

# Two-tier medicine – An Insidious Inequality?

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# Two-tier medicine: The questions

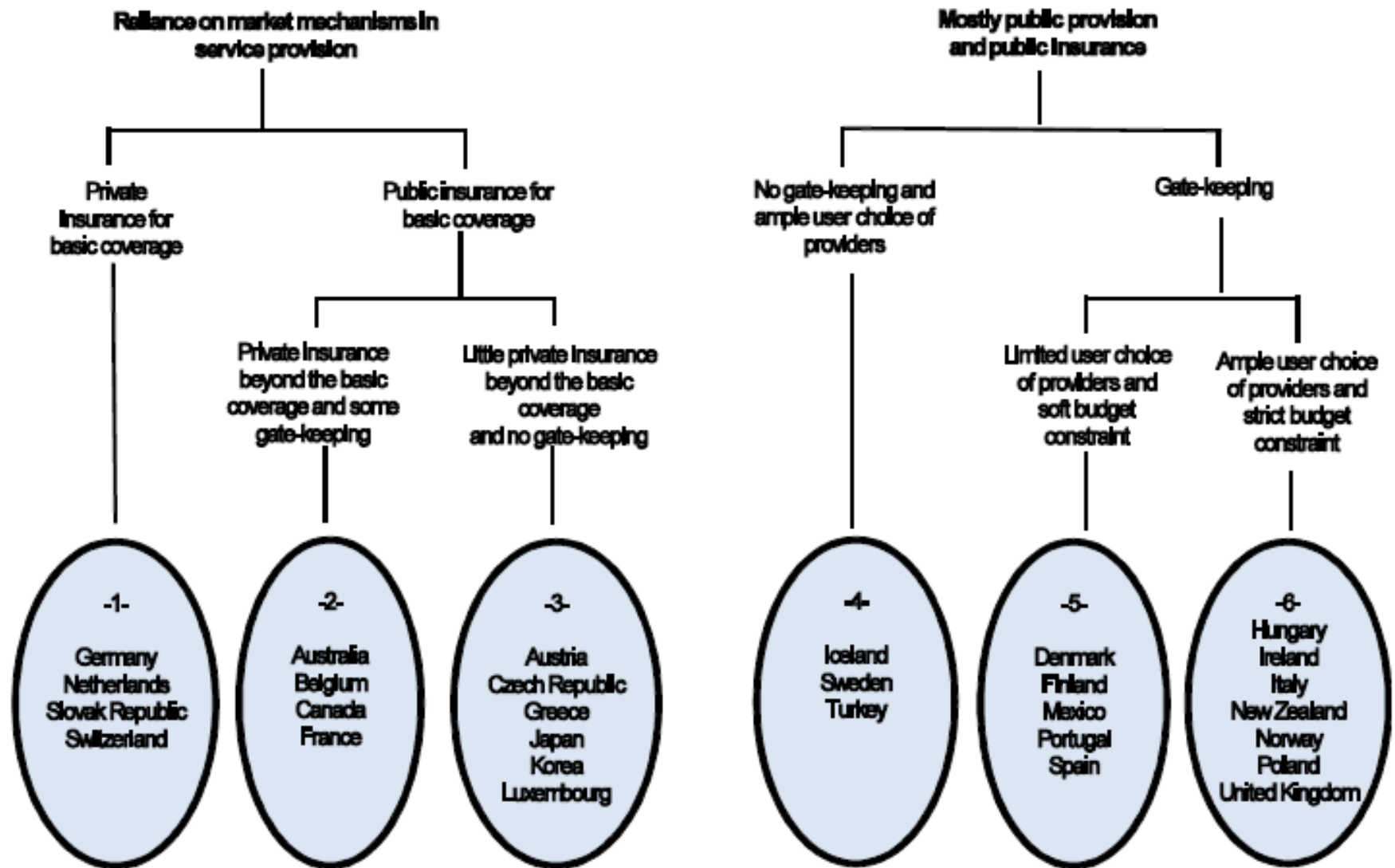
- What is it?
- Does it exist?
- Why does it exist?
- Can and/or should PHI be eliminated based on efficiency or equity arguments?
  - Do patients with PHI receive *different/better* HC?
  - Do patients with PHI have *different/better* outcomes?

# What is it?

# Definition (Wikipedia)

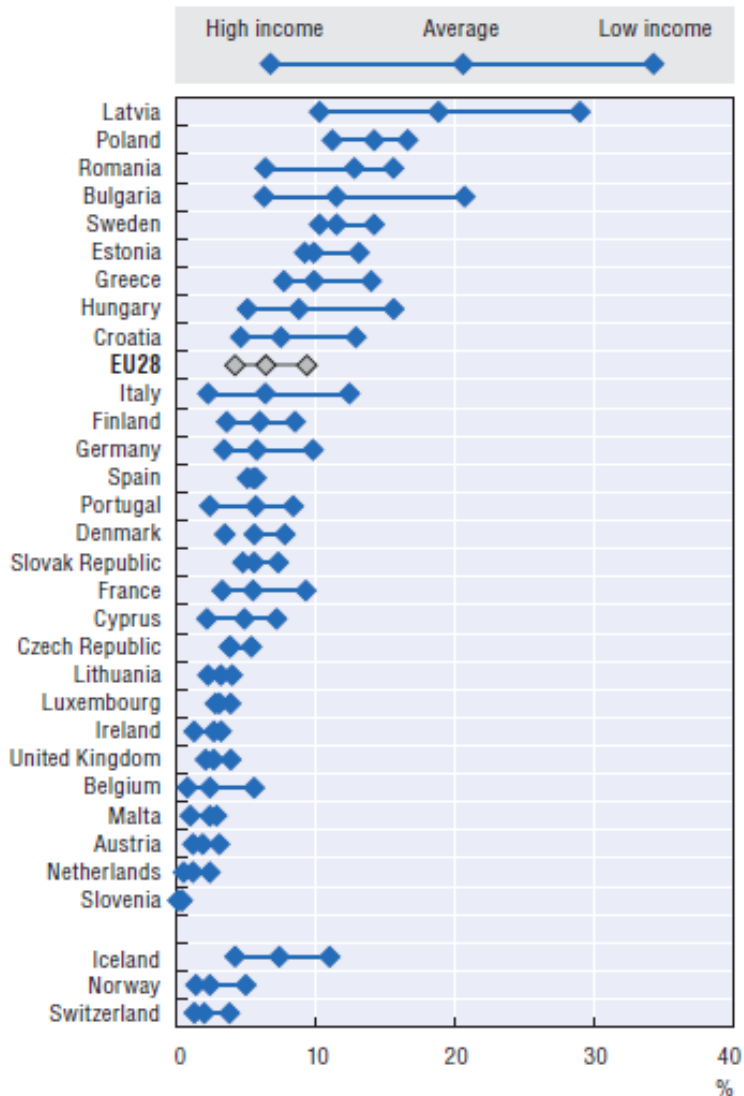
- **“Two-tier health care/medicine** is a situation that arises when a basic government-provided health care system provides basic, medical necessities while a secondary tier of care exists for those who can purchase additional health care services or receive better quality and faster access.”
- „„Zwei-Klassen-Medizin“ ist ein negativ besetztes politisches Schlagwort. Es bezeichnet ein Gesundheitssystem, in dem die Güte der medizinischen Versorgung davon abhängt, ob der Patient gesetzlich („Kassenpatient“) oder privat krankenversichert ist.“

Figure 3. Groups of countries sharing broadly similar institutions



Source: OECD Economics Department Policy Notes No. 2, 2010

5.4.1. Unmet need for a medical examination  
(for financial or other reasons), by income quintile, 2011:



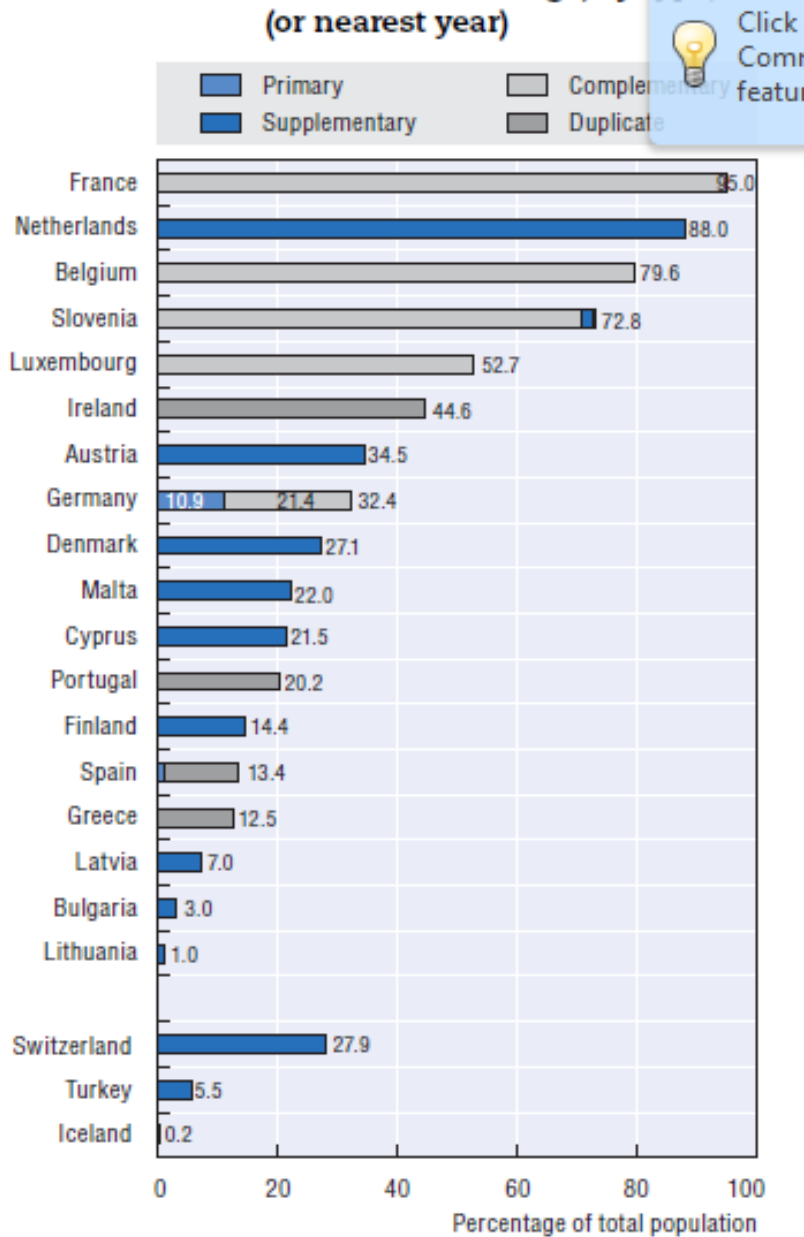
OECD (2014), Health at a Glance: Europe 2014, OECD Publishing,  
[http://dx.doi.org/10.1787/health\\_glance\\_eur-2014-en](http://dx.doi.org/10.1787/health_glance_eur-2014-en)

Note: 2011 data for Austria and Ireland.

Source: Eurostat Statistics Database, based on EU-SILC.

# Does it exist?

### 5.1.2. Private health insurance coverage, by type, 2012 (or nearest year)

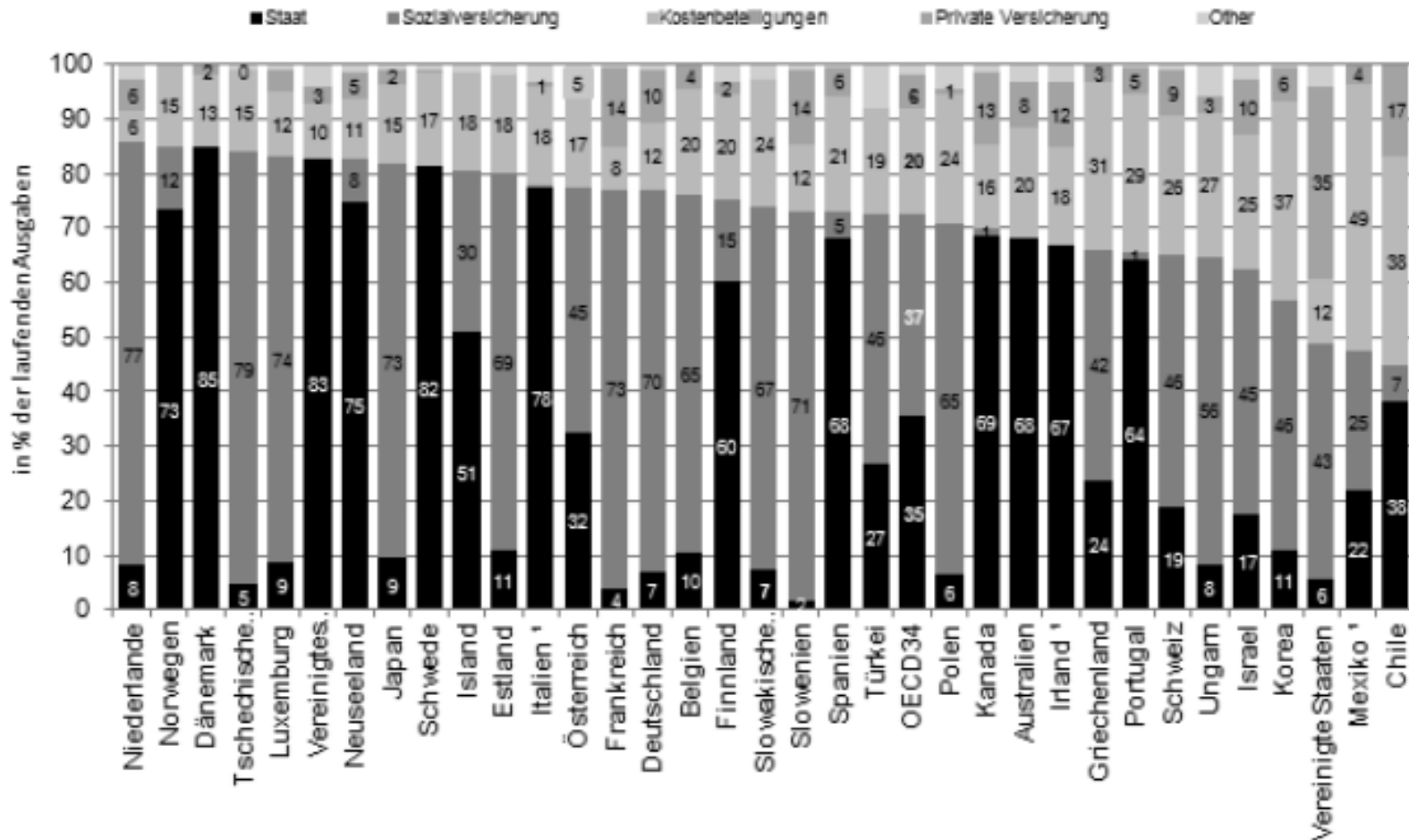


OECD (2014), *Health at a Glance: Europe 2014*, OECD Publishing, [http://dx.doi.org/10.1787/health\\_glance\\_eur-2014-en](http://dx.doi.org/10.1787/health_glance_eur-2014-en)

Note: Private health insurance can fulfil several roles. In Austria and Denmark, for example, it can be both complementary and supplementary.  
 Source: OECD Health Statistics 2014, <http://dx.doi.org/10.1787/health-data-en>; European Observatory Health Systems in Transition (HiT) Series for non-OECD countries.



Abbildung 1: Gesundheitsausgaben nach Finanzierungsträger, 2011  
(oder letztverfügbares Jahr)

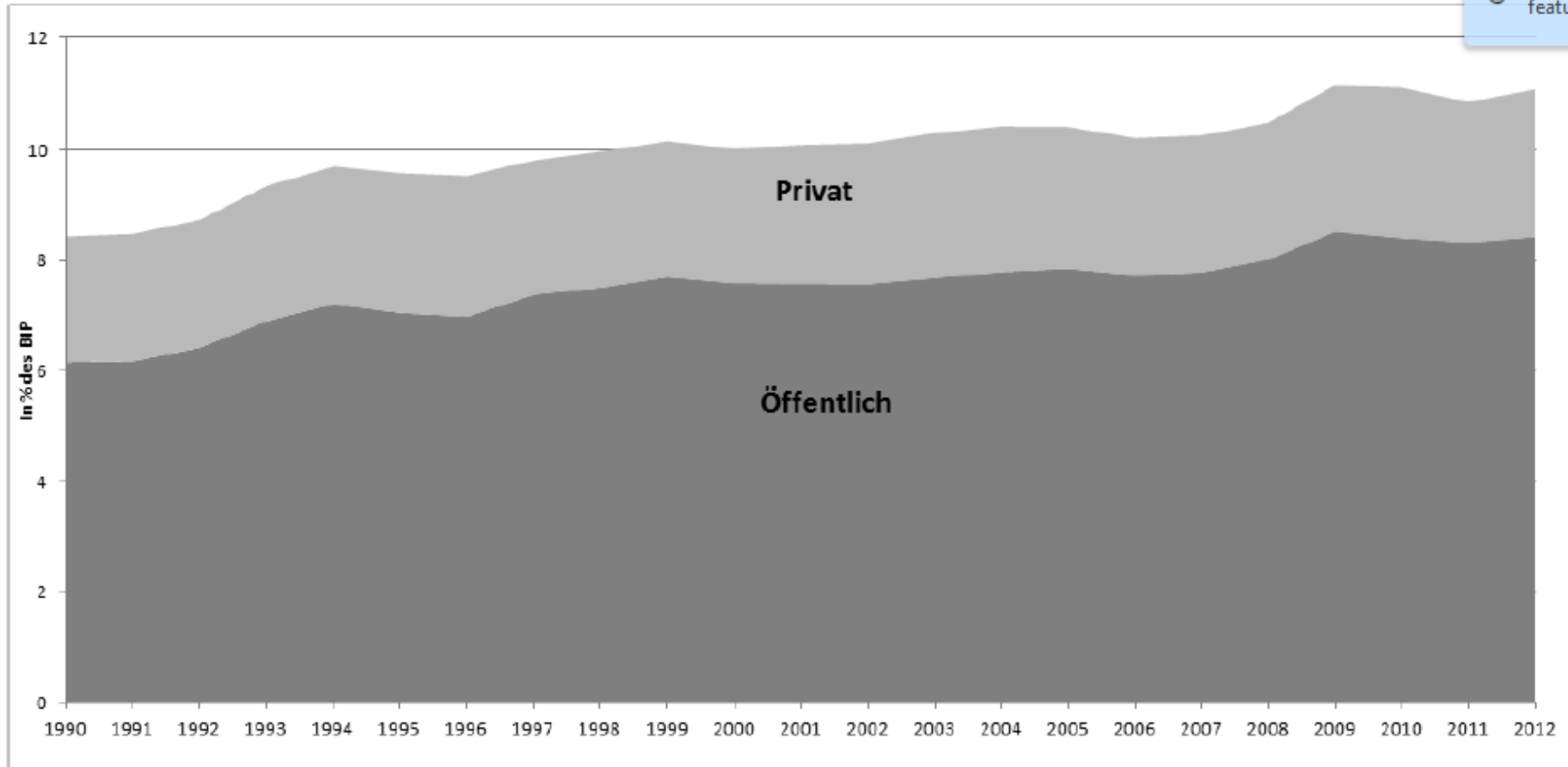


1 Daten beziehen sich auf die gesamten Gesundheitsausgaben

Quelle: OECD Health Statistics 2013, abrufbar unter [dx.doi.org/10.1787/health-data-en](http://dx.doi.org/10.1787/health-data-en)

Source: MM Hofmarcher, Wirtschaftspolitische Blätter 3-4/2014

Abbildung 3: Entwicklung der Gesundheitsausgaben in Österreich, in % des BIP



Quelle: Statistik Austria 2014

Source: MM Hofmarcher, Wirtschaftspolitische Blätter 3-4/2014

# Why does it exist?

# Market failure in health care

- Historically free market structure
- Market failure:
  - Risk and uncertainty about illness lead to insurance markets
    - Moral hazard, adverse selection and escalating costs
  - Externalities
  - Imperfect/Asymmetric information (doctor-patient, purchaser-provider)
  - Principal-agent relationship (doctors are both demanders and providers of HC)
  - Professional licensure (monopoly)

# Regulation is inevitable MEDICAL UNIVERSITY OF VIENNA

- All public and private health care markets are inefficient
- Therefore, non-market methods required to allocate goods and services
- Governmental regulations are inevitable and have been introduced internationally
- Level and method of these regulations differ
  - Social insurance (e.g. France, Canada, Austria)
  - Tax funded (e.g. UK)
- Objectives other than efficiency that the market does not meet (e.g. *equity*)

# Equity

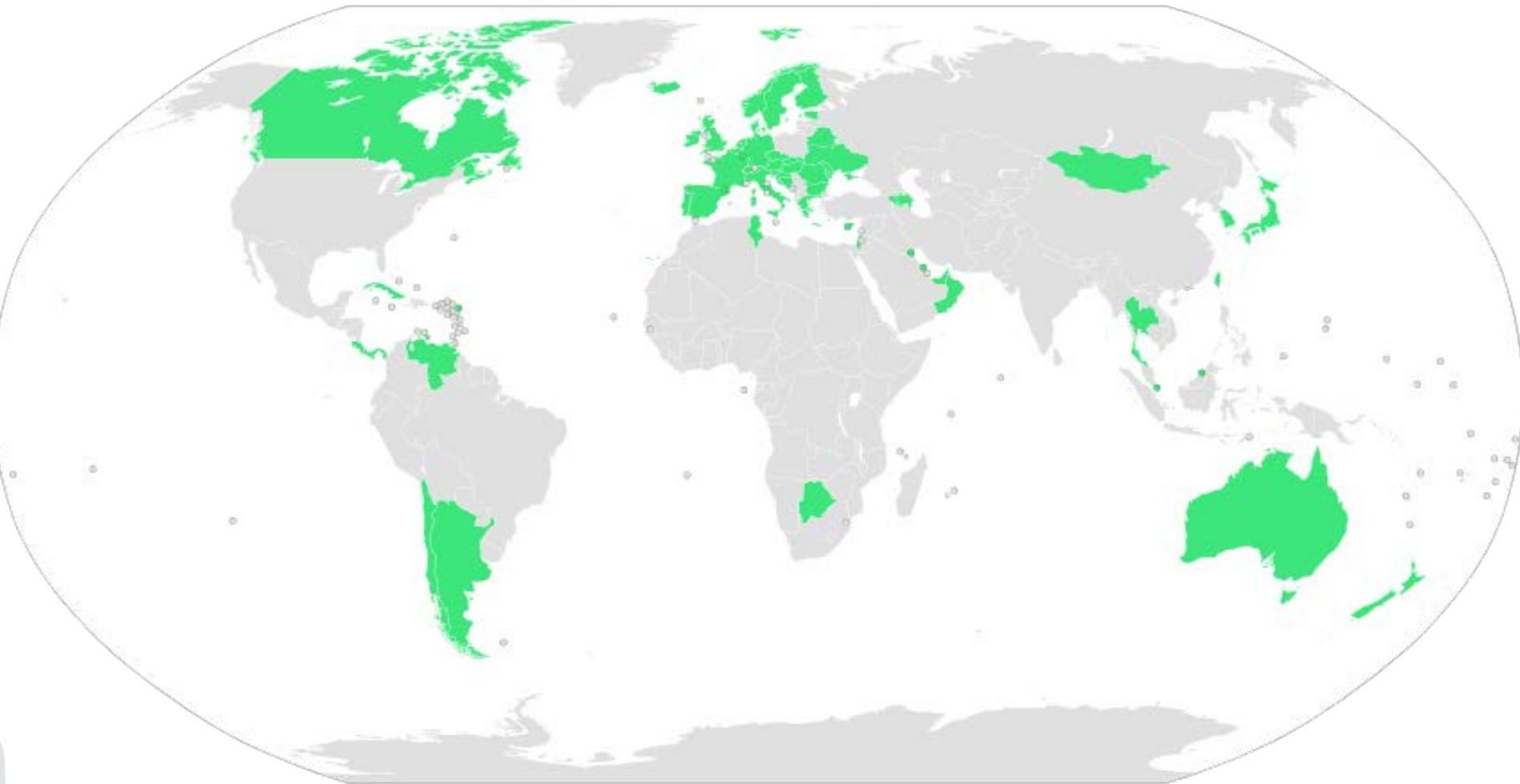
- Equity of what?
  - Health
  - Health care consumption
  - Access to health care

- Access to all irrespective of ability to pay (universal coverage)
- Scope of coverage (type of services)
- Depth of coverage (most effective treatments)

- HC spending has risen by over 70% in real terms since the early 1990s across the OECD countries
- Current OECD average is 9% of GDP, Austria 10.8%
- Public HC spending could increase by further 3.5-6% points of GDP by 2050 across the OECD countries
- Budget constraint



# Universal health coverage (2009)



Stuckler, David; Feigl, Andrea B.; Basu, Sanjay; McKee, Martin (November 2010). The political economy of universal health coverage. Background paper for the First Global Symposium on Health Systems Research, 16–19 November 2010, Montreaux, Switzerland.

# Rationing

- Scope of coverage:
  - What kind of services are covered?
  - Basic/core package of services
- Depth of coverage:
  - Cost-effectiveness and not effectiveness alone as decision rule

# Do patients with PHI receive *different/better* HC?

# Evidence

- Fee-for-service reimbursement: more HC
- More and better hospitality services (US example):
  - Obama Care (PPACA 2010)
  - 30% of Medicare reimbursement depends on patients satisfaction survey scores
  - Focus is on making patients happy rather than well
  - Improvement of hotel services vs. safety and quality of care (Walt Disney as consultant)

# Evidence

- VKI reports (Austria):
  - 2011: waiting times
  - Private patients have shorter waiting times
  - KaKuG Novelle: law on compulsory reporting of waiting times with info on insurance status

- Competition (price)
- Financial (rewards, penalties)
- Non-financial (performance measurement and transparency)

## „Die Aufteilung der Sondergebühren (AEK OÖ):

Gesetzliche Grundlage ist die Bestimmung des § 54 OÖ Krankenanstaltengesetz. Demnach gebührt den Ärzten in Krankenanstalten von Sonderklasseversicherten Patienten (bzw. Deren Versicherung) ein Ärztehonorar. Die Aufteilung desselben ist einvernehmlich durch die betroffenen Ärzte vorzunehmen. Dabei sind die fachliche Qualifikation sowie die Leistung zu berücksichtigen. Zur genaueren Ausformung der – doch ziemlich unbestimmten – gesetzlichen Grundlagen hat die Ärztekammer für OÖ. eine Richtlinie zur Aufteilung der Sondergebühren erlassen... Grundsätzlich sind die Ärzte (Primar, Fachärzte, Assistenten) einer Abteilung selbst berufen die für ihre Abteilung geltende Aufteilung festzulegen. Sie sind bei dieser Festlegung in keinsten Weise an die Richtlinie gebunden, können also in jeder beliebigen Art und Weise davon abweichen. Eine einzige Voraussetzung muss dabei jedoch erfüllt werden: es müssen alle Ärzte der Abteilung damit einverstanden sein...“

- Historically patients opted out of NHS treatment and into private care to avoid waiting lists
- NHS consultants allowed to practice both as NHS and private doctors, were in charge of waiting lists, had financial incentives to shift patients to private practice
- Blair government reforms:
  - Strict rules for waiting lists
  - Transparency (compulsory reporting)
  - >18 weeks patient has the right to go private on NHS budget



Do patients with PHI have  
*different/better* outcomes?

# Evidence

- No robust evidence
- Issue of overdiagnosis?
- Move from process measures to health outcome measures

# Thoughts

- Rationing is evident in both private and public HC systems, one uses price, the other time (waiting lists)
- It is less the type of system but rather how it is managed/regulated what matters
- *Better* and not *more* regulations are needed
- Patients' incentives: Difference between needs and wants
- Revision of providers' incentives to improve practice

- Evidence of better outcomes for patients with PHI is necessary to determine the real implications of a two-tier HC system
- The argument of inequity due to two-tier medicine in social HC systems with universal coverage and a broad basic HC package may not be warranted
- „Inequalities are often caused by factors that have little to do with the HC system itself, such as social status and education“ (OECD, 2010)
- The right question is: What is the best mix of public vs. private for the local context?

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