Introduction to Public Policy

Lecture 8

Path Dependence and the health care debate

FULBRIGHT
Economics Teaching Program

Sampling with replacement

- Probability of selecting one brown sweet = 0.5
- Probability of selecting one white sweet = 0.5
- Probability of selecting a second brown sweet = 0.5
- Probability of selecting a second white sweet = 0.5
- Probability of selecting two brown sweets = 0.5 * 0.5 = 0.25

Sampling without replacement

- Probability of selecting one brown sweet = 20/40
- Probability of selecting one white sweet = 20/40
- Probability of selecting a brown sweet in the second round = 19/39 = .487
- Probability of selecting a white sweet in the second round = 20/39 = 0.513
- Probability of selecting two brown sweets = 0.5 x 0.487 = 0.2435

Polya's urn problem

- Probability of selecting one brown sweet = 20/40 = 0.5
- Probability of selecting one white sweet = 20/40 = 0.5
- Probability of selecting a brown sweet in the second round = 21/41 = .512
- Probability of selecting a white sweet in the second round = 20/41 = 0.487
- Probability of selecting two brown sweets = 0.5 x 0.512 = 0.256

Path dependence

- When an economic process or policy has started down a track and it is very expensive to reverse course (high exit costs).
- In the presence of increasing returns, the relative benefits of continuing down the same path are higher than all possible options
- Example: QWERTY typewrite (Paul David 1985)
- Trade patterns and specialization

Path dependence and policies

- When a policy entails major setup costs and large numbers of people who must devote time and resources to developing expertise, early choices become difficult to reverse
- "increasing returns"—where the benefits of a policy increase as more people organize their activities around it—those early decisions become self-reinforcing.

US health care system

- 57 million Americans do not have health insurance
- Estimated 45,000 premature deaths per year
- One million people forced into personal bankruptcy because of medical bills
- High cost private system: now absorbs 18% of GDP, higher than other developed countries
- Yet worse health outcomes, for example lower life expectancy and higher child mortality rates

Health care indicators

	(A)	(B)	(C)
Australia	9%	81	4.4
Belgium	10%	79	4.2
Canada	10%	81	4.8
France	10%	81	5.2
Germany	11%	79	5.4
Italy	9%	81	5.0
Japan	8%	83	4.2
New Zealand	9%	80	6.4
Norway	10%	80	4.4
Singapore	3%	80	4.1
Sweden	10%	81	4.0
United Kingdom	8%	79	4.8
United States	**18%**	**78**	**6.3**

(A) % GDP spent on medical care
(B) Life expectancy at birth
(C) Under five mortality per 1,000 live births

Universal health coverage in selected countries

Country	Year	Type
Australia	1975	Basic coverage provided by government, supplemental private insurance
Belgium	1945	Compulsory national insurance
Canda	1966	Single-payer (one public sector insurer)
France	1974	Univeral coverage provided free through local, non-profit insurers
Germany	1941	Social insurance, universal through private and non-profit insurers
Italy	1978	Single-payer (one public sector insurer)
Japan	1938	Single-payer (one public sector insurer)
New Zealand	1938	Primary health providers funded through taxation
Norway	1912	Single-payer (one public sector insurer)
Singapore	1993	Compulsory savings and price controls
Sweden	1955	Free provision by local councils
United Kingdom	1948	National health service
United States	2014?	Currently private system with government insurance for the elderly and poor

Health care systems reflect unique history in each country

- UK's National Health Service: Grew out of war-time Emergency Medical Service
  - Cared for wounded soldiers and civilians and evacuees
  - Doctors mostly on government salaries by end of war
  - Many pre-war private hospitals destroyed
  - Despite the war general population health improved
- France built on system of pre-war employer insurance funds, gradually adding new categories of insured
- US employer-based insurance: During Great Depression of 1930s employers could not raise wages, but offered health benefits to attract employees

Health care in Vietnam

- Price control and state subsidy
  - Subsidies cover less than half of operating costs
  - So providers do not adhere to statutory prices
  - Insurers only cover official fees: providers also demand side payments
- Increase health insurance coverage through compulsory state health insurance in formal sector and Health Care Fund for the Poor.
- Financial autonomy (Decree 43) for providers
  - To encourage them to collect fees to reduce state subsidy
  - Revenue channeled into higher staff salaries