PART I Political Incentives in Healthcare Systems

1 The Political Design of Health Systems

GOVERNMENT AND HEALTHCARE

What is the role of the government in healthcare? Can healthcare services be efficiently delivered by markets alone? In a seminal 1963 article, Kenneth Arrow remarked that when economists argue that free markets are able to allocate scarce resources better than any alternative mechanism, they probably do not have healthcare in mind. More precisely, he pointed out that: 'it is clear from everyday observation that the behavior expected of sellers of medical care is different from that of business' (Arrow, 1963, p. 949). He later proceeded by stating: 'it is the general social consensus, clearly, that the laissez-faire solution for medicine is intolerable' (Arrow, 1963, p. 967). Arrow's claims were likely in support of the controversial idea of adopting what would, only two years later, become the first widespread public health insurance scheme in the history of the United States (USA), the joint introduction of Medicare and Medicaid programmes. Arrow's groundbreaking view has had an enduring effect on the health system choices of many different countries around the world.

A simple exercise through which one can appreciate the proliferation of public health insurance schemes (and national health systems) can be conducted by examining cross-country health expenditure trends. Through this exercise, several stylised facts become apparent.

First, as countries become richer, in terms of GDP per capita, total health spending as a share of total GDP increases too (Figure 1.1).[1]

[1] This apparent trend has led to debate in the literature over whether healthcare should be considered a normal or luxury good (see Costa-Font et al., 2011a for an empirical account), which has subsequent implications in rationalising a more, or less, ambitious public intervention.

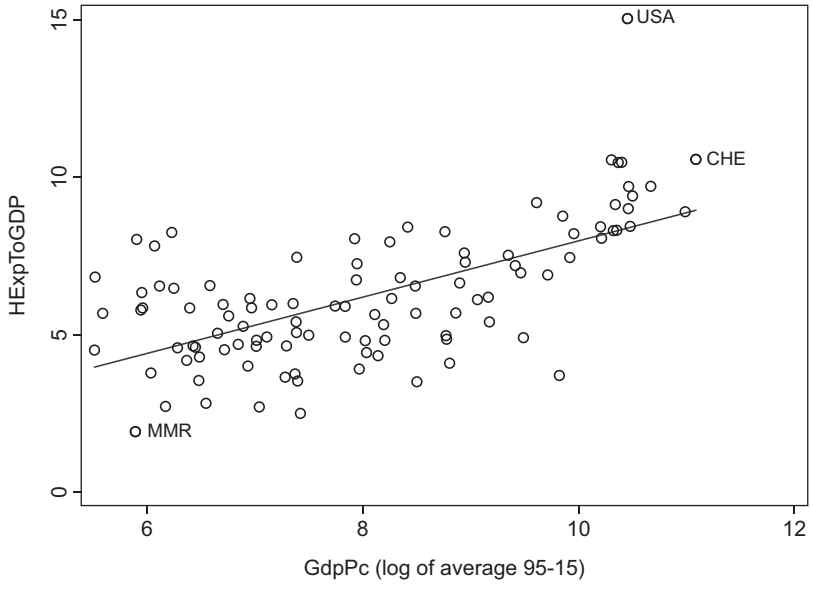

FIGURE 1.1 Health expenditure to GDP (HExpToGDP) correlated with per capita GDP (GdpPc) (average 1995–2015)
Source: Our elaboration from World Health Organization (WHO) data. Sample of countries with more than 4 million population on average for the 1995–2015 period

That is, healthcare is typically a normal good. Both the demand for healthcare and the expectations of better health and quality of care increase with income.

A second, and more salient stylised fact given the focus of this book, is that as countries develop economically, their share of public health spending tends to grow, both in terms of share of total health spending and of total government spending, respectively (Figures 1.2 and 1.3). That is, an expansion of a country's economic development gives rise to an opportunity to widen public interventions in the health sector. We offer a number of explanations which we do elaborate upon throughout this book, among them the expansion of democracy, an instance which comes together with economic development. The central role for the government in healthcare, as we argue below, increasingly situates each individual at the core of the system. Each one of us takes two roles: as a 'patient', interested in obtaining healthcare services of good quality; and as a 'citizen',

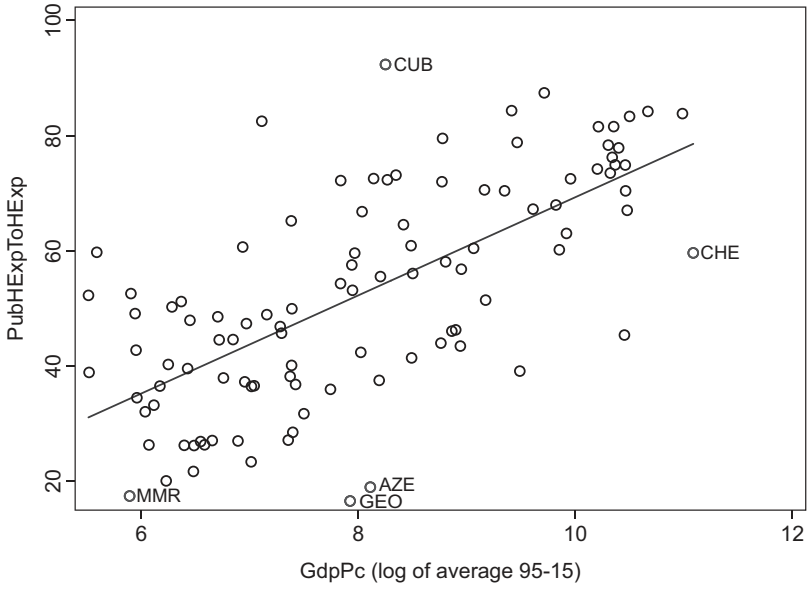

FIGURE 1.2 Public health expenditure to total health expenditures (PubHExpToHExp) correlated with per capita GDP (GdpPc) (average 1995–2015)

Source: Our elaboration from WHO data. Sample of countries with more than 4 million population on average for the 1995–2015 period

funding these services and voting for political representatives to legislate on bills shaping health services. These agency relationships between the patient citizen (PC) and the state have progressively become central in the expansion of healthcare activity. Arrow's words have become a self-fulfilling prophecy, as government policy is increasingly at the core of any health system today.

There is a limit to public intervention, as the public financing of the system clearly affects the financial well-being of the PC. That is, insurance premiums, social security contributions or taxes all reduce individuals' income, and hence their consumption of private goods. However, the well-being of the PC increases as the public monies are used to provide quality healthcare services. In our framework, healthcare providers might be a government organisation and/or an independent agent outsourced by the government, as well as market driven private organisations. Some systems are mixed, and allow public and

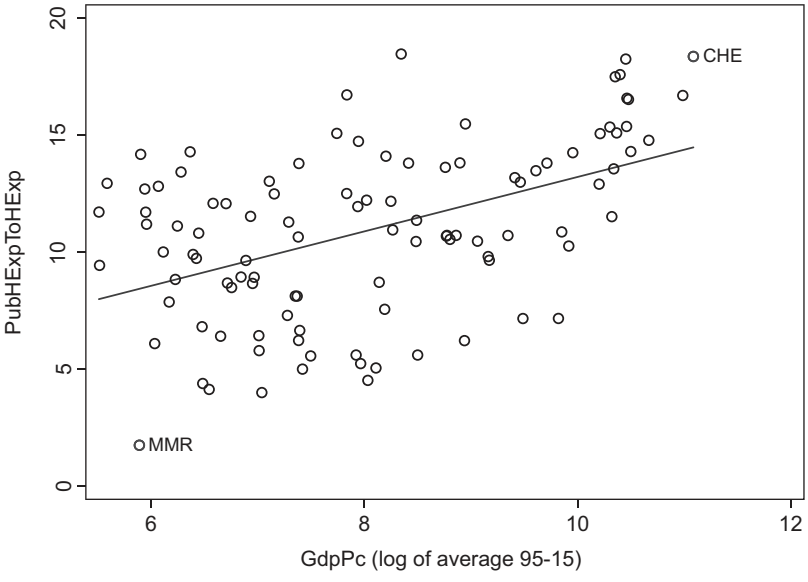

FIGURE 1.3 Public health expenditure (PubHExpToHExp) to total government expenditures correlated with per capita GDP (GdpPc) (average 1995–2015)
Source: Our elaboration from WHO data. Sample of countries with more than 4 million population on average for the 1995–2015 period

private providers to compete, so that market allocations can coexist with equity in the access to healthcare.[2] The implicit assumption here is that the productivity of providers (e.g. such as physicians and hospitals) improves with extrinsic monetary incentives (e.g. a fixed payment per PC treated), but without crowding out other intrinsic motivations, providers naturally have, such as to improve the health and well-being of the PC.[3]

[2] In other words, public funding and provision is a way of guaranteeing financial equity, while private provision will stimulates efficiency. This is the idea behind the 'quasi-markets', in which prices are heavily regulated. A variant of these structures when all providers are public is called the 'internal market', as in the UK's reforms in the 1990s.

[3] See, e.g. LeGrand (2002). Whether they work or not as an organisational solution to improve efficiency depends on whether the productivity increase outweighs the transaction costs of operating the market.

Historically, healthcare markets have unfolded in some way or another in almost all countries. They are commonly defined as part of a compact where insurance finances a package of healthcare services. However, when the PC is confronted with the decision about which healthcare providers assure better 'value/quality for money', such judgement is hampered by significant *information imperfections*, as individuals cannot fully judge healthcare quality by themselves. This puts physicians in an advantageous position with respect to the PC (as they can better observe the 'true quality' of care the PC is set to consume). Physicians can either honour their ethical code and become what is labelled as a 'perfect agent' of the PC, or use their informational advantage to pursue alternative courses of action such as induce demand for certain types of healthcare that might, in turn, provide them with additional rents (e.g. Labelle et al., 1994).

A common reaction to the presence of information asymmetries is the *regulation and surveillance of* healthcare, which gives rise to the proliferation of independent agencies that carry out the quality assessment of healthcare services on behalf of the PC. This involves, in many cases, a significant investment in standardising healthcare procedures, for example by developing a taxonomy of treatments that can be classified using Diagnostic Related Groups (DRGs). This allows for instance to adjust the specific case mix of certain providers, and to identify a specific tariff for the public insurer to reimburse each treatment. It also involves developing measures of quality of life such as Quality Adjusted Life Years (QALYs) and other measures of clinical effectiveness, and estimating the value (cost-effectiveness) of different programmes. These designs serve several purposes, including preventing providers from using their private information to maximise the reimbursement they can retain from their medical actions, especially when this might come at the expense of healthcare quality.[4]

Another market imperfection refers to the fact that healthcare contracts are often incomplete, as quality of care and side effects of specific treatment are unobservable to the regulator and the patient,

[4] However, their implementation in practice is limited by providers strategic reactions.

and cannot be fully contracted explicitly. As a result, unregulated healthcare markets are not likely to function properly either, which reveals the need for efficient regulation. However, regulation alone might not suffice as special interest groups can develop strategies to lobby regulators and, when opportunities emerge, influence regulation in ways that might not benefit the PC (such as corruption). Hence, monitoring government activity is also necessary to protect the well-being of PCs. Approaches that ignore the latter, and assume that government is perfectly aligned with the interests of the PC, are unrealistic. In real life, health systems, political parties, bureaucrats, lobbies and voters, to mention a few, all play a role in influencing the policy process in the pursuit of specific private goals. Some of those processes might be (and generally are) in conflict with public welfare (Buchanan and Tullock, 1962; Mueller, 1976; Buchanan, 1986).

The pursuit of the private interest in the political arena depends on the design of efficient institutions, or as in North's (1990b) terminology, the rules of the game in a society. Institutions make a significant contribution to constraining the actions of the different stakeholders in the health system. Consider for instance the case of healthcare reforms that require the constitutional approval of two chambers elected under different procedures. This opens up the potential for veto by one of them, which can produce a 'joint decision-making trap': no decision is frequently reached given the significant consensus necessary. However, whether the latter reduces the probability of reform, and guarantees that decisions align with the wider preferences of the constituents, depends on the capacity of agents to reach out to other parties and form cross-party agreements. In advanced democracies, one typically finds processes of logrolling (Stratmann, 2004); that is, transversal exchange of votes between agents that have a veto role, which helps at times to overcome such political impasse. When such exchange is not possible, reforms might not take place or might require amendments. Broader constitutional designs can explain why some health insurance designs are not easily exportable internationally.

Broadly speaking, this book studies the role of institutions and their underpinning political incentives in influencing health and health

care. That is, we study of how different institutional designs affect the attainment of socially desirable outcomes such as good health, a more equitable distribution of well-being, an efficient allocation of health resources, and the highest possible quality of care. All these objectives can be obtained (missed) by successfully aligning (or not) political decision-making with the preferences of the PC, the individual at the core of this book. Our definition of 'political economy' is inspired by Buchanan and Tullock (1962). They define 'political economy' as 'the study of the political organization of a society of free men' (p. 3). Although the discipline of political economy is more than two centuries old, it has exhibited significant transformations over time. And as government activity and regulation has made inroads into the health sector, including matters regarding access to healthcare and health finance, the political economy of healthcare has become a central area of study for scholars interested in health policy and practice.

GOVERNMENT INTERVENTION AND THE HEALTH SYSTEM

A healthcare system refers to the organisation of individuals, resources and stakeholders that delivers and finances healthcare needs. It involves interrelationships between payers of healthcare, providers of medical goods, devices and services and, of course, patients and their families as well as the government. This includes the institutional framework in which all implicit and explicit contracts emerging between actors are cast (see Figure 1.4). However, one can contemplate different institutional designs depending on the role of the government and the institutions in place. Even when the government does not directly provide nor fund healthcare, governments play a role in influencing individuals health as they might regulate and tax unhealthy behaviours, or might license new drugs and accredit new hospitals. Such interventions are grounded in authority and compulsion and tend to be motivated by political incentives raising government revenues and exerting authority over industries. More recently, governments design the default options and nudges to attain some of those goals.

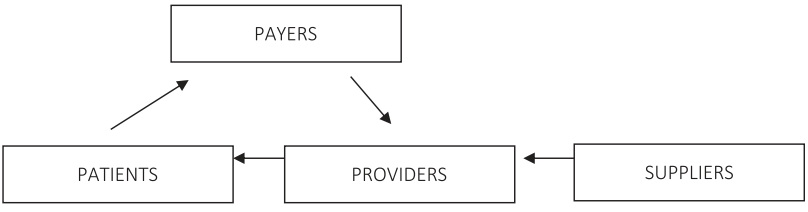

FIGURE 1.4 Defining healthcare systems

A Fully Private Market for Services

When insurance markets are not developed, one commonly observes two markets defining the provision of healthcare, namely, one where a private provider delivers healthcare services to patients in need in exchange for a user fee, and a second one where providers (such as hospitals) buy the medical devices and medicines they need to produce such service. This situation is still common nowadays in some sub-Saharan African countries. In these countries most healthcare spending is privately funded and the role of insurance companies is fairly limited.[5] Table 1.1 indicates that in Nigeria private health expenditure accounts for roughly three-quarters of the total, and households are subject to user fees. Out-of-pocket payments by households were as high as 95 per cent of private spending in 2008: back-of-the envelope calculations suggest that 72 out of 100 naira (the local currency) spent in buying healthcare services are paid directly out-of-pocket from households.

Consider now two markets: a market for healthcare services and a parallel market for medical supplies (e.g. drugs, medical devices). If these were two competitive markets (not facing market failures), efficient allocations would arise without a role for the state beyond framing the rules of the game where markets operate. The fundamental

[5] Almost all real-world cases are characterised by mixed models, where private funding is used together with public funding to cover healthcare spending. The differences across models are in the relative importance of these two components of funding, as well as in the relative importance of the insurance market in covering healthcare risks with respect to direct out-of-pocket payments.