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The Health Policy Conundrum

Comprehension Questions

Indicate whether the statement is true or false, and justify your answer. Be sure to state any additional assumptions you may need.

1. If members of a society have transitive preferences, then that society as a whole must also have transitive preferences.

   FALSE. In a shocking 1951 paper, economist Ken Arrow (1921-) proved that societies do not necessarily have transitive preferences, even when all its members do. His finding is known as Arrows Impossibility Theorem.

2. The goal of health policy is to maximize health, wealth, and equity.

   FALSE. In an ideal world, all three goals would be attainable at once, but in practice, it is impossible to have everything. Any attempt by a nation to move closer to one of these three goals necessarily involves a tradeoff that moves that nation further away from some other goal.

3. Health systems focused on promoting equity typically have purely private insurance markets.

   FALSE. Private insurance markets often result in some uninsurance, which can leave some members of society without affordable access to health care if they are diagnosed with cancer or diabetes for instance. Conversely, universal public insurance does further the goal of equity.

4. Insurance mandates do little to combat the problem of adverse selection.

FALSE. A mandate, which is a legal requirement that everyone in a population purchase an insurance contract, confronts adverse selection by effectively banning it. Even robust customers who would prefer to opt out are legally required to buy into the system.

5. Cost-sharing is used to combat moral hazard at the expense of equity.

   TRUE. Cost-sharing (such as the use of deductibles, coinsurance, and copayments) controls moral hazard in a way that is sometimes more politically palatable than CEA. But it also makes health care less accessible for patients.

6. Queues can help equitably reduce moral hazard.

   TRUE. The hassle of waiting in line constitutes a non-financial cost that all patients "pay" when they want care. Therefore queues can replace financial cost-sharing arrangements as a way to limit moral hazard. A queue-based system may also be more equitable than a cost-sharing one if it means that rich or poor alike must wait in the same line for care.

7. Prospective payment systems align the interests of doctors and their patients.

   FALSE. The shift towards prospective payment systems has turned some doctor-patient relationships adversarial by making health care providers partly responsible for containing costs. This introduces a note of distrust - patients now have to worry that their doctors might prioritize reducing costs over improving their patients' health.

8. There is no such thing as "too much competition" in the private hospital market.

   FALSE. Too much competition can be a problem in hospital markets due to information asymmetries between doctors and patients, and the ubiquity of insurance. Too much competition can exacerbate inefficient quality competition, lead to a medical arms race, and drastically increase the costs of health care.

9. A country operating below its own health production frontier is said to be productively inefficient.

   TRUE. A country that is below its own health production frontier is said to be productively inefficient since it could spend less on health care and achieve the same health outcomes, or spend the same on health care and achieve better health outcomes.

10. If a country is productively efficient and hence on its own health production frontier, it is spending the optimal amount of money on health care.

    FALSE. It is possible, for example, that the marginal dollar spent on education or parks produces more utility for the population than the marginal dollar spent on health care. Such a country is said to be allocatively inefficient since it spends too much on health care relative to other productive activities. Since the country is on its health production frontier, shifting money to other activities will reduce health, but increase the overall welfare of the population. The opposite is also possible – the country on its health production frontier spends too little on health care and too much on other activities.

11. If health disparities exist within a country, then it cannot be operating on its health production frontier.

    FALSE. Countries whose subpopulations vary widely in income levels or in their preferences for unhealthy habits may appear to be productively inefficient on average, even though each individual subpopulation with the country is on the health production frontier.