

Can and should markets provide our healthcare? A view from economics and politics.

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In much of the developed world, experiments are underway to bring elements of the market into healthcare. In the UK this has produced considerable debate regarding increasing patient choice and health service responsiveness. It is worth, at this point, taking a step back and considering what is wanted from a health service, and whether a health care market can and should provide this.

Figure 1 shows as countries get richer they tend to avoid leaving health care to the market [1]. The 1993 World Development Report found that 60% of health care spending world wide is spent by governments [2]. Why is this? Why is health not left to the market like other goods? The World Development Report discerned two possible economic reasons for the public dominance of health care provision. The first surrounds health care as a “public good” which, as will be shown, economic theory predicts the

market will under-provide. The second proposes that certain unique properties of health care may cause the market to fail in efficiently producing health care. This article views these as valid concerns, but finds more strength in critiquing the equity of the market, which stems from the intensely moral and political nature of health care delivery.

Can we market healthcare? Lessons from economics.

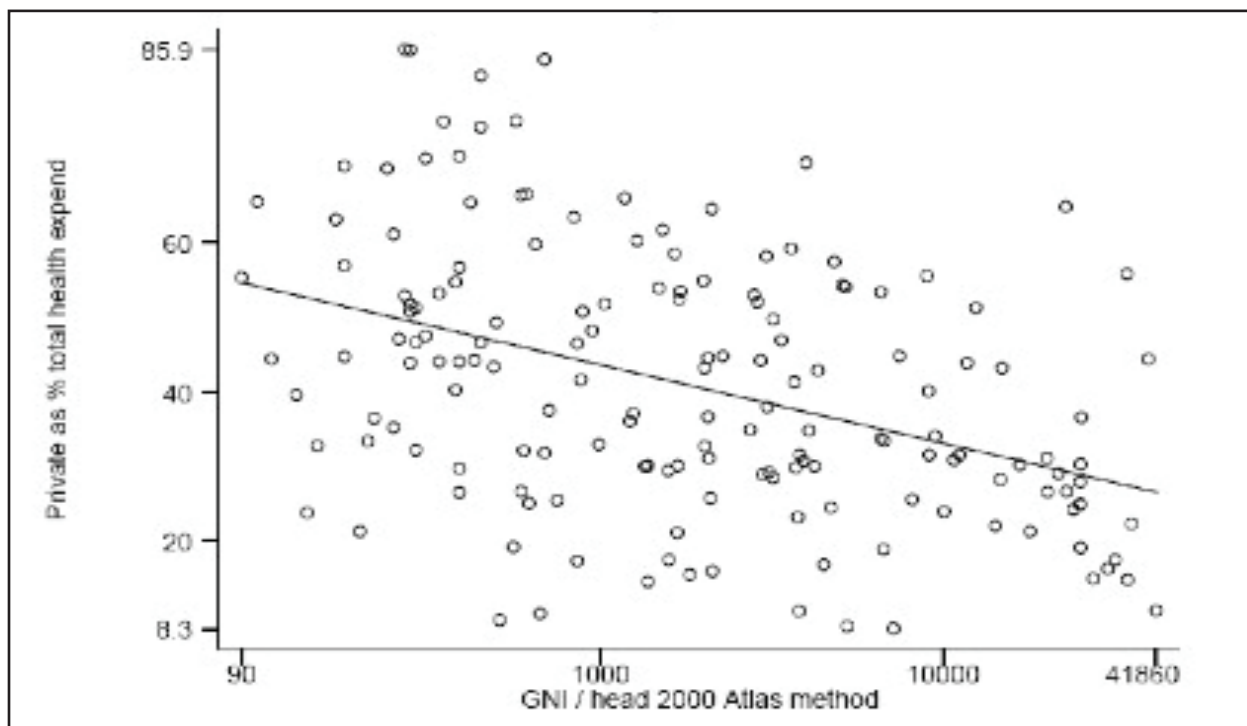
One argument against a health care market is that health is a “public good”. Public goods are commodities that all can enjoy. Economically, public goods are defined as non-excludable and non-rival [3]. No one can be excluded from using them, and when one does so, they are not used up, thus others can enjoy them as well. It is argued that because public goods cannot be parcelled up and sold privately to only those that pay for them, they are effectively non-marketable goods.

Samuelson noted a further result; a person’s utility is not dependent on the amount in society generally [4]. The classic case is national defence. No individual uses this privately, but we all gain utility in proportion to the total security. Health care is limited, is used up when accessed, and from which it is possible to exclude people.

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Figure 1: Falling private expenditure on health as countries get wealthier. 2000 WHO and World Bank data. [11]



It is rival and excludable, and thus on the surface it is not a public good [5]. Crucially then, it is marketable.

Holtermann [6] argues that the traditional public good-private good dichotomy is too simplistic. Many commodities have characteristics of both public and private goods. This can be shown in three ways. To begin, certain commodities have public good sides to them. Immunizations provides a private good, which enters an individual's utility function (Hurley [7]). But immunizations also create herd immunity, creating a safer society. This enters everyone's utility function in non-rival and non-excludable ways. Perhaps then, health security as a whole is a public good. Woodward and Smith [8] have similarly described global disease surveillance as a global public good.

Next, Holtermann [6] considers the whole

health care system to be a mixed good, with utilization of health care a private good and availability of health services a public good because it makes everyone feel secure. This implies that just having an accessible high quality health service makes the public happier, regardless of whether it is used. Cuyler [9] argues that a final public good dimension derives from altruism and concern for equity. Because it is valued by all, all gain from ensuring the poor get treated. This enters everyone's utility function in a public good manner. Therefore herd immunity, health care availability, and health equity are all unmarketable. Since no one can be charged for them, markets will tend to under-provide them.

Private charity may be able to make up for the market's under-provision, but faces problems of free-riding [10]. Everyone gains when someone gives to charity, but people in general gain even if they personally do not. Thus an economic in-

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centive exists to “free-ride” on others’ charity. As game-theory predicts, the result is under-provision of public goods [9]. If it is accepted that health care is part public part private good in nature, the market can thus be expected to undersupply health care proportionate to the level of public good nature in the system, even with private charity added.

Four further challenges to the health care market exist [11]. Arrow [12] argued that uncertainty in medicine is the key cause of market failure. This creates uncertainty in the price and product, resulting in inefficiencies. For example, imagine a patient arriving in an ambulance with chest pain. He may just need cheap antacids and reassurance for indigestion, or he may need major heart surgery and long term medical help. The doctor may not even know until investigation and treatment are started.

The second problem is information asymmetry, which allows the highly informed provider to manipulate the vulnerable sick consumer for profit. A third challenge to the perfect market surrounds the economies of scale needed to provide good health care. This may result in a natural oligopoly forming, with a few huge health corporations controlling all health care, thus aggravating the poor bargaining position of the ill patient [5]. The final problem lies in the positive externalities of healthcare goods like immunisations, which improve others health but can’t be charged for, and will thus be socially underprovided by the market.

Due to the public good elements, the uncertainty, the information asymmetry, the economies of scale and the externalities all inherent in healthcare, healthcare markets will be sub-optimal. Despite these strong arguments, Cuyler [9] cautions that this doesn’t necessarily mean government provision will be superior.

Should we market healthcare? The political view.

There are more fundamental reasons why healthcare shouldn’t be left to the market. Health is part of a group of societal goals regarded to be of special moral importance. Health is considered a human right [13], a fundamental element of human freedom [14] and human security [15]. People even spend their way into dire poverty in order to be healthy [16]. The main purpose of health care systems is to maintain and improve health, which means maintaining an individual’s opportunity to function in society [17]. Their life, citizenship and dignity are all at stake. Its importance demands a stronger consideration of equity than in other industries. Can markets meet this social justice element?

There are always competing claims for limited healthcare resources. In deciding between claims social justice asks the question: on what basis do we make these decisions? And equally important, who makes this decision?

Daniels calls these the fairness and legitimacy problems [17]. Fairness questions include: Do we treat according to need or ability to pay? Do we prioritise the old or the young? Do we treat the most ill or those patients most likely to benefit? Daniels argues that we currently do not have societal consensus on these hard issues of distributive justice, and we potentially never will. Instead we must create a legitimate health care system able to discern generally agreed rules for equitable health care. In Daniel’s view this is not a matter for experts, or the market’s preference for the biggest wallet, but for society to discuss and negotiate its core values. Social deliberation of values and democratic decision making produces the fairest and most legitimate process possible for rationing health care equitably. The market by contrast is not able to

democratically negotiate these societal values, nor do so legitimately.

Conclusion

Market failures and the semi-public good nature of health care reduce market efficiency. This makes it harder to justify leaving health-care to the market, but doesn't rule it out. The real challenge to the market, however, comes from healthcare's special moral status. Making equitable decisions on health care distributions requires a legitimate social institution that only a deliberative democratic process can provide.

References

1. Koivusalo M, Mackintosh M. Health Systems and Commercialisation: In Search of Good Sense. UNRISD international conference on Commercialization of Health Care: Global and Local Dynamics and Policy Responses. Geneva: UNRISD 2004.
2. World Bank. World Development Report 1993. New York: Oxford University Press; 1993.
3. Parkin M, Powell M, Matthews K. Economics. 6th ed. Harlow: Pearson Education Limited 2005.
4. Samuelson PA. The Pure Theory of Public Expenditure. *The Review of Economics and Statistics*. 1954;36(4):387-9.
5. Wonderling D, Gruen R, Black N. Introduction to Health Economics. Maidenhead: Open University Press 2005.
6. Holtermann SE. Externalities and Public Goods. *Economica*. 1972;39(153):78-87.
7. Hurley J. Chapter 2 An overview of the normative economics of the health sector. In: Culyer AJ, Newhouse JP, eds. *Handbook of Health Economics*. Amsterdam: Elsevier 2000:55-118.
8. Woodward D, Smith RD. Chapter 1: Global public goods and health: Concepts and issues. In: Smith RD, Beaglehole R, Woodward D, Drager N, eds. *Global public goods and health: health economic and public health perspectives*. Oxford: Oxford University Press 2003.
9. Culyer AJ. The nature of the commodity 'health care' and its efficient allocation. *Oxford Economic Papers*. 1971;23(2):189-211.
10. Hahnel R. *The ABCs of Political Economy*. Sterling: Pluto Books 2002.
11. McGuire A, Fenn P, Mayhew KEN. The assessment: the economics of health care. *Oxford Review of Economic Policy*. 1989;5(1):1-20.
12. Arrow KJ. Uncertainty and the Welfare Economics of Medical Care. *The American Economic Review*. 1963;53(5):941-73.
13. Hunt P. The human right to the highest attainable standard of health: new opportunities and challenges. *Transactions of the Royal Society of Tropical Medicine and Hygiene*. 2006;100(7):603-7.
14. Sen A. *Development As Freedom*. Oxford: Oxford University Press 1999.
15. King G, Murray CJL. Rethinking Human Security. *Political Science Quarterly*. 2001 Winter;116(4):585-610.
16. Whitehead M, Dahlgren G, Evans T. Equity and health sector reforms: can low-income countries escape the medical poverty trap? *The Lancet*. 2001;358(9284):833-6.
17. Daniels N. *Setting Limits Fairly*. New York: Oxford University Press 2002.