The Daily Dish

The Intersection of Health Policy and Economic Policy

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Eakinomics: The Intersection of Health Policy and Economic Policy

It has been my experience that a lot of people believe that health and health policy are "different" from other policy areas, and thus are either immune to, or should be exempt from, the lessons of economic policy. I will grant that the primary objective of health care, sustaining life itself, is a bit more emotional and morally compelling than buying Twizzlers (well, morally compelling anyway). But with nearly 20 percent of the economy devoted to health care, it is dangerous to exempt it from the same objectives of innovation, productivity growth, and price competition.

That is the broad lesson of "Hospital Markets and the Effects of Consolidation" by AAF's Tara O'Neill Hayes and Kate Dixon. (Kate has since left AAF and is a podcast jockey in Kansas.) The more particular lessons are that the most expensive part of the nation's health care bill — hospital care — is getting pricier, mergers and consolidation are causing concentration to rise, prices are higher in more concentrated areas, and quality doesn't improve with concentration. Let's take these in turn.

Non-nerds are often surprised that 38.6 percent of personal health care expenditures was attributable to care provided in hospitals in 2017, compared to 32 percent for physician services provided outside the hospital and only 11.3 percent for prescription drugs. Hospitals accounted overall for roughly $1.1 trillion in spending that year. Despite this fact, prescription drug prices get way more attention, presumably because only 3 percent of hospital costs are paid by patients out-of-pocket (OOP). In contrast, OOP spending accounts for nearly 5 times as much (14 percent) of drug spending. It is time to give hospital costs and quality comparable policy attention.

The second key fact is that hospital mergers are rising. According to Hayes and Dixon, "Between 1998 and 2018, there were 1,667 hospital mergers, but the frequency has increased in the past decade: 66 percent of those mergers occurred in 2006 or later. Further, roughly half of these mergers were between hospitals in the same market, hindering competition. Between 2013 and 2017, the number of hospitals that were part of a hospital system increased 5 percent." It is time to rethink health policies from the perspective of whether they are incentivizing concentration.

The increasing concentration has implications for the quality of competition. The Health Care Cost Institute has done detailed work on hospital market concentration. Its recent Healthy Marketplace Index found that 72 percent of metropolitan areas had highly concentrated hospital markets in 2016. It is not surprising that prices are often higher, and sometimes profits too, in more concentrated areas. But not always. "One study found that high prices may simply reflect a more expensive (less efficient) cost structure: High-price hospitals had operating margins (which measures revenue in excess of daily expenses and is considered to be a measure of a business's efficiency) of negative 2.8 percent, while low-price hospitals had operating margins of positive 1.5 percent."

But perhaps the most depressing finding (Hayes specializes in depressing findings) is that "study after study has failed to document improvements in quality; rather, quality is often worse in highly concentrated markets even while prices are higher." One might have thought the opposite: Consolidation is necessary to better coordinate care and improve patient outcomes. That was the logic behind the laws, regulations, and payment structures underneath Accountable Care Organizations and Patient-Centered Medical Homes.

In short, health policy is not simply cookie-cutter economic policy. But good health policy will include avoiding economic incentives for mergers, concentration, higher prices, and reduced quality.