Markets in Action: Economics of Health Care

Who should pay for health care?

In 2008 the British National Health Service celebrated its 60th birthday but the future of the NHS as it exists at present always seems to be under question. How much longer can most NHS treatments and other services be provided free at the point of treatment and based on clinical need rather than people's ability to pay?

In most advanced countries the state is the dominant provider and funder of health care. The lowest share is in the United States where state funding represents less than fifty per cent of total health spending. In Canada, Britain and Sweden, the health service is funded mainly through general taxation. In Germany and France the system is funded largely from compulsory contributions made by employers and workers and from voluntary private insurance.

In most countries, health care is provided by the mixed economy. Doctors are usually self employed or in private practice. The government sector is most heavily involved in operating hospitals. Although in Britain, the government is giving hospitals greater autonomy in running their own affairs and in contracting out some health care to the private sector through its foundation hospital system

Four of the possible funding options for health care are

1. **Co-payments** - Ask patients to contribute towards the cost of non-emergency surgery, such as hernias and varicose veins.
2. **Ration care** - To some extent, this is already done by the National Institute for Clinical Excellence watchdog,
3. **NHS tax** - A specific tax could be levied to help pay for treatment
4. **Social insurance** - Public could be asked to pay into an insurance scheme

Equity and Efficiency in Health Care

(1) Economic Efficiency

Consider first the two main types of efficiency – **allocative** and **productive**:

- Does the health care provided in Britain meet people's changing needs and wants (i.e. do we achieve allocative efficiency?)
- Is health care provided at the lowest possible cost per treatment (i.e. do we achieve productive efficiency?) or could improvements be made in the efficiency with which health services are provided for millions of people?

(2) Equity

Are people's health needs met by health treatments on the basis mainly of **clinical need** or alternatively based on an **ability to pay for health services**? Are health outcomes in the UK reasonably equal across localities, regions, ethnic groups, age groups and by gender? Or are there unacceptable inequalities in the provision of health care across different sections of the population? The issue of equitable provision of health is an important ongoing issue.

Market Failure in Health Care

What might cause market failure in the provision of health services?

1. **Imperfect information among health care providers and consumers** - Consumers may under-value the long-term private benefits of consuming health care – due to information failure (or 'patient ignorance'). Health providers such as doctors and consultants have more specialised knowledge than consumers – an example here of asymmetric information.
2. **Moral hazard**: Many consumers in the healthcare market take out insurance to help pay for treatment; this, however, leads to a problem of moral hazard, where they take more risks and therefore require more treatment because they are insured. Again, this is a consequence of asymmetric information in the market where consumers know more than insurers about their intended future actions
3. **Lack of adequate health insurance:** It is virtually impossible for people to predict their future health needs. Sudden illness or injury may require extensive and expensive medical care for which most people are unlikely to have adequate health care insurance. Indeed the private health insurance market will not provide cover for all groups of people. High-risk individuals may find it impossible or expensive to get medical insurance if the market was the only provider of health care. The 'failure' of health insurance companies to provide cover for high risk groups is an example of **'missing markets'** – another cause of market failure
4. **Externalities arising from health care provision:** Health services are normally assumed to be **merit goods** providing a private benefit for people who consume them and additional **external benefits** for society as a whole.
5. **Inequalities in access to basic health care**: There are regional and local differences in the quality and quantity of health care available (media stories are fond of discussing so-called "**postcode prescribing**"). Millions of people are wholly dependent on the NHS for health care– they have no hope of being able to fund private health insurance. If people were required to pay for more treatments they would often be unable to afford them
6. **Monopoly power among health care suppliers:** if there was a wholly free market in providing health care, it is likely that in the long run, several dominant health care providers would emerge raising concerns about increasing market concentration and the opportunities for these firms to exploit their monopoly power.

The fundamental policy question regarding health care in the UK is this: Should it remain essentially **funded by the tax system** and provided mainly **free at the point of need?**

In the **United States,** which remains the world's largest spender on health care, state provided and state-financed health care goes mainly to the old and families on low incomes. Most American workers are insured privately through the **health insurance schemes** run by their employers. But this does not stop many millions of Americans being unable to afford their own health care insurance – this has become a huge political issue in the United States. There are also huge worries among US companies about the soaring cost of employer-funded health benefit schemes.

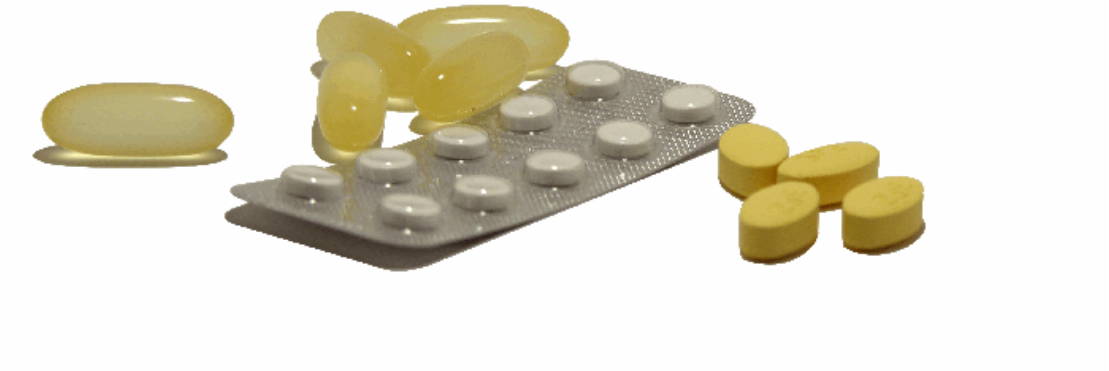
In rich developed countries, health care spending on average takes up nearly ten per cent of national income (GDP) and the projections for the years ahead see that figure continuing to rise.

The NHS will always face the problem of **resource scarcity** because our ever-growing demand for different types of health care exceeds the available supply. The Labour government is committed to significant increases in real spending on health + share of health in total GDP.

Fundamental Principles of the National Health Service

The Fundamental building blocks of the NHS are as follows:

- Providing a national universal (comprehensive) service
- Health care free at the point of use
- Medical care is not based on ability to pay but rather on the basis of **clinical need**



Who should pay for the drugs dispensed by the National Health Service?

The Economic and Social Importance of Health Care

- **Quality of Life and Poverty**: Health and well-being in childhood affect educational attainment with consequences for people throughout their lives. Ill health in adulthood is associated with poverty and long periods out of work. There is now solid evidence that improvements in medical care pay off in the long term in terms of healthier and longer lives.
- **Employment:** The NHS is the largest employer in UK with over 1.3 million people employed in the NHS in England alone. After social security payments, health is the biggest single component of government expenditure.
- **Productivity**: Ill health imposes a restriction on the productive potential of the economy. Around 2 per cent of working days each year are lost due to short-term sickness, while more than 7 per cent of the working age population is unable to work due to long-term sickness or disability costing over £12 billion a year in welfare benefits.
- **Higher Economic Growth and Standard of Living**: If average life expectancy could be increased by five years, UK real GDP could be £5 billion a year higher.

Fundamental Problems Facing the NHS

Rarely a day goes by without a health story featuring in the newspapers. The NHS faces many challenges – these are four of the main ones:

(1) **Persistent resource crises**: Resource problems are the consequence of under-funding and under-investment in the health service over many years – affecting the quality and quantity of the capital stock available to health providers

(2) **Hospital waiting lists:** There are persistent delays in people receiving appointments to see consultants and delays in receiving emergency treatment

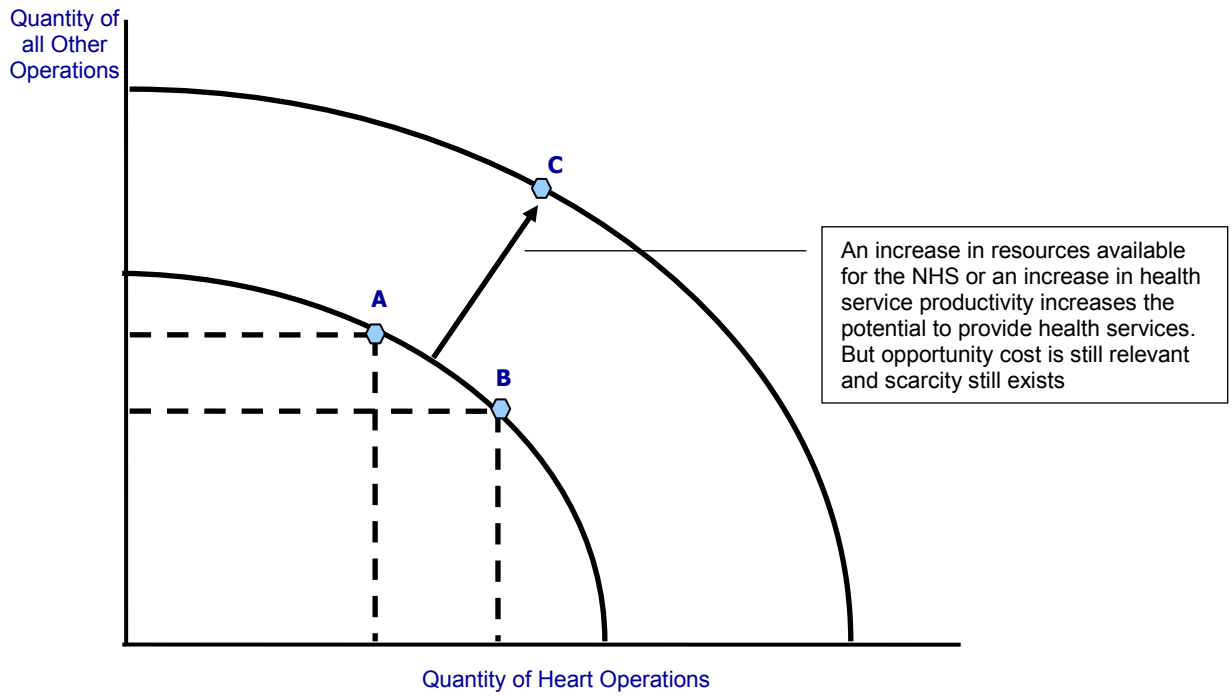
(3) **Problems in recruiting sufficient well qualified staff** which leads to long hours for NHS staff and contributes to wide disparities in the quality of care and range of care from region to region and between local health authorities.

(4) **Meeting the growing demand for health care**: There are growing doubts as to whether the NHS is meeting changing consumer preferences and growing health needs

Health Care Rationing – An Inevitable Process

Health rationing occurs because **demand for health care always outweighs supply**. In a free market, markets match supply and demand by altering price. This form of rationing relies on the simply fact that post-tax incomes are unequal and that those households on relatively low incomes will be the first to be priced out of the market. Rationing in the NHS is inevitable - no amount of resources from the Government funded by taxation could possibly meet all of our demands for health care when the NHS system remains based on the fundamental principle of most health services being free at the point of need.

In the diagram below, even if the government invests higher levels of money into the NHS system permitting an outward shift in the PPF for health care services, there is still an issue of scarcity to resolve even though the total "output" of the NHS can rise as a result.



The NHS currently rations health resources in a variety of ways

(1) **Government rationing**: Ministers and Parliament decide on the overall size of the NHS budget thus dictating the type and volume of care the NHS can provide

(2) **The National Institute for Clinical Excellence (NICE)** advises the NHS on clinical and economic benefits and costs of certain health care interventions

(3) **Health authorities and primary care groups allocate money to particular disease/treatment areas**. Treatment decisions for individuals are made at the clinical level by health care professionals

Key Factors Putting Increased Financial Pressures on the NHS

(1) **Developments in medical technology and new treatments:** The fruits of research and development in health sciences has brought us many new medical procedures (such as transplants); new treatments and new products (e.g. magnetic-resonance imaging scanners)

(2) **New drugs** including drugs that reduce the "risk" of disease rather than the symptoms of illness – e.g. statins to lower cholesterol

(3) **The increased costs of staffing in the NHS** -the NHS is a highly labour intensive industry. The costs of staff can take up to sixty per cent of the operating expenses of a hospital.

(4) **Growing health problems** including diseases associated with affluence and the health issues following an increase in relative poverty – for example the costs of treating smoking related diseases and the costs of treating illness associated with rising levels of obesity

(5) **Long term change in age structure of the population** - The cost of health care rises dramatically for older patients and the UK population along with that of many other countries is becoming older as average life expectancy continues to grow

(6) **Increasing expectations of patients and their families** – in part the result of politicians promising to achieve improved health outcomes from extra funding

Demographic Change and the NHS

The UK population is ageing. The medical conditions that account for the majority of the burden of disease in the UK are primarily related to old age – e.g. cancer and coronary heart disease. Spending on health varies significantly with age. The beginning and end of life are the most expensive. On average, around a quarter of all the health care someone consumes in their lifetime is consumed in the last year of their life. Just over a third of all spending on hospital and community health services is for people who are over the age of 65.

Case for Maintaining a Tax Funded Health Care System

1. The NHS can exploit **economies of scale** and provide health services for millions of people at an efficient cost – these scale economies include the benefits of specialization and significant buying power in the purchasing of drugs from pharmaceutical companies
2. Revenue to fund the NHS is drawn from a millions of taxpayers who pay mainly through a progressive system of direct taxation- satisfying the principle of **vertical equity.** Higher income taxpayers are therefore paying more towards the general provision of health care – the NHS is a means towards greater equality of opportunity within society
3. Basing health care treatments on being able to pay might discourage people from seeking important treatments

Case for using the Market Mechanism

1. With user charges, households would choose their own pattern of consumption and the supply of health care would then adjust to the pattern of preferences
2. The demand for health treatments would be linked to the private benefit to the patient – so a wider system of charging / private sector provision would lead to a lower demand for non-essential treatments and free up resources for more urgent treatments
3. Some user charges already exist within the NHS such as those for dental treatment, eye examinations and prescriptions – the principle of user charges could be extended without challenging the fundamental principles upon which the NHS is based

The Rise of Health Tourism

Fed up with lengthy waiting lists, rising prices and the fear of acquiring infections such as MRSA during a stay in hospital, record numbers of British patients are travelling abroad for medical and dental treatment and often taking in a package holiday at the same time! An estimated 100,000 people travelled abroad for treatment in 2007 to places as far as South Africa and South East Asia up from 70,000 in 2006. Hungary is the most popular destination for dental treatment and Cyprus is popular for cosmetic surgery whilst India is a favoured location for general surgery and scans. In most cases, the danger of experiencing health care of a lower quality than that available at home has not materialised - although health professionals in the UK warn that patients must also consider the costs of after-care and possible complications.

The European Commission is considering plans to open its borders to medical tourists, allowing citizens of any of the 27 states to seek treatment in a neighbouring country with their home country, in certain circumstances, picking up the bill. The EU claims that this move will encourage countries to specialise in certain health treatments and benefit from economies of scale. Member nations of the EU spend in total €1,000bn (£796bn) annually on healthcare, and at present just 1 per cent is "across border". According to polls, 4 per cent of Europeans had treatment in another country last year - most of whom were people on their holidays.

If the proposals are approved, the expansion of choice will focus attention on the performance of the NHS against other health systems on the Continent. The British Government says it will not finance 'health tourism' and will instead prioritize in providing high quality treatments for NHS patients close to home.

Source: Adapted from news reports, March-July 2008

Rationing treatment in the NHS – the role of NICE

The National Institute for Clinical Excellence (NICE) was created in 1999 and given the task of making decisions about which types of drugs ought to be made available through the National Health Service. One of their aims is to ensure a standardised level of medical care throughout the country and minimise the risk of postcode prescriptions - where healthcare seems to be determined by where someone lives rather than their clinical need. If a drug is recommended by NICE, the NHS in England and Wales has a legal obligation to fund it. NICE investigates the effectiveness and cost of new drugs and medical technologies and considers their impact on quality of life of patients. The system is different in Scotland.

At the heart of their decision making is the requirement to achieve cost-efficient health care. When assessing a range of drugs the concepts of **opportunity cost** and **cost benefit analysis** come into play. First, NICE must determine (using evidence-based medicine) whether a new drug is better value than the **next best alternative treatment** already in use. Second, NICE will assess the costs of providing treatments - decisions are made using the existing market prices for each drug – and calculate the like benefits to patients using metrics such as symptom free days, life years or months gained and also the impact on the quality of life during and after a treatment.

If NICE opts not to recommend a new drug or treatment, people have to find their own money to purchase it - and many choose to go overseas for medical care. There has been much coverage in the media in recent years about the expanding market for health tourism with Britons heading to Eastern European countries and further afield (including Africa) seeking treatments that meet their changing needs and preferences. Invariably many of NICE's decisions have been highly unpopular.

Recently NICE has been criticised for not recommending new treatments for Alzheimer's, kidney cancer and in 2009 it advised against NHS funding for Tyverb, a treatment for an aggressive form of advanced breast cancer. In the autumn of 2009, NICE hit the headlines by announcing that "therapeutic" injections of steroids, such as cortisone, which are used to reduce inflammation, should no longer be offered to patients suffering from persistent lower back pain when the cause is not known. Instead NICE recommended to GPs that they offer patients remedies like acupuncture and osteopathy

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