The business of health care.

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The Frank G. Zarb School of Business, long recognized for innovation in business education, now directs its expertise to the health care field. Hofstra’s new M.B.A. programs in Quality Management and Health Services Management provide a balance between theory and practice through structured courses, case studies, guest lectures and internships.

If you are in the health care industry and have been thinking about earning an M.B.A., then consider one of Hofstra’s new concentrations in Quality or Health Services Management. Learn more about these new 15-credit components of the Zarb M.B.A. Program, designed in collaboration with the North Shore-Long Island Jewish Health System, by calling 1-800-HOFSTRA, ext. 641. Fall classes begin September 6.

The baby boomers (those born right after the end of World War II) will reach 60 this year, suggesting additional pressures on the system – not to mention on government finances, since these folks will eventually be covered by Medicare.

Focusing in on costs, an examination of past data shows that, until the mid-1960s, the cost of medical care rose just about in line with other items in the consumer’s market basket, as measured by the consumer price index, suggesting that demand for such services was met with adequate supplies. But the passage of Medicare and Medicaid in 1965 changed this equation by increasing the effective demand for medical services before the industry had a chance to build additional hospitals, graduate more doctors, and boost supplies of prescription drugs. This set in motion a vicious cycle of soaring health care costs that persists to this day (see chart in center). It is exacer-
hated by the fact that most health care decisions are made by patients and doctors – but paid for by a different entity (one’s insurance company and/or employer).

Speaking of employers, the United States is probably one of the few countries where a large part of individuals’ health care is paid for by business. This system apparently had its roots during World War II, when Washington imposed wage-price controls. To attract scarce employees in an era when wages were tightly regulated, many firms began offering fringe benefits such as medical care. This persisted after the war ended and grew into the system we have today, which, incidentally, has become partly subsidized by the government through tax breaks. In the days when Washington’s budget was basically balanced and Corporate America had little or no reason to worry about costs, this system worked just fine. But just as health care costs began to spiral upward in the mid-1970s, spending on these items had subsequently grown anywhere from twice to almost three times faster than people’s expenditures on everything else. It’s the only category of medical care where spending growth has consistently outstripped growth in total personal outlays. Spending on physicians, hospitals and health insurance, the remaining parts of health care, has also grown faster than average. However, for several years in the mid- to late-1990s, their growth rates fell below the growth in total consumer spending I can only theorize that this was a result of the Clinton administration’s far-reaching proposals to change the way we pay for and receive health care, which involved tight regulations and price controls. Although they never came to fruition, these proposals may have encouraged some participants in the health care system to hold the line on their prices, in an effort to show that such changes were unnecessary. Whatever the reason, once the Bush administration took office, spending increases once again outpaced the total.

In offering a prescription to address the twin concerns of coverage and affordability with a minimum of side effects, some minor surgery on the nation’s health care system would seem to be in order. Insular as coverage is concerned, keep in mind that lack of health care insurance should not be equated with lack of health care. Virtually everyone gets needed health care these days; the only difference is that the passage of Medicare and Medicaid suddenly boosted aggregate demand for health care, one might expect even more pressures on prices to result.

With this in mind, I would like to suggest a couple of changes regarding health insurance. First of all, health insurance should become the responsibility of individuals – not business. Indeed, such coverage should be mandatory for every citizen and lawful permanent resident. People buy their own fire and theft insurance for their homes or apartments. Those who own a motor vehicle or a boat usually must have liability insurance as well. In this light, responsibility for, and ownership of, health care insurance would not seem to be such a radical idea.

As to the method of acquiring such coverage, some people might find it expedient to obtain this insurance through their employers, since they might be able to avail themselves of group rates. Others whose employers would choose not to offer such coverage, or who are self-employed, would have to purchase this insurance on their own. Tax breaks would be available to help in the transition from employer-based to individual-owned insurance, with their size depending on individuals’ incomes. Coverage would then become portable. In other words, people would be able to take their insurance with them when they change jobs and/or retire. Breaking the link between employment and health insurance (which is already well underway) is vital to establishing the universal health coverage and financial security all Americans want and deserve.

Costs would then be contained by the marketplace – not by the government. As people start spending their own money for health care coverage rather than relying on their employer’s, they will be more apt to seek insurance plans and medical services that offer the best value for the lowest cost. This might seem problematic at first: comparison shopping is arguably difficult, since doctors don’t post a schedule of their fees. In addition, patients are unable to evaluate the costs and benefits of different treatments, or which hospital or drug is better or cheaper. But compared with the alternative (the status quo), this proposal would seem to be preferable. Allowing supply and demand to determine price will also help to maintain the quality of our health care system, which is arguably the best in the world. According to a recent survey of doctors, eight of the 10 most significant breakthroughs in health care in the past three decades originated in the United States. Health care costs in other countries would be a lot higher if American medicine was not as innovative as it has been.

To be sure, this prescription is not perfect. Health care is different from most other goods or services. For example, technological advances usually result in higher, not lower, costs. This is because complicated new machines are expensive to buy and to operate, yet are purchased by hospitals continuing to have the latest equipment in order to attract better doctors and more patients. For their part, the drug companies must spend lots of money on research and development in order to come up with just one scientific breakthrough and a commercial winner. And the insurance companies are unable to earn the kinds of returns from investing premium income that they used to, given the flatness of the stock market over the past seven years, and today’s still-low levels of interest rates. Still, it would seem to be the best available, if we are to achieve what on the surface could be