Role of Government in Health Care

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ROAD MAP

1. Rationales of Government Intervention
2. Types of Government Intervention
3. PPP in Health Care
4. Private Health Insurance

I. Rationales of Government Intervention in Health Care

Perfectly Competitive Market (Benchmark case) : case for no government intervention

Large number of sellers and buyers: price takers

Perfectly substitutable (homogeneous) goods and services

Perfect information/knowledge by buyers and sellers

No barriers to entry and exit

Perfect mobility of factors of production

I. Rationales of Government Intervention in Health Care

1. Market Failure in Health Care

a. Information Asymmetry: if the individual does not have the necessary information to make a rational decision (i.e., correctly valuate the benefits and costs of an action), inefficient resource allocation results

→ smoking, safety of drug, quality of medical care

→ Need safety regulation, regulation of price and provider behavior, regulation of advertising

- Information asymmetry in health care requires the licensure of providers, which then results in market power of them (entry barrier)

b. Public Good:

Communicable disease control, public health program

Non-exclusion: extremely costly to exclude individuals (non-payers) from the benefits of public goods

→ results in free riding, and pricing is not feasible

Non-rivalry in consumption: zero cost for an additional individual to benefit from public goods (consumption of an additional individual does not decrease the amount available to others)

→ inefficient to price (marginal cost pricing)

- Consequently, public goods will not be supplied by the market or will be supplied in insufficient quantity

  (e.g., national defense, light house, global health security)

-> Government directly finances or provides public good

c. Externality

External benefits (positive externality) and costs (negative externality) arise when one person's actions create benefits for or impose costs on others

- and those benefits and costs are not privately accounted from in individual's decisions

Negative externality:

smoking, drink and drive, pollution

-> over-consumption (than the socially optimal level) results

Positive externality:

CD control, scientific discoveries -> under-consumption

Remedy: Should make decision makers consider full social effects (benefits and costs) of their decision

- > Subsidies, taxes, user fees, regulations

2. Equity in Health/Public Finance

a. Vertical equity

Adequacy of the relationship between (tax) payments of individuals with different ability to pay

- Progressive: effective tax rate increases with income (capacity to pay)
- Proportional: effective tax rate is constant
- Regressive: effective tax rate decreases with income

2. Equity in Health/Public Finance (continued)

b. Horizontal equity

Equal treatment of individuals who are identical in relevant respects (i.e., ability to pay)

→ horizontal inequity can arise due to tax evasion, tax exemption favoring a specific group of people, tax on commodities that are mainly used by a specific group of people, etc.

Income	Share of (before-tax) income	Tax	Effective tax rate	After-tax income	Share of (after-tax) income	
40,000	40%	5,000	12.5%	35,000	38.9%	regressive
60,000	60%	5,000	8.3%	55,000	61.1%	
		4,000	10.0%	36,000	40%	proportional
		6,000	10.0%	54,000	60%	
		3,000	7.5%	37,000	41.1%	progressive
		7,000	11.7%	53,000	58.9%	
		10,000		90,000		

3. Equity in Health Care and Health

a. Vertical equity in health care payment:

need progressivity in payment for health care

→ The better off should pay more for health care than the poor pay

→ Degree of progressivity in general:

Income tax > SHI > Private Insurance > OOP

b. Horizontal equity in health care utilization:

need ETEN (equal treatment for equal need)

→ Health care utilization of the poor can be greater than that of the rich when there is no adjustment for different health status or health care need between the two groups, because the poor usually are sicker and have greater need for health care

c. Equity in Health

Inequality in health -> inequality in people's capacity to function -> inequity in earnings, well-being…

Role of Government Policy

- Tackle preventable, remediable inequality
- Tackle inequity in the determinants of health: Tackle unequal distribution of health determinants (role of upstream policy)
- Role of behavioral factors? -> some of the behavioral factors are not purely individual but more of system/policy factors, e.g., alcohol, obesity

➢ Health policy needs targeting, and attempts to not only increase the *average* level of health, but also decrease the *difference* in health across different socioeconomic groups

4. Self-interest and Government Intervention: Political Economy

Demand for government intervention:

e.g., entry barrier demanded by interest groups

Supply of government intervention

- politicians (legislature)
- administration (administrative rules, policy implementation)

Government failure or Non-market failure

4. Self-interest and Government Intervention (continued)

Evidence

- Collective action dilemma: e.g., concentrated benefits (to interest group) and diffused costs (to the public)
- Regulatory capture, revolving door, lobby power of medical profession, corruption in enforcement
- Inefficiency in the public sector/government bureaucracy, problems of capacity and incentive for regulators
- E.g., medicines manufacturing, distribution and service delivery

II. Types of Government Intervention in Health Care

1. Different Mechanisms

a. **Mandate**

- On the employer: final incidence?
- On the consumer

b. **Financial incen**tive (subsidy or tax): depending on the market mechanism

- tax exempt for not-for-profit hospitals, subsidy for NGOs/Social Franchise for service provision (e.g., MCH)
- Benefits and cost?: in terms of quality, equity

c. **Direct provision**: NHS (National Health Service), public hospitals

2. Different Types

1) Entry regulation/prohibition

- License (for minimum standards) or certificate

- Allowing new providers/beds according to government planning or need assessment/regional equity (e.g., CON (Certificate of Need) in the US)

  -> Enforcement issues in license and registration in LMICs, Potential anti-competitive issues in geographic distribution

2. Different Types (continued)

2) Price regulation

Price regulation of medical care (fee scheduling)

Price regulation of pharmaceuticals and device

- Mark-up regulation (cost-plus pricing)
- (external) Reference pricing
- Differential pricing
- Value-based pricing

2. Different Types (continued)

3) Quality regulation

- Safety and efficacy of drugs/device: transparency?

- Accreditation of providers (by government, insurance agency, or self regulation):

  -> capacity of the third-party payer?, payment liked to quality? pros and cons of self regulation?

- Consumer protection or Medical malpractice (fault-based or no-fault system?):

  - > deterrence and compensation

  -> difficult for consumers to win over defendants (providers)

2. Different types (continued)

4) Provision of information

To mitigate the problems caused by information asymmetry: Evaluation and dissemination of the information on quality

a. Evaluation of health care institutions:

input – throughput – output ?

b. Evaluation of services: e.g., C-section rate, antibiotics use -> how to adjust for patient severity?

c. Practice guidelines for providers

3. Different Sub-Sectors

1) **Physicians**: regulation on advertising
- informative or deceptive (wasteful competition)?
- depends on search, experience, and credence good (characteristic)

2) **Hospital**: requirement on personnel and facility for quality, or payment linked to personnel

3) **Payer**:
- Mandate for the payer to accept all applicants (no cream skimming)
- Uniform or minimum benefit package

3. Different Sub-Sectors (continued)

4) **Pharmaceuticals**

- Reference pricing
- Advertising on prescription drugs
- Generic or brand-name prescription
- Requirement of (or incentive for) substitution of generic for brand-name drugs
- Technology assessment
- Listing (positive or negative) for reimbursement

III. PPP in Health Care

1. Types of PPP

Service Delivery

- Different degree/modality of PPP
- Joint investment for facilities/equipment
- Contracting out: part of or entire public service
- Public insurance purchases services from private providers: purchasing

Financing

- Private insurance: substitutive or complementary
- Insurance management/carrier: India

1. Types of PPP (continued)

Financing

- Insurance management/carrier: India, US Medicare
- Private insurance: substitutive or complementary

Service Delivery

- Management contract for public hospital
- Contract-out clinical or ancillary (support) services: catering, cleaning, lab tests, diagnostic services
- Joint venture investment or Contract-in for equipment: invested by medical staff or external investors
- Private hospitals: reimbursed by public financing too (often smaller, more specialized in a few product lines)

2. Key Issues of PPP

How to improve accountability: *Same goal, different tools*

- Decision power
- Reporting requirement

Contractibility, transaction cost economics:

- How easy to define the service package?
- How easy to measure and monitor quality/performance?
- Payment method? Risk contracting?

Transparency

- How to draft a contract and select the contractor?

3. Types of Hospitals/Providers

(Harding and Preker, 2003; Maarse, et al. 2005)

Budgetary organization: government owned, command-and-control system, appointed senior officials, (detailed and inflexible) budget is set by the state agency, surplus cannot be used by the hospital, deficit is covered by the government

Autonomized organization: government owned but managers are given some autonomy in day-to-day operations, key decisions (e.g., staffing) are still made by government, *surplus* from some additional activities can be retained, global budgeting (savings in one area can be used for others) can be used instead of line-item budgeting, agreement between government and hospital on performance targets

3. Types of Hospitals/Providers (continued)

Corporatized organization: *public entity but operated as private firms*, more managerial autonomy and exposure to market competition, surplus is retained but hospital is responsible for loss (can be bankrupt), performance-based contract for management

Privatized organization: public hospital becomes a private hospital (not-for-profit or for-profit) although government can have some ***regulatory control*** and shareholding (in case of for-profit hospitals), fully exposed to market competition, no guarantee to fulfill social goals

-> Government regulation is a key to the performance of private hospitals

IV. Private Health Insurance

1. Nature of Private Health Insurance

Voluntary enrollment, consumer choice

Potential efficiency by competition between public financing scheme and private health insurance

Attractive to those who favor individual responsibility, private sector, market/competition

Access based on the willingness and ability to pay rather than on medical need

2. Types of Private Health Insurance

1) Substitutive Private Health Insurance

People can opt out (of SHI) for private health insurance

High risk groups stay in the public scheme because they cannot afford high (risk-based) premium of private health insurance

-> Increase in the premium of the public scheme

e.g., Germany

2. Types of Private Health Insurance (continued)

2) Complementary Private Health Insurance

When public financing scheme cannot provide a very extensive benefit coverage (to satisfy the entire population), public scheme can provide basic benefits and people can purchase complementary private insurance

a. If private insurance covers copayment (OOP) of the public scheme

-> increased medical care utilization under the public scheme (moral hazard effect, fiscal impact on the public scheme)

2. Types of Priv Health Insurance (continued)

2) Complementary Priv Health Insurance (continued)

b. If private insurance covers uncovered services under the public scheme or if it provides high priority (jumping) in waiting list for public scheme

- Two-tiered system: Those who purchase private health insurance use more medical care (or more quickly without waiting) -> inequity in medical care use
- Covered and uncovered services are usually bundled together by providers: those with private insurance use not only more un-covered services but also more services covered by public financing (fiscal impact on the public scheme)

3. Problems of Private Health Insurance

1) **Regressivity** of private insurance premium

Premium based on health risks, not income

2) **Multiple payers** in health care financing

Increasing bargaining power of medical providers
-> higher payment to providers (e.g., US),
higher administrative cost
-> Health care cost inflation

3. Problems of Private Insurance (continued)

3) Does private insurance **increase Efficiency**?:

Does competition work in private insurance markets?

Adverse selection and cream skimming

-> insurers segment markets and prefer group enrollment (adverse selection is less likely in group enrollment)

-> very high premium for individual-based enrollment or for the unhealthy

Difficult for consumers to rationally purchase/select private insurance <- very complicated structure of benefit package and premium

3. Problems of Private Insurance (continued)

4) Political support

When private insurance is prevalent, political support can decrease for the public scheme or for more funding to the public scheme

Who favor private health insurance?

- Providers: alternative source of financing and contract
  -> can avoid monopolistic public financer
  (government or SHI)
- the wealthy prefer risk-based premium (of private insurance) to income-based contribution (of SHI)