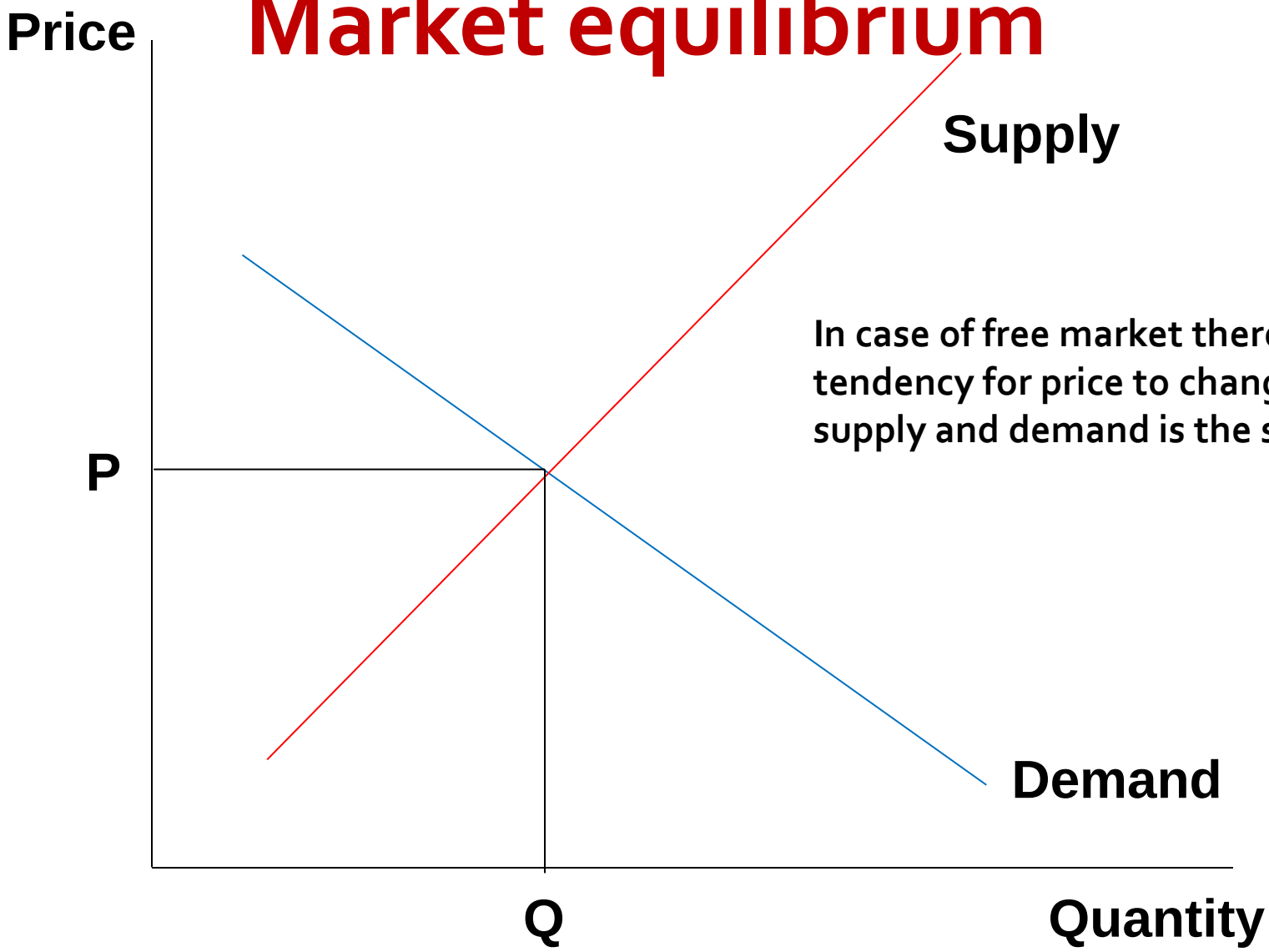
LATVIJAS UNIVERSITATE
ANNO 1919
UNIVERSITY OF LATVIA

Economic, social, cultural and organizational aspects of healthcare

Topics in lecture

- The benefits of free market
- Limits of free market in the case of healthcare
- Healthcare systems around the world– main organisational/financing principles
- Quiz

Market equilibrium

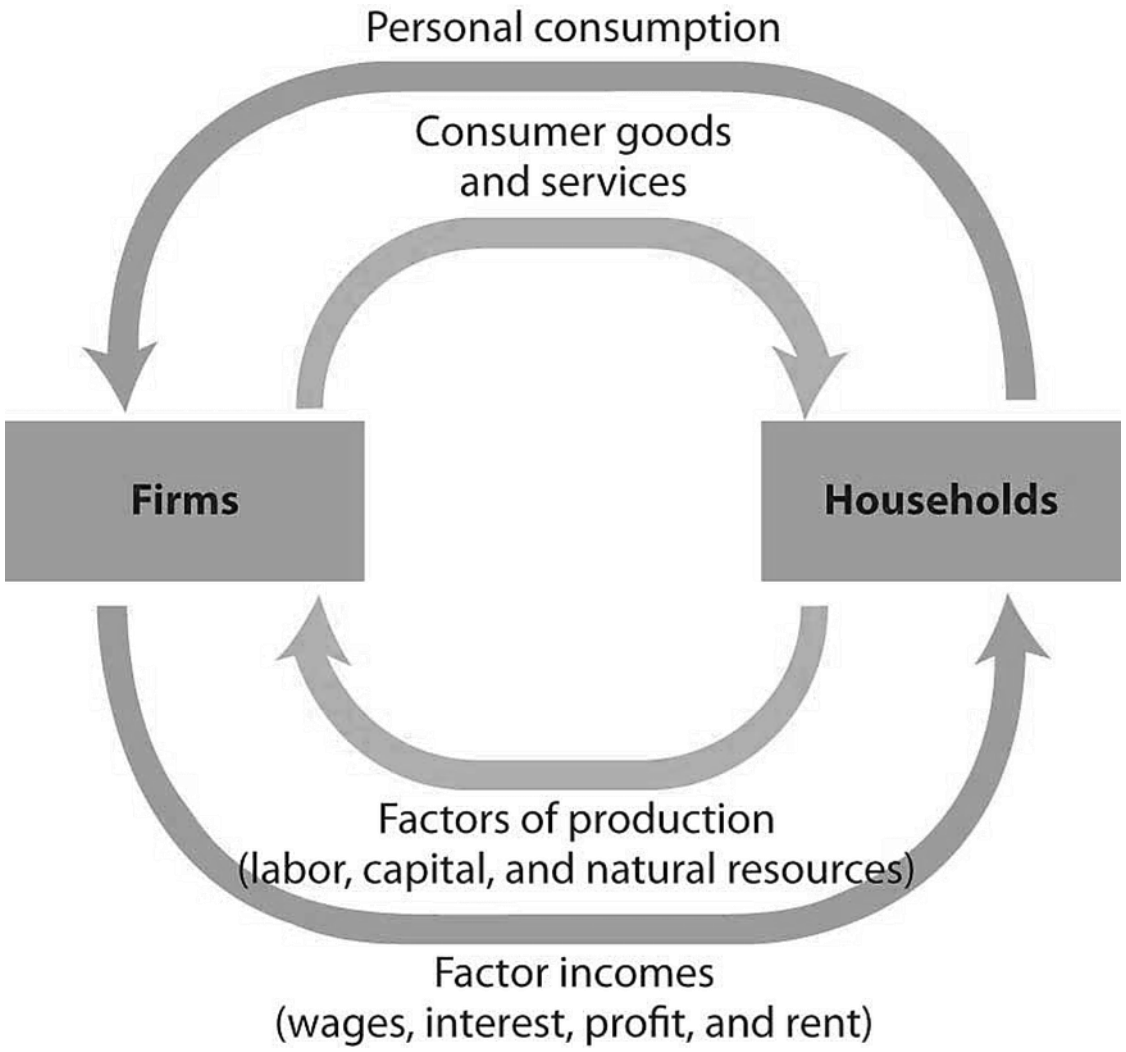


In case of free market there is tendency for price to change untill supply and demand is the same

In case of higher price, there develops surpplus and price drops
In case of lower price, deficit develops and price rise

Invisible hand (of free market) consist of the **self interests** of the economic agents that create natural forces leading towards equilibrium un an economy. As a result, this invisible hand creates **efficient allocation** of all resources and the whole society is better off

Circular Flow in Economics



Principles of Macroeconomics, v. 1.0 by Libby Rittenberg and Timothy Tregarthen

Supply IS INFLUENCED BY:

1. Price – in increases, more willingness to produce
2. Non-price factors:
    1. Price of production goods;
    2. Change in production technology (effectiveness!)
    3. Tax changes
    4. Price of other goods
    5. Number of suppliers
    6. etc

Demand influenced by:

1. Will be more demanded if price drops (*ceteris paribus*)
2. Non-price factors:
    1. Income level;
    2. Price of substitute good;
    3. Price of complimentary good;
    4. Change in preferences;
    5. Number of buyers;
    6. others (climate, political instability, disasters, wars)

Free market conditions

- Many purchaser, identical goods
- No barriers to enter market for suppliers
- There is no advantages for those already in market
- There is complete information regarding the price and the characteristics of good

Market regulation is insuficient (market failure):

1. Monopolies
2. Assimetry of information

How consumer become well informed?

- Market research
- Products research
- Repeated purchases
- Brand names - our beliewe in promise

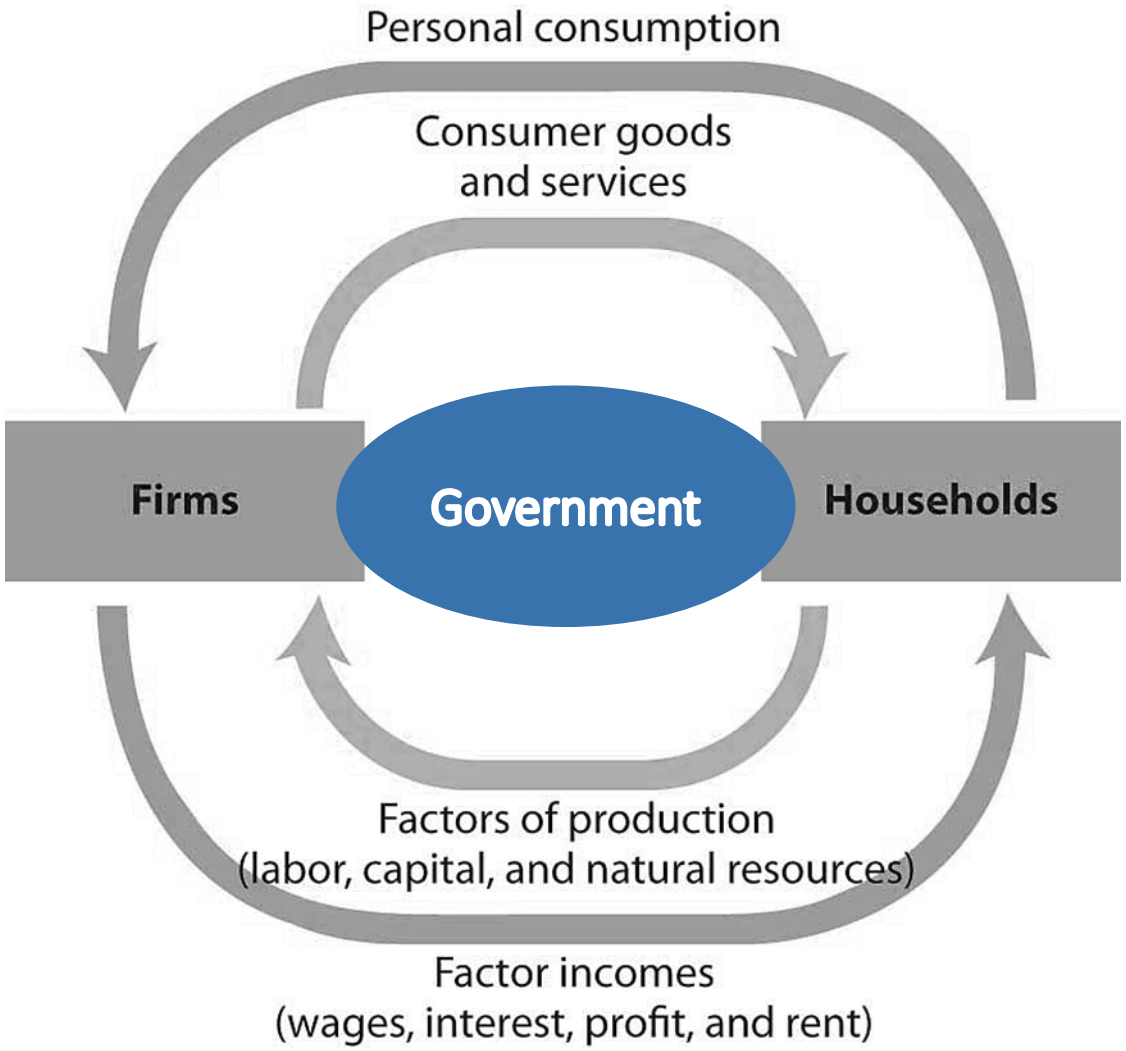
How consumer is protected in case he can not become fully informed?

- Warranties for purchases
- Added instructions, warnings
- Or in case of planned purchase we contract an expert (**agent**) to protect our interests

Information asymmetry in health care

- Imperfect information on ***demand*** side includes:
  - current health state/diagnosis
  - prognosis
  - available interventions
  - effectiveness/side-effects of interventions
  - costs of interventions
  - translating 'effectiveness' into 'utility'
- Supply side better informed about many of these

Circular Flow in Economics and market failures



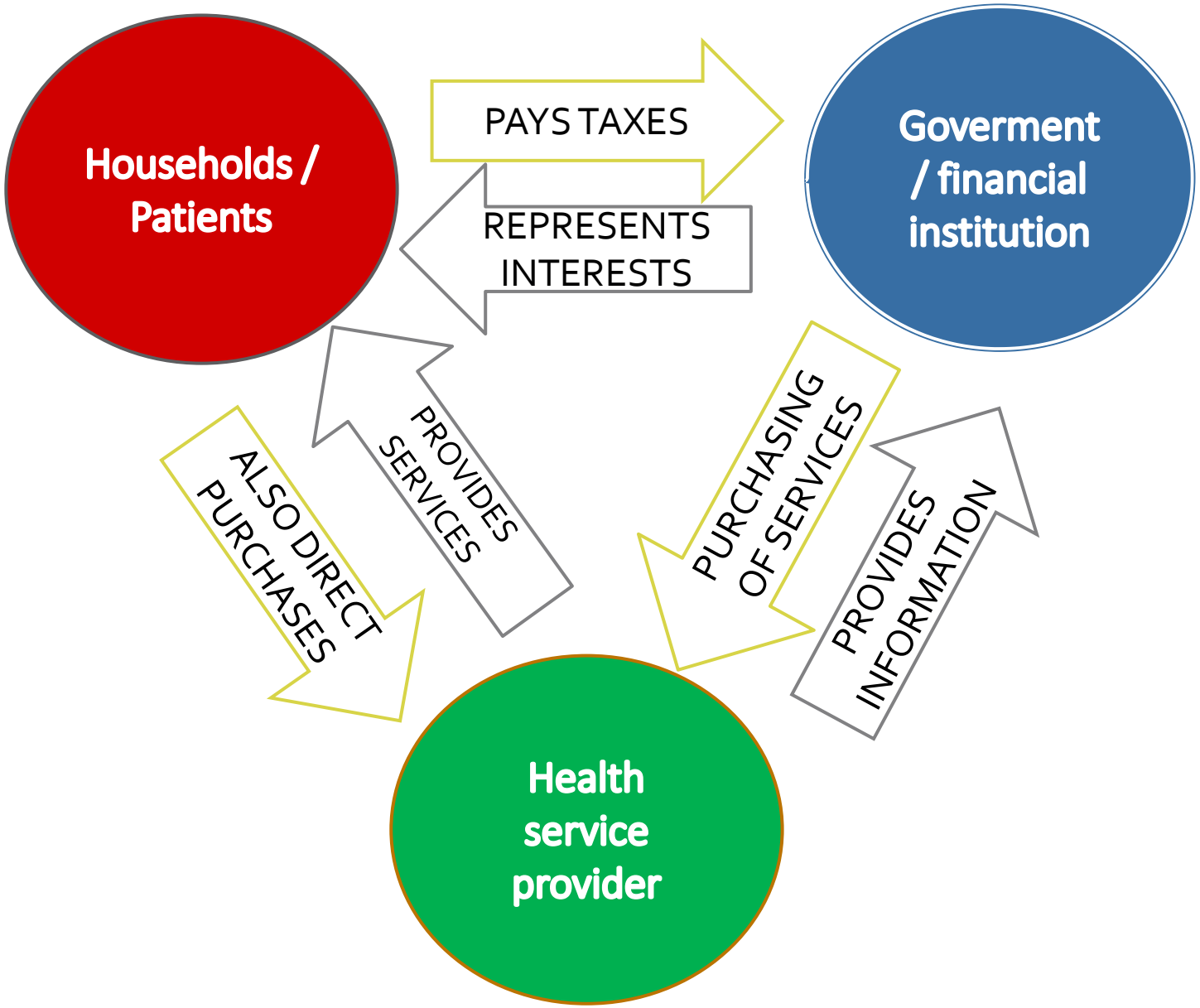
Principles of Macroeconomics, v. 1.0 by Libby Rittenberg and Timothy Tregarthen

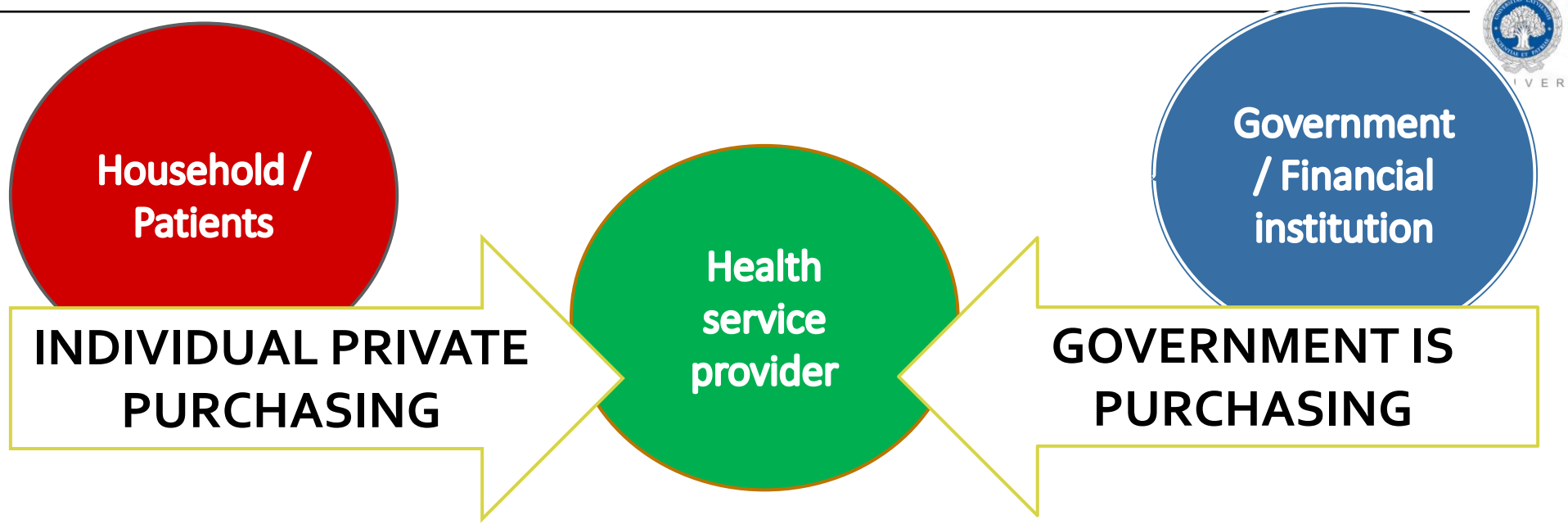
Universal health care systems (universal health coverage systems)

Governments acts with the aim to extend access to health care as widely as possible and setting minimum standards.

Universal health care is implemented through legislation, regulation and taxation.

Legislation and regulation direct what care must be provided, to whom, and on what basis.


Households / Patients
PAYS TAXES
REPRESENTS INTERESTS
Goverment / financial institution
PROVIDES SERVICES
ALSO DIRECT PURCHASES
PURCHASING OF SERVICES
PROVIDES INFORMATION
Health service provider



Supply is controlled by PROVIDER – **stimulates demand** and selects services to offer based on:

- Ability to pay
- Favourable localisation
- Favourable hours when service is available

Supply is controlled by PURCHASER – **rationing of services** by setting the rules for payments:

- Setting the payment principles
- Setting the standards and quality
- Limiting amounts of purchases
- Influencing the structure and location of service providers

Definition: ***healthcare system****, is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations.*

Main differences in the process of financing public health care:

- Where the money came from – taxes, payment for insurance (mandatory / voluntary / from employer / from employee)
- Pooled (to one organisation or to many)
- Redistributed to the third party payers (does primary care serve as fund keeper)
- Finally used to pay the providers for their services (purchasing mechanisms – payment for services provided on patient basis, fixed payments for running hospitals, mixed methods)
- Is there direct co-payment for services out-of – pocket to service provider

Main differences in organisation of health care provision:

- Ownership of health care institutions
- The role / gate keeping / fund holding function of primary care
- Purchasing / providing split
- The extent of market competition
- Ways providers are paid

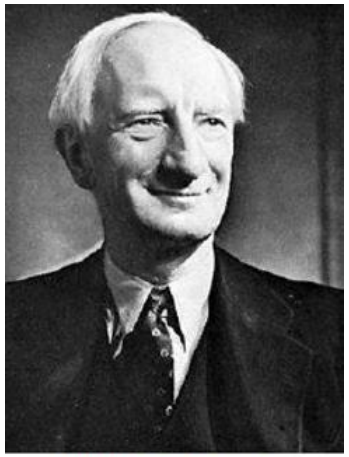
Universal coverage health care systems – classical models

Social health insurance system (Bismarck)

Otto von Bismarck

1815-1898

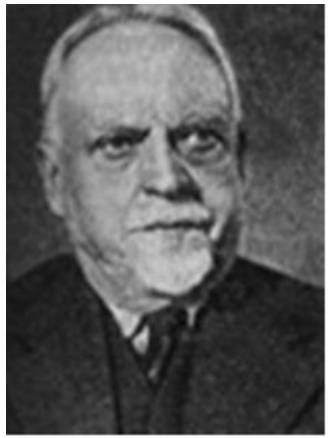
National Health Service (Beveridge)



William Henry Beveridge

1879-1963

Completely state-controlled system (Semashko)



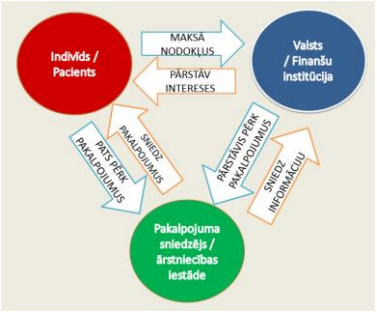
Nikolai Alexandrovich Semashko

1874-1949

Mixed systems or Market oriented systems

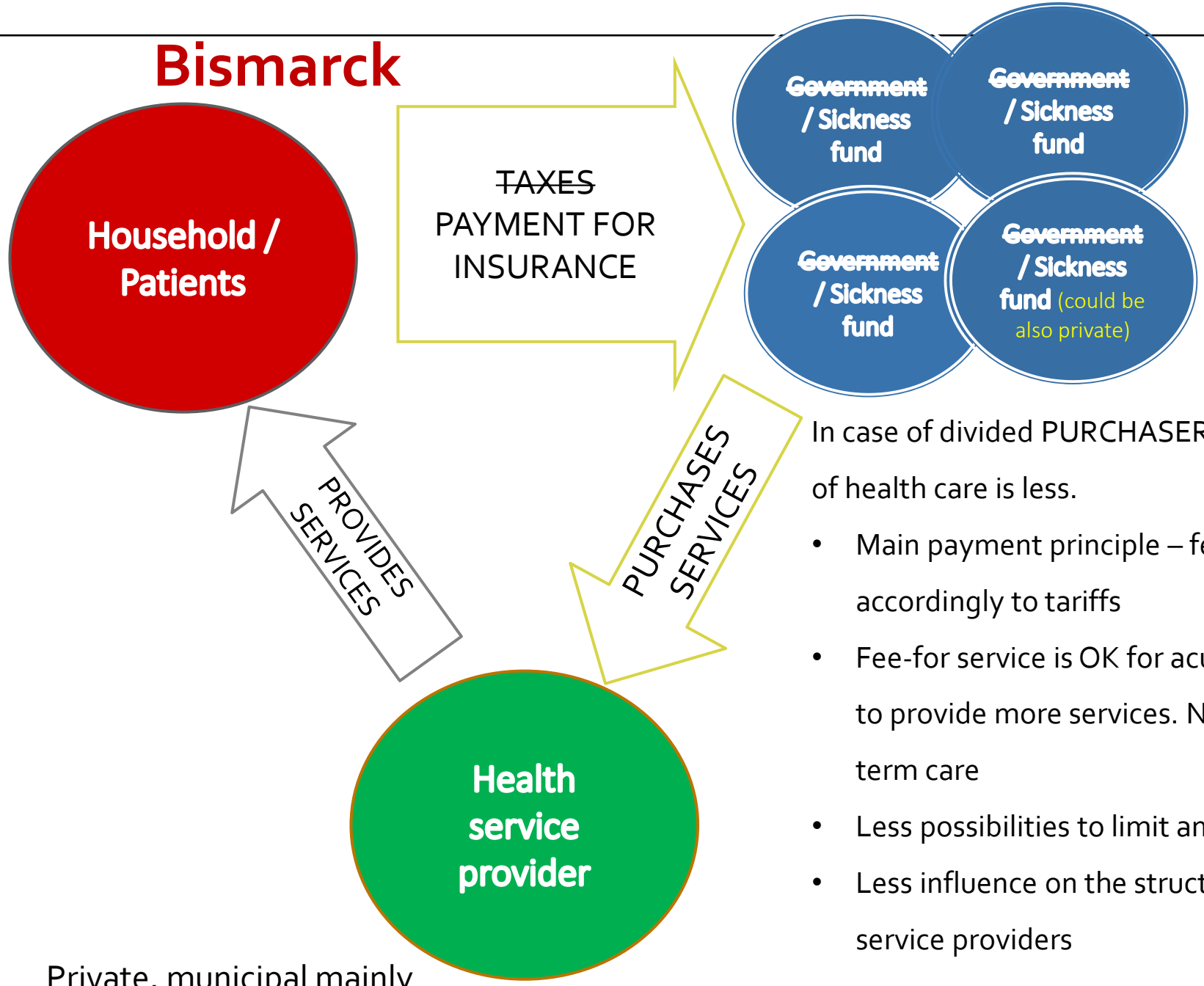
Health insurance system (Bismarck)

- Named after the former German chancellor Bismarck, who introduced this way to finance healthcare end of the 19th century
- A system of non-profit public health insurance(s)
- Every person up to a certain income has to pay for. The amount of the contributions depends on income.
- The system is decenralized and self-governed, the extent of the service is fixed by laws – the role of government is limited
- Doctors and hospitals are paid directly by the insurance, there is a catalogue of fixed prices for any service
- Generally every “necessary” diagnostics or treatment are paid
- Institutions are private enterprises, except a part of the hospitals
- Major weakness of the system is the lack of a power centre, cost control is difficult.



Examples: Germany. Austria, partially Neatherlands, France,)

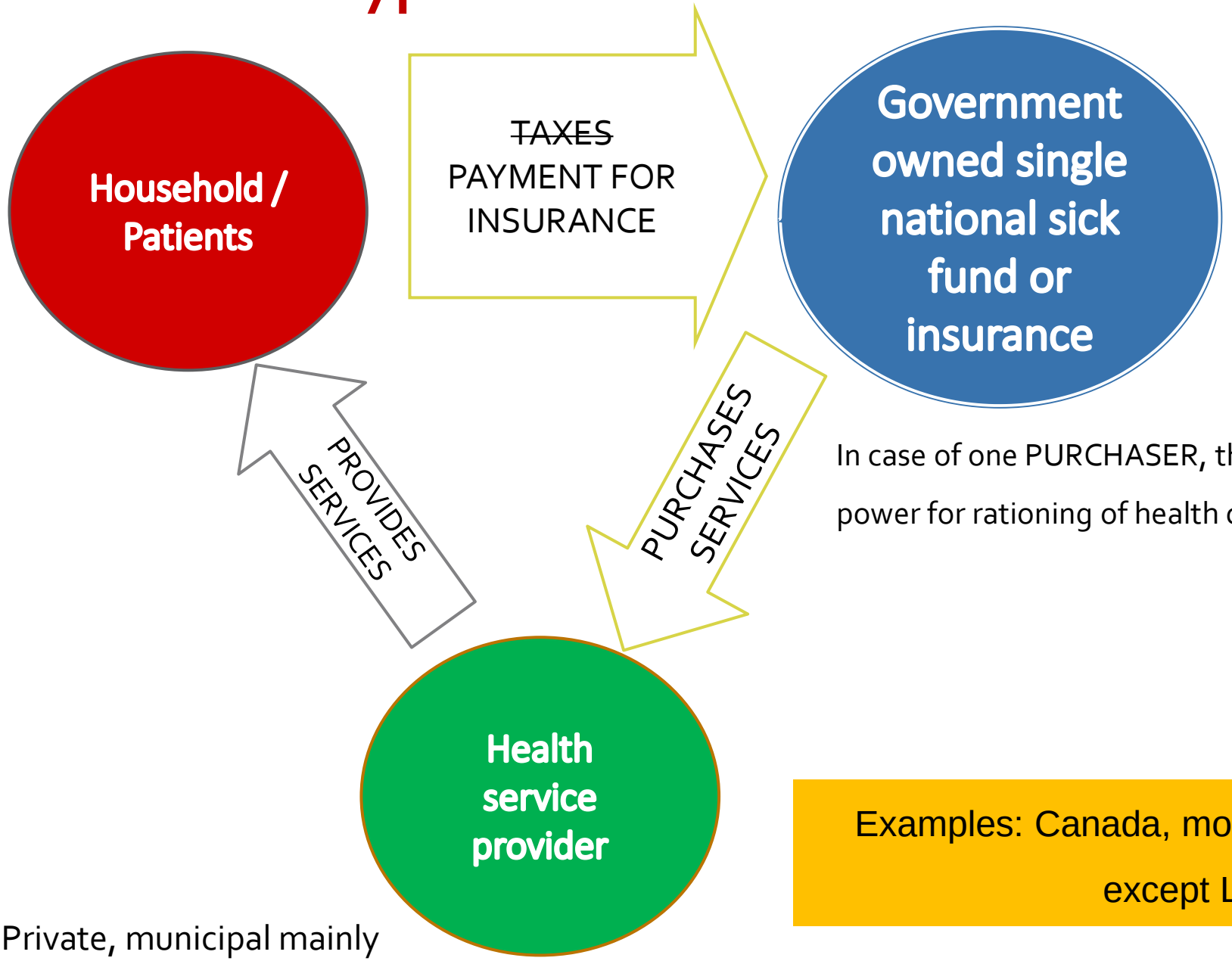
Bismarck



In case of divided PURCHASERS, power for rationing of health care is less.

- Main payment principle – fee for service accordingly to tariffs
- Fee-for service is OK for acute care, but stimulates to provide more services. Not optimal for long-term care
- Less possibilities to limit amounts of purchases
- Less influence on the structure and location of service providers

Bismarck subtype – national health insurance system



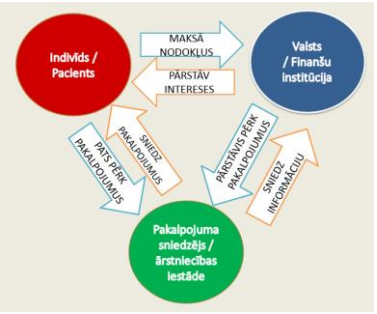
In case of one PURCHASER, there is more power for rationing of health care

Private, municipal mainly

Examples: Canada, most new EU countries, except Latvia

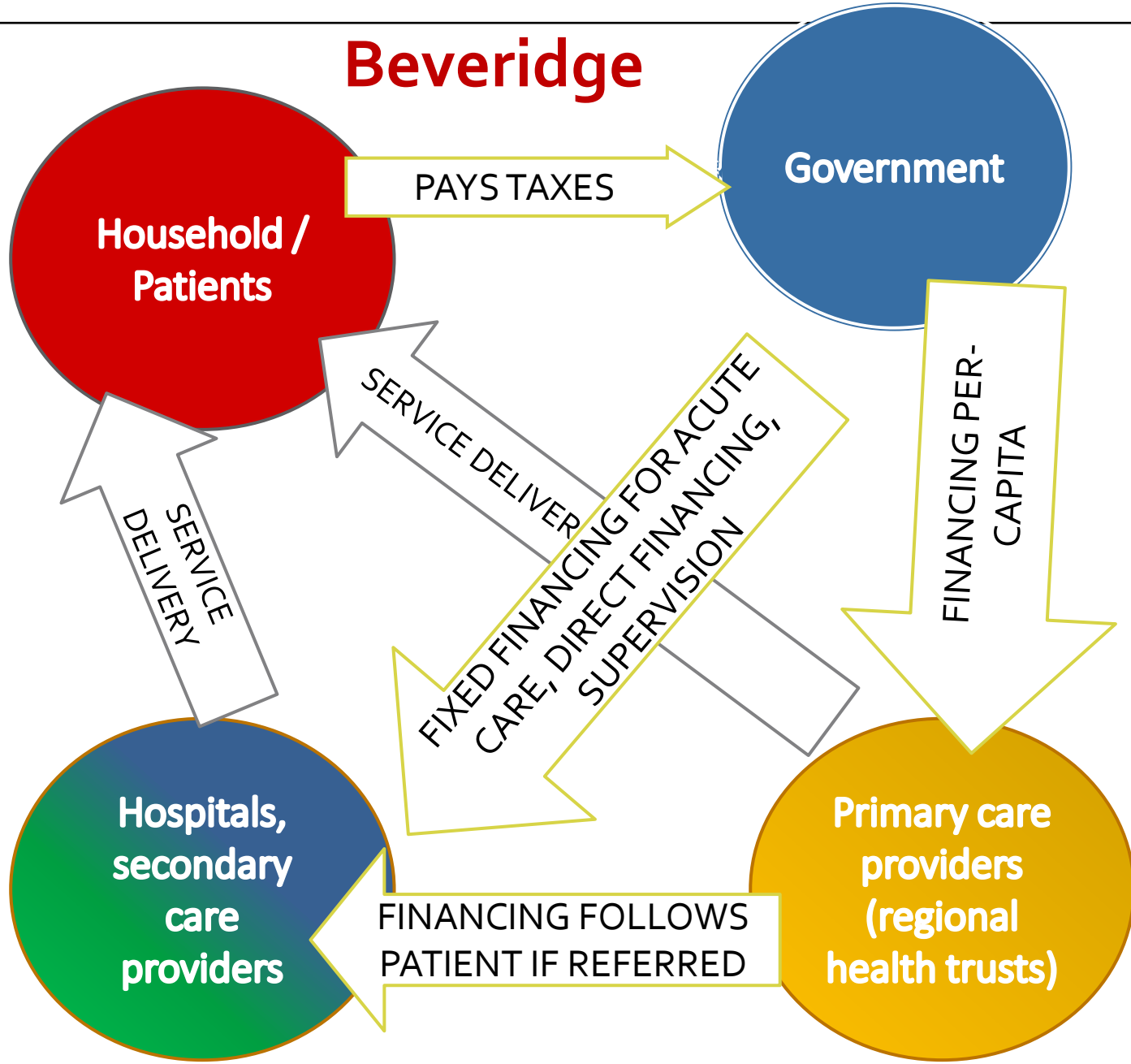
Beveridge system

- Named after the British economist and social reformer, Beveridge, was introduced end of World War II.
- Funded from general government revenues, coverage for entire population (universal coverage)
- Funding base similar to that of Soviet system, but providers much more independent
- The administration is made by a national institution, the NHS.
- **The crucial role of primary care – general practitioners as "gate and fund keepers" for redistribution of health funds**
- Capitation payment principle for primary care (per-capita), money follows patient to secondary care only if patient is referred in case of elective treatment and diagnostics.
- In parallel direct budget funding for acute care to hospitals, secondary care
- Insignificant private sector



Example: UK, partially Nordic countries, in some extent Latvia

Beveridge



SUPPLY effectively is controlled by PURCHASER – supply is rationed by:

- Payment principles
- Influence on structure, localisation, management of service providers
- Amount of care ir rationed by setting systemic gate and fund keeping function for primary helth care

Example: UK, partially Nordic countries, in some extent Latvia

Bismarck → Social Security Health care system **Beverige → National Health Services (NHS)**

Countries with SSH system	Countries with NHS system
■ Austria	■ Denmark
■ Belgium	■ Finland
■ France	■ *Greece (from 1983)*
■ Germany	■ Ireland
■ *Greece (until 1982)*	■ *Italy (from 1978)*
■ *Italy (until 1977)*	■ Norway
■ Luxembourg	■ *Portugal (from 1979)*
■ Netherlands	■ *Spain (from 1986)*
■ *Portugal (until 1978)*	■ Sweden
■ *Spain (until 1985)*	■ United Kingdom
■ Switzerland	

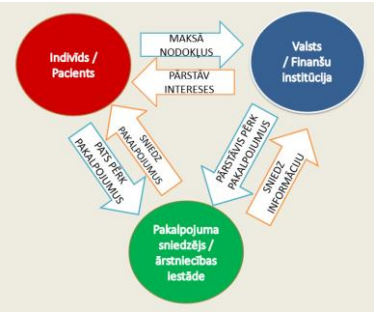
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1934356/

Additional reading

1. The **convergence** of different HC models:

https://www.oecd.org/gov/budgeting/49095378.pdf

Soviet Semashko system



- This system is completely state-controlled and owned, including hospitals and practising doctors.
- Funded from general government revenues, coverage for entire population
- Healthcare principally is free for everybody
- Fixed salaries and budgets for providers (flat fee)

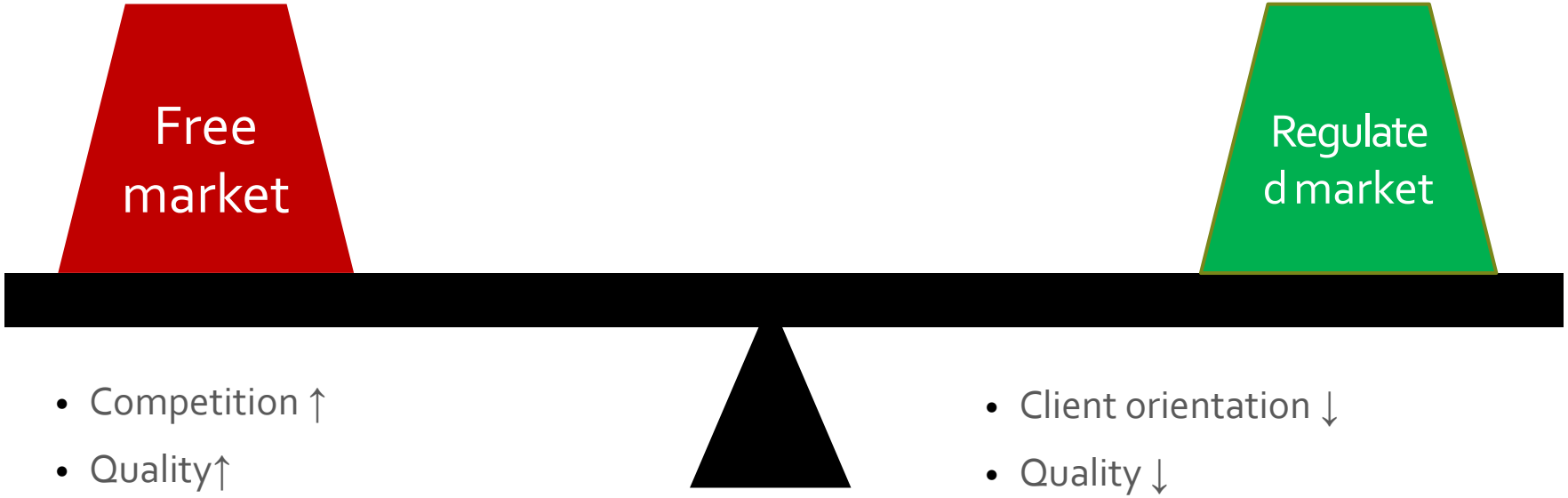
Examples: Cuba, historically Soviet countries

Non-universal, segmented, market oriented systems

- Patients and health care providers are segmented – parallel health care systems for different groups

Examples: USA, Latin America

- In fact non-universal but socially more fair system – **Cyprus**
  - Basic health care (primary care, partially secondary care is provided form tax income for free only for those with income below certain limit
  - More expensive and complex care is is provided universally to all for free.



- Competition ↑
- Quality↑
- Price ↓
- But: universal principle of health care availability ↓

- Client orientation ↓
- Quality ↓
- Access?

One day is enaugh to understand how fee market works.
A life is to short to understand what to do if it fails

TEST in e-studijas