

Why Health Care Will Never Be Equal

By N. GREGORY MANKIW

EVERY morning, I take a small white pill that makes me think deep philosophical thoughts about the American health care system, the value of life, and the relationship between man and state. No, it is not some illegal psychedelic left over from the 1960s along with my tie-dyed T-shirts. But if you bear with me, I bet this pill will have the same effect on you.

The pill is a statin — a type of pharmaceutical developed over the last few decades to lower a person's cholesterol. My father died of cardiovascular disease, and unfortunately I inherited his genetic predisposition. Yet I am hoping that modern medicine will help me avoid his fate. So like millions of middle-age men, I take my little pill every morning.

Here is the question I ask as the pill passes through my lips: Is it worth it?

Now you might be tempted to say, "Of course it is." Most people would prefer to avoid an early death. If the wonders of modern science might put off the inevitable for a while longer, why not give it a shot?

And that is, indeed, how I thought about the decision when my doctor recommended the treatment. One thing I did not consider was the price. Like most consumers of health care, I was insulated from economic concerns. I knew that the insurance company — and, indirectly, all its policyholders — would pick up most of the tab. This arrangement, encouraged by the tax system, ensures that I get the benefit of the pills while paying little of the extra costs they generate.

An optimist might hope that my doctor, or someone higher up in the health care hierarchy, made a rational cost-benefit calculation on society's behalf. To figure out whether my treatment makes sense, one would have to weigh the cost of the drug against the benefit of an extended life. And to do that, one would have to put a dollar value on my life — the kind of calculation that makes everyone but economists squirm.

Not long ago, I read that a physician estimated that statins cost \$150,000 for each year of life saved. That approximate figure reflects not only the dollars patients and insurance companies spend on the treatment but also — and just as important — an estimate of how effective it is in prolonging life. (That number is for men. Women have a lower risk of heart disease.)

That estimate is, at best, approximate, but it certainly suggests that preventive care is not always cheap. The magnitude of the figure also brings to mind hard questions of political philosophy.

Imagine that someone invented a pill even better than the one I take. Let's call it the Dorian Gray pill, after the Oscar Wilde character. Every day that you take the Dorian Gray, you will not die, get sick, or even age. Absolutely guaranteed. The catch? A year's supply costs \$150,000.

Anyone who is able to afford this new treatment can live forever. Certainly, Bill Gates can afford it. Most likely, thousands of upper-income Americans would gladly shell out \$150,000 a year for immortality.

Most Americans, however, would not be so lucky. Because the price of these new pills well exceeds average income, it would be impossible to provide them for everyone, even if all the economy's resources were devoted to producing Dorian Gray tablets.

So here is the hard question: How should we, as a society, decide who gets the benefits of this medical breakthrough? Are we going to be health care egalitarians and try to prohibit Bill Gates from using his wealth to outlive Joe Sixpack? Or are we going to learn to live (and die) with vast differences in health outcomes? Is there a middle way?

These questions may seem the stuff of science fiction, but they are not so distant from those lurking in the background of today's health care debate. Despite all the talk about waste and abuse in our health system (which no doubt exists to some degree), the main driver of increasing health care costs is advances in medical technology. The medical profession is always figuring out new ways to prolong and enhance life, and that is a good thing, but those new technologies do not come cheap. For each new treatment, we have to figure out if it is worth the price, and who is going to get it.

The push for universal coverage is based on the appealing premise that everyone should have access to the best health care possible whenever they need it. That soft-hearted aspiration, however, runs into the hardheaded reality that state-of-the-art health care is increasingly expensive. At some point, someone in the system has to say there are some things we will not pay for. The big question is, who? The government? Insurance companies? Or consumers themselves? And should the answer necessarily be the same for everyone?

Inequality in economic resources is a natural but not altogether attractive feature of a free society. As health care becomes an ever larger share of the economy, we will have no choice but to struggle with the questions of how far we should allow such inequality to extend and what restrictions on our liberty we should endure in the name of fairness.

In the end of our day of philosophizing, however, we face a practical decision:

Who gets the magic pills, and who pays for them?