ALTERNATIVE HEALTH CARE SYSTEMS:
Market Model vs. Public Provision

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Princeton University

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November 3-4, 2003
ALTERNATIVE HEALTH CARE SYSTEMS: Market Model vs. Public Provision

I. WHAT IS “MARKET” AND “PUBLIC PROVISION”?
## Alternative Mixes of Funding and Provision

<table>
<thead>
<tr>
<th>Provision of Health Care</th>
<th>Funding of Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>Collective: A</td>
</tr>
<tr>
<td>Private, NFP</td>
<td>Individual: D</td>
</tr>
<tr>
<td>Private, FP</td>
<td>Collective: B</td>
</tr>
<tr>
<td></td>
<td>Individual: E</td>
</tr>
<tr>
<td></td>
<td>Collective: C</td>
</tr>
<tr>
<td></td>
<td>Individual: M</td>
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ALTERNATIVE HEALTH CARE SYSTEMS: Market Model vs. Public Provision

I. WHAT IS “MARKET” AND “PUBLIC PROVISION”?  
II. “PRICE-” vs “NON-PRICE” COMPETITION
### Forms of Competition in Health Care

<table>
<thead>
<tr>
<th>On What Variable Does Competition Take Place?</th>
<th>Who Reacts to the Variable of Competition?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Money Price</strong></td>
<td>Insurer or Government?</td>
</tr>
<tr>
<td><strong>Clinical Quality</strong></td>
<td>The Patient</td>
</tr>
<tr>
<td><strong>Patients’ Satisfaction</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **A**
- **B**
- **C**
- **D**
- **E**
- **F**
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I. WHAT IS “MARKET” AND “PUBLIC PROVISION”?

II. “PRICE-” vs “NON-PRICE” COMPETITION

III. HEALTH SYSTEMS IN THE REAL WORLD: A TAXONOMY
## A Taxonomy of Health-System Components

### The Financing of Health Care

<table>
<thead>
<tr>
<th>Ownership of Providers</th>
<th>Health Insurance</th>
<th>Direct Payment (Out of pocket)</th>
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<tbody>
<tr>
<td>Government</td>
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<tr>
<td>Private, and commercial</td>
<td>Private Insurance</td>
<td>Non-Profit</td>
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### Notes:
- **Government** insurance is provided by public entities such as government programs.
- **Private, but non-profit** insurance is offered by private companies that operate with non-profit status.
- **Private, and commercial** insurance includes both private and commercial providers.
# The Financing of Health Care

## Ownership of Providers

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<td>Private Insurance Non-Profit</td>
<td>E H K N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F I L O</td>
</tr>
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<td>Private, and commercial</td>
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- **Purely Socialized Medicine** (U.K. NHS, Hong Kong Hospital Authority, U.S. Veterans Health System)
- **Direct Payment** (Out of pocket)
## The Entire British Health System Today

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### The Financing of Health Care

- **Government Insurance**
- **Social Insurance**
- **Private Insurance**
  - Non-Profit
  - Commercial

**Direct Payment (Out of pocket)**
# The Canadian and Taiwanese Health Systems

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</tr>
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<td>Private, and commercial</td>
<td>Private</td>
<td>O</td>
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### Government Insurance
- A

### Social Insurance
- D
- E

### Private Insurance
- G
- H
- I
- J
- K
- L

### Direct Payment (Out of pocket)
- M
- N
- O
### Germany's Health System

#### The Financing of Health Care

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<td>C, F, I, L</td>
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# The Pluralistic American Health System

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Market Model vs. Public Provision

I. WHAT IS “MARKET” AND “PUBLIC PROVISION”? 
II. “PRICE-” vs “NON-PRICE” COMPETITION 
III. HEALTH SYSTEMS IN THE REAL WORLD: A TAXONOMY 
IV. SOCIAL ETHICS AS A DRIVER OF HEALTH SYSTEMS CHOICE
PER CAPITA HEALTH SPENDING IN SELECTED OECD NATIONS, 2000
In purchasing-power parity adjusted equivalent U.S. Dollars

<table>
<thead>
<tr>
<th>Country</th>
<th>Per Capita Health Spending</th>
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<tbody>
<tr>
<td>United States</td>
<td>$4,631</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$3,222</td>
</tr>
<tr>
<td>Germany</td>
<td>$2,748</td>
</tr>
<tr>
<td>Canada</td>
<td>$2,535 55% of U.S. level</td>
</tr>
<tr>
<td>France</td>
<td>$2,349</td>
</tr>
<tr>
<td>Australia</td>
<td>$2,211</td>
</tr>
<tr>
<td>Japan</td>
<td>$2,012</td>
</tr>
<tr>
<td>OECD Median</td>
<td>$1,983</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$1,763</td>
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SOURCE: OECD Data, 2002; DoH, ROC, 2001 Health Statistical Trends.
ALTERNATIVE HEALTH CARE SYSTEMS: Market Model vs. Public Provision

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IV. SOCIAL ETHICS AS A DRIVER OF HEALTH SYSTEMS Choice

A. Alternative theories of distributive justice

1. LIBERALISM:
   • Libertarians (look askance at redistribution)
   • Egalitarian Liberals (favor redistribution)
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   A. Alternative theories of distributive justice  
      1. LIBERALISM:  
      2. UTILITARIANS  
         • standard, market oriented welfare economics  
         • extra-welfarist (objective) utilitarians
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A. Alternative theories of distributive justice

A. Alternative perspectives on the social role of health care
A PURE SOCIAL GOOD TO BE AVAILABLE TO ALL ON EQUAL TERMS

A PURE SOCIAL GOOD FOR ALL BUT A SMALL MONEYED ELITE

A PRIVATE CONSUMPTION GOOD, LIKE FOOD AND HOUSING

One-tiered
CANADA, TAIWAN

Two-tiered
EUROPE

Multi-tiered
U.S.
THE MULTI-TIERED AMERICAN HEALTH SYSTEM

THE LUXURIOUS TOP TIER
Purchased by employers for the executive tier or by the wealthy for themselves. Open-ended indemnity insurance without cost sharing. There is effectively no rationing at all.

THE MULTIPLE MIDDLE TIERS
Purchased by employers for the lower echelon or by self-employed for themselves. Insurance is coupled with managed care and heavy cost sharing. There is rationing to varying degrees, although relatively mild, so far.

THE MULTIPLE BOTTOM TIERS
The uninsured (now close to 18% of the population). For them health care is rationed severely on the basis of price and ability to pay. Often they receive minimal care on a charitable basis.
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V. PRICE COMPETITIVE COMMERCIAL MARKETS IN HEALTH CARE  
   A. The valuation of health care in commercial markets
THE ECONOMIST’S DEFINITION OF
“VALUE”

Res tantum valet, quantum vendi postest

(A thing is worth what you can sell it for)
THE “VALUE” OF A THING IS THE MAXIMUM PRICE PEOPLE WOULD PAY PER UNIT, IF PUSH CAME TO SHOVE

- Market Demand or Willingness-to-Pay Curve

- Bid Price

- # of Units

- Chen

- Rodriguez

- Jones
IN A FREE MARKET, RODRIGUEZ’ VALUATION SETS THE PRICE.
CHEN GETS A REAL STEAL. JONES’ NEEDS OR DESIRES AND
VALUATION DO NOT COUNT AT ALL.

BID PRICE

MARKET SUPPLY

PRICE

MARKET DEMAND

# OF UNITS

CHEN

RODRIGUEZ

JONES (whose views don’t count)
Consider, for example, the ethical implications of a proposal made by American Nobel Laureate economist Milton Friedman. He has proposed that the U.S. government:

- abolish Medicaid for the poor;
- abolish Medicare for elderly Americans;
- mandate that every American family have catastrophic health insurance policy with an annual deductible of $20,000 or 30% of the family’s income, whichever is lower.
UNDER MARKET VALUATION, THE SOCIAL VALUE OF THE 3RD PEDIATRIC VISIT IS $40 FOR POOR, SICKLY BABY SMITH BUT $100 FOR HEALTHY BABY CHEN
According to market theory, “willingness-to-pay” or “demand” curves signal the social valuation of goods or services in the consumer’s mind.
REMARKABLE INSIGHT FROM STANDARD WELFARE ECONOMICS:

The social value of a good or service depends on the wealth of the individual who receives that good or service, and it usually rises with that wealth.
WHAT MILTON FRIEDMAN WOULD CALL AN “EFFICIENT” MARKET WOULD ALLOCATE 3 VISITS/YR. TO SICKLY BABY SMITH AND 5 VISIT/YR. TO HEALTHY BABY CHEN.

![Graph showing supply and demand for infant-physician encounters per year. The graph illustrates the price (or marginal value) per visit against the number of infant-physician encounters per year.]
ANOTHER REMARKABLE INSIGHT FROM STANDARD WELFARE ECONOMICS:

A what Milton Friedman would call “efficient” market could easily allocate more health care to wealthy and healthy people than to poorer and sicker people.
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   A. The valuation of health care in commercial markets  
   B. Price discrimination in commercial markets
Because health care typically cannot be resold by its recipients, it is easy to segment the commercial health care market into different classes of customers, each of which are charged a different price for the same thing.

The net effect will be that the value society puts on the work of doctors and other health care providers will vary with the wealth of the recipient.
QUESTION: WHAT SHOULD SOCIETY TELL A PEDIATRICIAN ABOUT THE VALUE OF THAT PEDIATRICIAN’S WORK ON BEHALF OF ANY OF THESE LITTLE PATIENTS?

Should that value vary by the wealth and insurance status of the little patient’s parents?
American federal and state legislators, for example, think nothing of telling, say, pediatricians that they will pay them, say, $20 to treat a poor child from the inner city (on Medicaid) but $60-$80 to treat these legislators’ own children.

Many American physicians take the strong valuation signal given to them by the legislators by refusing to accept Medicaid patients.

Is this desirable? The answer depends on one’s ethical precept.
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V. PRICE COMPETITIVE, FREE MARKETS IN HEALTH CARE

A. The market’s social valuation of health care

B. Are markets more “efficient” than alternative systems?
PROPOSITION

There is no empirical evidence—nor could an honorable economists show it on theoretical grounds— that a market-driven health system is more “efficient” than a government regulated system, such as Canada’s.

These two types of systems tend to achieve different social goals—that is, different distributions of economic privilege among members of society.
"EFFICIENCY" VERSUS "SOCIAL DESIRABILITY"

ONE-TIER HEALTH CARE

GOAL 1

POLICY A
Efficient

POLICY B
Inefficient

MULTI-TIER HEALTH CARE

GOAL 2

POLICY C
Efficient

POLICY D
Inefficient

Cannot meaningfully be compared in terms of relative efficiency
TRAVELLING EFFICIENTLY EFFICIENCY ACROSS THE U.S.

SEATTLE

A

B

SAN DIEGO

C

D

NEW YORK
AN IMPORTANT INSIGHT

The inefficient road to San Diego is better than the efficient road to Seattle, if to San Diego one really wants to go (and not to Seattle).
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V. PRICE COMPETITIVE, FREE MARKETS IN HEALTH CARE  
VI. SO WHAT IS BETTER? THE “MARKET” OR “PUBLIC PROVISION”?
THE CENTRAL ISSUES OF INTEREST ARE:

- contributions by ability to pay?

  or

- contributions based on actuarial principles?

  or

- same payment for same service regardless of who the patient is?

  or

- price discrimination based on patient’s ability to pay?
PUBLIC PROVISION

- Can easily be made fairly egalitarian and universal
- Can be made simple (and cheap) to administer
- In theory, provide simple platforms to implement IT and other technological change (e.g., EBM)
- But, can easily be under-funded (e.g., Canada)
- Can be highly vulnerable to managerial mistakes
- Will leave the top 20% or so of the income distribution dissatisfied and, alas, the bottom 80% apathetic
COMMERCIAL PROVISION

• Tend to suck more money into health care and thus facilitate provision of ample, luxurious capacity for those able to pay

• Facilitates experimentation and innovation

• Lets agonizing trade-offs be made without political fanfare

• By its very nature, is not egalitarian (it rations health care by income class)

• Tends to entail horrendous non-medical costs (marketing and administration—as choice costs money)

• Tends to get low satisfaction scores in public opinion surveys
IN THE END, WE FACE THIS THE TRADE-OFF IN HEALTH CARE

Quality of the Health-Care Experience and of Life

Free Market Without Universal Coverage

Health System With Universal Coverage

Top 25% Bottom 25%

Of Income Distribution

Top 25% Bottom 25%

Of Income Distribution
THE END