Health Economics: The Physician's Visitor

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Almost everyone has had this nightmare: A threatening presence, just out of view, pursues the dreamer, whose legs are unable to carry him to safety. To a physician in 1997, this nocturnal tormentor takes the form of an economist.

Health economics has become a turbulent corner of economics because rapidly rising costs are bearing down heavily on those who provide care (physicians, hospitals, etc.) and those who pay for it (insurers, governments, employers, individuals). The family physician once seemed inoculated against economics. Ideally, at least, patients expected the best care possible, and medical choices depended on medical issues--not on costs.

What produced this qualitative gulf between health care and other expenditures? Health economists have built a veritable industry around trying to answer this question. Their answers vary, but often boil down to these: Until recently, medical technology was primitive enough that one could rarely spend more than a moderate amount on a given patient. Medical needs usually topped any patient's spending priorities. And if a patient couldn't afford treatment, it was at least feasible for someone else (family, charities, governments, caregivers) to cover the costs. In truth, economics always shaped health care (someone paid for research, medical education, hospitals, etc.), but doctor-patient relations seemed aloof from the distractions of supply and demand.

Now, the doctor turns uneasily in his bed and the dream returns--the economist now in full pursuit. Thanks to miracle technologies like heart transplants and treatable plagues like AIDS, a single patient's care can consume millions of dollars. People quickly view new technologies as needs, not wants, so the definition of "minimal" care steadily expands. Medical care grew from 5% of the U.S. economy in 1965 to around 15% in 1997. And, because individual costs can explode, the public demands that public and private insurance programs pay for health care. These trends reinforce one another: Patients demand expensive treatments because insurance covers them, companies develop new technologies to attract ever-higher national health expenditures, etc.

And so, the individual doctor's daily routine is shaped by institutions (HMOs, Medicare, regulations, etc.) summoned forth by the questions that health economists ask, including:

- What determines the quantity of care consumers demand?
- How do we measure quality of care?
- What factors affect providers' willingness to give care?
- How does insurance affect consumer behavior?
- How do we measure medical prices?
- How do we measure success or failure in medical care?
- What incentives induce physicians to give patients the care they desire?
- How do we assure that competition exists among health care providers?
- How does America's health care compare with that in other countries?

- How many doctors should there be in each specialty?
- How do we control costs without diluting the quality of care?

And now, the doctor awakes in a cold sweat, only to realize that the economist's approach is no dream. The realities of supply and demand and, most of all, of budget constraints, have come to visit the medical profession.