 1 (1995): 126-139.
6. J.C. Goodman, "Designing Health Insurance for the Information Age," in *Consumer-driven Health Care*, ed. Herzlinger, 224-241.
7. J.C. Goodman, "Making HSAs Better," Brief Analysis no. 518 (Dallas: NCPA, 2005).
8. C. Smith et al., "Health Spending Growth Slows in 2003," *Health Affairs* 24, no. 1 (2005): 192.
9. Health on the Net Foundation, "Evolution of Internet Use for Health Purposes," February/March 2001, <http://www.hon.ch/Survey/FebMar2001/survey.html> (accessed 11 July 2006).
10. C. Wiebe, "Doctors Still Slow to Adopt Email Communication," *Medscape Money and Medicine* 2, no. 1 (2001).
11. See J.D. Kleinke, "Access versus Excess: Value-based Cost Sharing for Prescription Drugs," *Health Affairs* 23, no. 1 (2004): 34-47.
12. R. Hillestad et al., "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs," *Health Affairs* 24, no. 5 (2005): 1103-1117.
13. J.D. Kleinke, "Dot-Gov: Market Failure and the Creation of a National Health Information Technology System," *Health Affairs* 24, no. 5 (2005): 1246-1262.
14. See S.L. Norris, M.M. Engelgau, and K. Narayan, "Effectiveness of Self-Management Training in Type 2 Diabetes: A Systematic Review of Randomized Controlled Trials," *Diabetes Care* 24, no. 3 (2001): 561-587.
15. P.G. Gibson et al., "Self-Management Education and Regular Practitioner Review for Adults with Asthma," *Cochrane Database of Systematic Reviews* no. 3 (2002): CD001117.
16. D.M. Herrick, "Why Are Health Costs Rising?" Brief Analysis no. 437 (Dallas: NCPA, May 2003).