PERSPECTIVES ON THE APPROPRIATE ROLE OF THE PRIVATE SECTOR IN MEETING HEALTH-CARE NEEDS

Uwe Reinhardt,
Professor of Economics and Public Affairs
Woodrow Wilson School of Public and International Affairs
and
Department of Economics
Princeton University

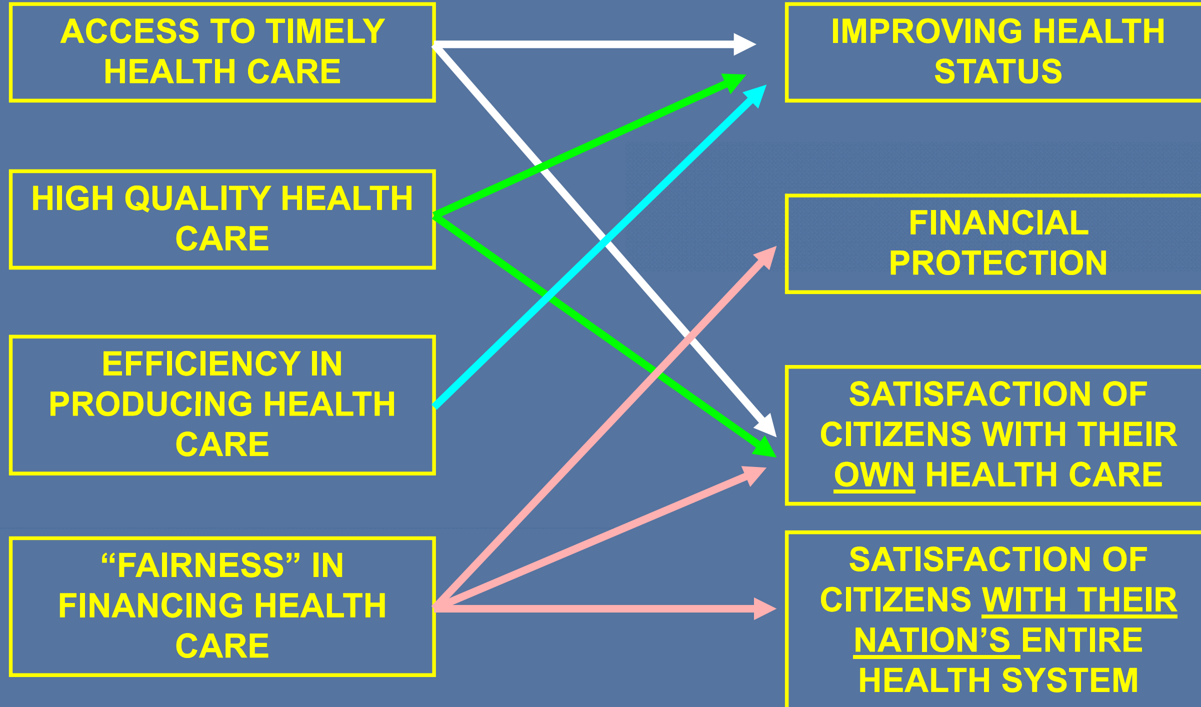
International Monetary Fund

OAP/FAD Conference: Public Health reform in Asia

Tokyo, Japan

October 3rd, 2011

I. WHAT GOALS SHOULD A HEALTH SYSTEM ACHIEVE?



II. HEALTH CARE AND THE MODEL OF COMPETITIVE MARKETS

The typical textbook model of private enterprise operating in competitive markets is based on a number of stringent assumptions not met for most health care, among them:

1. The commodity being produced and traded are fully and accurately understood by potential buyers who therefore can assess properly the desirability of the commodity.
2. There is a limit to the physical harm that faulty products can visit on the buyer.
3. Buyers pay the full price charges for the commodity.
4. Competing producers post these prices publicly and are easily understood by potential buyers (i.e., they are not multi-dimensional).
5. Producers can enter the market freely and exit it at low-cost.

Very few items of what we call "health care" fit this model.

1. There is great asymmetry of information, meaning that usually patients do not know whether they actually need the services and products (e.g., drugs) doctors and other sellers of health care may prescribe to them.
2. The truth is that even highly honorable physicians themselves often disagree on how to best treat given medical conditions.
3. If patients have health insurance, they may not care much about the full price and cost of producing health care and insurers are far away.
4. In any event, it would be difficult to post prices on most health care because (a) usually it is not known ahead of time what treatments patients need, and (b) there rarely is a standard unit of "health care" that can be priced.

Under these circumstances, it seems reckless to entrust the health care system to the free market operated by profit-maximizing, investor-owned enterprises or even to income-seeking not-for-profit enterprises.

In fact, no nation does this.

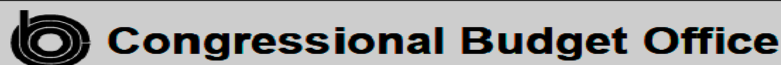
Private enterprises and private markets certainly can and should play a productive and useful part in any health system – and almost everywhere do – but they must be strictly supervised by government (and by public and private insurers who pay for health care) to make sure that they do not:

a) **Deliver (sell) to patients health care services or products that are not clinically needed or may even harm patients (drugs, imaging);**

b) **Deliver poor-quality and possibly harmful services and products;**

c) **Engage in price-gouging *vis a vis* sick, anxious people.**

Unfortunately, waste, fraud and abuse are widespread in health care the world over. The U.S. is by no means an exception.



Testimony

Statement of
Peter R. Orszag
Director

The Overuse, Underuse, and Misuse of Health Care

before the
Committee on Finance
United States Senate

July 17, 2008

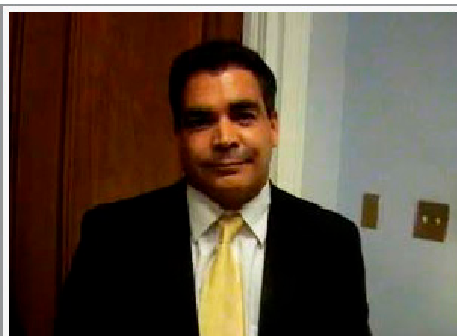
Probably the best way to reduce fraud is to punish it severely.

FEDERAL COURT

Judge sends Medicare offender to prison for 50 years

Like Confirm

A judge socked a convicted Miami healthcare executive with a 50-year prison sentence, longest ever imposed for Medicare fraud offender.



Lawrence S. Duran

BY JAY WEAVER
JWEAVER@MIAMIHERALD.COM

New York transplant Lawrence Duran once ran a multimillion-dollar mental health company in Miami, lobbied Congress for his industry and tooled around town in a Maserati.

His next stop: federal prison — likely for the rest of his life.

On Friday, a federal judge slammed Duran, 49, with a 50-year prison sentence for orchestrating a staggering $205 million scam at his Miami-based chain of mental health clinics.

The sentence may end up being the longest prison term ever imposed on someone convicted of Medicare fraud.

Duran's lawyer, Lawrence Metsch, had urged the judge to be realistic and give him a sentence between 20 and 25 years, arguing that 50 years means a "death sentence because he would die in prison."

See also http://www.stopmedicarefraud.gov/

III. IS INVESTOR-OWNED PRIVATE ENTERPRISE MORE EFFICICIENT THAN NON-PROFIT OR GOVERNMENT ENTERPRISE?

Economists theorize – and simple intuition suggests – that a given task usually is accomplished more "efficiently" by private, investor-owned, for –profit enterprise than by non-profit or governmental enterprises.

By "efficiently" is meant that the given task will be accomplished at lower real-resource costs.

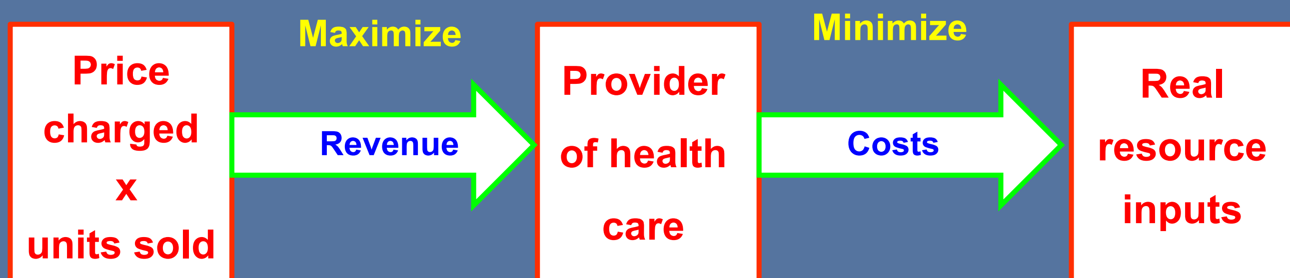
That theory is intuitively appealing, because profit-driven enterprises have powerful incentives to minimize the cost of producing whatever they produce.

By contrast, government-owned and operated enterprise is thought to have the following drawbacks:

1. Without the discipline imposed by the suppliers of private financing, public entities may lack the incentive to minimize costs for a given output.
2. Without that external discipline, public enterprise may invite inefficient nepotism.
3. Depending on the context, public enterprise may become the victim of political patronage imposed on management.
4. There are no well defined people to whom strict accountability is rendered annually.

In somewhat milder forms, some (b y no means all) not-for-profit private enterprises may be subject to the same drawbacks.

But production costs are not the same as prices charged customers. Private enterprises have every incentive to maximize (via prices) the revenue they earn from selling their services or products.



Too many economists fail to distinguish between price and cost, apparently assuming that heath care markets are perfectly competitive – a completely unrealistic assumption.

III. HOW DIFFERENT HEALTH SYSTEMS ENGAGE PRIVATE ENTERPRISE

A TAXONOMY OF HEALTH-SYSTEM COMPONENTS

OWNERSHIP OF PROVIDERS	FINANCING AND HEALTH INSURANCE: SOCIAL INSURANCE (Ability-to-pay financing)		PRIVATE INSURANCE (Actuarially fair financing)		NO HEALTH INSURANCE (Out-of-pocket)
	Single Payer	Multiple Payers	Non-Profit	For-Profit	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

SOCIALIZED MEDICINE

FINANCING AND HEALTH INSURANCE

OWNERSHIP OF PROVIDERS	SOCIAL INSURANCE (Ability-to-pay financing)		PRIVATE INSURANCE (Actuarially fair financing)		NO HEALTH INSURANCE (Out-of-pocket)
	Single Payer	Multiple Carriers	Non-Profit	For-Profit	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

MEDICARE

FINANCING AND HEALTH INSURANCE

OWNERSHIP OF PROVIDERS	SOCIAL INSURANCE (Ability-to-pay financing)		PRIVATE INSURANCE (Actuarially fair financing)		NO HEALTH INSURANCE (Out-of-pocket)
	Single Payer	Multiple Carriers	Non-Profit	For-Profit	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

SINGLE-PAYER SYSTEMS

OWNERSHIP OF PROVIDERS	FINANCING AND HEALTH INSURANCE				
	SOCIAL INSURANCE (Ability-to-pay financing)		PRIVATE INSURANCE (Actuarially fair financing)		NO HEALTH INSURANCE (Out-of-pocket)
	Single Payer	Multiple Carriers	Non-Profit	For-Profit	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

MULTIPLE-PAYER SOCIAL INSURANCE

OWNERSHIP OF PROVIDERS	FINANCING AND HEALTH INSURANCE				
	SOCIAL INSURANCE (Ability-to-pay financing)		PRIVATE INSURANCE (Actuarially fair financing)		NO HEALTH INSURANCE (Out-of-pocket)
	Single Payer	Multiple Carriers	Non-Profit	For-Profit	
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

THE PRIVATE HEALTH INSURANCE SECTOR

FINANCING AND HEALTH INSURANCE

OWNERSHIP OF PROVIDERS	SOCIAL INSURANCE (Ability-to-pay financing)		PRIVATE INSURANCE (Actuarially fair financing)		NO HEALTH INSURANCE (Out-of-pocket)
	Single Payer	Multiple Carriers	Non-Profit	For-Profit	CDHC
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

THE PRIVATE HEALTH INSURANCE SECTOR

FINANCING AND HEALTH INSURANCE

OWNERSHIP OF PROVIDERS	SOCIAL INSURANCE (Ability-to-pay financing)		PRIVATE INSURANCE (Actuarially fair financing)		NO HEALTH INSURANCE (Out-of-pocket)
	Single Payer	Multiple Carriers	Non-Profit	For-Profit	CDHC
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O

Ranking different countries' health systems in terms of outcomes or cost-effectiveness is very difficult and highly controversial, because so many variables other than health care drive health-status indicators, such as mortality rates or disability rates.

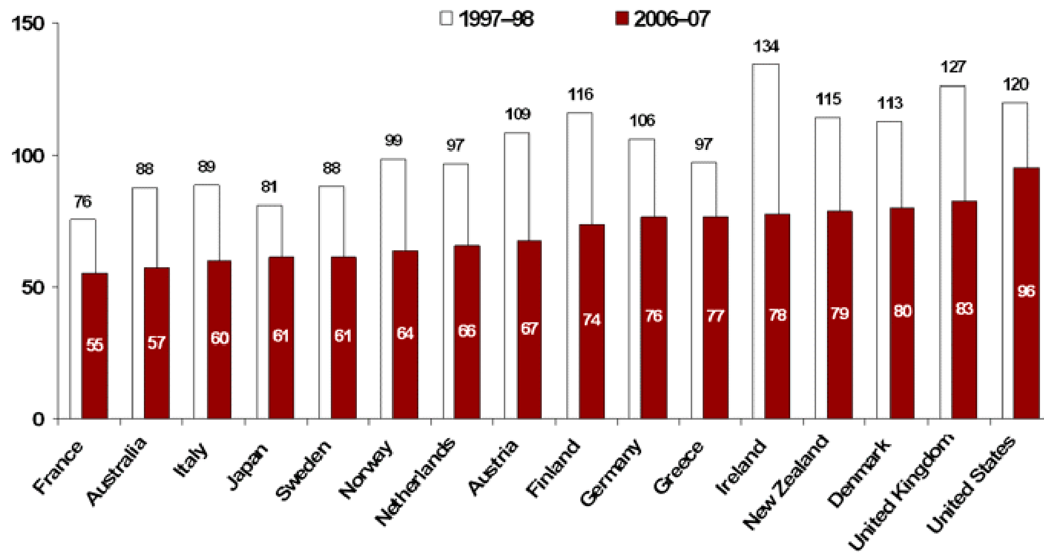
With this caveat, the following study just came out.

Variations in Amenable Mortality–

September 23, 2011

Authors: Ellen Nolte, Ph.D., and Martin McKee, M.D., D.Sc.
Journal: *Health Policy*, published online Sept. 12, 2011
Contact: Ellen Nolte, Ph.D., RAND Europe, enolte@rand.org
Summary Writers: Deborah Lorber
Access to full article: View Article

U.S. Lags Other Countries: Mortality Amenable to Health Care



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Source: Adapted from E. Nolte and M. McKee, "Variations in Amenable Mortality—Trends in 16 High-Income Nations," *Health Policy,* published online Sept. 12, 2011.

IV. SUMMARY AND CONCLUSIONS

1. Because health care does not fit the textbook model of private competitive markets driven by investor-owned private enterprise, it does not make sense to entrust the health system to normal private market forces.
2. In fact, I know of no nation that does so – not even the United States and even less so Switzerland and the Netherlands.
3. At the same time, all nations have found ways to engage private enterprise and private market forces to various degrees, but within a larger framework of tight regulation and government supervision.

4. The success of engaging private enterprise and markets in health care productively, so that they serve socially desired ends, depends on a number of factors.

   a) How smart and workable are the regulations issued by government.
   b) How diligently existing regulations are enforced (remember here financial markets!)
   c) How easy it is for interest groups with money to purchase the affection and legislative favors of politicians (a problem everywhere, especially in the U.S.)
   d) Last, but not least, how honorable and ethical the providers of health care are.