Arrow on the economics of health care

Broad themes

If you look closely at my argument there is a ... kind of sociological thesis. The market won't work — it doesn't work well in the health context. But something else supplements the market, and the thing I put stress on in the paper are the elements that put a non-economic influence on the market: professional commitments to provide a service, to engage in services that aren't self-serving. Standards of caring decided by non-economic actors. And one problem we have now is an erosion of professional standards. In a way there is more emphasis on markets and self-aggrandizement in the context of healthcare, and that has led to some of the problems we have today. ... The common theme is that some people in the health market know more then others.[1]

Q. ... why do you think the professional standards have changed?

Sometimes I think it's because of the Chicago School. I think there has been a general drift around the country towards the idea that greed is good. Look at Wall Street. All of these industries involve a professional element in which information is flowing. You're supposed to be constrained to be honest about it. I don't really know why. But there is now more of an emphasis on popularization, which does improve efficiency but can also lead to an erosion of professional standards. There was this idea that professional standards were a mask for monopoly power — a Chicago theory, which I believe came from George Stigler. I don't know if they were that influential, but they seemed to be saying a lot of things that people were taking up in practice. I'm not totally sure why these professional standards changed, but it's more than medical reasons.

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[1] Conor Clarke, "An Interview with Kenneth Arrow, Part Two," *The Atlantic Monthly* (website), July 28, 2009.

The problem with health insurance

One point was that health is a random event. It's not like buying automobiles. Whether you're sick or not is hard to predict. Some get sick and some don't. That uncertainty makes it an ideal scenario for insurance. Some houses burn and some don't, but you know whose. So you have fire insurance. ... But the question that I started with was why health insurance coverage was limited. There was virtually no insurance outside of hospitalization, which was limited and heavily taxed. When I heard about this myself, it was just as a consumer. My first health-care plan as a professor had a $15,000 ceiling. A ceiling? I was thinking that should be a floor! $15,000 I can handle, but above that... it would be a problem.

Anyway, that was the nature of insurance. It was a cautious time for insurance, and the question was why. And then it occurred to me that the insurance company couldn't be sure about what it was getting involved with. It's not like a fire when you know the problems: Did you set it? How did it happen? It's all pretty definite. But in the case of health care there are three players: the insurance company with the health plan, the physician, and the patient. The physician presumably has a better knowledge of what the patient needs — at least better than the insurance company does. So the insurance company could never put together a bill. There is also a physician and patient relationship, but the physician knows more than the patient.

There are information asymmetries in this story. Health insurance is limping along. It's limited in scope, and then you other consequences. Insurance companies have high premiums to protect themselves. The ones who come to the insurance company are sicker and the people have to pay more. You have adverse selection. You have moral hazard. And the doctor does what's on the safe side — defensive medicine — without regard to cost. These are fundamental conditions that make health insurance difficult. You have some things that help. Some doctors understand that they shouldn't abuse the system. But you still see problems in the way doctors behave towards patients.