# Social Values and the Health System

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## Abstract

There are as many health systems and models as there are countries. This is because healthcare is a public good and, thus, reflects the social and cultural values of the societies that design and adopt them.

## Paper

### I. Social and Cultural Values

We should distinguish social and cultural values from economic and operational values. Efficiency, for instance, is an economic-operational value, not a social-cultural one. Equity (though often considered an economic criterion) is actually a normative social-cultural value whose pursuit often comes at a steep economic price and is non-efficient. Health systems can be categorized according to which class of values they emphasize: the American (US) health system is geared to satisfy economic-operational requirements while European health systems place a premium on social-cultural ones.

In this paper, I deal with three social-cultural constraints: solidarity, equity (vs. inequity), and progressivity (vs. regressivity), including the issue of redistribution. There are many other social-cultural values that I do not cover in here: fairness, dignity, and choice come to mind. Finally, I provide a discussion of the concept of "public good" in current literature.

### II. Social Solidarity

Social solidarity is both vertical and horizontal and both contemporaneous and inter-generational.

Members of the same society ought to strive to share the burdens of the sick, the young, the poor, the weak, and the disenfranchised. This is usually done by transferring economic resources among population groups and by promoting fairness. At the same time, people should feel morally obliged to provide aid and succor to their peers and relatives, neighbors and colleagues, compatriots and friends by encouraging social cohesion and sharing of responsibilities (for instance, within the nuclear or extended family).

Such attitudes cut also across generations, so that the current generation is held answerable to future generations for their well-being and the reasonable fulfillment of their needs. This "solidarity across time" is at the foundation of most modern pension systems, for instance.

Some health systems are explicitly founded on social solidarity, others only implicitly so. However, there are health systems which partly or altogether eschew social solidarity as a defining principle and a determinant.

Health systems of the first type are usually universal, uniform, and comprehensive. They rely on tax revenues or a social insurance scheme or on a combination of both. Health systems of the second type depend on private insurance, are not universal, and are more diverse in the types of medical coverage offered (albeit this diversity comes with increased transaction costs).

Introducing means-testing (asking the rich to pay additional or higher user-fees, co-insurance, deductibles, or participation) does not affect social solidarity. On the contrary, taxing the rich to pay for the poor is the very essence of a solidary state. Similarly, introducing safety nets (such as voucher systems) is a solidary act. Whether such an approach is ideal, from the economic point of view is outside the scope of this paper.

### III. Equity

There are three types of equity:

**1. Equity of financing (affordability):** can the poor, the unemployed, the homeless, the old, the young, the weak, the chronically sick, and the disenfranchised afford the healthcare offered? Are the expenses they have to incur catastrophic? Do certain expenditures (for instance user fees, or participation in the costs of medications) deter utilization? Do the payments reflect one's income or wealth, are they "fair"?

**2. Equity of utilization** (accessibility) is comprised of two components:

***(i) Vertical equity:*** Can everyone access healthcare services and facilities and make use of them easily and equitably (on the same terms and conditions, regardless of income)? This type of equity correlates with the progressivity of the health system (see chapter below.)

***(ii) Horizontal equity*** is the extent to which people with identical incomes are treated similarly. This type of equity correlates with the redistributive aspects of the health system (see chapter below.)

**3. Equity of quality:** Is the level of quality healthcare provided in all regions of the country and in rural vs. urban settings the same?

**Medical savings accounts** adversely affect equity because they skew economic incentives and the allocation of healthcare resources towards the rich and men. Women and the poor cannot save as much and have greater healthcare needs.

**User fees** may actually increase equity under certain conditions: (1) That the income they generate is targeted at the poor and the chronically ill (2) That the poor and chronically ill are exempted from paying them and (3) That the level of funding from other sources (taxes, contributions) is not reduced.

**Devolution of healthcare** services may create inequity as rich municipalities are able to spend more on healthcare than poorer ones. The government should create an equalization fund or use general tax revenue to transfer resources from wealthier to more destitute regions. Pooling of funds among regional or competing funds guarantees more equity.

**Regional health insurance funds** increase inequity as they are faced with the same problems described under "Devolution" above: poorer regions cannot compete with richer regions on the purchasing and provision of healthcare.

**Social health insurance** and tax-based healthcare financing maintain the same level of equity of financing. Negative co-payments (no-claim bonuses); income caps (or ceilings) on contributions; the inclusion of dependants in the coverage at no additional cost; and the extent of cost-sharing determine how equitable and progressive the social insurance scheme is.

The introduction of private health insurers and voluntary health insurance to compete with the statutory health insurance fund or even merely to complement or supplement it would increase inequity especially with regards to women and low-income groups. Women are usually charged higher premiums though their incomes are often lower than men's.

**Risk-rated premiums** decrease equity as they discriminate against the already ill and may deter them from seeking care. On the other hand, exemptions granted to specific population groups (and not based on income) increase inequity: the sick and the old may gain better access to quality healthcare than other, equally deserving beneficiaries.

**Risk-adjusted** (e.g., DRG) capitation systems enhance vertical equity.

Informal payments dramatically decrease equity because: (1) Access is restricted to those who can afford to pay (2) Payments terms and levels are arbitrary and changeable (3) Certain services and goods are rendered unaffordable (4) Public, more equitable services suffer (5) Lack of regulation creates variable quality of healthcare, fiscal irresponsibility, and lack of fairness.

### IV. Progressivity and Redistribution

Though progressivity (and redistribution) are often conflated with equity, these are two separate issues. We can imagine a progressive system of health funding which is not equitable and can conceive of the reverse as well.

We say that healthcare funding is progressive when rich people pay more (as a proportion of their income) than poorer folk; the system is proportional when both rich and poor use up the same proportion of their disposable income to defray healthcare costs; it is regressive when poor people pay a higher portion of their income than the affluent to consume healthcare goods and services.

Progressivity largely determines whether there is a redistribution of resources from the rich to the government (not necessarily to the poorer segments of

the population). How extensive and ubiquitous the redistribution from the government to the poor is depends on how involved the state is in the economy (in other words, it depends on the tax burden, the incidence of public spending, and on the absolute level of tax revenue, among other factors).

**Tax-funded healthcare** is progressive (assuming that most of the tax revenue is generated from direct taxes, not from consumption or indirect taxes which are regressive). It is less progressive than social health insurance when: (1) Indirect taxes constitute a major source of budget revenue and (2) The informal sector that does not pay taxes is large.

**Earmarked ("sin", or hypothecated)** taxes on alcohol, tobacco, motor vehicles, and medicines are regressive (though their regressivity is intentional as they are intended to deter consumption).

**Social health insurance** is generally less progressive than a tax-based system because it does not tax income from interest, rent, capital gains, and non-wage types of income. This is especially true when there is an income ceiling (above which contributions are not levied); when there are no exemptions for low-income groups; and when the rates are uniform regardless of the size of the wages they are levied on.

Still, Social health insurance is more redistributive than private insurers: (1) It charges uniform or community rates (2) It insures dependants at no extra cost (3) The length and extent of healthcare goods and services provided is not related to previous or cumulative contributions (4) It caters to the needs of the old (inter-generational redistribution). Still, this type of redistribution has negative economic effects (which are outside the scope of this paper).

The introduction of private health insurers to compete with the statutory health insurance fund is neutral as far as progressivity goes. Only where private insurance has supplanted social insurance as the main source of funding did regressivity increase markedly. Risk-rated premiums, however, are regressive.

**Medical savings accounts** have no regressive or progressive effect as they do not redistribute income. All types of savings are neutral as far as progressivity or regressivity go.

**User fees** are highly regressive, regardless of any supplementary policy measures (such as exemptions). Only the introduction of means-testing can reduce regressivity.

**Informal payments** are highly regressive as the poor are asked to pay a high proportion of their income or assets (even when they are charged less than richer patients).

**Tax deductibility of healthcare expenses** is highly regressive (people with higher income tax rates receive a higher deduction).

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