Victor Fuchs: Who Shall Live?

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Introduction to this edition

- healthcare requires scarce resources that have alternative uses
- importance of non-medical determinants of health
- physicians have a dominant role in healthcare expenditures
- necessity of choice at the individual and social level

Trends in health

- recent decline in mortality explained by decline in mortality from heart and cerebrovascular diseases: understanding of the importance of high blood pressure + new drugs to treat high blood pressure
- cross-sectional relationship between socioeconomic factors (e.g., education) and health very strong, but over time mortality reductions have recently come from changes in medical care (vs 19th and 20th century: changes in socioeconomic variables + public health were important)
- unfavorable trend: increase in obesity

Trends in demographics

- aging: more people alive but inactive over 65
- increase in consumption and medical care
- over half of the healthcare for 65+ people financed from transfers from people under 65

Trends in healthcare

- rapid rate of growth of expenditures
- increases on healthcare expenditures mean cuts in other areas
- because employers pass the costs of health insurance onto workers, increasing healthcare costs can mean stagnating real wages
- aging population not the most important cause of increasing healthcare spending
- most important cause is the development of new medical technologies

Why does the US spend much more than its peers?

- higher administrative costs
- higher ratio of specialists to primary care physicians
- more standby capacity
- open ended funding
- less social support in the US for the poor sick
- more malpractice suits in the US
- higher drug prices in the US
- higher physician incomes in the US

Trends in technology and medical practice

- lot of innovations partly because third parties not the patients pay for them and their use adds to providers' revenue
- we don't have an effective mechanism to sort out how much value various drugs/devices provide
- few constraints on use
- little understanding of heterogeneity in effectiveness for various patients
- lot of technological innovations, but organizational and delivery innovations are rare
- some development of accountable care organizations
- rise of managed care
- physicians are key to cost reduction; they need: information, infrastructure, incentives

- changes in hospitals:
  - decrease in inpatient beds
  - increase in hospitalists to treat inpatients
  - use of information technology

Health policy trends

- substantial increase in the share of healthcare expenditures paid by insurance
  - especially for prescription drugs
  - some increase in share of insurance coverage for physician services
- increase in the government's share of healthcare spending

Obamacare

- primary goal: reduce the number of uninsured
- increase regulation of insurance companies (e.g., no discrimination for pre-existing conditions)
- improvement in the market for individuals and small groups (insurance exchanges)
- income-related subsidies to purchase insurance
- mandates on individuals and employers

Introduction: Health and Economics

- economic vs romantic vs monotechnic point of view
- economic point of view:
  - resources are scarce
  - resources have alternative uses
  - people have different wants and put different weights on their wants
- romantic point of view: doesn't recognize the scarcity of resources relative to wants
- monotechnic point of view: doesn't recognize the diversity of individual preferences

Chapter 1: Problems and Choices

Problems

- cost = quantity x price
- some increases in quantity utilized
- rapid growth of price
- possible cost containment approaches:
  - changes in supply
  - improving population health
  - controls and planning
  - greater cost consciousness
  - physician compensation changes
- access
  - special access problems for rural areas and minorities
  - general access problem: mismatch between supply and demand, especially primary, emergency, and home care
- health level: relative to other developed countries the US is not doing too well
- health disparities between different groups in society

Choices

- health vs other goals
- medical care vs other health programs
- physicians vs other medical providers
- how much equality?
- consumption vs investment ("today or tomorrow?")
- whose life matters how much ("your life or mine?")
- individual vs collective responsibility ("the jungle or the zoo?")

Chapter 2: Who Shall Live?

- effective medicine now contributes greatly to life expectancy
- disappearance of the relationship between per capita income and life expectancy above a certain level of income

First year of life

Key factors to study:

- prematurity
- income
- schooling
- race
- medical care
- international comparisons
- infant health

Youth (15-24)

- lot of deaths from motor vehicle accidents
- homicide for black males
- suicide for white males

Prime of life (35-44)

- heart diseases (death rate twice higher for blacks than for whites)
- cancer

Late middle ages (55-64)

- chances of death increase a lot
- suicides markedly higher for white than for blacks

Connection of mortality with schooling

- strong correlation between health and schooling
- chain of causality not well understood

Women

- different lifestyles
- as lifestyles become more similar with men, differentials in mortality narrow
- correlation with marital status

Summary

- from the mid-18th to the mid-20th century rising incomes resulted in unprecedented health improvements
- during this period, medical care (not the same as public health) was insignificant in the improvements
- from the mid-1930s therapeutic advances are very important
- now income is not significantly associated with better health, except for infant mortality (this association is also weaker than previously)
- as medical care has widely diffused, its marginal contribution to health is now small
- there is a lot of potential to improve health through lifestyle changes

Chapter 3: The Physician

- physicians are in a preeminent position in healthcare delivery because of laws, customs, and more extended training
- physicians are very important for cost of care
- others involved in the actual delivery of care (e.g., nurses, pharmacists) take instructions from physicians
- interesting change: growth in the full-time staffs at hospitals
- high physician incomes
  - fast rise since WWII in fees relative to other consumer goods
  - long and expensive education + long hours of work
- physicians'choices have a lot of influence on other aspects of the cost of care
- maximizing income is not the only driver of physicians decision-making; the other factors include:
  - peer approval
  - patient approval
  - "instinct of workmanship", "best medical practice"
  - lifestyle preferences
- problems of licensure: limits competition; alternative proposals:
  - voluntary certification
  - institutional licensure
- importance of uncertainty in medical care (Arrow)
- physicians also have an important "caring" role besides "curing"
- access problems:
  - care is distributed more equally than before across groups in society
  - growth in specialization
  - need for other types of personnel besides physicians
  - geographic disparities
- "doctor shortage" and "surgeon surplus"

Chapter 4: The Hospital

- previously: a place for the poor to die
- today: "the doctor's workshop", place to get effective medical care
- current change: "health care centers" for the community; importance of preventive medicine, health education, ambulatory care, home care, rehabilitation services
- key problem: high cost
  - overutilization
  - inefficiency
  - excess capacity
- hospital size: many hospitals are too small, some hospitals are too large
- ownership: government, private non-profit, private for-profit - are there differences in quality?
- substantial geographic variation in expenditures
- teaching hospitals: teaching vs research vs service provision
- changes:
  - increase in average size
  - growth in the importance of outpatient care
  - expansion of the hospital industry
- why are costs high?
  - accounting explanation: growth in expenditures on both labor and non-labor inputs
  - behavioral explanation: generous Medicare and Medicaid programs from the mid-1960s
- possible ways to limit cost growth:
  - Expenditures = Admissions x Length of Stay x Cost per Patient Day
  - Admission: change incentives that make it advantageous for physicians to admit patients for inpatient stay and for patients to favor inpatient stay over outpatient services
  - Length of Stay: unclear if longer hospital stays have advantages; there is also a need for extended-care facilities
  - Cost per Patient Day: too much service? need payment reform?
  - incentive reimbursement
  - competition
  - regulation

Chapter 5: Drugs

- drugs beyond the basics became important in the 20th century
- drug manufacturing is a highly-concentrated industry
- price discrimination:
  - pharmacies vs hospitals
  - domestic vs export
- product differentiation:
  - positive side: therapeutic effectiveness
  - negative side: increased prices
  - importance of marketing
- retailing issues:
  - high markups
  - decrease in the importance of pharmacists because products are most often compounded and packaged at factories
  - issue of price advertising in pharmacies
  - lot of price variation even within cities
- new drug issues:
  - FDA regulation might be keeping useful drugs off the market
  - drugs can be available in foreign countries but not America
  - we might be using the wrong standards when comparing the effectiveness of new drugs with that of existing drugs
- some overuse and misuse of drugs - unclear how to regulate
- drug costs:
  - only 10% of expenditures
  - only 40% of revenues used for material and labor inputs
  - large amounts spent on marketing
  - high profit rates
  - research expenditures
  - rise of generics
- ethical considerations:
  - placebos
  - should physicians themselves dispense drugs for profit?

Chapter 6: Paying for Medical Care

- key point: the public must pay for medical care in one way or another
- the US has a diverse system of financing medical care:
  - government (federal, state, local)
  - direct payment by patients
  - private insurance
- arguments for universal coverage:
  - healthcare is a right
  - if too many benefits are conditional on income, less incentive to work
  - dealing with the "free rider" problem in healthcare
  - separate public plans only for the poor will be low quality, while a universal plan will need to satisfy the majority
- what should be covered?
  - catastrophic vs "first-dollar" coverage
  - "first-dollar" coverage comes with substantial moral hazard
  - catastrophic (major-risk) approach has the advantages of lower premiums and less moral hazard, but possible problems are:
    - large administrative burden
    - less incentive for early and preventive care
    - government-provided catastrophic insurance could be complemented by private "first-dollar" insurance
- how would national health insurance work?
  - how to raise money?
  - how to administer the plan(s)?
  - how to use financing to change the organization and delivery?
- HMOs
  - prepaid group practice or medical care foundation
  - comprehensive coverage: different incentives
    - patients less likely to seek hospitalization
    - physicians less likely to provide unnecessary care because of capitation payments
  - possible disadvantages:
    - skimping on care
    - risk selection
  - current evidence suggests better cost control with no change in health

Conclusion: Health and Social Choice

- health status depends on many things besides medical care
- current variations across individuals and groups are determined largely by genetic factors, environment, and lifestyle
- changes in the health of populations over time are influenced by medical care, but mostly through scientific advances and not changes in quantity
- in developed countries, the marginal contribution of medical care to life expectancy is very small
- hospitals have seen the larges increases in expenditures, likely the place to limit cost growth
- drugs are less important for cost but important because of their potential to influence health
- there are significant opportunities to save on drugs costs

Recommendations

1. Universal comprehensive insurance
2. Decentralized delivery system
3. Capitation payments for enrolled populations
4. Competition among alternative health plans
5. Elimination of restrictions on health manpower
6. Rational physician supply
7. Rational hospital utilization

What Every Philosopher Should Know About Health Economics

- what are the goals of the system?
  - the US is at the technology frontier
  - the US ranks below other developed countries in most population health measures
  - importance of caring and service
  - distributional equity
  - efficiency in the use scarce resources
- conditions for universal coverage:
  - subsidization for those who cannot afford coverage
  - compulsion for those who don't want to get coverage
  - one without the other is unworkable
  - explicit healthcare tax with implicit subsidies for the poor or healthcare mandate (implicit tax) with explicit subsidies for the poor
- cost containment will make some groups unhappy
- fundamental problem of health economics: risk aversion vs moral hazard
- second fundamental problem: heterogeneity in marginal benefits across patients
- problem of an aging society