

Macroeconomics healthcare assignment

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Macroeconomics of Healthcare Douglas A. Propp, MD, MS, FACEP, CPE Chair, Department of Emergency Medicine Advocate-Lutheran General Hospital Clinical Associate Professor of Emergency Medicine University of Chicago As Emergency Physicians, we are frequently peripherally exposed to healthcare economic statistics, policies, and debates with little concern for mastering these concepts, feeling that they have little to do with our practice of Emergency Medicine. Although a working knowledge of microeconomics will not aid in arriving at the diagnosis for the elderly patient with mental status changes who we are evaluating at 3 A.

M. , an understanding of these principles will enhance our roles in positively contributing to the healthcare debate, given our overall limited societal resources. Although not intended to be comprehensive, I will introduce several relevant concepts to hopefully whet your appetite in case you want to pursue them further. Economics Economics is the study of how resources are allocated with the marketplace. I make the analogy between the disciplines of Physics and Economics.

Whereas Physics are the laws which explain the observed behavior of matter, Economics are the rules which explain the behavior of people who pursue (and compete with others for) the limited resources (goods, currency, health, etc.) within a society. The interest in healthcare economics has blossomed over the past several decades as spending on healthcare has continued to escalate, now representing well over \$1 trillion (with approximately 40% going to hospitals and 20% going to doctors), and occupying over 16% of the nation's Gross Domestic Product (cumulative value of domestic goods and services produced).

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Many of the healthcare economic principles focus on how people make decisions related to expenditures for the health given competing alternative (e. g. , food, clothing, housing, hobbies, travel, education, etc.) Insurance Insurance allows typically risk-averse individuals to face uncertainty and spread their potential financial risk across a large number of people, thus limiting the maximal exposure for any one individual.

By capitalizing on the “ law of large numbers”, an individual, for example, would not have to pay the total cost of replacing an automobile destroyed in a collision or an expensive hospitalization due to unanticipated but inevitable illness or injury. Unlike other countries, and certainly since the introduction of the Medicare and Medicaid programs in the 1960s, American have relied on health insurance to fun their consumption of healthcare resources. Insurance companies, who indemnify the cumulative financial risk of the covered group, utilize various methodologies to determine a fair price for their product.

Their risk is related to arriving at a fair “ up front” premium prior to them realizing the subsequent costs during the coverage period. Experience rating (based on knowledge of prior claims of the covered group) differs from community rating where the insurance company prices their product to cover all subscribers in a given location, irrespective of age or health experience. For a comparably priced product, one could expect insurance companies to pursue healthier individuals for their coverage (favorable selection) rather than the sick and elderly who are likely to have increased consumption of healthcare resources (adverse selection).

It has been well studied that individuals who benefit from insurance coverage (not limited to healthcare) tend to over-utilize resources, compared to their use if they had to pay for all of the consumed resources themselves. Who hasn't had patients request unnecessary x-rays, assuring us that their insurance will pay for it? This concept of insurance induced demand is referred to as the Moral Hazard. ² As we look for explanations for why the cost of healthcare continues to escalate; many have identified this moral hazard related to health insurance as a major contributor.

Over the past several decades we have witnessed innovative mechanisms for the transfer of financial risk to both patient and/or provider (physician and hospital) in order to constrain healthcare expenditures. Whereas indemnity insurance was formerly the prevalent means to fund healthcare expenses in this country, the increasing impact of co-payments and deductibles assumed by the consumer has limited resource demand. In addition, capitation which provides an upfront fixed payment to the provider, allowing them to manage the financial risk associated with subsequent expenditures for their patients gained popularity over the past decade.

Many have questioned whether the behavior required of the provider in order to balance the revenues and expenses inherent in a capitation arrangement could be appropriately managed within the context of the overriding patient-physician relationship and might even violate the ethical principle of patient beneficence. One should be able to see that different provider (physician or hospital) behavior can be incentivized based on the payment methodology utilized. For example, if a hospital was paid a fixed amount of money for a hospitalization (e. g. DRG), it would be incentivized to

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limit both the length of stay and intensity of services for the patient. On the other hand, if the payment methodology was fee for service, the institution might attempt to increase both the length of stay and intensity of services. A per diem arrangement where the hospital receives a fixed daily payment would incentivize a longer length of stay but decreased intensity of services for the patient. Finally, capitation would incentivize minimizing the opportunity for the utilization of costly services (e. g. hospitalizations).

Supply and Demand Within any marketplace there are those willing to supply a good and other interested in acquiring the same good. One would expect the supplier to seek to extract a higher price for the transfer of a good to a demander who would be interested in minimizing their expenditure. The transfer of goods is consummated when two parties can agree on the appropriate transaction equilibrium price. Elasticity refers to how much the demand for a product (dependent variable) would be affected by a change in its price (independent variable).

For example, the demand for the pain relief and care of a fractured leg would be inelastic, as the patient would highly value immediate care, regardless of the price. On the other hand, an individual (facing competing choices for their limited disposable income) might, for example, defer the purchase of needed medications for the “ silent” hypertension if its price increased a relatively small amount (a highly elastic demand), instead of deciding to allocate their resources for an overdue vacation. The theory of agency refers to the scenario where one person with unique knowledge (e. . the physician agent) is given the authority to make decision by, and for the less informed principal (patient). There are few similarities outside of healthcare, to the <https://assignbuster.com/macroeconomics-healthcare-assignment/>

common practice, for example, where a physician can order expensive tests and/or medications for the patient, based on asymmetric knowledge, while transferring the financial risk to the patient or third party payor (insurance company) for that decision (with the exception of a capitation arrangement).

This creates the opportunity for supplier induced demand where the physician is increasing the cost of care (e. . ordering more tests) with the ulterior motive presumably being to positively impact their own wellbeing (e. g. personal income). Costs There are many different types of costs that define a health care event. 3 Direct costs are those which can be accurately correlated with an event. For example, the direct cost of the reagents and technician time needed to perform a given test in the lab contrasts with the indirect costs (overhead) of the rent, heat, quality control and Pathology Director's salary in order to ultimately support the performance of the test.

Fixed costs are those that do not vary based on the volume of output or production. For example, the cost of the x-ray machine does not change whether one or thousands of films are obtained by its use. The variable cost of the leaded film however does depend directly on how many films are obtained. For any given decision, there is the forgone alternate decision that might have been chosen by an individual. When one analyzes each of these decisions, the opportunity cost related to the value of the alternative not selected must be acknowledged.

For example, if one chooses to allocate personal resources to a high fat diet instead of antihypertensive medication, one should factor in the opportunity cost of the good health which is given up (e. g. morbidity and mortality related to a subsequent cardiovascular event) into that decision when

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evaluating all costs. As the risk of ill health becomes more likely, and its opportunity cost increases, the rational decision-maker would pursue a better diet and compliance with anti-hypertensive treatment. Unfortunately, opportunity costs are frequently ignored when less than ideal decision-making occurs.

Although this review is not intended to be exhaustive, I hope that the reader will be intrigued to learn more about the many of the principles described, so that they can better assume the leadership role many physicians have unfortunately abdicated to others as we as a society struggle to maximize the cumulative value (quality/cost) of healthcare. 1 Folland S. , Goodman A, Stano M. The Economics of Health and Health Care. Prentice Hall, New Jersey 1997. 2 Phelps C. Health Economics. Harper Collins, New York 1992. 3 Propp DA, “ Fixed vs. Variable Costs of Hospital Care” JAMA August 18, 1999; Vol. 282 (7): 630.