Conferencia Interamericana de Seguridad Social

Centro Interamericano de Estudios de Seguridad Social

VOL. 4 NUM. 2 SECOND SEMESTER 2008

Well-being and Social Policy

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Health Public Insurance
Guest Editor
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WELL-BEING AND SOCIAL POLICY
VOL 4, NUM. 2, pp. 127-131

BOOK REVIEW. BEYOND SURVIVAL. PROTECTING HOUSEHOLDS FROM HEALTH SHOCKS IN LATIN AMERICA, BY BAEZA, CRISTIAN C., AND TRUMAN G. PACKARD

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The book by Cristian Baeza and Truman Packard is based on the next hypothesis: adverse health events reduce the consumption of goods and services different from health services, and many households become poor because of that. While the authors recognize that the evidence they present on the topic is limited, they propose the use of a "universal risk pool" as a way to eliminate the problem of poverty caused by health events.

Baeza and Packard make frequent reference to the literature on market inefficiencies associated to the special information structures in health services' provision. Yet, they do not fully explain why the strategy they propose will reduce those negative features. The strategy they propose is based upon a fund to pool risks across society. While the universal risk pool can support families that face liquidity constraints because the private insurance markets and the social security institutions offer products that are too expensive, it is not clear how other market deficiencies will be faced.

Let's take a look at the archetypal problem that leads to bad market results, even to the non-existence of markets: lack of information on the quality of the health services' provider (hospital or physician). The problem arises from the impossibility of forcing physicians and hospitals to reveal the information they know, both about themselves and about the patient. The best solution to this problem is to improve the information flow to patients, perhaps through consumer protection rules, through a regulatory commission that oversees the quality of providers, through civil actions to deter physicians from hiding information, or from organizational and work rules that eliminate the possibilities or incentives that physicians and hospitals may have for discriminating patients in a pecuniary way. For example, in a managed care environment or in a vertically integrated social security agency, physicians are salaried and they are not interested in selecting patients to exploit private information on them to charge them more. Forcing all citizens to participate in a single financial risk pool does not advance in the solution of this problem.

It should not be lost that the longest chapter in this book on health insurance actually deals with labor issues. This is no coincidence, because health insurance is often linked to labor

contracts. Thus, in the realm of contemporary economics, the health status of individuals is seen as part of human capital, a set of characteristics that allows being more productive on the job and on the household economy, and to enjoy life and leisure more. The discussion on chapter 5 puts well the issues faced by households on deciding to participate in the economy through an informal job or through one covered by social security. Nevertheless, one point called my attention. First, given the high relevance given by Baeza and Packard to hypothesis predicting inefficient functioning of health services' markets, there is basically no mention of analogous problems in labor markets.

A comment of a different nature on the chapter on labor issues, and one that goes to the basic problem stated in the book, has to do with the issue of discrimination. Baeza and Packard list the "poor, the high risk, and the self-employed and informal workers" as groups that pose significant challenges to health insurance policy. Let us ask about the next list: Indians, blacks, women and children. A difference between the two groups is that the first one is a list of market defined quantities; the second is defined by personal unchanging characteristics. If the problem of lack of insurance is in fact a market issue, the first list is better to think about policy solutions. But if lack of access is defined by preferences' based on discrimination, the second one may be the right one to think about the problem. This is relevant for the topic in the book because the high risk, the self-employed and the informal workers are often non-poor, and in any country (at least throughout the Americas), a poor adult male can become wealthier with higher probability than an Indian women or a black child. Alesina, Glaeser and Sacerdote (2001) have studied the role of race in determining the lower incidence of insurance in the United States in relation to Europe. They propose that the main cause for the gap is related to the higher level of racial heterogeneity in the United States. In their indexes of racial fractionalization and the size of the welfare state, Brazil and the United States are amazingly similar (see Figure 4, page 46), and the countries with the toughest challenges to increase social insurance coverage are also among the most fractionalized: Guatemala, Colombia, Trinidad & Tobago, Mexico and Bolivia. If their argument is correct, then the abundant debates on achieving universal health insurance in that country through the creation a universal risk pool—not very different from those proposed by Baeza and Packard—are somewhat misguided. Whatever the financial-purchasing-stewardship effectiveness of the national risk pool, the discrimination problem will not go away with its adoption, and different actions would be needed to correct the lack of access.

This is a book on proposals, and it is understandable that it does not include all evidence and analysis. Valuable background empirical papers were commissioned as part of the project. Nevertheless, there are two general empirical issues where the analysis may need to be evaluated. One is empirical, the other theoretical.

On the empirical issues, one of the main pieces of evidence presented is that out-of-pocket expenditures for health services falls as the income of a country increases. This is viewed as evidence of something going wrong. It is said that paying cash for health services is a bad deal, and that the main way to measure the impact of health expenditure on the welfare of families is through the ratio of cash payments to insurance arrangements. Yet, if the market for health services is in fact inefficient, families with extra cash at hand will do better paying cash for health services than buying insurance. Thus, out-of-pocket expenditures may say something about the efficiency

of the health market (and there can be public interventions to improve on that area), but families spending more cash may be better off. There are three hypotheses to support this argument.

First, when moral hazard by providers is a major issue in the provision of health services, then buyers (households) will want to retain as much control as possible to pay, preferably paying after services are received and results are known. Thus, out-of-pocket expenditures may not only be a very bad idea, it can be a pretty good way to reduce the problem of negotiating with providers—certainly, the insurance problem remains, but there is not a direct relation between a form of payment and welfare. A second hypothesis is that the fixed cost of managing insurance can be large, and for low income families, it may be preferable to go around without insurance—this does not mean that low income families should be left without health services, it only means that it may not always be a good idea to use complex financial instruments to support delivery of those services. The third hypothesis has to do with the cost of collecting taxes; if this is very high, a country may be better off keeping smaller public programs. How large can this cost be? For Canada and the Unites States, sometimes viewed as efficient tax collectors among OECD countries, the marginal cost of funds can be around 30% and for specific taxes the cost can go up to 100% or more. When the labor supply subject to taxation is highly elastic, as is the case in countries with large informal economies and relatively low rates of compliance, the marginal cost of funds can be several multiples of those figures (Dahlby 2008). This can explain why national populations may not easily support political initiatives to raise taxes, even if these can help to reduce a market distortion or increase social expenditures.

The other empirical issue has to do with the way public and private goods are defined. Baeza and Packard have a discussion on the public and private nature of health services, and propose regulations and financial formulas to classify and finance goods "correctly". The issue with this is that there is no reason why public and private goods should be unbundled mandatorily in a particular way. Bundling goods is a common feature in many activities. It is also common that public and private providers bundle public and private goods. For example, highways often provide car insurance that has to be bought even by those users that have their own insurance. Highways are a public good, and insurance is a private good, but this tie-in does not imply any sort of distortion. In private good markets, bundling is pervasive, and only in special cases can a presumption of inefficiency be raised. Thus, there is little basis to support a recommendation to regulate health insurance and service provision on the basis of classifying services as public and private. Doing so may force undesirable options, such as keeping separate providers for "public" (often preventive) services, and other services.

Summarizing: 1) inefficiencies in health care and labor markets may not be fully compensated by a universal insurance pool, 2) there are significant issues that block access to health services and will not be solved through a financial solution, 3) while having insurance for all is desirable, for large segments of the population the cost of managing insurance may be too high, and, 4) a regulatory separation of "public" and "private" health consumption may lead to excessive costs.

The book by Baeza and Packard is highly recommended. It deals with an important and complex policy issue, and hopefully we will see more efforts on the field. Part of this complexity comes from the heterogeneity of the Latin American region. In the pension arena, the World Bank's

management itself has accepted evaluations that point out that there is quite a bit of learning to do in policy making, and that the conditions of countries determine that there is no recipe to be applied in all cases.

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