

Discuss the various methods used to allocate scarce resources in the US health care system. What are the implications of these allocations (in terms of quality, outcomes, efficiency, and equity) and how can the “system” improve its performance by addressing these allocative decisions?

Both domestically and abroad there are several methods of allocating scarce resources in healthcare systems. In the United States we currently have a capitalistic hybrid system that evades a concrete categorization; many European nations and Canada utilize social systems based on justice and equity. We discussed most notably methods of allocation in the free market system, the social justice system, and the combination system.

Free Market System, Regulation, and Outcomes

The free market system essentially existed in America prior to 1965 (although we agreed it truly was a combination system considering there were charity hospitals). The free market economic principles of supply and demand helped shape healthcare delivery, which was primarily indemnity based. In the most pure (and completely theoretical) form, the production and consumption of health care as “goods” are based on cost, price, competition, need, desire, and available funds. People believe that by paying more for greater quality, they will in fact receive as much. Health resources are allocated according to consumers' purchasing behaviors; need is based on consumers' wants and desires. Physicians charge whatever the market will bear and limit the amount of charity care they provide in order to maintain profitability (see market power discussion below). Those who cannot pay simply go without care. Drug companies and high-technology providers sell their wares in any kind of forum (e.g., direct-to-consumer marketing). For consumers, the byline is "buyer beware."

At present, very few free market-based enterprises exist as stand-alone commodities; they are nestled within the context of a combined system in the United States. The specialty clinics, wherein providers perform specific procedures like plastic surgery, LASIK, or maybe special diet clinics are our best modern free market examples. Perhaps these practices receive some government funding or tax benefits, but most patients who receive care there are 1) getting an elective procedure usually not covered by insurance and 2) are paying out of pocket, so they had to shop around to find what works for them. This follows most closely the standard tenets of supply and demand, a pure economic panacea.

It is clear that the economic system of health care suffers from imperfections. Because of risk and uncertainty inherent in the health care business, it does not function as a perfectly competitive market, thereby limiting the influence of straightforward economic theory. Health insurance shields & insulates people from the true costs and values of ‘care.’ Health insurance even incorporates moral hazards; in fact, peoples’ choices may not reflect their true values at all. Market power suggests that prices will exceed marginal costs and will compound the distortions caused by insurance. An additional imperfection, termed ‘externalities,’ attempts to describe actions taken by consumers for

private/internal (versus public/external) benefit. Consumers fail to realize the full benefit or costs of their actions, which ultimately have an impact (positive or negative) on the system as a whole.

Because of these externalities interfering in the system, the government employs many regulatory tools based on the concept of rational consumer ignorance, which questions the ability of consumers to make good decisions (i.e. that they need some sort of protection from the consequences of their questionable decisions). The government's somewhat paternalistic regulatory role within the current system has implications in terms of quality, outcomes, efficiency, and equity.

Price control is an effective and ubiquitous regulatory tool in the free market system, as governmental interventions and pricing schema have a profound effect on institutional spending/purchasing/delivery. For example, controlling Medicare reimbursements to hospitals and providers has a drastic economic impact on everyone involved in healthcare.

Market systems use pricing to ration goods and services, and the same applies in healthcare; differing levels of health insurance make available differing levels of medical coverage and options. Rationing is a difficult and emotional issue within the free market framework; however, as consumers equate it to overzealous governmental oversight in an attempt to limit health and deny expected services. Additionally, increased cost sharing (increased co-payments, etc) reduces total utilization (and Lee states that this occurs with minimal effects on health)...spending decreases.

Managed care organizations act as agents as well via capitation and global payments, providers have incentives to allocate care only as necessary (although most providers will follow their collective consciences and deliver the appropriate care regardless of compensation). The managed care companies attempt to encourage frugality and efficiency in this manner.

The free market system as we practice it at present does a remarkably fine job with outcomes (such as mortality rates, success of cancer treatments), despite the implementation of various oversight and rationing programs. Outcomes research is a powerful means of assessing performance; clinical outcomes are what matter to patients. A historical perspective will demonstrate that we have achieved progressively better results as our knowledge and technology have improved.

As providers and clinicians, we realize that quality (defined as superiority in kind), and outcomes are variable with every encounter in the US healthcare system; overall, our experiences have been positive. The domestic healthcare paradigm is dynamic and in great flux, causing much consternation about quality. As is true with all methods of delivery, providers' ethics and values typically favor (and produce) good quality healthcare, regardless of financial incentives.

Because of the intense complexity of our delivery system, some level of inefficiency can be expected. Our healthcare system has incorporated clinical guidelines and evidence-based medicine principles in an effort to improve quality, outcomes, and efficiency. Although this allocation method overall appears successful and does a great deal of 'good,' it is debatable if it is a model of allocative and productive efficiency; we ask does society want the healthcare that is actually being delivered, and is delivery occurring at the lowest possible cost? Perhaps it is impossible to achieve satisfactory levels of quality, efficiency, and cost.

As a group we certainly agree that it is not a wholly equitable system, as approximately 40 million persons in the US are uninsured for various reasons. We emerged from a fee-for-service and indemnity system in the recent past, and the shift to socialization (implying universal coverage) has been slow. Governmental regulations based on rational consumer ignorance and concepts of inequality have benefited many, though, and the process continues. Once again, it is debatable whether horizontal equity (equal treatment of equal need) and vertical equity (the extent to which individuals who are unequal should be treated differently) are practices achieved as often as society determines they should be achieved.

Social Justice, Adaptations, and Outcomes

The second method of resource allocation is the social justice system. It is essentially national health insurance. Defining this entity is troublesome, since we must decide what 'need' is and what services are covered – are only basic clinical services (e.g. primary care visits, screening exams, mental health visits) included, or do we also include public health and spa benefits? And, then, who is covered for what services? Are prisoners and the very old in the same risk category to receive care and organ transplants? How about unusual circumstances, such as rescuing mountain climbers from an avalanche? Who pays in this case? Although people contribute heavily via taxes, not all services can be provided free of charge; money is a scarce resource regardless of the system in place. Perhaps the managers of these plans need to institute cost-sharing practices. Considering some of the European healthcare plans, there does exist some rationing of services; as we discussed in class, cash payments in some systems alleviate rationing constrictions to some degree, but this is not a universal characteristic.

Single-payer systems organized by government greatly reduce bureaucratic overhead and the moral hazard of "free riders" who overuse the services. Maintaining physicians on a fee schedule, as opposed to letting the market establish the price of services, keeps the amount of gross domestic spending on health care low. This also eliminates the adverse selection problems that deny insurance coverage to people who consume a greater-than-average share of health care.

Based on healthcare in other social justice markets (Europe), the quality of care provided appears comparable to other technology-driven healthcare systems. Our sense is that much of 'quality' is based upon providers' ethics and beliefs to do the best that is possible for the patient. We must consider, however, the potential effects of minimizing (or

eliminating) competition. Quality and outcomes may suffer, though, if rationing of infrastructure/technology limits access to care (such as waiting 4 months for a cataract procedure). This seems to occur frequently in many social justice-based systems.

As mentioned, outcomes may suffer based upon availability of technology and services; however, emergent care and subsequent outcomes likely remain quite comparable (to the US). Once again, though, outcomes may depend on an ethical component of society - who gets what, and why? Deaths from specific renal & cardiovascular diseases may remain high (perhaps unacceptably high in some societies?) due to availability of transplant treatment facilities and ancillary personnel. There is a level of sacrifice that must be made for the greater good – who decides?

Efficiency and equity are strongly correlated within social justice. A method of allocating healthcare resources whereby providers are funded on the basis of an average level of need for care, but may serve 'patients' with below average or above average need would be efficient and equitable. Both implications convey maximizing the expected improvement in health status produced from a given amount of health care resources, and hence populations with greater potential for improvement are allocated more resources. Some would argue, however, that long potential waiting times for certain routine, non-life threatening procedures may indeed be an inefficient system. The nations with these systems claim to have lower stress within their societies (and that is indeed what a few of us have experienced & seen when traveling), so the overall impact on healthcare may include less chaos at the primary care level. Less congestion (less utilization) would improve efficiency. Localities in the US have established social healthcare programs with varying degrees of success. Milwaukee, WI, experienced social justice in healthcare from 1910-1960 (driven by the socialist reform platforms of the mayoral and gubernatorial leaders), achieving not only good health care for nearly all, but also clean streets and efficient municipal services.

Additionally, with one insurance plan, the administrative cost to providers should shrink and this should have a positive impact on the overall price and efficient delivery of healthcare. Those that are financially more well off can afford to pay out-of-pocket, or for additional insurance, for a higher standard of healthcare or specialty service not covered by a national plan. As mentioned in the free market discussion above, it is debatable whether levels of allocative and productive efficiency are satisfactory to individual members of society within the social justice system. Equity introduces the notion of fairness into the allocation of resources - provide equal resources for populations with equal needs but unequal resources for populations with unequal needs (horizontal and vertical equity). This notion applies for basic clinical and preventive medicine. However, as mentioned above, who receives what becomes an issue in the era of cost-containment. Are allocations determined by distribution of health care facilities and providers of care or by a national program oversight board (and what are their priorities)? Is it equitable to ration organs and other major procedures? Is it equitable to ration organs and other major procedures? Is it equitable to institute a progressive tax plan to fund healthcare? The methods in place cannot provide everything for everyone. Social worth muddies the picture.

So what is the criterion of 'need' that drives the social justice system? Here is one broad working definition: "need" for health care is ability and desire to benefit from health care; it is welfare for all. With this understanding, reasonable access to care (i.e. access without financial or other barriers) does not imply availability in response to demand for care; rather it implies availability where the use of such services would lead to improvement in health status. We still must determine what society deems appropriate for basic human rights, for universal basic care, and for care beyond the purview of the greater good.

Combination: A Work in Progress

A third method of resource allocation is a combination of the two discussed. This combined system (nearly impossible to describe) is what has developed and existed in the US for decades; there are elements of social justice, such as charity, military, Medicare and Medicaid, along with an overriding (and changing) devotion to free market economics, as we are all indoctrinated with the benefits of capitalism from a very early age. Future manifestations are unclear at this time, however, although everyone agrees that the system in place needs improvement.

Ideally, we desire a combined method of allocation that realistically defines and achieves good quality and outcomes in an efficient and equitable manner. One that provides coverage for all, without bankrupting individuals, insurance companies, or governments, and with respect for rights and liberties, is possible. A system that combines the best of free market and social justice is theoretically attainable provided that Americans are willing to modify their expectations and behaviors. Drawing from our thoughts from the last paper, since we spend \$1.3 trillion on health care annually, we can indeed afford to create a balanced system if allocated properly; this may contradict the desires of powerful special interest groups and political action committees, unfortunately. Several other factors also have an impact: technology rationing, preservation of Medicare reimbursement (and incorporation of a higher fee schedule under a single-payer system to balance the current practice of risk sharing), and impact of salary modifications to productivity, to name a few.

A benefit of the social justice method and single payer system is that the administrative cost to providers should shrink and this should have a positive impact on the overall price of healthcare. Juxtapose this with a probable decrease in governmental interference, and productive efficiency should slowly maximize (salaries notwithstanding). Allocative efficiency, on the other hand, is too nebulous a concept for predictions; longer waits to be seen will undoubtedly occur and taint overall perceptions of efficiency (and possibly quality & equity).

With incorporation of social justice, we can hope to maintain adequate levels of quality as long as proper funding supports our medical infrastructure; this relates directly to outcomes as well. Once again, professional ethics and practices are the key element in these aspects of clinical care. As discussed, equity (and access) is at the heart of the evolving continuum from fee-for-service to indemnity to free market to combined to social justice. We discussed the many elements that comprise social justice, and they are

ideals to which we can aspire, depending upon innumerable variables. Maximizing improvement in the health status of the population (primarily through behavior modification) is an ongoing struggle, but we've had many successes in doing so. By targeting prevention, we can decrease morbidity (read demand). Less morbidity allows for redirection (read rationing) of finances to those who, in the past, may have been outsiders to the healthcare system. In turn, the acuity of certain care could be directed to our enlarging geriatric populations.

Conclusion

We have evaluated and discussed implications of three methods of allocating scarce resources: free market, social justice, and a hybrid model. There are obvious negative and positive benefits to each. The evolving hybrid system that exists in the US is attempting to incorporate the best aspects of each method and its implications on quality, outcomes, efficiency, and equity. With these in mind, it is clear that classic supply/demand economic theory inaccurately predicts healthcare change as a commodity. Healthcare reform, therefore, is a work in progress, hopefully improving with time.

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