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Facing the facts on health-care reform

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Scientists like to distinguish between so-called positive and normative statements. The former relate to factual explanations, while the latter are likely to entail opinions about what ought to be.

Obviously, that distinction is easier described than accomplished because even the decision about what to research reflects a judgment - namely about what is important.

This deeply philosophical question aside, it is apparent that the current debate (very normative) over health care reform could benefit from discussions that are more steeped in fact.

So, where does one look for accurate information in a debate that is fraught with influence by powerful interest groups, shaded with ideological blinders and sometimes outrageously disingenuous?

Peer-reviewed academic journal articles and reports by respected scientific bodies are always a good source for fairly unbiased analysis.

The current debate over health care reform revolves around two issues: costs and access. All sides seem to agree that costs need to be reined in. As for access, some appear to use potentially higher costs - inherent in making medical insurance more widely available - as a bludgeon to beat back attempts to close the gaping hole in coverage in the nation.

Others like to ignore or downplay the costly effects of suddenly adding tens of millions to the insurance rolls.

Unfortunately, those who claim to champion free markets and free enterprise sometimes get even the basic economics wrong. Stating that any effort to lower cost would suddenly get us to a system, which involves rationing, is like declaring that switching from private cars to public transportation will make us drive.

In either case, driving would be involved.

Moreover, it is indisputable that our marked based health care system is utilizing prices and individuals' ability to pay to ration (!) access.

As almost always in economics, the question is not if rationing will occur, but in what manner it should be institutionalized.

Markets usually excel at using the pricing system to beget efficient outcomes. However, it's no accident that health care markets often are textbook examples for so-called market failures.

Those are situations in which government intervention may (!) sometimes improve market outcomes. Thus, some additional government-induced transparency and accountability might transcend a situation in which the U.S. pays more for less per person in terms of health outcomes than other nations.

A report this week - available online at tinyurl.com/p2yv4f [1] - by the Institute of Medicine, a member of the highly respected National Academies, should be used as guidance in that effort.

The institute laid out a list of 100 priorities to improve our knowledge about the comparative effectiveness of treatment options.

The need for such an effort is reinforced by a recent article in the often-cited New England Journal of Medicine under the title "Slowing the Growth of Health Care Costs - Lessons from Regional Variation" (available at tinyurl.com/d86b66 [2]).

The authors found evidence that it is not necessarily newer (more expensive) technology, but variations in treatment choices by physicians that led to cost differences.

Moreover, higher expenses did not result in better outcomes.

Such details might come as a surprise to many entrenched interests on all sides of the health care discussion.

No matter what comes out of this debate, if it does not result in changing the disturbing pattern of us paying (much) more for less, then it will have been a failure - and that is a fact.

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