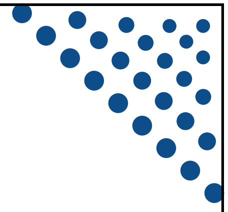

The Economics of Healthcare

San Ramon Valley Democratic Club

June 26, 2023
Jon Haveman, Ph.D.
NEED

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National Economic Education Delegation

- **Vision**
  - One day, the public discussion of policy issues will be grounded in an accurate perception of the underlying economic principles and data.
- **Mission**
  - NEED unites the skills and knowledge of a vast network of professional economists to promote understanding of the economics of policy issues in the United States.
- **NEED Presentations**
  - Are **nonpartisan** and intended to reflect the consensus of the economics profession.

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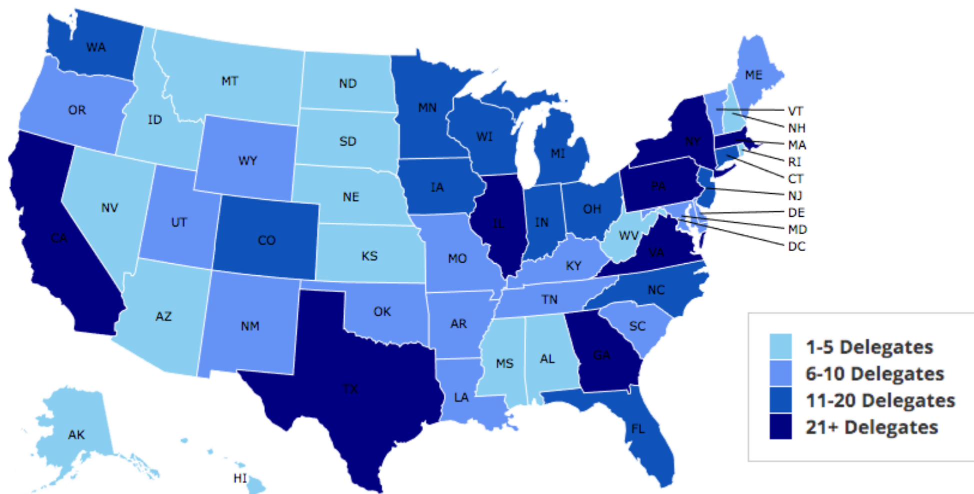
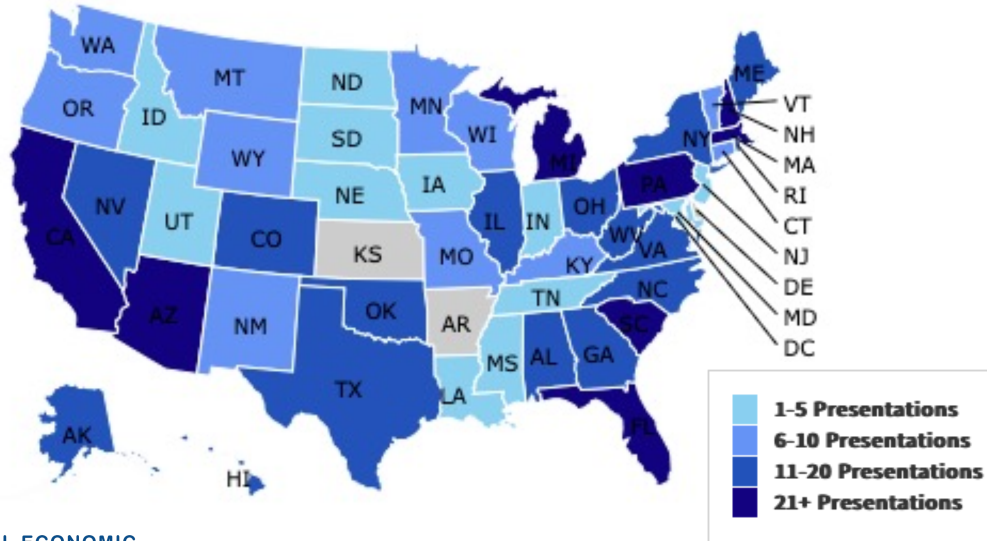
Who Are We?

- **Honorary Board: 54 members**
  - 2 Fed Chairs: Janet Yellen, Ben Bernanke
  - 6 Chairs Council of Economic Advisers
    - Furman (D), Rosen (R), Bernanke (R), Yellen (D), Tyson (D), Goolsbee (D)
  - 4 Nobel Prize Winners
    - Akerlof, Smith, Maskin, Bernanke
- **Delegates: 652+ members**
  - At all levels of academia and some in government service
  - All have a Ph.D. in economics
  - Crowdsource slide decks
  - Give presentations
- **Global Partners: 48 Ph.D. Economists**
  - Aid in slide deck development

Where Are We?



Where Have We Presented? (1,166 Talks)



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Credits and Disclaimer

- **This slide deck was authored by:**
  - Veronika Dolar, SUNY Old Westbury
  - Jon Haveman, NEED
- **This slide deck was reviewed by:**
  - Jonathan Gruber, MIT
  - Robert Hansen, Dartmouth College
- **Disclaimer**
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  - It is, however, inevitable that presenters will be asked for and will provide their own views.
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Outline

- What is Health(care) Economics?
- Health Insurance and Outcomes
- Health Care Systems and Institutions

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Health Economics is Big Business

- The United States spends A LOT on healthcare:
  - In 2019, U.S. national health expenditures were **17.5% of GDP**, which is equivalent to around **$3.8 trillion**.
  - U.S. Healthcare is the 5th largest economy in the world.
- For comparison, GDP in each country in 2019:
  - Germany: $3,845 trillion (4th largest economy)
  - US Healthcare $3.8 trillion
  - UK: $2,827 trillion (6th largest economy)
  - France : $2,715 trillion (7th largest economy)

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Markets Studied in Health Economics

- **Markets for:**
  - Physicians
  - Nurses
  - Hospital facilities
  - Nursing homes
  - Pharmaceuticals
  - Medical supplies
    - such as diagnostic and therapeutic equipment
  - **Health Insurance**

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The Three Legs of the Healthcare Stool

ACCESS

QUALITY

COSTS

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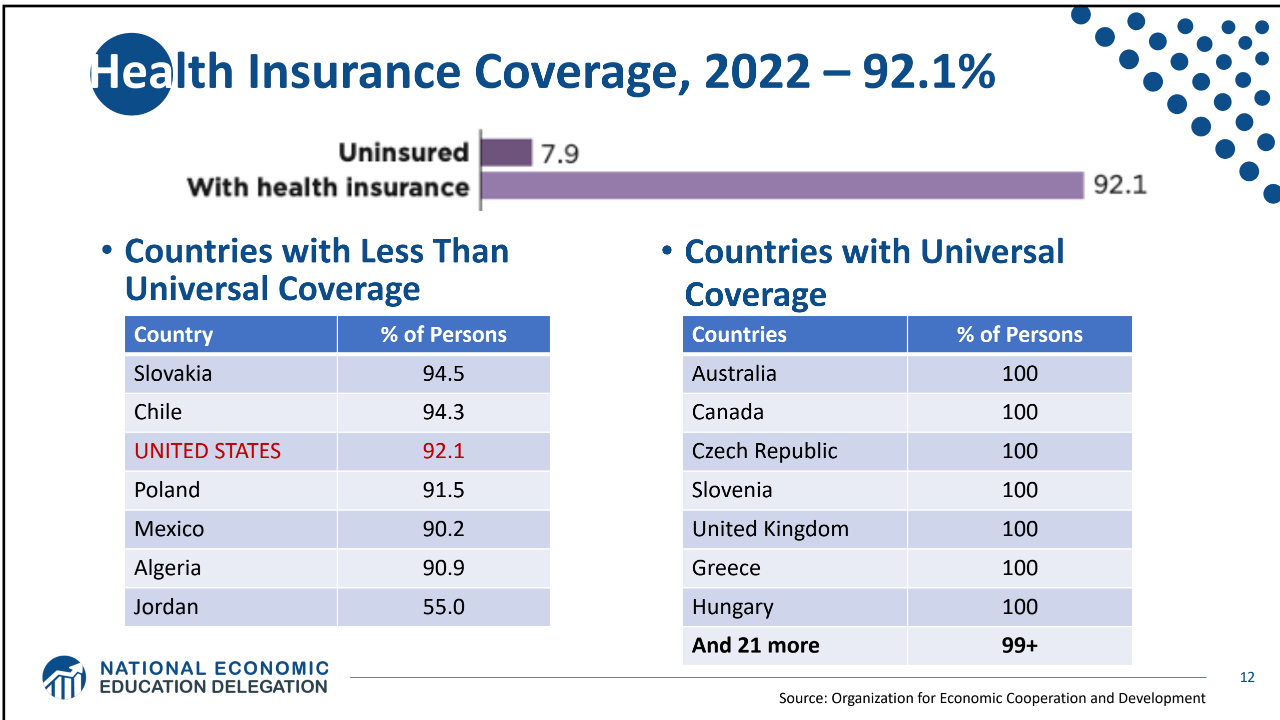

Country	% of Persons
Slovakia	94.5
Chile	94.3
UNITED STATES	92.1
Poland	91.5
Mexico	90.2
Algeria	90.9
Jordan	55.0

Countries	% of Persons
Australia	100
Canada	100
Czech Republic	100
Slovenia	100
United Kingdom	100
Greece	100
Hungary	100
And 21 more	**99+**

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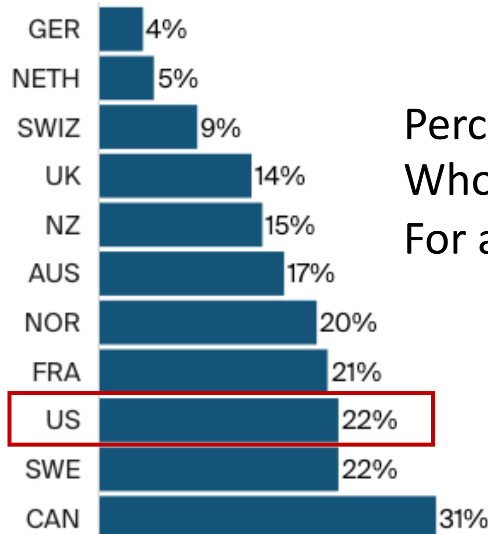
But What About Wait Times?



Percentage of adults aged 65+
Who waited more than 6 days
For an appointment when sick.

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Source: Commonwealth Fund, Comparing Nations on Timeliness and Coordination of Health Care, 2021

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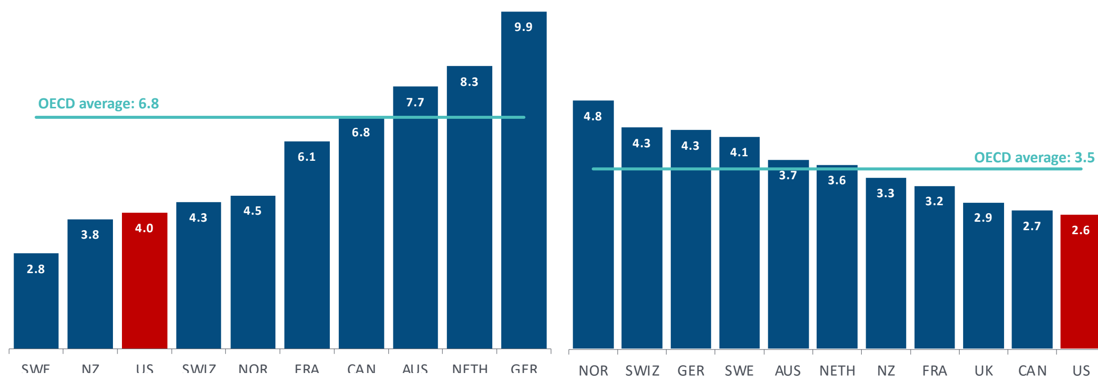
Physician Visits and Physician Supply

Average physician visits per capita, 2017

Practicing physicians per 1,000 population, 2018



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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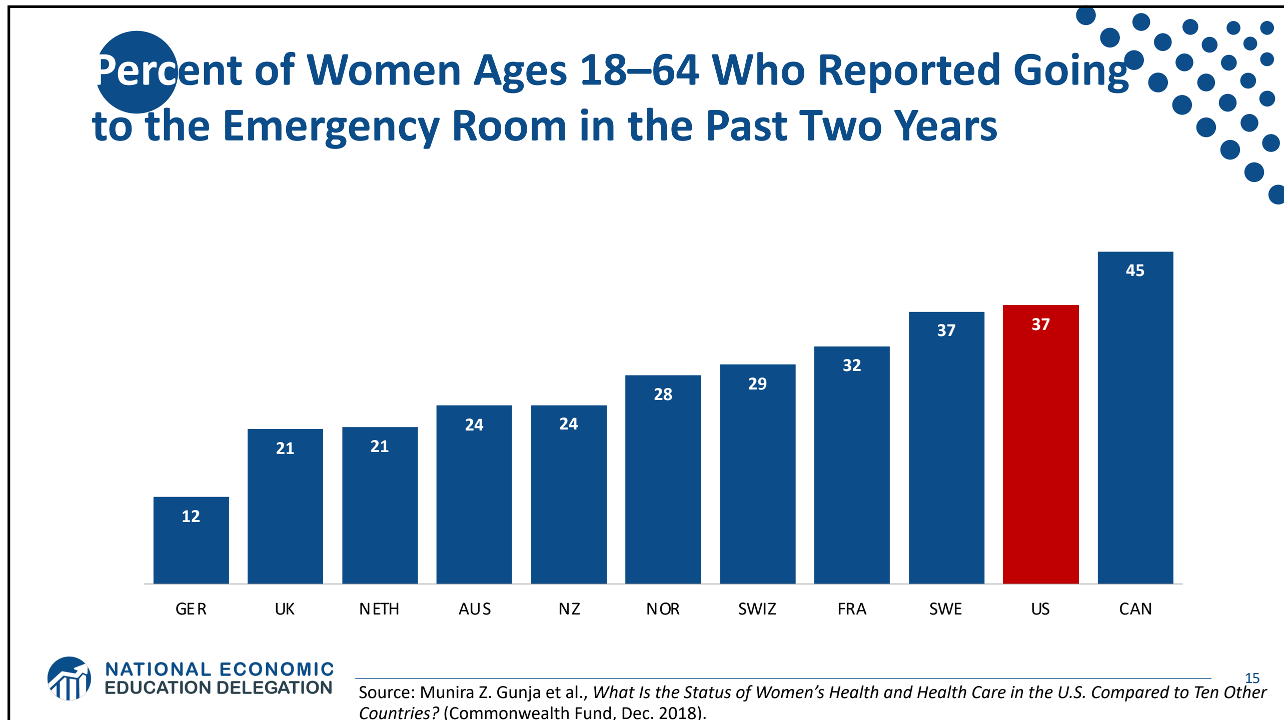

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Access Notes

- **Insurance coverage in the U.S. is not universal.**
  - It is universal in every other developed country.
- **Wait times are not necessarily lower in the U.S.**
- **Supply of medical personnel and equipment may be lower than elsewhere.**
- **Emergency room use is higher in the U.S. than elsewhere.**

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Quality

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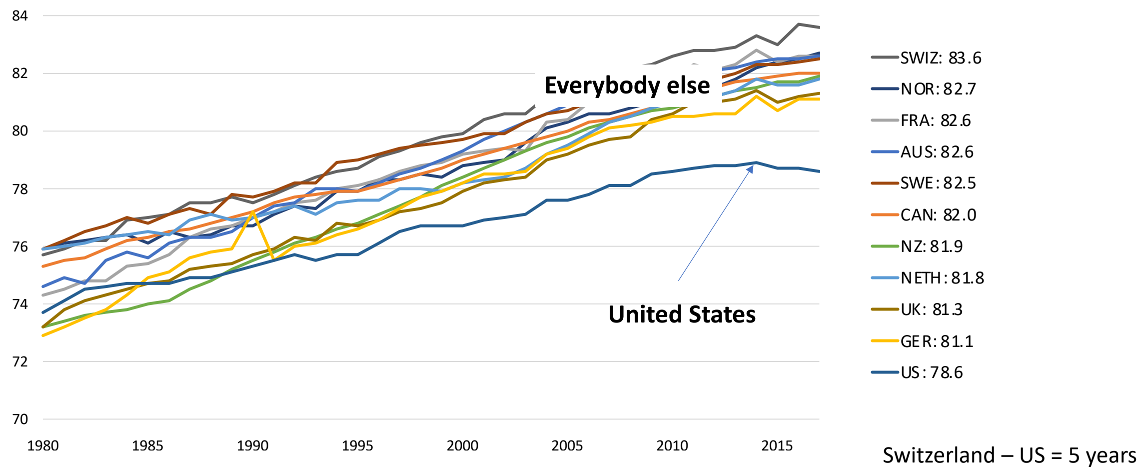
Life Expectancy: How Does the US Compare?



Switzerland – US = 5 years

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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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Life Expectancy at Birth by Race/Ethnicity, 2019

Race/Ethnicity	Life Expectancy (Years)
All Races	78.8
White	78.8
Black	74.8
Hispanic	81.9
Asian	85.6

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Source: KFF, Key Data on Health and Health Care by Race and Ethnicity

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Income Also Matters – Reflecting Access?

Sex	Income Category	Life Expectancy (Years)	Difference High vs Low
Women	**Highest** Incomes (top 1%)	88.9	10.1 years
	Lowest Incomes (bottom 1%)	78.8	
Men	**Highest** Incomes (top 1%)	87.3	14.6 years
	Lowest Incomes (bottom 1%)	72.7	

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Source: https://healthinequality.org/documents/paper/healthineq_summary.pdf

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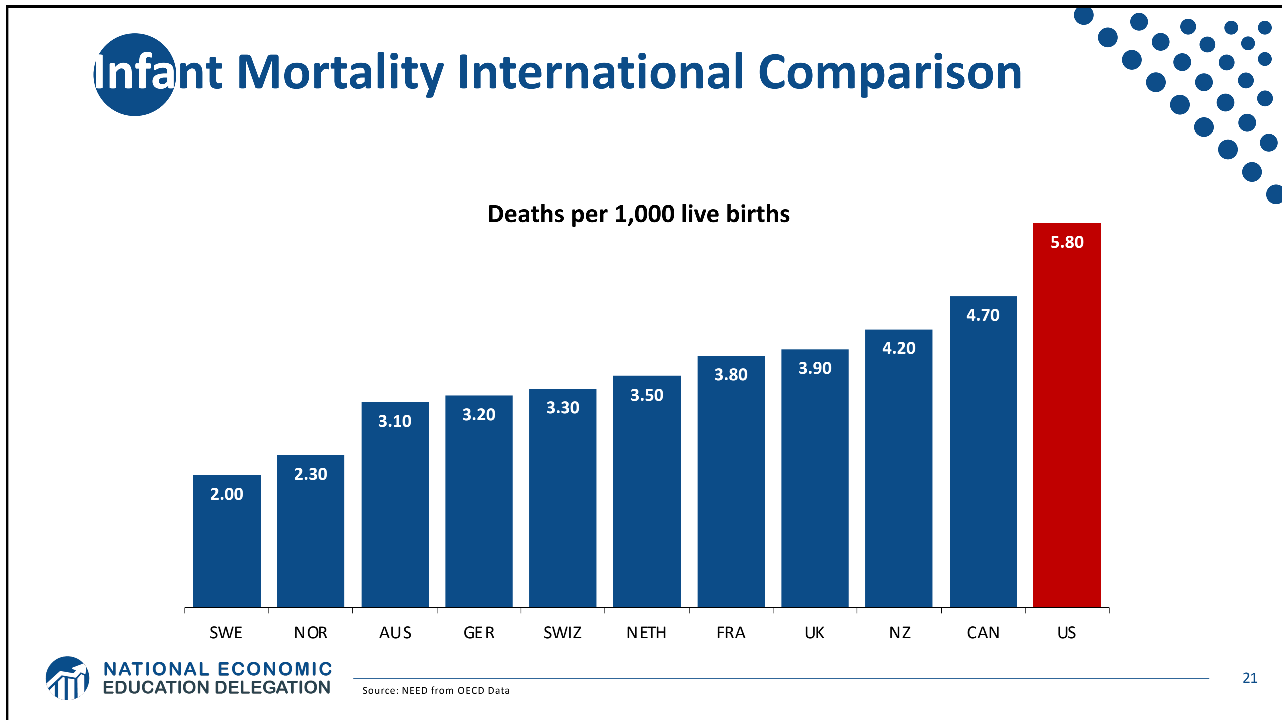

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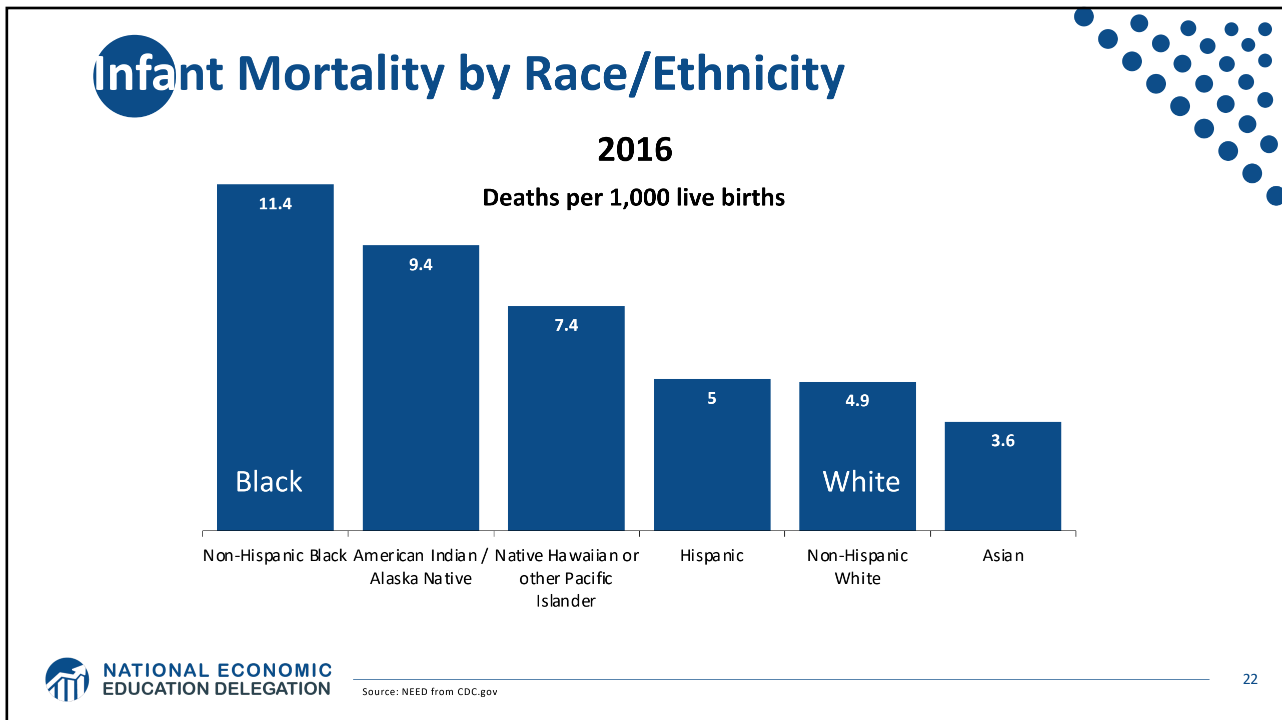

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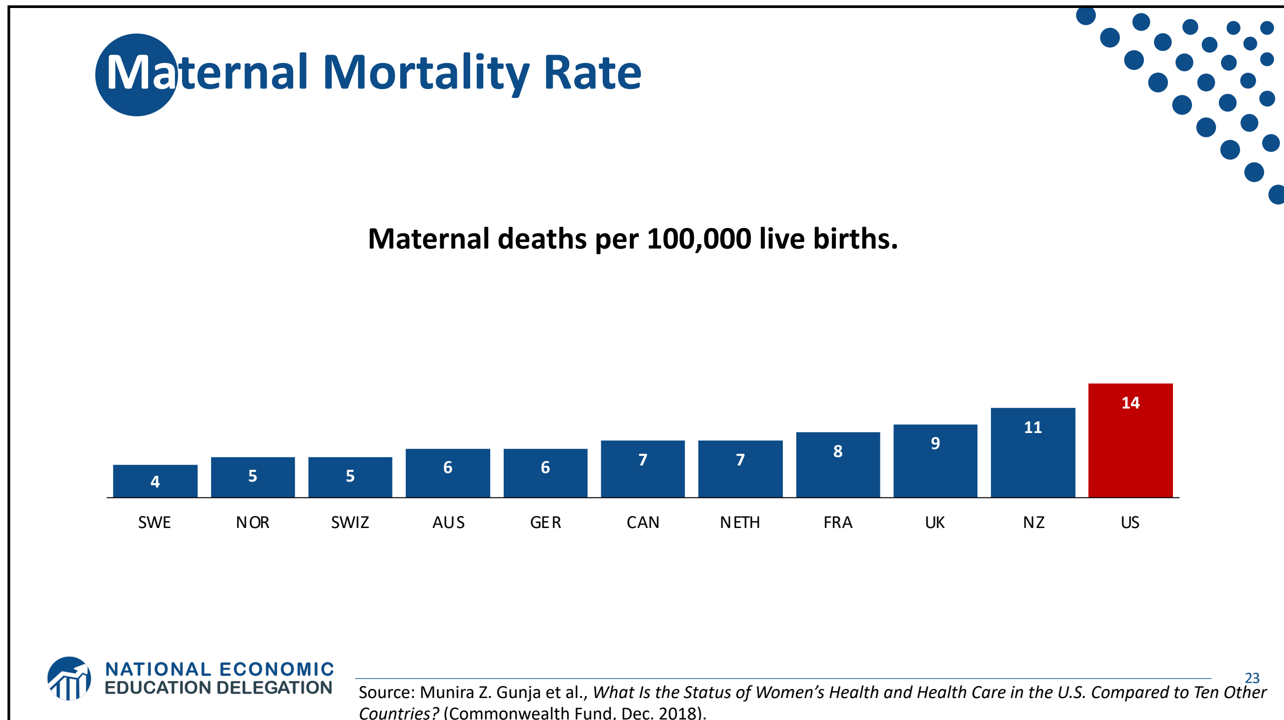

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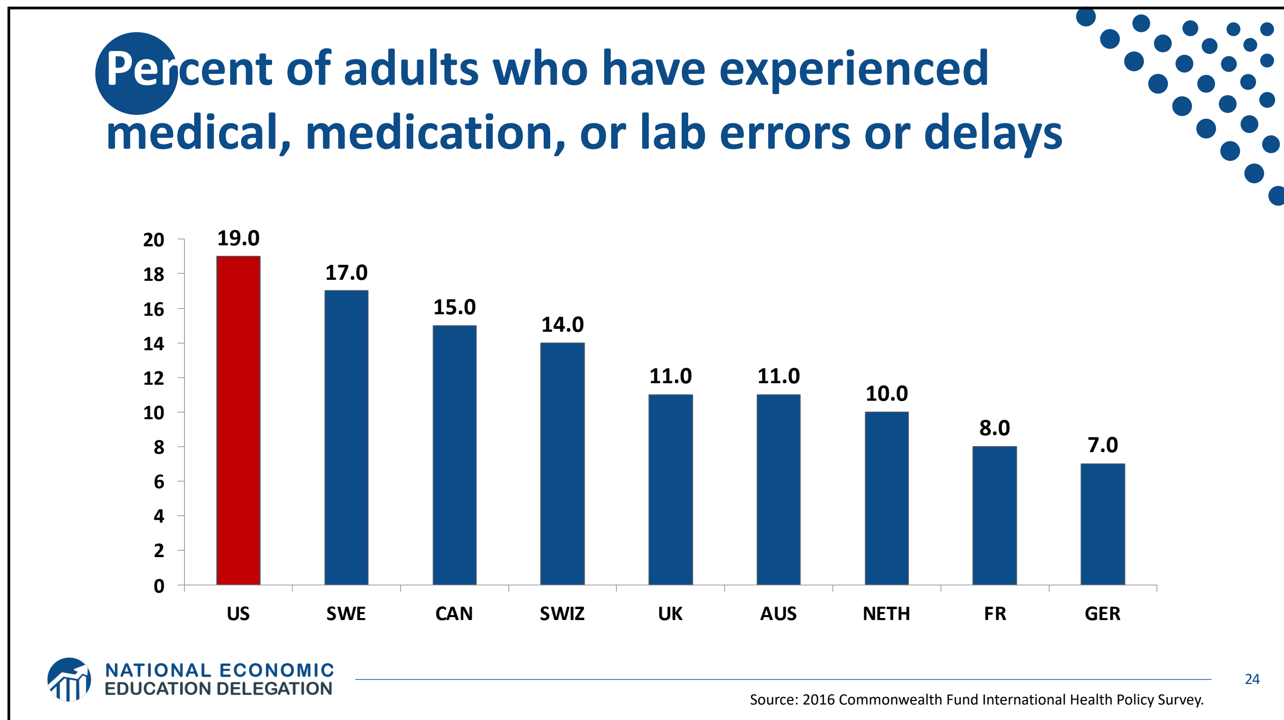

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Prevention and Screening

- The U.S. excels in **some** prevention measures (high ranking:
  - including **flu vaccinations** and **breast cancer screenings**.
- The U.S. has:
  - The highest average five-year survival rate for breast cancer,
  - but the Lowest for cervical cancer.

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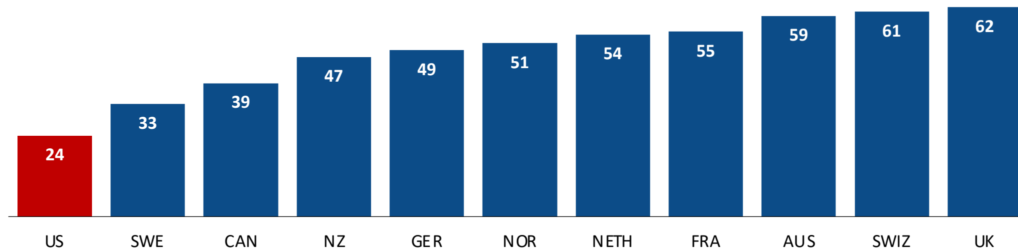
Perception of Quality of Medical Care

Percent of women ages 18–64 who rated their quality of medical care as ***excellent or very good****.*



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Source: Munira Z. Gunja et al., *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?* (Commonwealth Fund, Dec. 2018).

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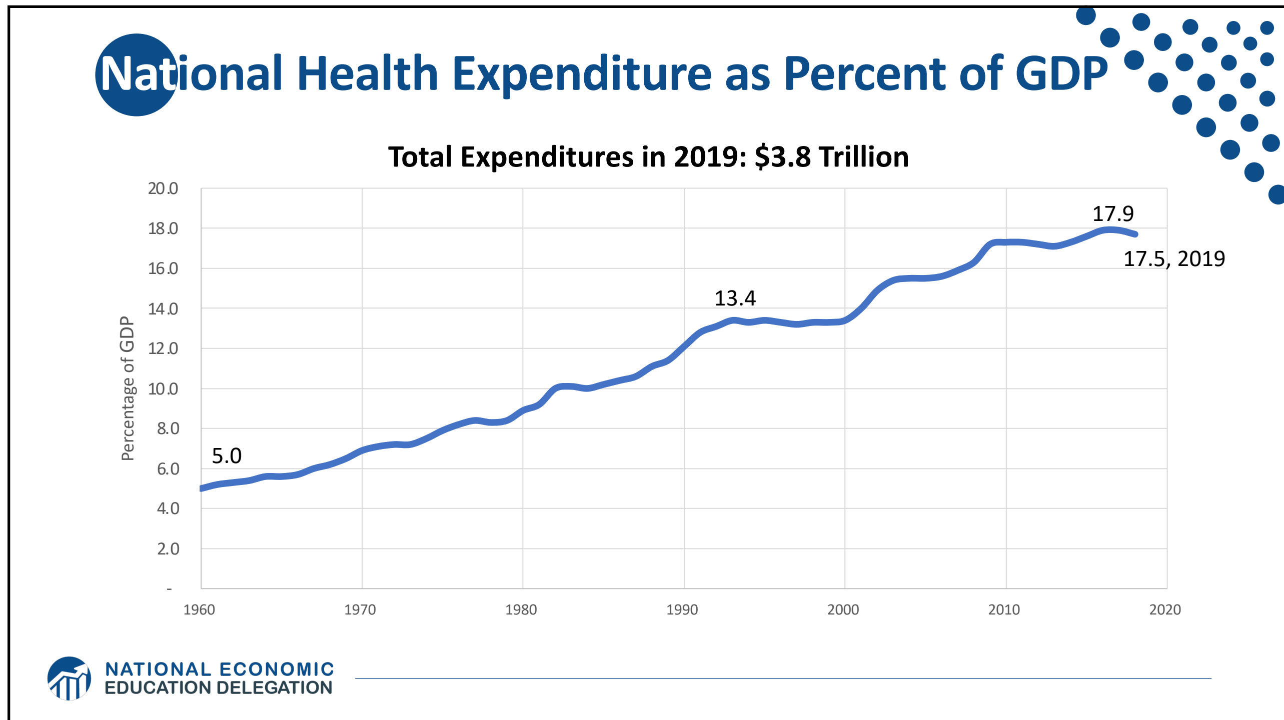

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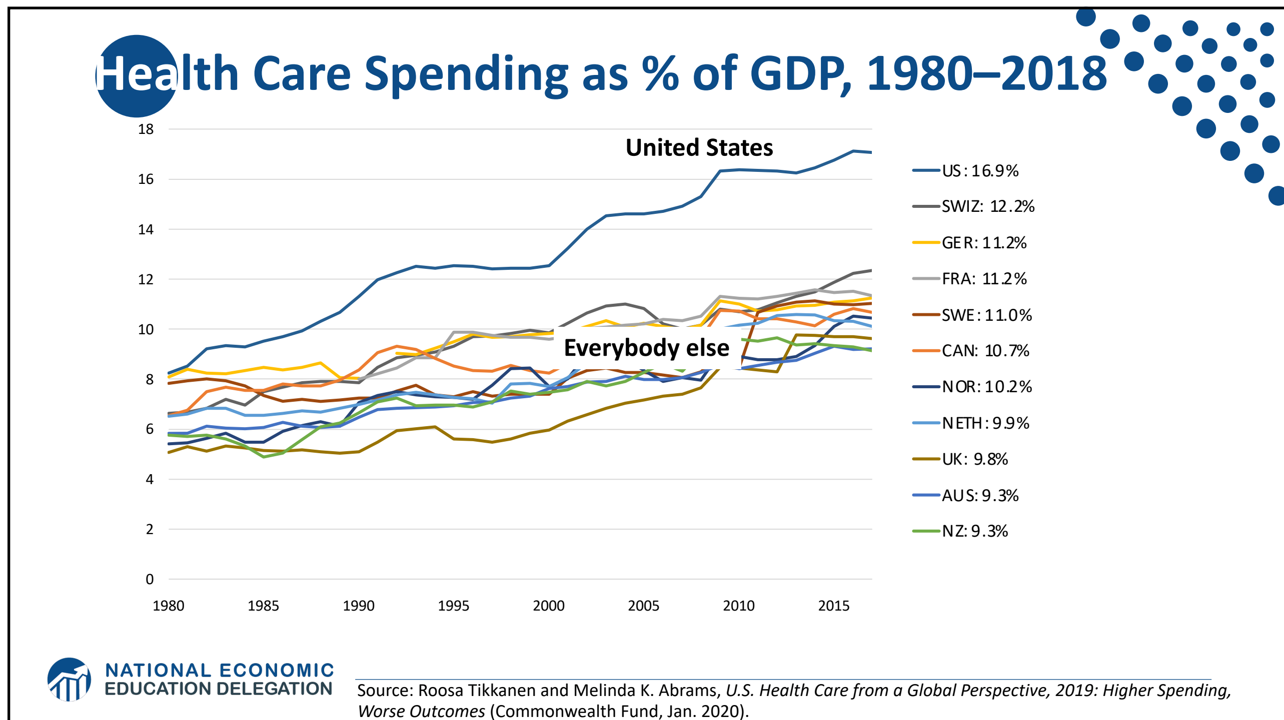

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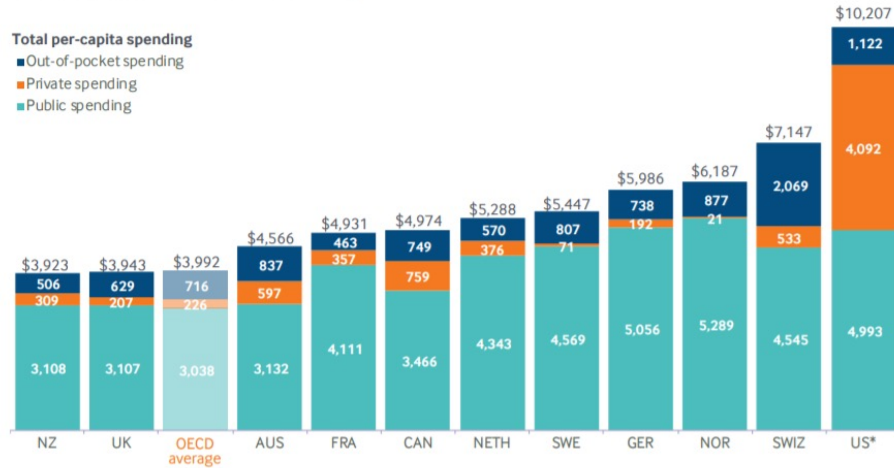
International Per Capita Healthcare Spending



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Source: Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes* (Commonwealth Fund, Jan. 2020).

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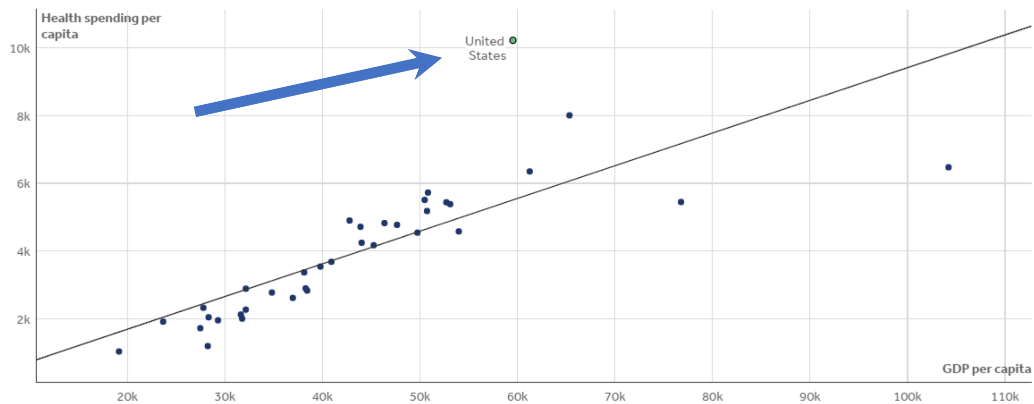
GDP per Capita and Health Spending per Capita, 2017



Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • Get the data • PNG

Peterson-KFF **Health System Tracker**

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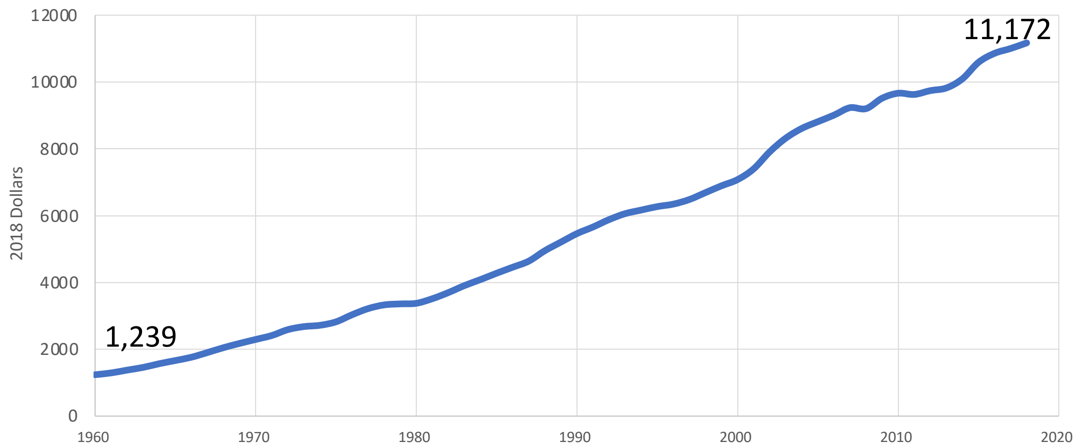
National Healthcare Expenditure Per Capita



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Why is Healthcare Spending Increasing?

- Costs in the United States, and elsewhere are increasing rapidly.
- The share of economic spending on health care has been steadily increasing for all countries because:
  - Health spending growth has outpaced economic growth.
  - Richer countries demand more services, like attention to health.
- Also because of:
  - Advances in medical technologies.
  - Increased demand for services.
  - Rising prices in the health sector – why?

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Why Are Costs so High in the US?

One Reason:

The United States is the only profit-motivated healthcare system in the world.

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Why Are Costs so High in the US?

Another Reason:

Our public health system isn't very good.

(We have a health RESTORATION system, NOT a health CARE system.)

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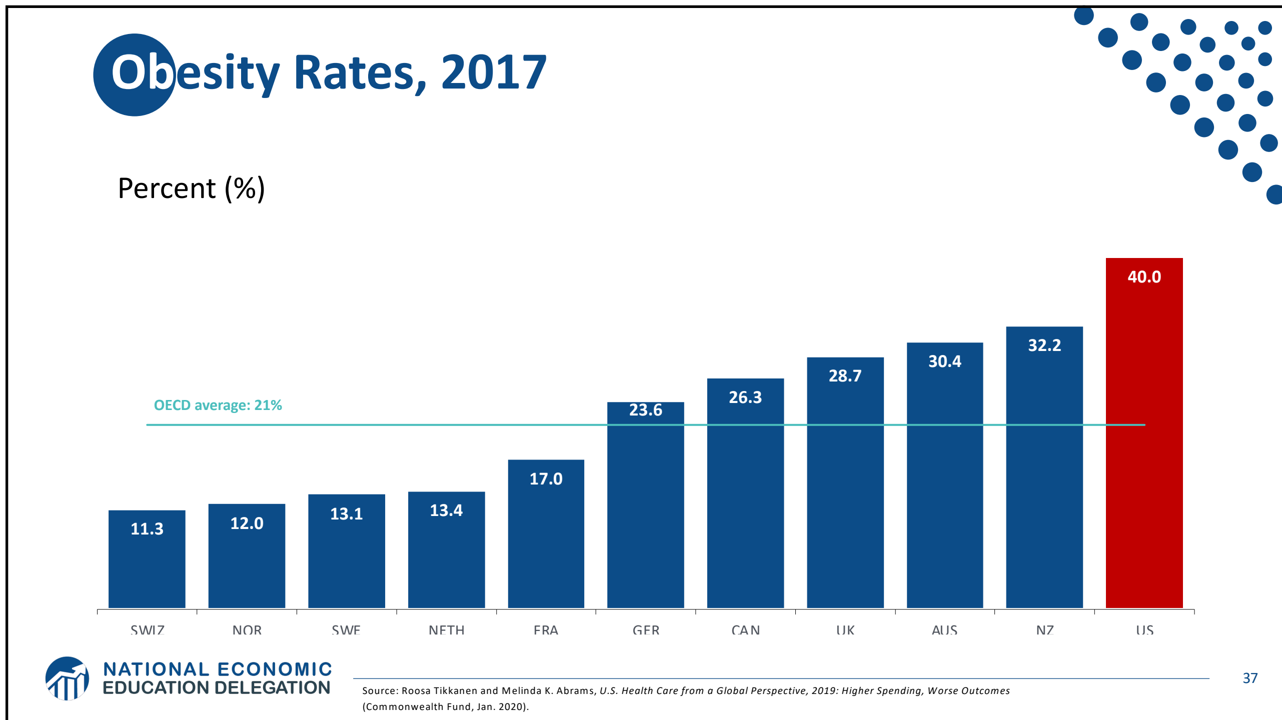

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Markets Matter for Costs

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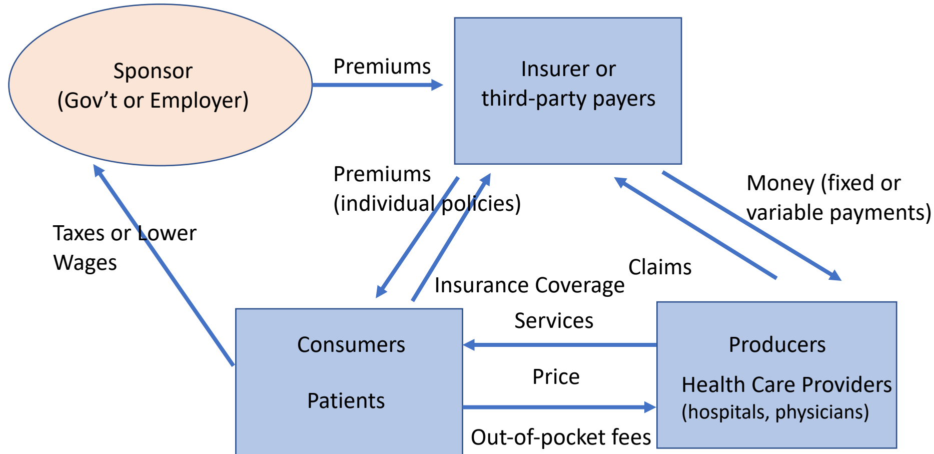
Health Care Markets are Different



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How Much Did Your Flu Shot Cost?

- **Who knows? It's generally offered for free.**
- **Providers of the shot do pay for it.**
  - Some reported prices:
    - Sacrament, CA $85
    - Long Beach, CA $42
    - Washington, DC $15
- **Who really pays for the flu shot?**
  - YOU DO! Higher premiums.

Prices are negotiated with the Vaccine producer.

Differences are a reflection of More or less bargaining power.

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Source: https://kffhealthnews.org/news/the-startlingly-high-cost-of-the-free-flu-shot/

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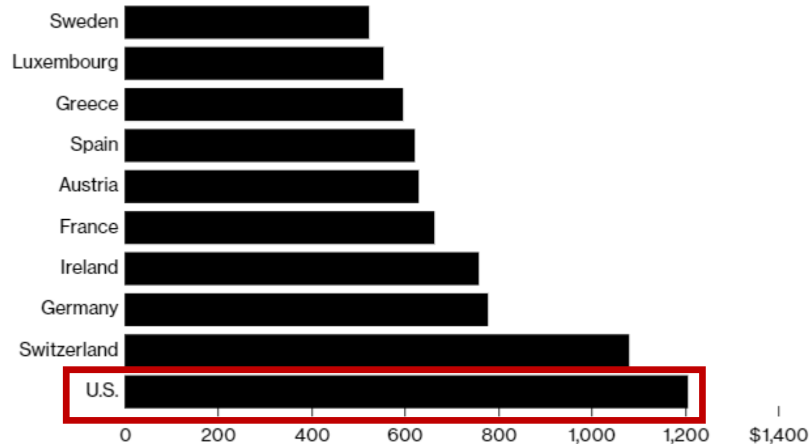
Policy Matters for Costs

Hospital Monopolization

- Less competition in health systems, hospitals, medical groups, and health insurers has surged in recent years.
- Over an 18-month period between July 2016 and January 2018:
  - Hospitals acquired 8,000 more medical practices.
  - 14,000 more physicians left independent practice to become hospital employees.
- Between 1999 and 2018, hospital profit margins soared!
  - From 100% in 1999 to 317% in 2018.

Spending on Pharmaceuticals



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Medicare Modernization Act

- Prescription Drug Component
- Medicare Part D, **by law**, can**not** negotiate drug prices like other governments do.
- In 2017, Medicare spent nearly $8 billion on insulin.
  - The researchers said that if Medicare were allowed to **negotiate** drug prices like the U.S. Department of Veterans Affairs (VA) can, Medicare could **save about $4.4 billion *just* on insulin**.

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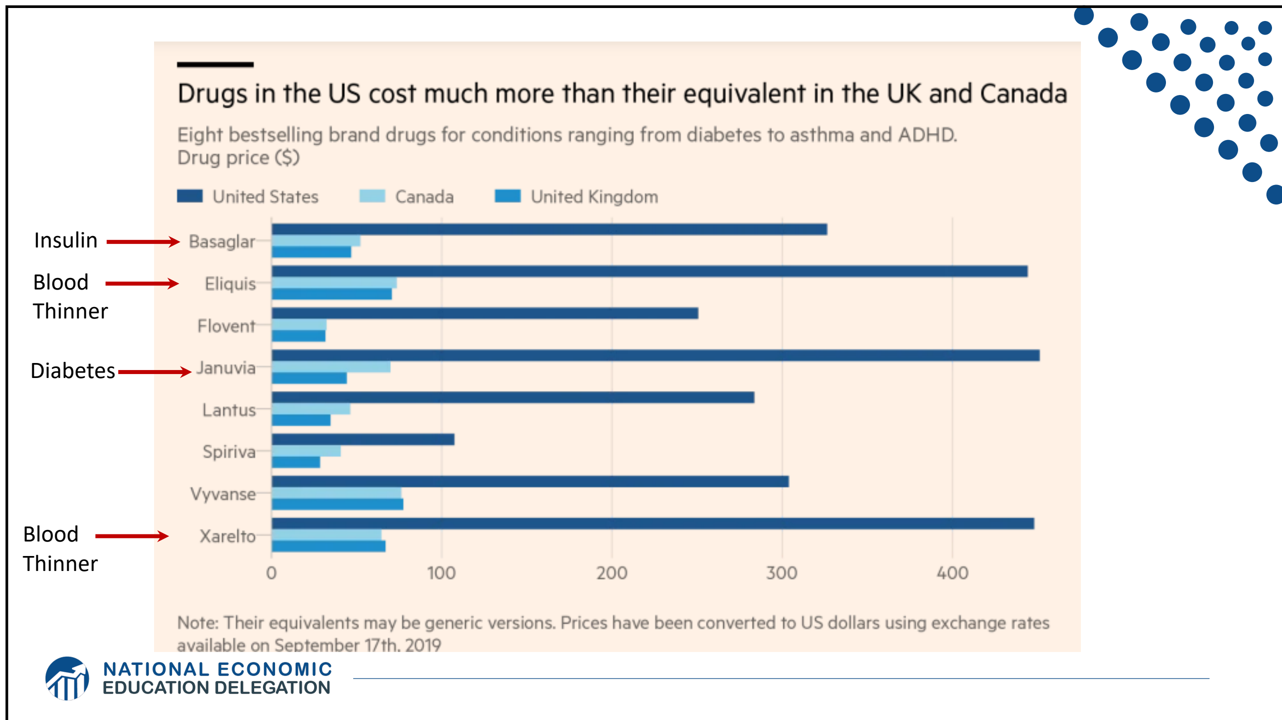

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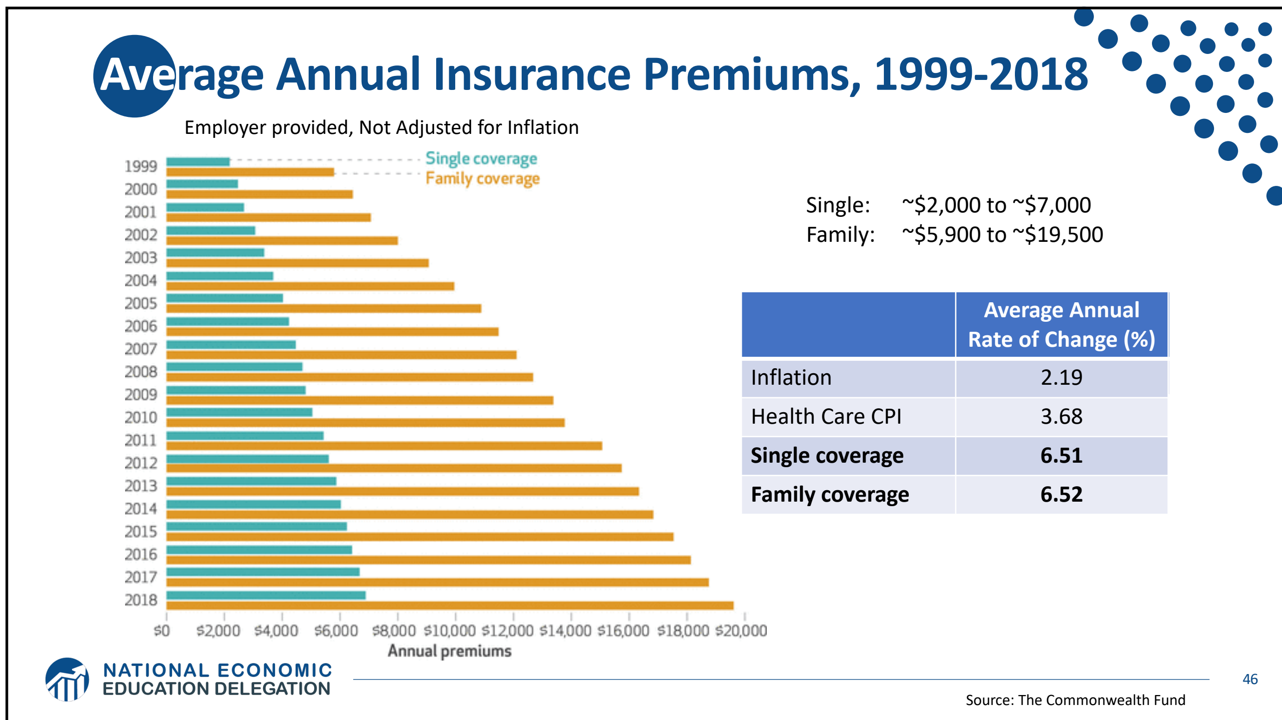

	Average Annual Rate of Change (%)
Inflation	2.19
Health Care CPI	3.68
Single coverage	**6.51**
Family coverage	**6.52**

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Reason for Higher Health Insurance Rates

- Rising prices in the health sector
- Advances in medical technologies
- Increased demand for services
- Lack of competition in health insurance markets

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Monopolization of Health Insurance Markets

- As of 2011, there were close to **100 insurers** in **Switzerland** competing for consumer health care dollars, **forcing firms to compete** by setting prices to just cover costs.
- In 2019, of the 50 states and the District of Columbia:
  - 21 had only 1 or 2 insurers
  - 14 had 3 or 4, and
  - 16 states had 5 or more. (CA had 11)

Source: KRR, Number of Issuers Participating in the Individual Health Insurance Marketplaces

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Health Care Systems and Institutions

Definition: Universal Coverage

- **Universal coverage –** refers to health care systems in which ***all*** individuals have insurance coverage.
- Generally, this coverage includes:
  - Access to all needed services and benefits.
  - Protects individuals from excessive financial hardships.
    - Medical indebtedness is the #1 cause of bankruptcies in the United States.
- Canada has universal coverage, the United States does not.

Definition: Single-Payer

- **Single-payer** - refers to financing a health care system by making one entity solely and exclusively responsible for paying for medical goods and services.
  - Not necessarily the government.
- It is only the financing component that is socialized.
  - The money for the payment can be either collected by:
    - Taxes collected by the government.
    - Premiums collected by National or Public Health Insurance.
- **Single-payer systems: 17 countries**
  - Norway, Japan, United Kingdom, Kuwait, Sweden, Bahrain, Brunei, Canada, United Arab Emirates, Denmark, Finland, Slovenia, Italy, Portugal, Cyprus, Spain, and Iceland.

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Definition: Socialized Medicine

- **Socialized medicine** – this model takes the single-payer system one step further.
  - Government not only pays for health care but operates the hospitals and employs the medical staff.
- This has NEVER been a part of the debate in the United States.

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Definition: Third-Party Payer

- A **third-party payer** is an entity that pays medical claims on behalf of the insured. Examples of third-party payers include government agencies, insurance companies, health maintenance organizations (HMOs), and employers.
  - Employer-sponsored health plans
  - Individual market health plans
  - National health insurance

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Health System Classification

- **Developed countries of the world have each taken a different approach for their health care delivery systems.**
- **5 basic models:**
  - Beveridge – socialized medicine (United Kingdom, Spain, New Zealand)
  - Bismarck (France, Germany, Japan, Switzerland)
  - National health insurance (Canada)
  - Out of pocket model – self insurance
  - Mixed (United States)

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Model 1: Beveridge

- **In this model, health insurance is paid for through TAXATION.**
  - Everybody has insurance, universal coverage. Everybody receives care at no cost.
  - All insurers are public.
  - Supplemental insurance is available in the private market.
  - Similar to public libraries and police forces.

- **Pros:**
  - Universal coverage.
  - Government controls quality of care, so cost of care may be low.
  - No medical bills or co-pays.

- **Cons:**
  - Taxes are high, regardless of use of healthcare.
  - Government controls quality of care, so service availability might be low.
  - Longer waiting times for non-emergency care.
  - Potential for excessive use of the system.

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https://www.ahaap.org/beveridge-model

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Model 2: Bismarck

- **In this model, health insurance is paid for through PREMIUMS.**
  - Everybody must have insurance, only poor don't have to pay premiums.
  - Premiums are paid into the "gov't sickness fund" or directly to private insurers.
  - All insurers are private, but can't make money off the sickness fund.

- **Pros:**
  - Everybody is covered and can avoid expensive healthcare bills.
  - Administrative costs are much lower than in the U.S.
  - Little waiting time to receive basic services.

- **Cons:**
  - Focus on low costs can mean fewer services are available in rural areas.
  - Mandatory premiums are high.
  - Longer waiting times for elective services.

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https://www.ahaap.org/bismarck-model

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Model 3: National Health Insurance

- **This model has elements of both Beveridge and Bismarck.**
  - Like Beveridge: government is the single payer and paid for through taxes.
  - Like Bismarck: All health-care providers are in the private sector.
- **Pros:**
  - Lowers the cost of healthcare for the economy – bargaining power.
  - Low administrative costs for care.
    - No incentive to deny claims.
  - Healthier workforce.
- **Cons:**
  - Everybody pays regardless of health care received.
  - May stop people from being careful about their health.
  - Limits payouts to doctors.
  - May affect technology adoption.

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https://www.ahaap.org/national-health-insurance-model

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US Health Care System

- **Medicare – National Health Insurance**
- **Military Veteran Care – Beveridge model (socialized medicine)**
- **Employer-sponsored insurance – Bismarck model**
- **Individual market health plans – Bismarck model**
- **Uninsured – Out of pocket model**

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Summary

- US HealthCare system is **not preforming well**.
  - Very expensive with low quality and access.
- One of the main reasons for very high costs is the **monopolization** of healthcare markets.
- **Universal health insurance** would increase access and perhaps also reduce costs.
- Changing the **focus** from maximizing **profits** to maximizing **care** would help.

A Few Simple Solutions Could Reduce Costs

- **Encourage competition in healthcare markets.**
- **Introduction of a public option in the health insurance market.**
- **Allow the US government to negotiate drug prices**
  - like most every other nation.

Thank you!

Any Questions?

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