ALTERNATIVE HEALTH CARE SYSTEMS:

Market Model vs. Pubic Provision

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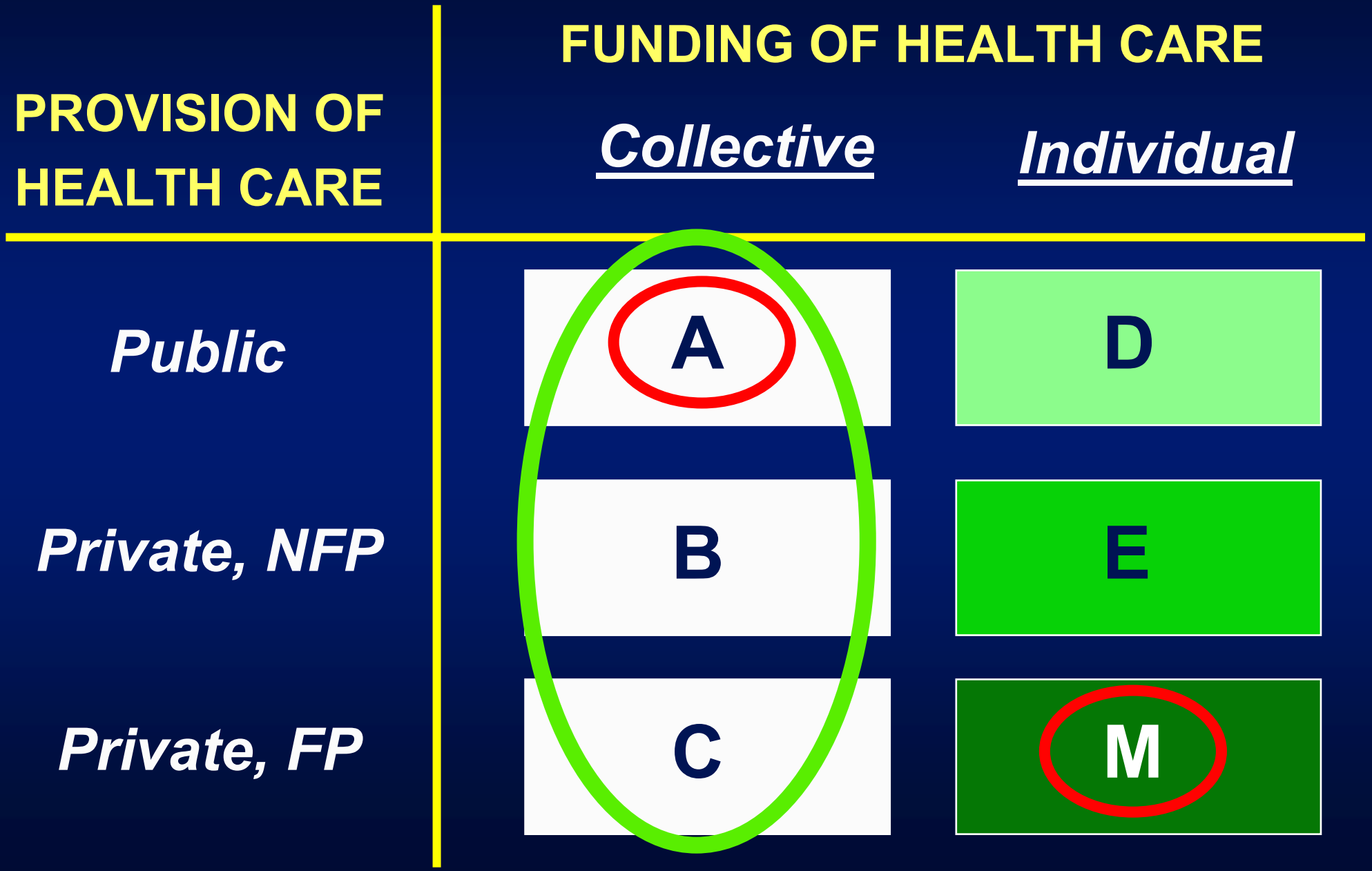
I. WHAT IS “MARKET” AND “PUBLIC PROVISION”?

ALTERNATIVE MIXES OF FUNDING AND PROVISION



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

FORMS OF COMPEPTITION IN HEALTH CARE

ON WHAT VARIABLE DOES COMPETITION TAKE PLACE?	WHO REACTS TO THE VARIABLE OF COMPETITION?	
	Insurer or Government?	*The Patient*
Money Price	A	D
Clinical Quality	B	E
Patients' Satisfaction	C	F

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III. HEALTH SYSTEMS IN THE REAL WORLD: A TAXONOMY

A TAXONOMY OF HEALTH-SYSTEM COMPONENTS

OWNERSHIP OF PROVIDERS	THE FINANCING OF HEALTH CARE				
	HEALTH INSURANCE				DIRECT PAYMENT (Out of pocket)
	Government Insurance	Social Insurance	Private Insurance		
			Non-Profit	Commercial	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

PURELY SOCIALIZED MEDICINE (U.K. NHS, HONG KONG HOSPITAL AUTHORITY, U.S. VETERANS HEALTH SYSTEM))

THE FINANCING OF HEALTH CARE

OWNERSHIP OF PROVIDERS	HEALTH INSURANCE				DIRECT PAYMENT (Out of pocket)
	Government Insurance	Social Insurance	Private Insurance		
			Non-Profit	Commercial	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
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THE ENTIRE BRITISH HEALTH SYSTEM TODAY

THE FINANCING OF HEALTH CARE

OWNERSHIP OF PROVIDERS	HEALTH INSURANCE				DIRECT PAYMENT (Out of pocket)
	Government Insurance	Social Insurance	Private Insurance		
			Non-Profit	Commercial	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

THE CANADIAN AND TAIWANESE HEALTH SYSTEMS

THE FINANCING OF HEALTH CARE

OWNERSHIP OF PROVIDERS	HEALTH INSURANCE				DIRECT PAYMENT (Out of pocket)
	Government Insurance	Social Insurance	Private Insurance		
			Non-Profit	Commercial	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

GERMANY'S HEALTH SYSTEM

THE FINANCING OF HEALTH CARE

OWNERSHIP OF PROVIDERS	HEALTH INSURANCE				DIRECT PAYMENT (Out of pocket)
	Government Insurance	Social Insurance	Private Insurance		
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THE PLURALISTIC AMERICAN HEALTH SYSTEM

OWNERSHIP OF PROVIDERS	THE FINANCING OF HEALTH CARE				
	HEALTH INSURANCE				DIRECT PAYMENT (Out of pocket)
	Government Insurance	Social Insurance	Private Insurance		
			Non-Profit	Commercial	
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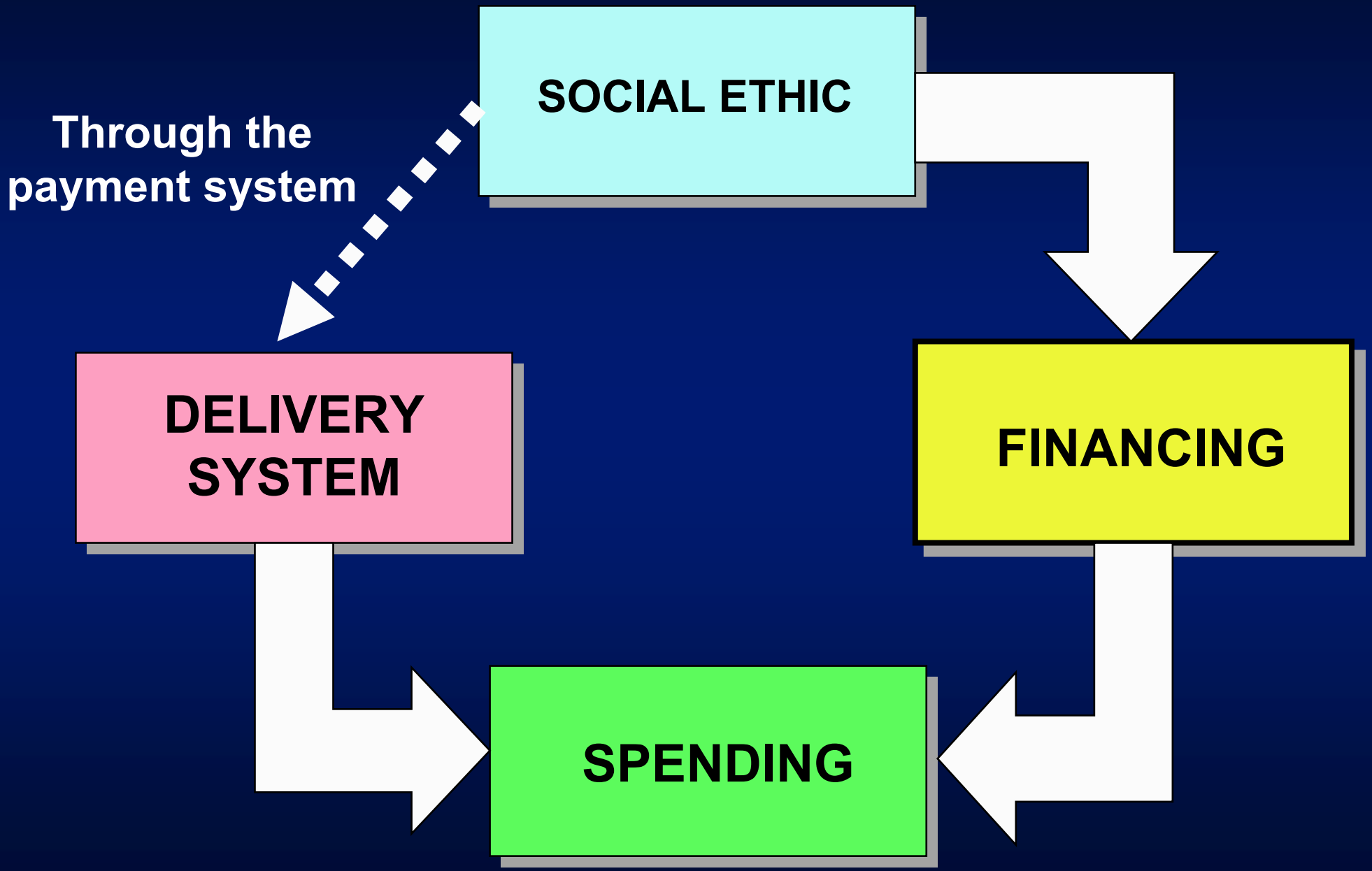
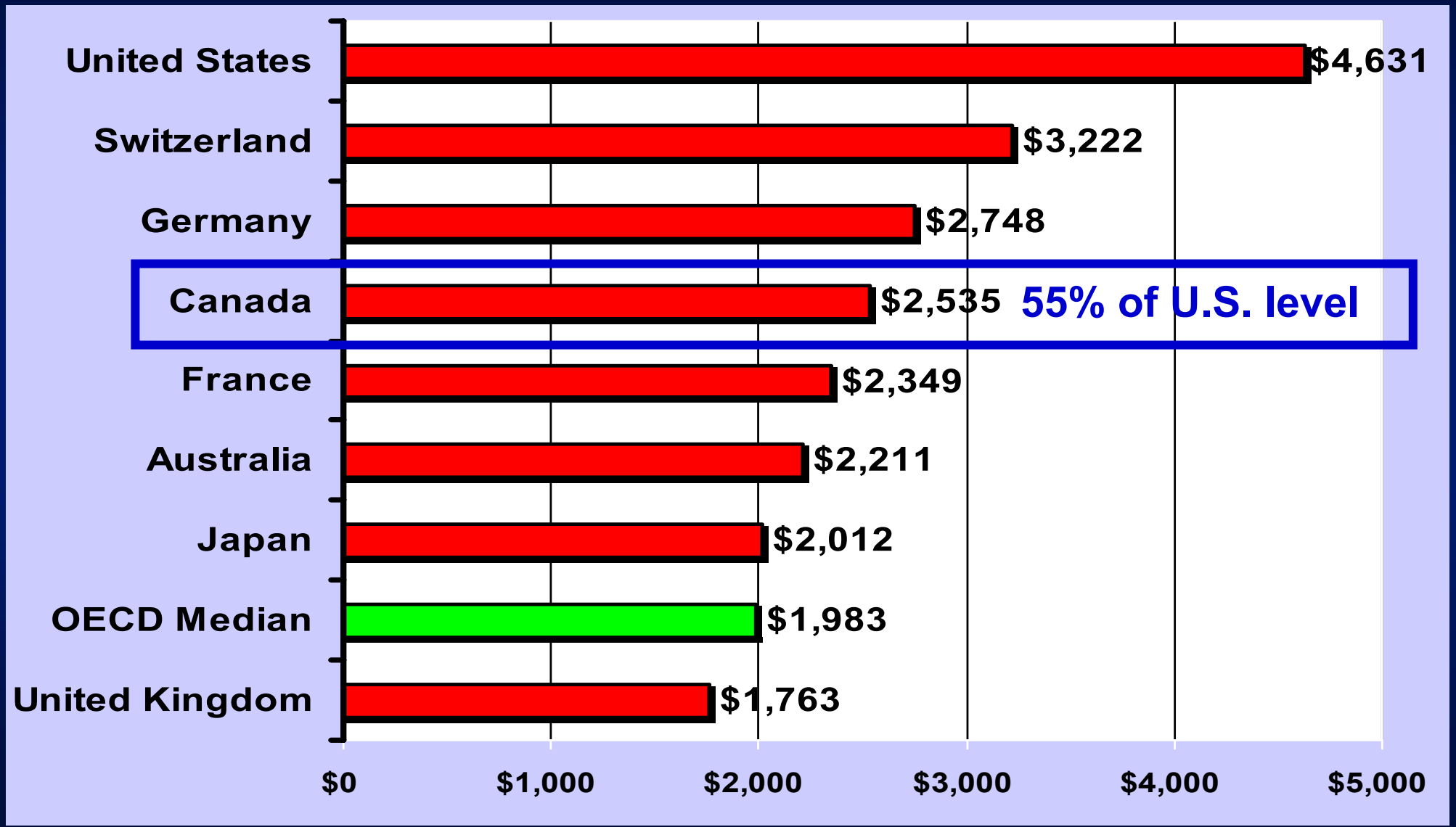

SOCIAL ETHIC
Through the payment system
DELIVERY SYSTEM
FINANCING
SPENDING

PER CAPITA HEALTH SPENDING IN SELECTED OECD NATIONS, 2000

In purchasing-power parity adjusted equivalent U.S. Dollars



SOURCE: OECD Data, 2002; DoH, ROC, 2001 Health Statistical Trends.

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A. Alternative theories of distributive justice

1. LIBERALISM:

- **Libertarians (look askance at redistribution)**
- **Egalitarian Liberals (favor redistribution)**

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1. LIBERALISM:

2. UTILITARIANS

- **standard, market oriented welfare economics**
- **extra-welfarist (objective) utilitarians**

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A. Alternative perspectives on the social role of health care

IDEOLOGICAL PERSPECTIVES ON HEALTH CARE

Health care is:

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 hevay 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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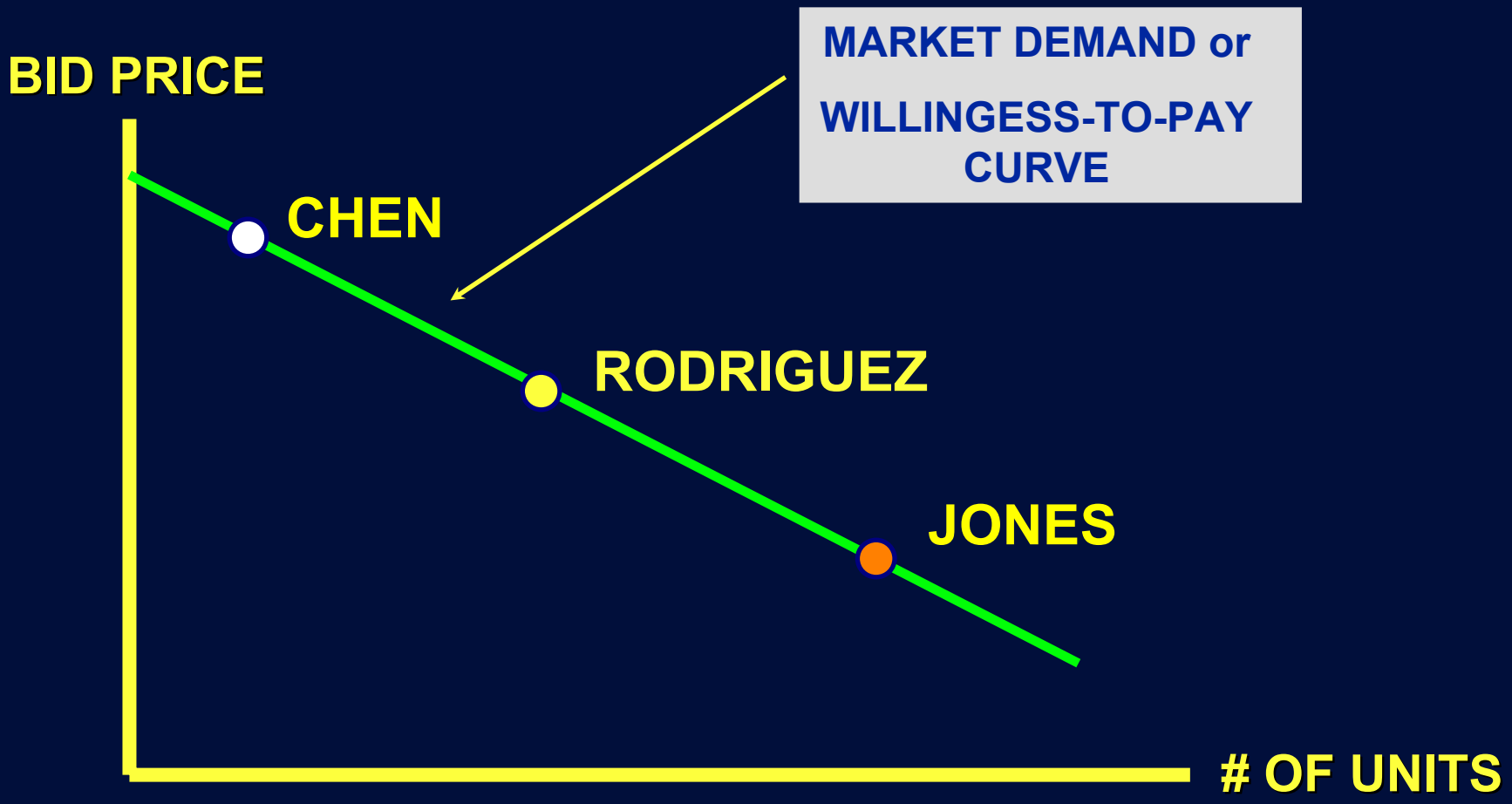
A. The valuation of health care in commercial markets

THE ECONOMIST'S DEFINITION OF "VALUE"

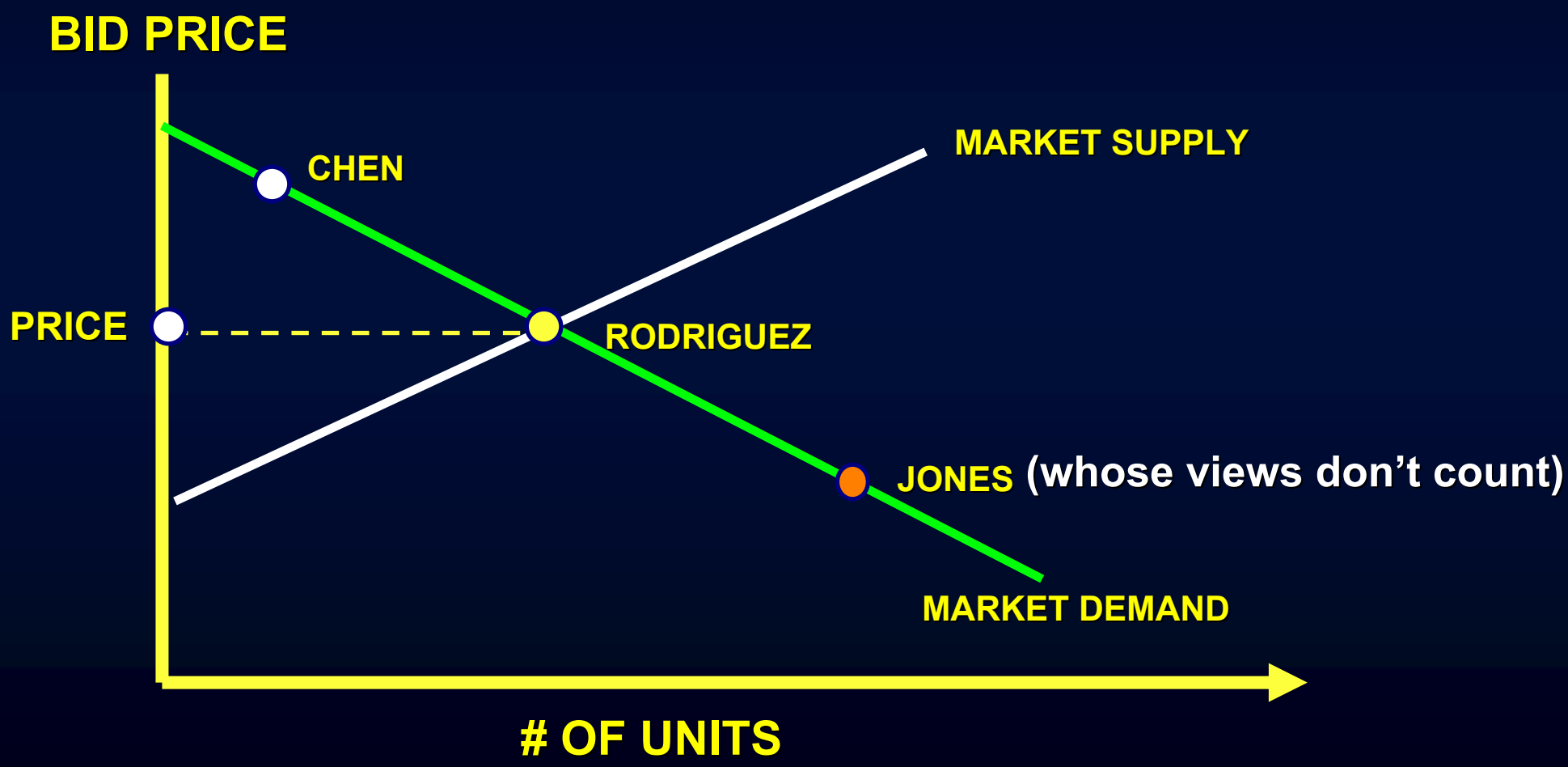
Res tantum valet, quantum vendi postest

(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



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 .



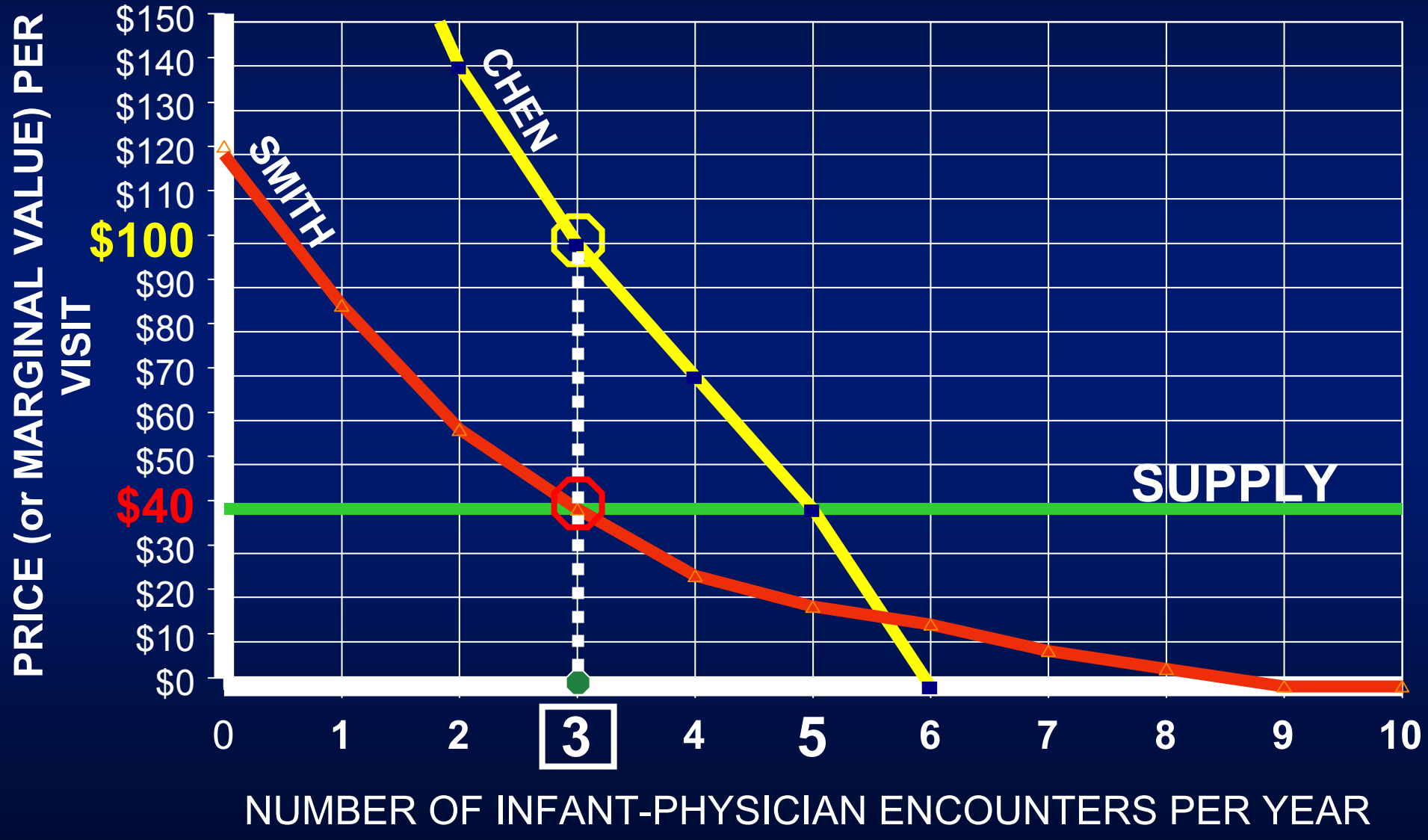
Consider, for example, the ethical implications of a proposal made by American Nobel Laureate economist Milton Friedman. He has proposed that the U.S. government:

-abolish Medicaid for the poor;

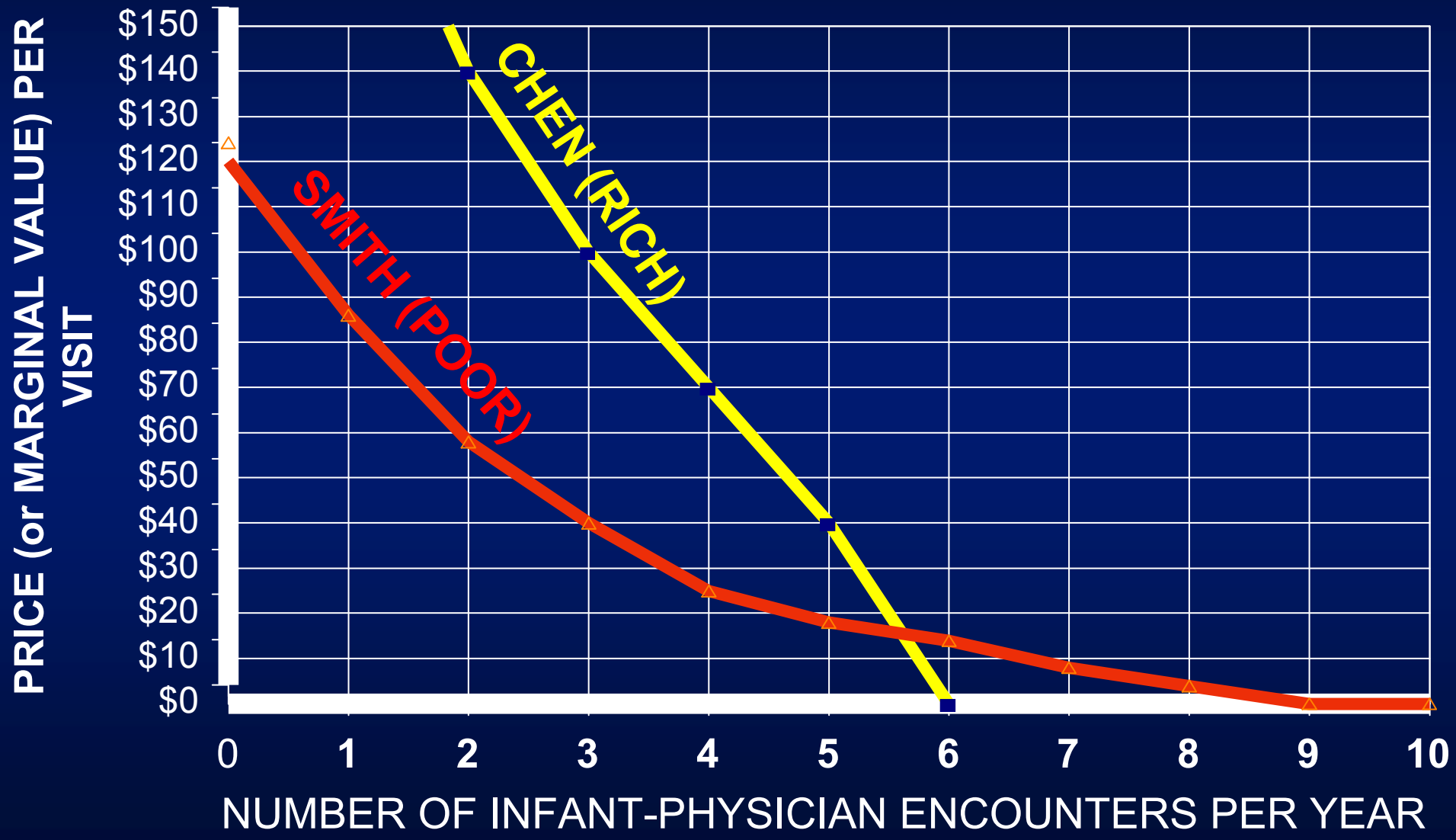
-abolish Medicare for elderly Americans;

-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

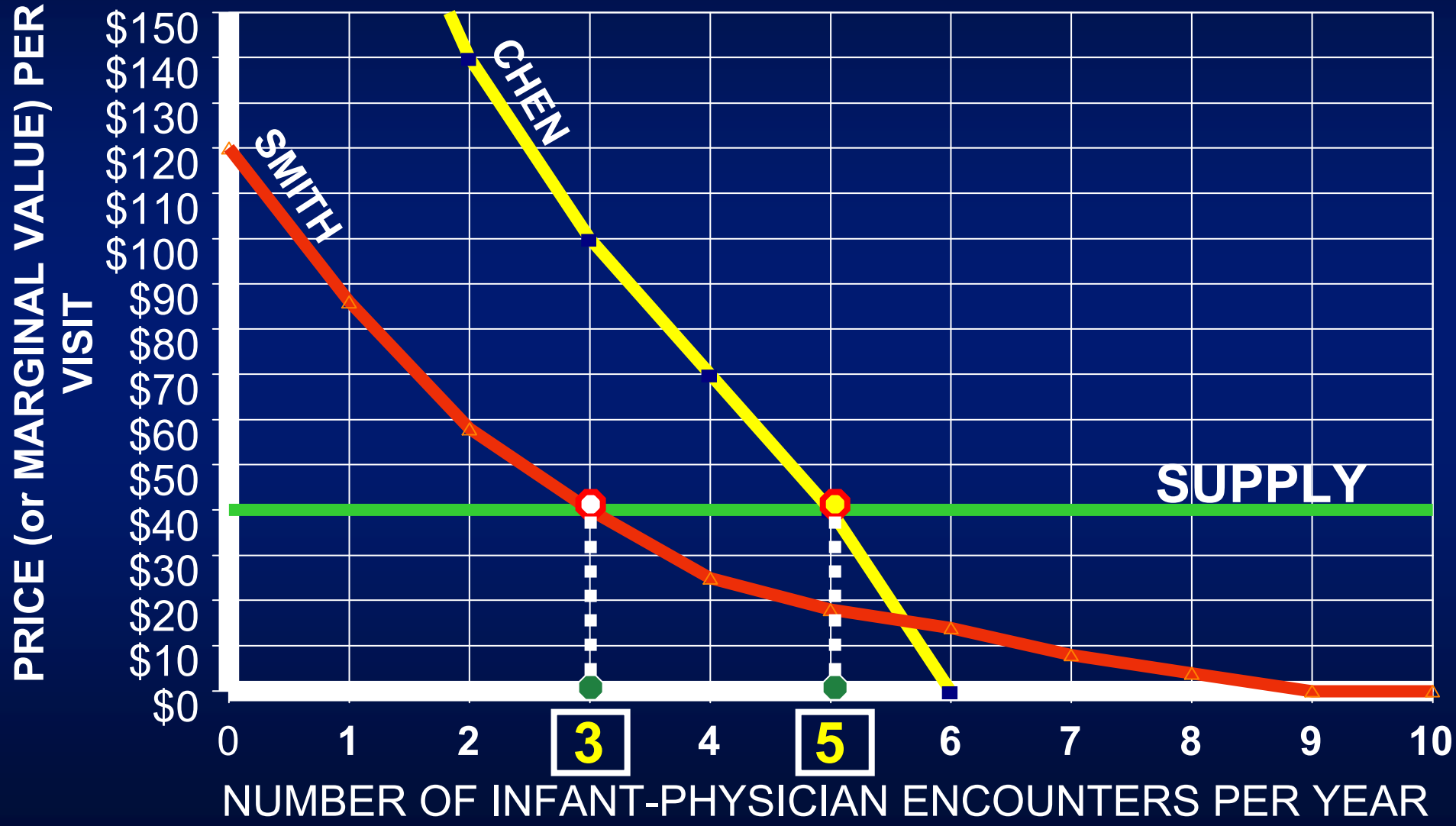


REMARKABLE INSIGHT FROM STANDARD WELFARE ECONOMICS:

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



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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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

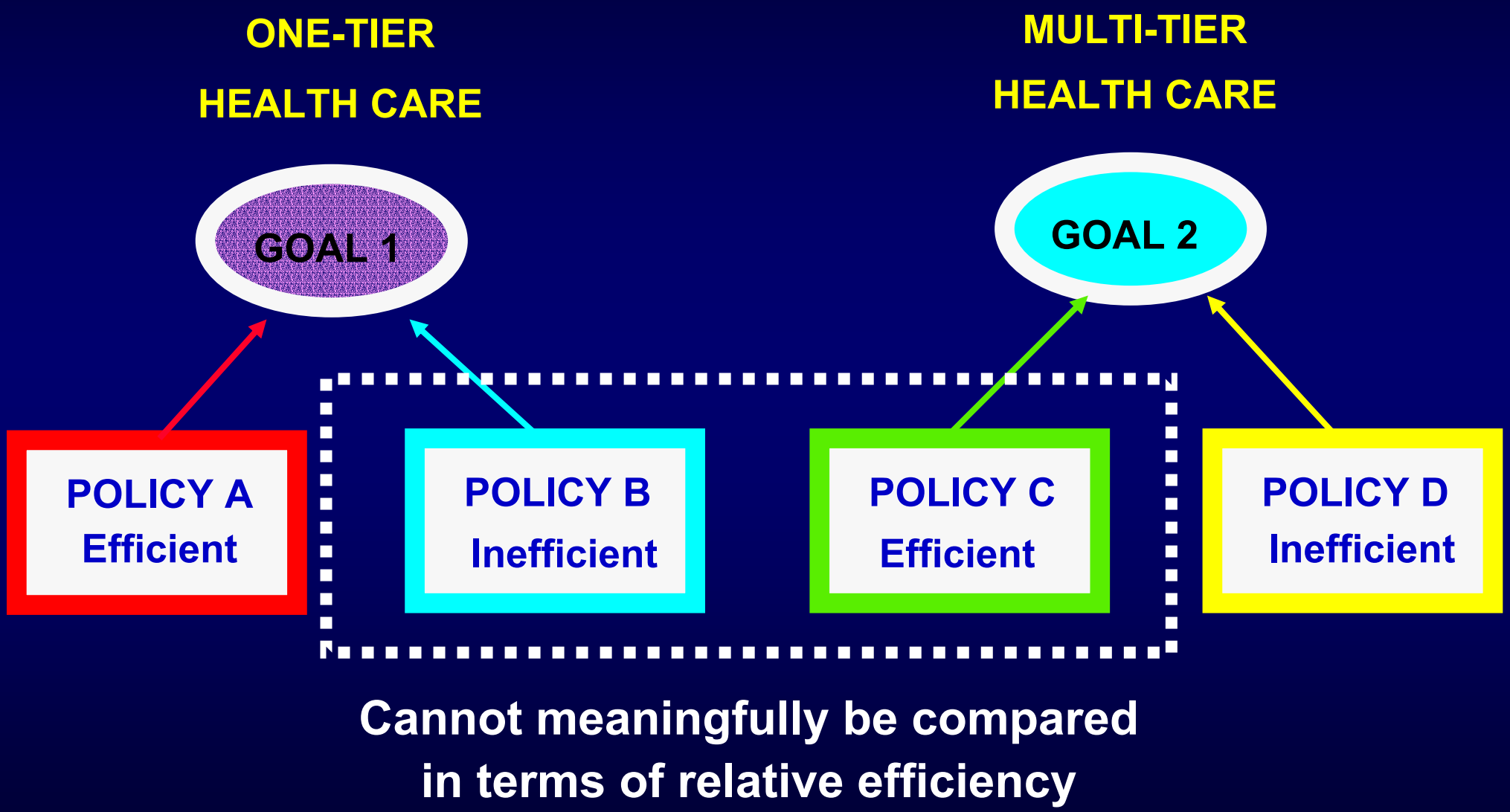
B. Are markets more "efficient" than alternative systems?

PROPOSITION

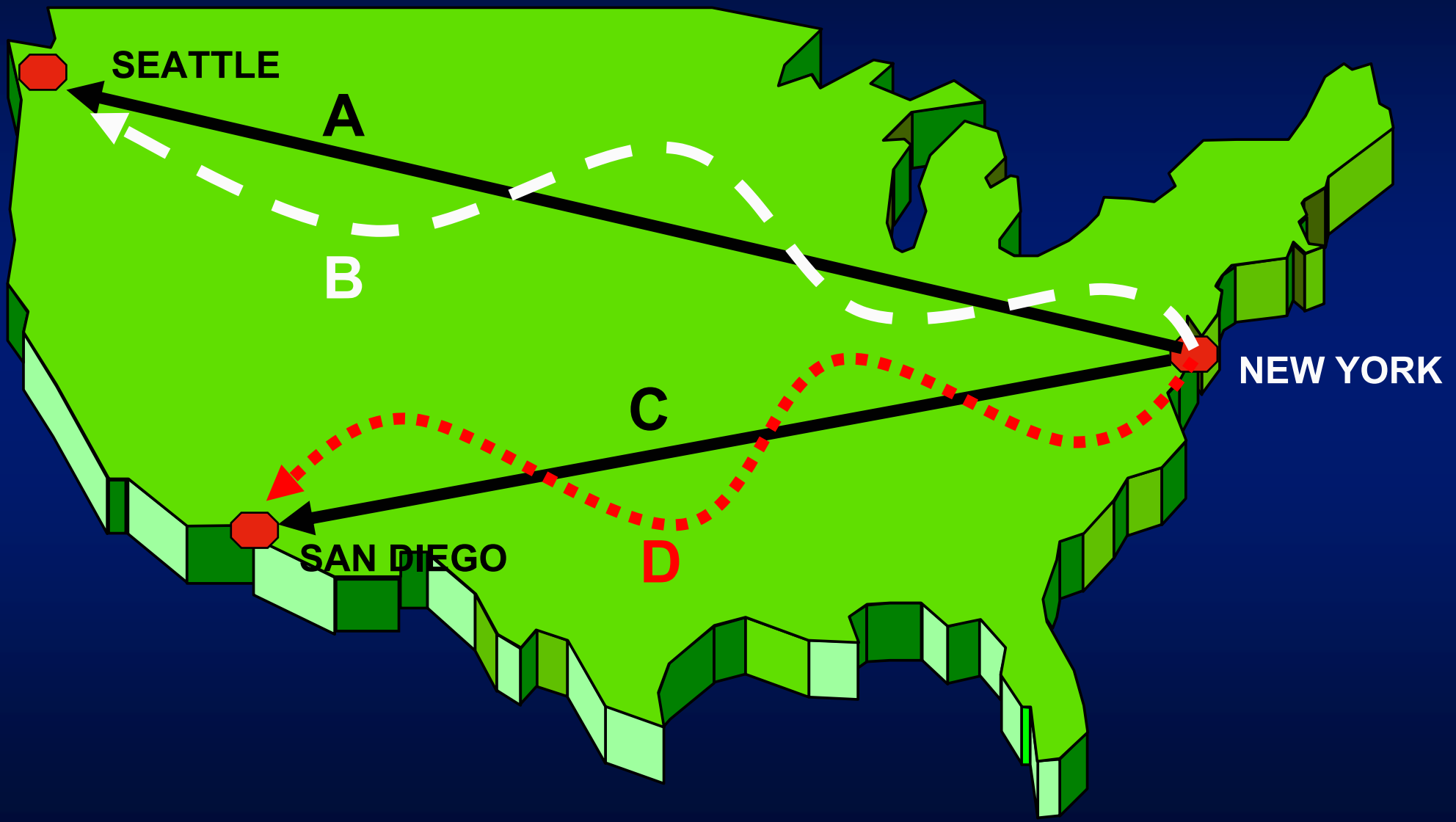
There is no empirical evidence—nor could an honorable economists show it on theoretical grounds– that a market-driven health system is more "efficient" than a government regulated system, such as Canada's.

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"



TRAVELLING EFFICIENTLY EFFICIENCY ACROSS THE U.S.



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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VI. SO WHAT IS <u>BETTER</u>? THE “MARKET” OR “PUBLIC PROVISION?

THE CENTRAL ISSUES OF INTEREST ARE:

- contributions by ability to pay?

or

- contributions based on actuarial principles?

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

or

- price discrimination based on patient's ability to pay?

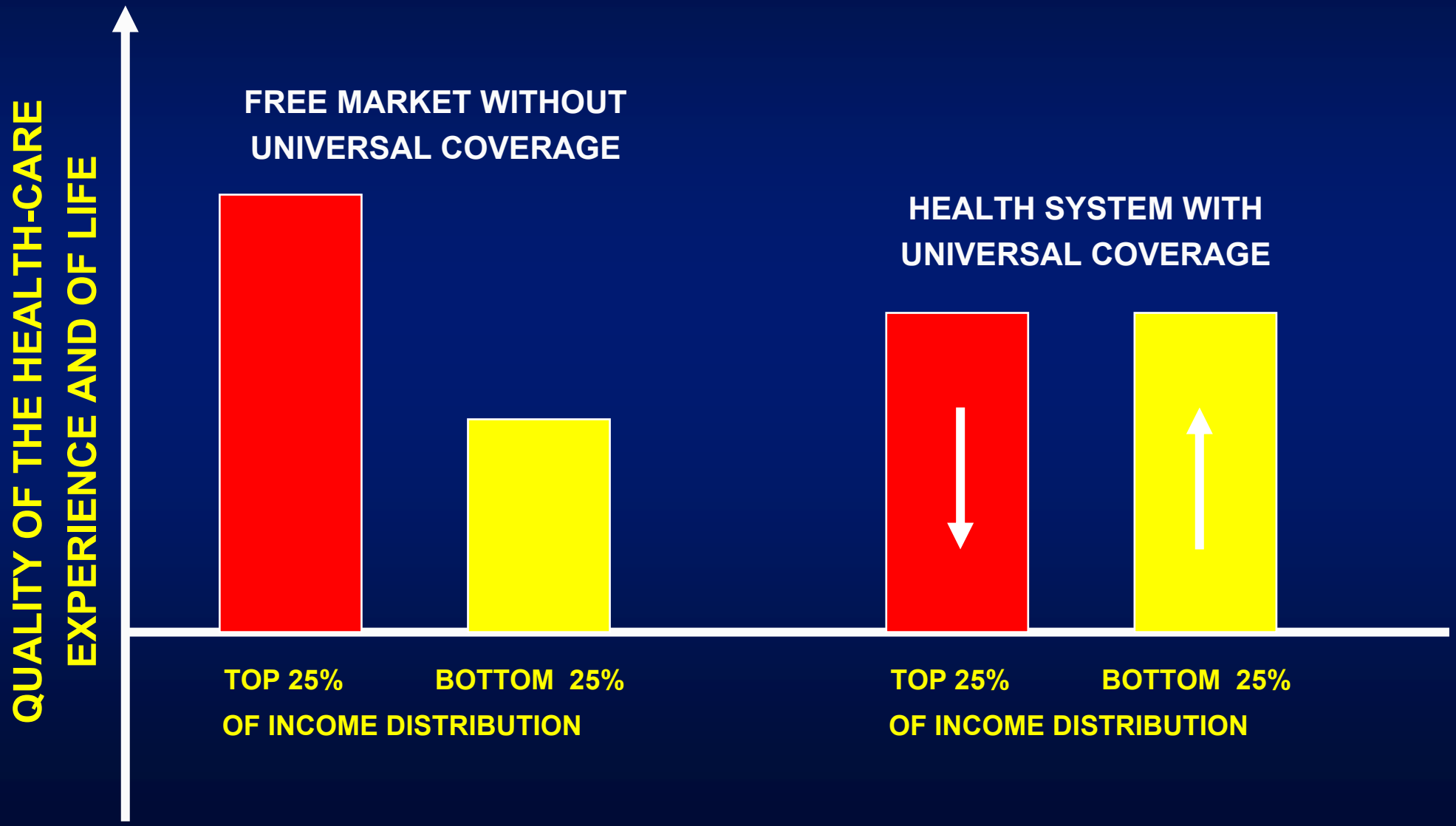
PUBLIC PROVISION

- 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 9and, 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



THE END