ISSUES IN RESOURCE ALLOCATION TO HEALTH CARE

Steve Onyeiwu
Department of Economics, Rensselaer Polytechnic Institute, Troy, New York, USA

Keywords: Cost, insurance, financing, subsidies, reform

Contents

Summary

As health care costs continue to increase all over the world, countries increasingly grapple with how to provide quality and affordable health care for their citizens. This task has often been undertaken in the context of very tight fiscal regimes that these countries are forced to operate under. As countries try to cut budget deficits and shrink the size of government, so also has there been an increase in the demand by the citizenry for more and better social services. Herein lies the dilemma: how might the government provide access to quality and affordable health care, without unduly compromising its objective of maintaining fiscal prudence? This article explores the various issues involved in resource allocation to the health sector, with a view to setting the stage for a more detailed examination of the implications and problems of the various mechanisms for resource allocation in the health sector, and reviews the standard methods of financing health care, highlighting their strengths and weaknesses.

1. Introduction

Analysts of all shades of opinion agree that the costs of health care have been escalating around the globe, and that these costs are likely to be even higher in the near future **(see** *Costs of Health Care throughout the World*). At present, developed industrial economies spend about 10% of gross domestic product (GDP) on health care, while other countries spend an average of about 5% of GDP. Health care costs will continue to rise astronomically, as long as expensive medical innovations and technologies continue to be introduced.

What makes the rising costs of health care even more perplexing and troubling is that it is occurring at a time when countries are increasingly preoccupied with fiscal discipline, reducing the size of government, and relying on market forces for the allocation of scarce resources. One of the consequences of this new pattern has been a rapid decline

in budgetary allocation to social services, particularly health care. Faced with dwindling resources, many countries have therefore been exploring alternative mechanisms for financing health care (see *Sources of Health Care Funding throughout the Globe*). The dilemma many countries face is how to reduce the cost of health care, while ensuring that the populace has access to it.

In trying to maximize the returns from investment in the health sector, many economists seem to be unaware of the interdisciplinary nature of health care. Specifically, they gloss over the fact that in many developing societies optimal resource allocation to the health sector is largely influenced by the social structure, values, and cultural norms of these societies (see *Environmental Degradation and Sustainable Health: A Review of the Contending Issues*). Indeed, many of the health care problems in these societies arise largely from a complex interaction between their economic realities, and certain aspects of their social lives. Take the AIDS epidemic as an example. Its explosion in developing countries can be attributed to a combination of economic and sociological factors. In South Africa, the unusually high incidence of AIDS is partly due to the existence of migrant workers (particularly in the coal and gold mines) who stay away from home for long periods and are therefore more likely to patronize prostitutes and contract the disease. In many developing countries, high rates of illiteracy have also promoted ignorance about the prevalence and cure of diseases such as AIDS, cholera, tuberculosis, and polio (see *Health Economics in Developing Countries*).

The above considerations suggest that the problem of the rising costs of health care can be addressed from the demand side through preventive measures such as increased awareness of the prevalence and mode of transmission of diseases, as well as the changes in lifestyles required for a better health profile. But preventive measures can hardly be effective without an integrated and interdisciplinary approach. By encouraging practitioners from different disciplines to work together, an integrated approach offers a much more comprehensive solution to the multifaceted problems of health care.

As already indicated, countries all over the world are currently exploring innovative ways of financing health care, with the intention of making health care both affordable and of high quality. The major mechanisms for financing health care will be discussed in this paper, with an emphasis on the interactions between economic and social factors.

2. Financing Health Care through the Insurance System

Access to health care through the market mechanism is typically through the health insurance scheme. This is a system whereby people purchase a predetermined set of health services through a health maintenance organization (HMO). An HMO may be a profit-maximizing firm or a not-for-profit organization. People pay a monthly or yearly premium to the HMO, and visit doctors, hospitals, and other health practitioners designated by the HMO. Most HMOs typically require their clients to obtain their permission before they access health services through practitioners outside the network. The amount of premium payable depends on many factors, including age, health profile (whether the insured has "preexisting conditions," for instance), and geographical location. Health insurance may also be purchased as a group, such as workers in a

private firm, government employees, unions, or students. When health insurance is purchased as a group, members of the group pay a uniform premium. Economies of scale and bargaining power means that members of a group usually pay a lower premium than those who purchase coverage as individuals.

The United States is the only advanced country that relies on insurance for health-care delivery. The provision of health care in the United States has been mainly undertaken by the private sector. Large-scale hospital chains—both private and not-for-profit—are also important in the provision of health care. Doctors, hospitals, and other medical practitioners receive payments from the HMOs on a fee-for-service basis. The predominance of managed care in the United States arose from the realization that substantial portions of health services delivered to patients were unnecessary. In 1980, just nine million people in the United States were covered by HMOs. This figure rose to about 23 million in 1986 and over 41 million (or over 15% of the population) in 1992.

One advantage of the health insurance system is that it reduces the cost of health care. Because of the competition among the HMOs, premiums have been decreasing. For instance, the growth of health insurance premiums in the United States fell from 10.6% in 1992 to 1.2% in 1996. This cost reduction has been brought about through infrequent use of expensive and discretionary procedures, as well as fewer hospital admissions. Because the HMOs adopt the process of "utilization review"—under which HMOs review proposals for major medical procedures before they are undertaken—hospital costs are said to have been reduced by 10%–15% (see *Costs of Health Care throughout the World*).

The health insurance system, or managed care, has also come under increasing criticism. Some analysts suggest that the introduction of differentiated rates seems to have increased the number of people without coverage. For instance, premiums are now higher for individual subscribers than for communities or groups. Higher premiums have reduced access to health care, particularly for older subscribers. People who otherwise would have been able to afford health insurance are unable to do so under the current system of rating. Unemployed persons also do not have access to the lower experience rates offered to groups, and are least able to purchase individual coverage. It is instructive to mention that, although the United States spends more on health care than any other country, it ranks twenty-fourth in the world, based on the healthy life expectancy of its citizens. Japan ranks first, followed by Australia, France, Sweden, Spain, and Italy.

Critics have also argued that funding through insurance tends to give health care providers powerful incentives to prescribe unnecessary procedures, thereby increasing the total cost of health care. The current exclusion clauses for poor health risks have also made it difficult, if not impossible, for those with preexisting conditions to obtain insurance. Premiums for these subscribers are so high that many cannot afford coverage. Thus, any health-care reform that seeks to promote universal coverage must pay due attention to insurance rating. Apart from fixing the problem of rating, the following alternative measures might facilitate universal coverage: a health insurance loan program, the "single-payer system," and employer mandates. These are discussed in detail below.

-
-
-

Bibliography

American Enterprise Institute (1980). *Compulsory Health Insurance Proposals*. Washington, D.C.: AEI Legislative Analyses. [Reviews the implications of providing universal access to health care through the health insurance market.]

Evans R.G. and Williamson M.F. (1978). *Extending Canadian Health Insurance: Options for Pharmacare and Denticare*. Toronto: University of Toronto Press. [Analyzes the implications of adopting the Canadian system of health care in the United States.]

Glaser W.A. (1991). *Health Insurance in Practice*. San Francisco: Jossey-Bass. [Examines the ramifications of the health insurance market, as well as highlighting its strengths and weaknesses.]

Griffith B. (1999). The perils of privatization. *New Left Review* **236**, 24–52. [Compares the market system of funding health care with public funding. Highly critical of the market system, and points to the strength of state intervention.]

Horrigan M.W. (1987) Time spent unemployed. *Monthly Labor Review*, July 3–15. [Provides statistics on access to health care by both the employed and the unemployed.]

Horvath F. (1987). The pulse of economic change: displaced workers of 1981–1985. *Monthly Labor Review*, June 4–11. [Presents statistical data on the relationship between unemployment and health insurance coverage.]

Keintz R.M. (1976). *National Health Insurance and Income Distribution*. Lexington: Lexington Books. [Analyzes the socioeconomic class of those with access to health insurance in the United States.]

Statistical Abstract of the United States (1992). Washington, D.C.: U.S. Department of Commerce, Bureau of the Census, Data User Services Division. [Detailed statistical compilation on access to health care; classification of the insured and uninsured into different socioeconomic categories.]

Swartz K. (1989). *The Medically Uninsured*. Washington, D.C.: Urban Institute Press. [Classifies the uninsured in the United States into different socioeconomic categories.]

Zedlewski S.R. (1991). *Expanding the Employer-Provided Health Insurance System*, Urban Institute Report 0897-7399; 91-3. Washington, D.C.: Urban Institute Press. [Discusses the implications of employer-sponsored health insurance systems in the United States.]

Biographical Sketch

Steve Onyeiwu received his Ph.D. in economics from the University of Connecticut, USA. He is currently an assistant professor of economics at Allegheny College, Meadville, Pennsylvania. He has taught previously at the University of Port Harcourt, Nigeria, Wesleyan University, Trinity College, and Rensselaer Polytechnic Institute in the United States. His research interests include economics of innovation and technological change, as well as economic development.