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Commentary Open Access

The Seven Myths of Health and Health Care

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Commentary

This contribution purports to expose seven myths about health, the nature of health care and its providers, and the role of the state. The author has been dealing with them during his 35 years of research and teaching in health economics.

Myth No. 1: Health must not be compromised in any way

Yes, health is of great importance to us all, and hardly anyone is prepared to sacrifice it in the way one is willing to go without a vacation in order to be able to buy new furniture. Yet when it comes to health risks, most of us take chances. Recall having run across a busy street on red just because there was a meeting not to be missed? Evidently, we accept a slightly smaller probability of being healthy in return for a benefit (which may not even be that great). Evidently, we perform trade-offs also when the chance of being healthy is at stake.

Myth No. 2: Health is a public good

Decades ago, health and health care did have a public good characteristic in the face of communicable diseases. If I get a vaccination, the likelihood of someone else being infected is reduced. However, by now health and in particular health care services have become goods that are as private as anything in most countries. My physician is expected to devote time and effort to me and no-one else, and that hospital bed must not be occupied by someone else. What is public is the financing of health care through taxes and insurance contributions, which are not scaled to risk – in contradistinction with just about any line of insurance (think e.g. of car insurance with its experience rating, also known as bonus-malus scheme). However, the 'public good myth' serves as a perfect pretext for politicians and public administrators to increasingly regulate our health behaviour (no tobacco, no obesity, no drugs, no…).

Myth No. 3: Prevention is better than treatment

Prevention calls for an investment in terms of time, sometimes also money. Frequently, the investment also amounts to a loss of utility (one may think of a smoker who clearly derives utility from smoking). Investment in prevention therefore has a cost that is certain but a return that is uncertain. No physician can guarantee a smoker to live in good health for x or more years after quitting. There is always the risk of suffering an accident or falling ill with a disease that bears no relationship with the consumption of tobacco. Most individuals, being risk averse, will think twice before undertaking an investment whose return is so uncertain. Rather than making the "wrong" preventive effort, they reasonably may wait until it becomes clear that it is their respiration (and not their feet e.g.) that is first to give up. In this way, they can harness the achievements of modern medicine to fix the problem in a targeted way. Their individual decisions clash with the wishes of politicians who would like to limit the increasing share of their budgets claimed by health by pushing less costly prevention.

Myth No. 4: Physicians decide in view of medical necessity

Physicians (and with them, service providers generally) pursue their own interests as everyone else. Since they often have to decide under uncertainty, they are rarely guided by their professional ethics in sufficient clarity. Studies using detailed information about medical billings and patient characteristics suggest that e.g. the prescription of drugs (admissible on the physician's own account in countries like Japan, South Korea, and Switzerland and parts of the United States where physician ownership in pharmacies is legal) is influenced by attainable margins. Even in the case of referrals, incentives prove important: Hospitalizations occur less frequently when physicians can achieve extra income in ambulatory care thanks to the possibility of billing their own laboratory and x-ray services as well as the prescription of drugs. It goes without saying that these relationships cannot be proven in a particular case; they emerge only when the number of observations becomes very large.

Myth No. 5: Public ownership of hospitals is absolutely essential

Public hospitals tend to be regional monopolies. From an economic point of view, this makes sense on two conditions: A hospital would have to be a 'natural' monopoly, meaning that the unit cost of service falls with size; and public ownership would have to be more efficient than the private alternative. There is no evidence in favor of either condition. The 'myth of essential public ownership' is particularly prevalent in Europe but less so in Asia and North America. There, citizens may have realized that all-inclusive services abound outside the healthcare sector (one may think of travel agency providing transportation, accommodation, excursions, and insurance). Why should a health insurer not be capable to procure the whole range of health care services on behalf of its clientele? If under the pressure of competition and reputation, why should it want to skimp on quality?

Myth No. 6: Nationally uniform fee schedules are beneficial

A health insurer has a mission comparable to that of a purchasing manager of a department store: Both procure goods and services that are called upon by their customers (insured, respectively) when needed. Yet confronted with a surge in demand, purchasing managers with quality-conscious customers are prepared to deal with their suppliers in a flexible way because the maintenance of quality takes precedence ("haste makes waste"). In contrast, managers sourcing for a price-conscious clientele expect their suppliers to come up with extra deliveries right away, often on the same conditions as before. Yet even in countries (such as Germany) where competitive health insurers are mandated to act as prudent purchasers, they are legally obliged to

contract with physicians, hospitals, and other service providers using a nationally uniform fee schedule and uniform conditions generally. In this way, they are prevented from concluding contracts tailored to the preferences of their respective clientele, to the detriment of consumers.

Myth No. 7: The aging of population causes a future cost explosion in health care.

Health insurance data that record not only the current age of patients but also the time of their death show that healthcare expenditure increases strongly during the last year of life-largely regardless of the patient's calendar age. Since the share of individuals in their last year of life is much higher at age 80 than at age 60 (say), average expenditure does increase with age at a given point in time. However, this does not imply that it increases over time. To see this, let longevity in industrial countries be 90 years rather than the current 80 years two decades from now. This means that the expensive last year in life will be shifted back by 10 years. Calculated over their whole life span, future generations will in fact be less costly than the current one–provided medical technology remains unchanged. In fact, it is new medical technology that causes healthcare expenditure per person to increase year after year. This insight confronts politicians (and ultimately taxpayers) with the uneasy question of whether they are willing to subsidize the health care of the poor (be it through lowered premiums as e.g. in U.S. Obamacare or through a National Health Service) to an extent that safeguards their access to the latest achievements of medicine.

But note: Myths have a long life!