

**PRINCETON UNIVERSITY      Woodrow Wilson School of Public and International  
International Affairs**

**WWS 598—THE POLITICAL ECONOMY OF HEALTH SYSTEMS**

**FALL TERM 2003**

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Seminars: Mondays and Wednesdays, 2:40 p.m. to 4:10 p.m.

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**A. COURSE DESCRIPTION**

The overall objective of this course is to help students understand the political economy of modern health systems. The course begins with a review of selected conceptual issues in health economics that are relevant to a cross-national study of health systems, including the fundamental question what, if anything, sets health care apart from ordinary goods and services traded in free markets. That exploration is followed with the development of an analytic framework for comparative health systems analysis and an examination of the major, prototypical models of health systems that now compete with one another around the world in the debate on health reform. The course ends with an analysis of the major steps involved in successful health reform.

It will be assumed that students in the course have taken a course in microeconomics, at a technical level equivalent to the B-track in the economics curriculum of the WWS graduate program. Because health reform in all countries is driven by economics, the course naturally emphasizes that facet of health systems. The assigned literature, however, will illuminate also other facets of health care.

The course is intended for graduate students in the Woodrow Wilson School's M.P.A. and Ph.D. programs

**B. TEXTBOOKS**

Acquisition of a textbooks is not required in this course, although the U-Store has been apprised that two basic texts in health economics will be highly recommended to students, to wit:

Sherman Folland, Allen C. Goodman and Miron Stano, *The Economics of Health Care*, 4th ed. (Upper Saddle River, N.J.: Prentice Hall, 2003).

Thomas Rice, *Health Economics Reconsidered*, 2<sup>nd</sup> ed., (Chicago, IL: Health Administration Press, 2003).

The first of these books is the most widely used textbook in courses on health economics. For the most part, its analytic platform is standard neo-classical theory and its focus the U.S. health system. It behooves students of health reform to be familiar with that perspective, as the U.S. government and, to some extent, the World Bank as well, has been trying for some time to persuade other nations to adopt a market-approach to health care. The second book is a sophisticated critique of the application of neo-classical economic theory to health care. Students who have harbored doubts about the validity of "welfare economics" in general, as it is taught in the United States, will find this book enlightening.

Students will be issued a copy of the following manuscript, soon to be published by Oxford University Press:

Marc J. Roberts, William Hsiao, Peter Berman and Michael R. Reich, *Getting Health*

*Reform Right*. (Boston, MA: Harvard School of Public Health, Draft January 2003).

Additional material will be available on reserve in the Stokes Library or will be distributed to students during the course or can be downloaded from the Internet. To distribute material, the course will take advantage of the excellent support provided by the Blackboard website.

### C. USEFUL WEBSITES

**The WHO's European Observatory:** In collaboration with a number of European governments and academic institutions, the European branch of the World Health Organization (WHO), based in Copenhagen, Denmark, operates a website that features up to date (as of 200 or 2001) descriptions of the health system of many countries around the globe, along with even more current reports on specific policy developments in each country. The home website is:

<http://www.euro.who.int/countryinformation>

Among the Observatory's recent publications are

- Richard B. Saltman, Josep Figueras and Constantino Sakellarides, eds. *Critical Challenges for Health Care Reform in Europe* (Philadelphia: Open University Press, 1998).
- Elias Mossialos, Anna Dixon, Josep Figueras and Joe Kutzin, eds. *Funding health care: options for Europe* (Philadelphia: Open University Press), 2002).
- Richard B. Saltman, Reinhard Busse and Elias Mossialos, eds. *Regulating entrepreneurial behavior in European health care system* (Philadelphia: Open University Press) 2002.

We will have occasions during the course for consulting this rich source of information on national health systems. (If the link shown above does not work, just Google *WHO European Observatory*. The first link appearing will get you there.)

**Bertelsmann Foundation:** A highly useful international collaboration was recently begun by the German Bertelsmann Foundation. Health policy researchers from about a dozen industrialized countries complete twice a year a common, highly structured questionnaire on recent health-policy developments in each country. These country reports are particularly interesting, because they are analytically structured to track policies from their original conception through various stages, including implementation, if they reached that stage. The website is:

<http://213.147.107.79>

**Other Website:** Additional sources accessible online are the World Bank ([www.worldbank.org](http://www.worldbank.org), especially [www.worldbank.org/data](http://www.worldbank.org/data)), the Pan American Health Organization (PAHO) whose home website page is [www.paho.org](http://www.paho.org) (especially its site <http://www.paho.org/search/DbSRReturn.asp>) and, of course, the World Health Organization (WHO) at <http://www.who.int/en/> whose reports will be used in the course. The WHO's website for statistical material is <http://www3.who.int/whosis/menu.cfm> and for its publications <http://www.who.int/pub/en/>.

## D. ORGANIZATION OF THE COURSE

Because in its initial year the enrollment in the course is expected to be small, it will be run like a seminar, with emphasis on classroom discussion, rather than a larger course based mainly on formal lectures. The class will meet twice weekly for seminar sessions of one and one half hours.

## E. WORK REQUIREMENT

The reading list is broken down into *assigned* and *recommended* readings. Students should have read the relevant, *assigned* material before each seminar and be prepared to present summaries of it in class or to discuss it. The recommended readings enrich the list. Students will benefit from at least skimming those readings, to see which of them they might want to read in greater depth.

Students will be asked to submit two short papers (15 pages or less)—one in the middle of the course and one at the end. The first of these papers should be on the topic described in item 7 in the *Course Outline* below. The topic for the second paper is to be chosen by the student, with the instructor's approval. It should be a cross-country comparison of some particular facet of a health system—e.g., the goals pursued by the system, methods of paying physicians, regulation of the pharmaceutical sector, or any other reasonable topic compatible with this course.

Finally, students will be asked to present one polished lecture on one or two nations' health system to the class, ideally with PowerPoint and other material to be distributed to the class, including a reading list on that country.

A two-hour written, final examination will test the student's grasp of (1) the conceptual material covered in the course and (2) the gist of each of the assigned articles other than chapters in textbooks. (E.g., state in a few sentences what the focus of the assigned article and the author(s)' main conclusions.)

## F. COURSE GRADE

The final course grade will be a letter grade, accompanied by a written evaluation of the student's work in the course. Both will be based roughly on

- class participation and presentation (20%),
- the two short papers (40%), and
- the final examination (20%).

## **COURSE OUTLINE**

**Note: A particular topic may require less or more than a full session.**

### **A. INTRODUCTION: ORGANIZATION OF COURSE AND OVERVIEW**

#### **1. The Major Economic Sectors of a Health System: An Overview**

*In this overview session, we will explore the various markets that interact with one another in any health system. We shall wonder in passing to what extent these sectors—e.g., health professional training or the market for physician services--can be left to the free play of market forces.*

**Assigned readings:**

- Paul J. Feldstein, *Health Economics*, 5<sup>th</sup> ed. (1999), Chapter 3 “Overview of the Medical Sector”; pp. 37-51.
- Folland, Goodman and Stano, Chapter 1 “Introduction”; pp. 1-19.
- Thomas Rice, Chapter 1, “Introduction”; pp. 1-8.

### **B. SELECTED CONCEPTUAL ISSUES IN HEALTH ECONOMICS**

**This part is essentially a selective sampling of *Health Economics 101*. We will review a number of theoretical concepts that should be understood in the comparative analysis of health systems. Ask yourself in what way, if at all, health care is inherently different from other goods and services whose production and distribution is entrusted to market forces.**

#### **2. Is Health Care Fundamentally Different from Other Goods and Services?**

*In the first half of the twentieth century, health economics as it is known today did not exist, because it was thought that health care cannot be understood as an ordinary commodity. Since about the mid-twentieth century, there has been a revolution in thinking about this question. In the end, economics has achieved a virtual hegemony over health policy around the globe. Nobel Laureate economist Kenneth Arrow's classic article on health care, published in 1963, has served as a major catalyst in this development. Although it is densely written and may warrant several readings, students of modern health systems should be familiar with it. The essay was recently celebrated by a series of multi-disciplinary papers published in the *Journal of Health Politics, Policy and Law* (October, 2001).*

**Assigned readings:**

- Kenneth Arrow, “Uncertainty and the Welfare Economics of Medical Care,” *American Economic Review* (December, 1963); pp. 851-883. (Arrow argues that health care differs from other commodities mainly because of several uncertainties surrounding it and the absence of certain private markets individuals would need to protect themselves against the risks growing out of those uncertainties.)
- Peter J. Hammer, Deborah Haas-Wilson and William M. Sage, “Kenneth Arrow and the Changing Economics of Health Care: “Why Arrow? Why Now?” *Journal of Health Politics, Policy and Law* (October 21, 2002): 835-49. (It may be noted that these authors write from the perspective of professors of law.)

- Kenneth J. Arrow, “Reflections on the Reflections,” *Journal of Health Politics, Policy and Law* (October, 2001): 1197-1204. (Arrows brief response to the articles in this volume of the Journal).

### 3. Asymmetric Information and Supplier-Induced Demand (SID) for Health Care

*Neoclassical economic theory assumes that there are a stable individual- and market demand functions for particular commodities. These functions are thought to summarize crucial information on the consumers' valuation of the commodity and, as such, are one of the pillars of so-called “welfare economics.” The market demand curve also functions as a constraint on suppliers. If suppliers can easily manipulate the demand for their services—as physicians may be able to do—then many of the normative and positive economic analyses based on the demand functions come into question. Not surprisingly, then, there has long raged among economists a fierce debate on whether the asymmetrically distributed information about health care enables physicians to induce demand for their own services and, if so, how serious a problem that is for health economics. If the so-called supplier-induced demand (SID) is significant, then health reforms that rely on patients (“consumers”) as a prime countervailing power to the supply side—such as Medical Savings Accounts—might be dubious social policy. Furthermore, standard welfare economics might yield dubious normative propositions.*

#### Assigned Readings:

- Folland, Goodman and Stano, Chapter 9 “Asymmetric Information and Agency”; pp. 187-201 and Chapter 10 “Imperfect Information: Supplier-Induced Demand and Small Area Variation”; pp. 202-224. (An introduction to the subject).
- U. E. Reinhardt, “Commentary on an article in physician induced demand by Rizzo and Blumenthal,” *Medicare Care Research and Review*, September, 1996: pp. 274-87. (To be distributed). (A critical review of the economic profession's scholasticism regarding the physician-induced demand hypothesis.)

#### Recommended Readings:

- Thomas McGuire, “Physician Agency,” in Culyer and Newhouse, “*Handbook of Health Economics*,” vol. 1A (2000); pp. 461-536. (You may find his chapter, which is intended for graduate students in economics, tough going at spots, especially when mathematical notation and modeling is involved. Most of the chapter, however, is in plain prose. The chapter will give you an up-to-date distillate of the economic profession's collective wisdom on the role of physicians as their patients' agents and on the theory of physician-induced demand for care. If you master this paper, you will be an expert on the issue).
- Winnie Yip, “Physician response to Medicare fee reductions: changes in the volume of coronary bypass graft (CABG) surgeries in the Medicare and private sector,” *Journal of Health Economics* (1998): pp. 675-99. (A neat illustration of how economists try to explore the physician-induced demand theory empirically).
- Jean Mitchell and Tim Sass, “Physician Ownership of ancillary services: Indirect demand inducement or quality assurance?” *Journal of Health Economics* (1995); pp. 263-289. (This is another econometric inquiry into this topic).

## 4. The Economic Theory and Social Role of Health Insurance

*In modern health systems, the providers of health care receive most of their payments from third parties—either private or public health insurance programs. In this session we will examine how economists model health insurance, and why they impute inefficiency to it.*

### Assigned Readings:

- Folland, Goodman and Stano, Chapter 7 “Demand and Supply of Health Insurance”; pp. 141-62.
- Paul Feldstein, op. cit., Chapter 6 “The demand for Health Insurance”; pp. 111-54. (Covers roughly the same ground as the previous reading, but also describes what is meant by “adverse selection” and “preferred risk selection.”)

### Recommended Readings:

- Paul Feldstein, op. cit. Chapter 18 “National Health Insurance: An Approach to the Redistribution of Medical Care”: 514-61.

## 5. Does Ownership of Health-Care Facilities Matter? The Economic Behavior of Not-for-Profit Providers of Health Care

Non-profit institutions are prominent in the provision of health care worldwide, just as they are in education. In this session, we shall explore the reasons for that phenomenon and what difference, if any, there may be between the behavior of for-profit and non-profit health-care providers. The aim is to separate ideology from fact.

### Assigned Readings:

- Folland, Goodman and Stano, Chapter 13 “Nonprofit Firms”: 281-304

### Recommended Readings:

- Frank A. Sloan, “Not-For-Profit ownership and Hospital Behavior,” in Culyer and Newhouse, *Handbook of Health Economics*,” vol. 1A (2000); pp. 1141-74. (Somewhat more advanced state-of-the art paper.)
- Arnold Relman and Uwe Reinhardt, “Debating For-Profit Health Care and the Ethics of Physicians,” *Health Affairs* (Summer, 1986): 5-31. (A vigorous debate between the former editor of the *New England Journal of Medicine* and your instructor on the subject of for-profit health care that reveals your instructor’s own view (if not bias) on this issue. If nothing else, you may find the read entertaining. To be distributed.)

## 6. Cost-Benefit (CBA), Cost Effectiveness Analyses (CEA) and Cost-Utility Analyses (CUA) for Health Care

*In the literature on comparative health systems, one frequently runs across terms such as “cost-effectiveness,” QALYs and DALYs. Although an in depth exploration of these concepts lie beyond the compass of this course, a basic familiarity with these terms will be useful.*

**Assigned Readings:**

- Folland, Goodman and Stano, Chapter 24 “The Tools of Economic Evaluations”: 545-60.
- Werner Brouwer and Marc Koopmanschap, “On the economic foundations of CEA. Ladies and Gentlemen, take your positions!” *Journal of Health Economics*, 19(4) (July, 2000): 437-59. (A more penetrating exploration of the subject).

**Recommended Reading:**

- Alan Garber, “Advances in CE Analysis,” in Culyer and Newhouse, *Handbook of Health Economics*, vol. 1A (2000); pp. 181-220. (Advanced treatment. Although much of the chapter is accessible to non-economists, some parts involve mathematical modeling. It is, however, the state-of-the-art paper of the moment and well worth a look, especially section 5 on “Measuring Outcomes”, pp. 211-19).

**7. The Concept of “Efficiency” in the Context of Health Care**

*Fundamental to economic analysis is the concept of “efficiency.” Quite often, for example, it is argued in the United States that a “market approach” to health care is “more efficient” than are alternative approaches, e.g., government-controlled health systems such as Canada’s. The readings for this section will be assigned—and the lecture on it presented—after students have submitted their short essay on the following question:*

***“Is a ‘market approach’ to health care inherently more efficient than alternative approaches?”***

*The essay should cover; (1) a concise definition, preferably illustrated with neatly drawn visual displays, of what economists mean by “efficiency”, (2) what might be meant by a “market approach” to health care, (3) why it is argued by many economists that such an approach would be more “efficient” than are approaches relying on government financing and regulation of health care (think of, say, Canada’s health system as such an alternative approach) and (4) whether there are theoretical reasons to support that supposition a priori, even without examining the empirical record. If there space available, some attention to empirical data would be nice as well, but it is not crucial. The essay should not exceed 3,500 words (using the word count routine of Microsoft Word), excluding graphs and bibliography.*

**C. ANALYTIC FRAMEWORKS FOR STUDYING ENTIRE HEALTH SYSTEMS**

**In this part, we shall examine conceptual frameworks for the study of health systems and then examine certain crosscutting issues faced by any health system—e.g., how to finance them and how to compensate the providers of health care.**

**8. Conceptualizing Health System Systems**

*There are numerous ways in which one could design an analytic framework for health systems comparisons and health reform. One of these is the familiar model of neoclassical economics, as it is presented in the various chapters of the textbooks by Folland, Goodman and Stano and by Paul Feldstein. An alternative framework has recently been developed by colleagues at Harvard University (see the paper by Hsiao). That framework is not too dissimilar from the framework used by the World Health Organization. Yet another useful framework is suggested in the paper by Saltman.*

**Assigned Readings:**

- William Hsiao, “What is a Health System? Why Should we Care? Mimeographed. (August, 2003). (To be distributed).

- Richard B. Saltman, "A conceptual overview of recent health reforms," *European Journal of Public Health*, 4(4) (1994): 287-93.
- World Health Organization, *Health Systems: Improving Performance, World Health Report 2000*; Chapter1 "Why Do Health Systems Matter?": 1-20.

## 9. Theories of Distributive Justice and the Implied Notions of "Equity" in Health Systems Analysis

*Unfortunately, too much of the literature in health economics and health system comparisons fails to articulate the goals posited for a health systems, assuming tacitly that "we all want the same thing in health care." Different theories of distributive justice, however, lead one to posit different goals for a health system. Without articulating these goals, it is not meaningful to compare health systems in terms of their "efficiency" or other dimensions of "performance." We may need more than one session to cover this material.*

### Assigned Readings:

- Roberts et al., Chapter 3 "Judging Health Sector Performance: Ethical Theory."
- Alan Williams and Richard Cookson, "Equity in health," in Culyer and Newhouse, " *Handbook of Health Economics*," vol. 1A (2000); pp. 1864-1910.
- Adam Wagstaff, "Equity in Health Care Finance and Delivery," in Culyer and Newhouse, " *Handbook of Health Economics*," vol. 1A (2000); pp. 1804-62. (Read this paper to get a feel for the issue without getting bogged down in the section relying heavily on mathematical notation).

### Recommended Readings:

- E. van Doorslaer et al., "Equity in the delivery of health care in Europe and the US," *Journal of Health Economics* 19(5) (September, 2000): 553-84. (Using their definition of equity, the authors use a statistical analysis to show that the U.S. attains roughly the same degree of equity in the distribution of health care as do the European nations.)

## 10. Methods of Financing Health Care Systems: An Overview

*How health systems are financed has significant implications for (1) the economic distortions that be introduced thereby into the economy and (b) the "fairness" of the health system in the eyes of citizens. It is a fundamental pillar and characteristic of a nation's health system.*

### Assigned Readings:

- Robert G. Evans, "Financing health care: taxation and the alternatives," in Elias Mossialos, Anna Dixon, Josep Figueras and Joe Kutzin, eds. *Funding health care: options for Europe* (Philadelphia: Open University Press), 2002): 31-58;
- Roberts *et al.* Chapter 8 "Financing."
- Alan Maynard and Anna Dixon, Private health insurance and medical savings accounts: theory and experience, in Elias Mossialos, Anna Dixon, Josep Figueras and Joe Kutzin, eds., *op cit.*: 107-27.

- William Hsiao, "A Framework for Assessing Health Financing Strategies and the Role of Health Insurance," in David Dunlop and Jo. M. Martins, eds. *An International Assessment of Health Care Financing*, The World Bank (1995): 15-30. (To be distributed).
- George J. Schieber and Akiko Maeda, "A Curmudgeon's Guide to Financing Health Care in developing Countries," in George J. Schieber, ed. *Innovations in Health Care Financing*, Proceedings of a World Bank Conference (March 10-11, 1997):1-38.

## 11. Methods of Paying the Providers of Health Care: Health Professionals and Hospitals

*We will discover in this session that there does not exist an ideal method of paying these providers of health care and that any particular payment method chosen involves implicit trade-offs among desirable and undesirable features.*

### Assigned Readings:

- Roberts et al., Chapter 9 "Payment Systems and their Incentives."
- U. E. Reinhardt, "A Framework for Deliberations on the Compensation of Physicians," *Journal of Medical Practice Management*, Vol. 3, No. 2, (Fall 1987): pp. 85-95. (To be distributed).

### Recommended Readings:

- Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (March, 2002): Chapter 1 "How Medicare pays for services: an overview": pp.1-34. (The U.S. Medicare program is a federal, single-payer system covering the elderly and certain disabled individuals under age 65. Its payment methods, based on extensive health-services research, have attracted attention and imitators in other countries. This chapter provides an illuminating overview of these methods.)
- Folland, Goodman and Stano, section on "Prospective Payment" (for hospitals) and "Regulation of Physician Payment," pp. 432-43 (only) in Chapter 6 "Government Regulation—Principal Regulatory Mechanism." (The authors illustrate how economists model the impact of prospective payment for hospital payments and describe the nature of the relative value scale for physicians, both for Medicare).

## 12. Methods of Paying the Providers of Health Care: Pharmaceuticals

*The pharmaceutical industry is characterized by high fixed costs (mainly outlays on research and development) and low variable production costs. This so-called high "operating leverage" makes it difficult to set or negotiate prices that are efficient at any point in time (statically efficient) and also encourage an optimal time path of investment in innovation (dynamic efficiency). Once again, we shall discover that there does not exist a practical, optimal policy.*

### Assigned Readings:

- U. E. Reinhardt, "Perspectives on the Pharmaceutical Industry," *Health Affairs* (September/October, 2001): 136-148). (See especially the section on the virtue and vice of price discrimination for pharmaceutical products).
- Joseph P. Newhouse, "How much should Medicare pay for drugs?" Forthcoming in *Health*

*Affairs* (January/February, 2004). (Mimeographed; to be distributed. This paper represents a fine lecture on the impossibility of attaining both static efficiency and dynamic efficiency with drug prices under third-party payment).

- Panos Kavanos and Uwe Reinhardt, "Reference Pricing for Drugs: Is it Compatible with U.S. Health Care?" *Health Affairs* (May/June, 2003): 16-30. (Reference pricing is an increasingly popular method of engaging market forces to control drug prices).

#### **Recommended Readings:**

- G. Lopez-Casasnovas and J. Puig-Junoy, "Review of the literature on reference pricing," in G. Lopez-Casasnovas and Bengt Jönsson, eds., *Reference Pricing and Pharmaceutical Policy*, Springer-Verlag Iberica (2001): 1-41. (This is a fairly recent survey of the literature on reference pricing for prescription drugs and its application around the world. Its depth goes beyond the compass of this course, but students interested in the topic will find this survey helpful.)
- Marc J. Roberts, "Would we be able to recognize a socially desirable reference pricing system if it bit us in the ankle?" in G. Lopez-Casasnovas and Bengt Jönsson, eds., *Reference Pricing and Pharmaceutical Policy*, Springer-Verlag Iberica (2001): 161-177. (A wonderfully iconoclastic review of economic analyses marshaled in opposition to reference pricing. In fact, it is a trenchant commentary on the role of economic theorizing in health-policy formulation in general. **Highly recommended!**)

### **13. The Role of Governments in Modern Health Systems**

#### **Assigned Readings:**

- Folland, Goodman and Stano, Chapter 18 "Government Intervention in Health Care Markets": 401-424. (The standard, neo-classical economist's perspective).
- Thomas Rice, *The Economics of Health Reconsidered* (2003), Chapter 6 "The Role of Government": 201-270. (You may also want to read his Appendix: Overview of the Health Services Systems in ten Developed Countries": 275-305.)
- David Chinitz "Good and bad health sector regulation: an overview of public policy dilemmas," in Richard B. Saltman, Reinhard Busse and Elias Mossialos, eds. *Regulating entrepreneurial behavior in European health care system* (Philadelphia: Open University Press) 2002: 55-72.
- Roberts et al., Chapter 11 "Regulation"

#### **Recommended Readings:**

- Richard B. Saltman and Reinhardt Busse, "Balancing Regulation and entrepreneurialism in Europe's health sector: theory and practice," in Richard B. Saltman, Reinhard Busse and Elias Mossialos, eds. *Regulating entrepreneurial behavior in European health care system* (Philadelphia: Open University Press) 2002: 3-52.
- Paul J. Feldstein, *op.cit.* Chapter 17 "The Legislative Marketplace": 484-513. (A marvelously cynical but accurate analysis of the market for legislation and government regulation in the United States [and probably elsewhere as well].)

## 14. Evaluating the Overall Performance of Entire Health Systems

In 2000, the World Health Organization delivered itself of a report that attempted to rank the world's health system in terms of "overall performance." This highly controversial report, which ranked France No. 1, Colombia No. 22 and the United States only No. 37, is the ideal springboard for an exploration on the comparative evaluation of health systems. Students are asked to approach this subject critically.

### Assigned Readings:

- World Health Organization, *Health Systems: Improving Performance. The World Health Report 2000*, Chapter 2 "How Well do Health Systems Perform?": 21-46 and "Statistical Annex," including tables. (Students will be asked in exactly what the WHO did to get these performance ranking. You will also be asked to evaluate this methodology critically. Therefore the statistical annex, in particular, should be carefully studied.)
- Robert J. Blendon, Minah Kim and John M. Benson, "The Public Versus The World Health organization on Health System Performance" *Health Affairs* (May/June 2001):
- One or two additional readings concerning the WHO report will be distributed after it has been discussed in class.

## D. PROTOTYPICAL MODELS FOR THE REFORM OF HEALTH SYSTEMS

All national health systems are particular combinations of the cells in the grid below.

OWNERSHIP OF PROVIDERS	PAYING THE PROVIDERS OF HEALTH CARE				
	HEALTH INSURANCE				DIRECT PAYMENT
	Government Insurance	Social Insurance	Private Insurance		
Non- Profit			For- Profit	Out of Pocket	
Government	A	D	G	J	M
Private, non-profit	B	E	H	K	N
Private, for-profit	C	F	I	L	O

Although most countries spread their health system over many cells in this grid, the bulk of a country's system—measured by fraction of total national health expenditure or fraction of the population covered—typically occupies only a few cells. An exception is the United States whose health system is more evenly spread over all of the cells in the grid.

The major reforms proposed by health-reform analysts—as distinct from minor, incremental reforms of existing systems—tend to be particular, new combinations of the cells in the grid. In this part of the course, we shall examine some of these mega-ideas now being marketed, so to speak, by various proponents of reform. In exploring a particular approach, we should keep in mind the following series of questions:

1. *Does it automatically provide “adequate” financing for the health care system?*
2. *Does it raise funds in a manner that conforms to prevailing notions of “equity”?*
3. *Does it confront individuals and families with incentives to manage their own health care effectively and to use the health system cost-effectively?*
4. *Does it confront the providers of health care with financial incentives that are conducive to the production and delivery of cost-effective health care?*
5. *Does it encourage continuous quality improvements on the part of providers?*
6. *Does it hold the providers of health care transparently accountable for the quality and cost of their services (i.e., does it control cost and spending effectively)?*
7. *Does it distribute health care among citizens in a manner that conforms to prevailing notions of “equity”?*
8. *Does it contribute to overall satisfaction among the citizenry with the health system?*

In addition to the reading assignments shown below, student may wish to sample other relevant literature—e.g., the concise but somewhat superficial country descriptions in Bruce J. Fried and Laura M. Gaydos, *World Health Systems: Challenges and Perspectives* (2002) and the in-depth country reports featured on the website (listed at the beginning of the syllabus) of the European Observatory of Health Care Systems (<http://www.euro.who.int/countryinformation>)

## 15. The Public Health Service Model

At its purest, the *Public Health Service* model falls into cell A of the grid shown above. The distinguishing feature of the public health service model is that both the insurance facet and much of the health-care delivery facet (certainly hospitals) are publicly owned and administered. Physicians in these models may be employed by the public sector or work as self-employed independent professionals. The United Kingdom adopted this approach in 1948 in its National Health Service (NHS), which it operates to this day, albeit with constant incremental reforms. It is often viewed as the prototypical model of central-government public health systems. The Hong Kong Hospital Authority also represents that model. Sweden operates a public health system as well, although its basic administrative unit is not the central government but the counties. Finally, Italy's health system, too, can be categorized under this model, although like most other systems it is undergoing constant reforms.

### Assigned readings:

- European Observatory of Health Care Systems, *United Kingdom* (1999) (You can download it from the Observatory's website, shown at the beginning of the syllabus.)
- Julian Le Grand, “Britain: Competition, Cooperation or Control?” *Health Affairs* (May/June, 1999): 27-39.

- European Observatory of Health Care Systems, *Sweden* (2001) (You can download it from the Observatory's website, shown at the beginning of the syllabus.)

**Recommended readings:**

- European Observatory of Health Care Systems, *Italy* (2001) (You can download it from the Observatory's website, shown at the beginning of the syllabus.)

## 16. Social Insurance: Single-Payer, Government-Run Health Insurance

In this model (cells A, B and C in the grid), government uses tax revenues from a variety of sources to procure health care, on behalf of all citizens, from delivery systems that may have a variety of ownership patterns, including for-profit health care facilities. In effect, government acts as a *monopsonist* in the market for health care. Canada and Taiwan are the classic example of this genre, as is the U.S. federal Medicare program for the elderly and certain disabled and the state-run Medicaid programs for the poor and disabled. The advocates of the single-payer model view it as the fairest and most "efficient" organization of a nation's health system.

**Assigned readings:**

- The Physicians Working Group for Single-Payer National Health Insurance, *Journal of the American Medical Association* vol. 290 (August 13, 2003): 798-805. (The latest proposal in the U.S. to adopt a single-payer system. It attracted wide media attention.)
- Laurie J. Goldsmith, "Canada," in B. J. Fried and L. M. Gaydos, eds. *World Health Systems: Challenges and Perspectives* (2002): 227-48. (A concise overview of the Canadian system.)
- C. David Naylor, "Canada under Fiscal Duress," *Health Affairs* (May/June 1999): 9-26. (A diagnosis of the problems faced by Canada's health system.)
- Commission on the Future of Health Care in Canada (the Romanow Commission), Final Report: Building on values—The Future of Health Care in Canada, (November, 2002): Executive Summary (at [http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC\\_Executive\\_Summary.pdf](http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Executive_Summary.pdf)) (This is the final report of the so-called Romanow Commission).

**Recommended Reading:**

- Terrence Sullivan and Patricia M. Baranek, *First Do No Harm: Canadian Health Reform* (2002). (This short book, about 108 pages, provides one of the clearest description of how Canadian social values on health care differ from those driving the American health system. Highly recommended).

## 17. Social Insurance: The Multi-Payer Sickness Fund Models

The single-payer, government-run health insurance models typically must compete for funds with all other government programs—e.g., education and national defense. Typically, the multi-payer social insurance models (cells D, E and F in the grid) rely on earmarked "contributions" that resemble payroll taxes, because they typically are collected at the nexus of the payroll. Because these funds are earmarked, however, this type of social insurance program does not have to compete annually and head-to-head with other components of the government's budget. Indeed, they typically are not government-run, but instead administered by semi-private, non-profit "sickness funds" that operate under "self-governance", albeit under very tight government regulations that impose on them a high degree of uniformity. Finally membership in one of the social-insurance sickness funds is compulsory, at least for the bulk of the population falling below a threshold family income. Germany's social health insurance system is generally viewed as the pioneer of this genre. It was established in the law under Chancellor Otto von Bismark in 1887 as the *Reichsversicherungsverordnung* (Imperial Insurance Decree), a name the statute retains to this day, even after a

myriad of amendments. Many health insurance systems in continental Europe (e.g., France, Belgium, the Netherlands), Latin America (for employed persons) and Asia (e.g., Japan and Korea) are based on this model.

#### **Assigned readings:**

- European Observatory of Health Care Systems, *Germany* (2000) (You can download it from the Observatory's website, shown at the beginning of the syllabus.)
- Reinhard Busse and Markus Wörz, "German plans for "health care modernization." (Mimeographed; to be distributed). (At the time this syllabus is written, the German government is negotiating a new reform law with the opposition party. It may well have become law by the time this topic is before us, in which case additional literature on the particulars of that reform will be distributed.)
- Alison Evan Cuellar and Joshua Weiner, "Can Social Insurance for Long-Term Care Work? The Experience of Germany," *Health Affairs* (May/June, 2000): 8-25. (In 1995, Germany extended its social-insurance model to the coverage of long-term care, after a long debate over whether or not long-term care should be left to private insurance. That fairly bold policy initiative has become a model of interest to policy makers in other nations).

#### **Recommended Readings:**

- Christa Altenstetter, "From Solidarity to Market Competition? Values, Structure, and Strategy in German Health Policy, 1883-1997," in Francis D. Powell and Albert F. Wessen, eds. *Health Care Systems in Transition* (1999): 47-87.

## **18. Public or Private Catastrophic Insurance with Medical Savings Accounts**

The latest "new, new thing" in the American health system is the so-called "consumer-driven health care" which is, however, nothing other than the old idea of Medical Savings Accounts (MSA) long used in Singapore, albeit now coupled with the bells and whistles of modern information technology. The central idea of the MSA construct is that the insured should face a very high annual, out-of-pocket deductible (e.g., in the U.S. \$4,000 per year for a family or \$2,000 per year for an individual) before insurance sets in, but then be protected against further financial risk through a so-called "catastrophic" health insurance policy for medical bills exceeding the deductible. That catastrophic policy, of course, may still call for some coinsurance. To help pay for the deductible, provision is usually made for government or an employer to deposit a defined contribution (e.g., \$2,000 for a family and \$1,000 for an individual) into the MSA, leaving the insured to finance the remainder of the deductible from the household's budget. This concept has caught the attention of policy makers not only in the United States (where the application of the idea so far has been sparse), but also in developing nations (for example, Mainland China, which now uses the idea). It is a concept with which students of health systems and health reform must be familiar. The many readings below are all short pieces.

#### **Assigned readings:**

- Mark V. Pauly and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs* (Spring, 1995): 126-39.
- Deborah Chollet, "Why the Pauly/Goodman Proposal Won't Work," *Health Affairs* (Summer 1995): 273-4.
- Kenneth Thorpe, "Medical Savings Accounts: design and Policy Issues," *Health Affairs* (Fall, 1995): 254-9.
- William C. Hsiao, "Medical Savings Accounts: Lessons from Singapore," *Health Affairs*

((Summer, 1995): 260-6.

- Thomas A. Massaro and Yu-Ning Wong, "Positive Experience with Medical Savings Accounts in Singapore," *Health Affairs* ( (Summer, 1995): 267-72.
- Mark V. Pauly and John C. Goodman, "Medical Savings Accounts: The Authors Respond," *Health Affairs* ((Summer, 1995): 277-79.

**Recommended readings:**

- Michael D. Barr, "Medical Savings Accounts in Singapore: A critical Inquiry," *Journal of Health Politics, Policy and Law* (August, 2001): 709-45. (The author argues that the "success" of the Singapore MSA model rests on government control of inputs and outputs and the rationing of health services according to wealth.)

## **19. Private Health Insurance under "Managed Competition", with or without "Managed Care"**

In 1971, American physician Paul Ellwood had persuaded then President Nixon to endorse a strategy under which private health insurance plans would be forced to compete for insured enrollees on the basis of their premiums and the quality of the care they would procure for the uninsured. A somewhat similar idea had been sketched out at about the same time by Princeton's Herman M. Somers and Anne R. Somers. In this scheme, the insured would receive tax-financed vouchers toward the purchase health insurance from competing insurers. Ideally, the competing insurers would be fully integrated health plans that would own and manage their own set of health care facilities, such as the world-famous Kaiser Permanente Health Plan established during World War II by American industrialist Henry J. Kaiser for his employees. This idea was subsequently developed further by Stanford University's Alain Enthoven, who subsequently found support for the idea among a group of leaders from the health-care and health-insurance industry known as the "Jackson Hole Group." The concept of "managed competition" became the core of the ill-fated Clinton Health Plan in the mid 1990s and was sporadically and ineptly tried by private employers in the U.S. during the 1990s. The idea survives in President George W. Bush's current proposal to reform the Medicare program for the elderly, now before the Congress. Finally, the idea has been vigorously marketed by American health care consultants (virtual powerbook missionaries) abroad, although few countries have fully implemented the idea. It can fairly be said that, so far, the concept has failed to meet its ostensible objectives in the United States or elsewhere. In this session, we shall explore the theory and practice of this important idea, which has enough intuitive appeal at the blueprint level that it is unlikely ever to go away.

**Assigned readings:**

- Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* (Supplement 1993):25-48. (Enthoven, who fully developed the idea of managed competition, published his proposal in many outlets, in the U.S. and abroad, either alone, or with co-authors, or through the Jackson Hole Group. This paper, written at the onset of the Clinton presidency, provides a concise description of the principles of managed competition envisaged in his proposal.)
- Thomas Rice, Richard Brown and Ronald Wyn, "Holes in the Jackson Hole Approach to Health Care Reform," *Journal of the American Medical Association* 270(11) (September 15, 1993) 1357-1362. (An early critique of managed competition).
- Uwe E. Reinhardt, "Comment on the Jackson Hole Initiatives for a Twenty-First Century American Health System," *Health Economics* vol. 2 (1993) 7-14. (Another early conjecture on the likely success of managed competition).

**Recommended readings:**

- Paul M. Ellwood, "Health Maintenance Strategy," *Medical Care* (May, 1971): 250-6.

(Ellwood's early conception of managed competition).

- Anne R. Somers, "The Somers Plan: An Early Managed Competition Proposal," *Health Affairs* (Summer, 1993): 218-9. (Another early conception of managed competition, although called "regulated competition" in the Somers' plan. For the original paper, see
- Herman M. Somers and Anne R. Somers, "Major Issues in health Insurance," *The Milbank Memorial Fund Quarterly* (April, 1972): 177-210.
- President Clinton's Transmittal Letter to the Congressional Leadership of his *Health Security Act* (October 27, 1993), setting forth his concept of managed competition (to be distributed).
- Alain C. Enthoven and Sara J. Singer, "A Single-Payer System in Jackson Hole Clothing," *Health Affairs* (Spring (I), 1994): 83-95. (Enthoven's and Singer's vehement critique of the President's idea of "managed competition.")
- Uwe E. Reinhardt, "The Predictable Managed Care Kvetch on the Road from Adolescence to Mature Adulthood," *Journal of Health Politics, Policy and Law* (October, 1999): 897-910. (A vaguely amusing post-mortem on the demise of managed care.)

## 20. Government Mandates on Employers to provide Health Insurance

Health reformers around the world tend to look to employers as a major source for financing health care. In the social insurance schemes, that role is confined mainly to collecting premiums on behalf of government or private health insurers at the nexus of the payroll. Americans, on the other hand, have long expected employers to play a very active role in procuring and managing both the health and the health care of their employees. Because the economic role of employers in health care seems so widely misunderstood among the general public and, indeed, by business leaders, we shall explore in this session what the proper role of employers might be in health care, and who actually pays the health insurance premiums employers pay on behalf of their employees.

### Assigned readings:

- Linda J. Blumberg, "Who Pays for Employer Sponsored Health Insurance," *Health Affairs* (November/December, 1999): 58-61.
- Alan B. Krueger and Uwe E. Reinhardt, "The Economics of Employer versus Individual Mandates," *Health Affairs* (Spring(II), 1994): 34-53. (This paper explores whether health insurance is best financed through a mandate on employers to provide such insurance or a mandate on individuals to procure it. Pages 41-47 describe the underlying theory on the incidence of employer-mandated health insurance).
- Alain C. Enthoven, "Employment-Based health Insurance is Failing: Now What?" *Health Affairs WebExclusive* (May 28, 2003): 1-9. (Evidently disappointed with the role of employers as sponsors of managed competition and managed care, Enthoven here proposes a new approach. [http://www.healthaffairs.org/WebExclusives/Enthoven\\_Web\\_Excl\\_052803.htm](http://www.healthaffairs.org/WebExclusives/Enthoven_Web_Excl_052803.htm))

## 21. Extreme Pluralism in Health Care: The Case of the United States

A common refrain at health-care conferences and at political forums in the United States is that the American health system is the best in the world. It can explain why U.S. government agencies have long tried, with the zeal of powerbook missionaries, to push that model also on developing countries dependent on them for foreign aid, sometimes triggering deep resentment abroad. In this session, we shall take a look at the strengths and weaknesses of the complex American health system, which consists of a myriad of uncoordinated private and public health

insurance programs, each with its own rules, payment system and nomenclature.

**Assigned readings:**

- Khi V. Thai et al., op. cit., Chapter 5 “The United States Health System”: 99-133 and Chapter 6 “Like Plugging Holes in a Colander: Health Policy and Provision in the United States Circa the Millennium”: 135-206.

**The instructor’s lecture will be based on his manuscript:**

- U. E. Reinhardt, “The Mix of Private and Public Payers in the American health System” (2002). Mimeographed, to be published by the Nuffield Trust, London, U.K. (To be distributed at the lecture.)

## **E. THE PROCESS OF HEALTH-SECTOR REFORM**

**We will conclude the course with a look at the challenges of health reform in the field. That discussion draws on and ties together the various strands of analysis pursued in the earlier parts of the course. Although the global record in health reform is not invariably encouraging, we shall end on a positive note by look at Taiwan’s experience.**

**Assigned reading:**

- Roberts et al., Chapters 1, 2, 4 and 7. (Tacitly focused more on middle- and low-income countries.)
- Gill Walt, “Implementing Health Care Reform: A Framework for Discussion,” and Tom Rathwell, “Implementing Health Care Reform: A Review of Current Experience,” chapters 16 and 17, respectively, in Richard B. Saltman, Josep Figueras and Constantino Sakellarides, eds. *Critical Challenges for Health Care Reform in Europe* (Philadelphia: Open University Press, 1998). (Focused on high-income countries in Europe).
- Tsung-Mei Cheng, “Taiwan’s New National Health Insurance Program: Genesis and Experience So Far” *Health Affairs* (May/June, 2003): 61-76. (Description and analysis of a successful major health reform: Taiwan’s adoption of a single-payer national health insurance system during the 1990s).

**Recommended reading:**

- Richard B. Saltman and Josep Figueras, “Analyzing the Evidence on European Health Care Reforms,” *Health Affairs* (March/Aril 1998): 85-107.