

**H514 (section 6112): Health Economics
Fall 2006**

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Names and phone # _____
of 3 students _____

Course objectives and description: The course objectives are that the student develop:

- 1) an appreciation of how health care markets operate, particularly how price acts as an allocation mechanism;
- 2) skills in measuring and interpreting these economic relationships empirically, including the interpretation of regression equations.

The course is divided into two sections. In the first, we examine how economic incentives affect the different actors in the health (care) system. The same basic model of individuals trying to achieve their objectives under different financial, regulatory and technological constraints is used to describe the behaviour of the different health care players. The material should become easier to grasp as you become more familiar with this model. The purpose of this section is to develop a model of the overall system, including the relationships between the respective players. In the second section of the course, we apply the model developed above in two policy applications: health care evaluation and reform of the health care delivery system. There will be a greater emphasis on conceptual rather than analytical learning than in the first part of the course. Once you have mastered this material, you should have a much better idea of how health care actors can be motivated to behave "optimally", and how you and your health care organization may be affected by changes in the financing and delivery of services throughout the health care system.

The MHA Faculty identified 10 areas in which students should achieve competency by the conclusion of the program (see <http://php.spea.iupui.edu/aholmes/h514/Competencies.htm>). Although this course is designed to touch on all 10 areas, its primary contributions are to improve the student's knowledge of the health care system (including social context, institutional features of non-profits and for-profits), instruct students in the appropriate use of quantitative analysis (e.g., measurement issues, statistical analysis of health care relationships) and financial tools used in economic evaluation (e.g., inflation, costing methods, present value analysis), build a familiarity with national information resources, and understand the economic underpinnings of decision analysis.

Prerequisites: An introductory micro-economics course (e.g., E201) is a required prerequisite. It will be assumed that students are familiar with basic micro-economic principles. For students who require additional review, I have noted in the schedule of lectures the specific topics about which you will need to be familiar (specific readings from Pindyck and Rubinfeld, Microeconomics, 6th edition, Prentice-Hall are identified, although any microeconomic textbook will cover the same material).

Readings: Required text: Phelps, C. (2003). **Health Economics**, 3rd ed. Addison-Wesley. Readings are used to supplement the lecture material and may be accessed electronically, either through the Ruth Lilly Medical Library's Ovid Database or "Online Resources A-Z" (<http://www.medlib.iupui.edu>). A hard copy of readings is available in BS4032T.

Assessment:

Grades will be based on two problem sets (20 %), one mid-term test to come after the first section of the course (30 %), a final examination (40 %), and a presentation/participation mark (10 %). Additional problem sets or tests may be added as seems appropriate to gauge performance.

Problem sets may be done individually or in groups. If done in groups, each person in the group shall be assigned the same mark (hand in one copy only). Assignments are tentatively due September 20 and October 4. No late assignments will be accepted. Extra problem sets may be assigned if needed, but the portion of the grade for which they account for shall remain at 20 per cent. Participation will include a grade for case study presentations (to be done in assigned groups), as well as contributions made to class discussions (e.g., related work experiences). Attendance is highly recommended.

The mid-term test (tentatively scheduled for October 18) shall cover the first eight lectures of material (covering the basic analysis of health care systems). Make-ups will be granted only in exceptional circumstances (e.g., verified medical incapacitation). The final examination shall be comprehensive. It is scheduled for December 13, **5:45-7:45**. Policies regarding P/F, I, and W marks are given in the **SPEA Graduate Programs Bulletin** (<http://www.bulletin.iupui.edu/spea/>). It is expected that students will be familiar with policies regarding academic dishonesty as described in the **IUPUI Code of Student Rights, Responsibilities, and Conduct** (<http://www.iupui.edu/code/>). These issues are also summarized in http://php.spea.iupui.edu/aholmes/syllabus_addendum.htm.

Grades will be assigned on the following criteria:

A+:	95-100%	B-:	70-74%
A :	90-94%	C+:	65-69%
A-:	85-89%	C :	60-64%
B+:	80-84%	F :	0-59%
B :	75-79%		

Lecture Topics (tentative):

Lecture 1 (Aug 23)	The commodity “health” and how it differs from other goods
Lecture 2 (Aug 30)	The production of health and estimation of the relationship
Lecture 3 (Sept 6)	Demand for health I: health versus health care
Lecture 4 (Sept 13)	Demand for health II: health insurance
Lecture 5 (Sept 20)	Supply I: Manpower/physicians
Lecture 6 (Sept 27)	Supply II: Institutions/hospitals
Lecture 7 (Oct 4)	Integration I: Vertical integration in supply and dynamics
Lecture 8 (Oct 11)	Integration II: Regulation versus competition; Midterm review
Lecture 9 (Oct 18)	Mid-term test
Lecture 10 (Oct 25)	Project evaluation I: Cost-Benefit Analysis (costs)
Lecture 11 (Nov 1)	Project evaluation II: Cost-Benefit Analysis (benefits)
Lecture 12 (Nov 8)	System evaluation I: International comparison of delivery systems and performance
Lecture 13 (Nov 15)	Case-studies (class presentations)
Lecture 14 (Nov 29)	System evaluation II: The U.S. system and reforms
Lecture 15 (Dec 6)	Review

Lecture 1

topic: the commodity “health”

prerequisite knowledge: the student should be familiar with the concepts of equilibrium, allocative and technical efficiency, and how the “invisible hand” yields an optimal outcome in the perfectly competitive case. (Suggested optional reading: Pindyck and Rubinfeld (2005) *Microeconomics*, 6th ed. Upper Saddle River, NJ: Prentice-Hall [hereafter referred to as P&R], sections 2.1-3 [including example 2.4], and 2.6 – supply, demand and market equilibrium).

objectives: 1) to see how economic and medical models differ and why neither is completely satisfactory for studying the health care system;
2) to identify 4 inherent characteristics that make competitive markets inadequate in health care;
3) to define the commodity “health” and understand the implications for measurement, the “health care industry,” and policy.

readings:

Phelps, C. (2003). **Health Economics**, 3rd ed. New York: Harper-Collins, chap. 1 (hereafter referred to as Phelps (2003)).

- focus on the discussion of inherent characteristics (he discusses three: uncertainty, asymmetric information, and externalities); then try to link the government interventions (aka institutional responses) discussed to these inherent characteristics.
- read p 9-24 as preparation for the next 3 lectures.

Moynihan R., Henry D. (2006). The fight against disease mongering: generating knowledge for action. *PLoS Medicine*, 3(4): 425-8. (available through www.plosmedicine.org)

- Consider the interaction between the definitions of health and health care.

questions:

1. If you were working in quality assurance for an HMO company, which inherent characteristic would make your job most difficult? If you were instead working in the utilization review department, which inherent characteristic would be your main obstacle?
2. Which inherent characteristic is responsible for the evolution of insurance in health care? Can you use another inherent characteristic to explain why some countries adopt public insurance schemes, while others leave health insurance in the private market?

web exercises:

1. If you are unfamiliar with the electronic resources of the Ruth Lilly Medical Library, review the tutorials: <http://www.medlib.iupui.edu/ref/tutorials/ovidtut/index.html> and <http://atoz.ebsco.com/home.asp?Id=iuruth> (the first covers the Ovid Databases, while the second covers the journal articles available through the Online Resources page). For the Ovid searches, it is often more efficient to search by article title (or to combine this search with one on the author’s name). For Electronic Journals, the most efficient search strategy is to type in the journal name in the search box in the upper right corner.

2. To obtain some background about the national and local health care markets, visit the website for Health System Change (<http://www.hschange.com>) and review the Community Report “Continued Hospital Expansions Raise Cost Concerns in Indianapolis” (<http://www.hschange.com/CONTENT/749/>).

Lecture 2

topic: the production of health and the estimation of the relationship

prerequisites: knowledge of average, marginal, and total product and their relationships to each other. (Suggested optional reading: P&R, sections 1.3 (the consumer price index), 6.1-4 (production relationships), and the appendix on regression analysis).

objectives: 1) the student should understand how health status is determined and how health care can influence this relationship, distinguishing between marginal and average effects;
2) the student should be able to interpret an estimated production function.

readings:

Phelps (2003), chap. 3

- focus on the discussion of intensive and extensive margins (p 60-63)

Durch, J.S., LA. Bailey, and M.A. Stoto (editors). **Improving Health in the Community: A Role for Performance Monitoring**. Washington, D.C.: National Academy Press; 1997.

- Review the "Health Field Model" of Evans and Stoddart (Figure 1, on page 48), available in the Executive Summary.

<http://books.nap.edu/books/0309055342/html/1.html>

questions:

1. Suppose the following estimates of the relationship between average (per capita) health care expenditure and life expectancy (also an average) are produced:

$$\text{yrs} = 45 + 0.0005 (\text{HC exp}) \quad R^2 = .41 \\ (t=2.30)$$

In a world without health care, what is the predicted life expectancy? For every \$10,000 spent per person on health care, how much life expectancy do you buy on average?

2. For the equation in question (2), what does "t=2.30" tell you? What about "R²=.41"?

web exercises:

To become more familiar with the data resources available from Federal sources, visit CMS's website for information on various health care indicators

(<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-04.pdf>). Price indices are described on pages 27-31. Locate the price indexes for 2003 and 2004 for physician and clinical services and for hospital services (p. 29). Which experienced the greater rate of price increase between the two years? (Note: additional information can be obtained from the Bureau of Labor Statistics (<http://www.bls.gov>), including a fact sheet on the construction of the MPI (www.bls.gov/cpi/cpifact4.htm)).

Second, visit AHQR's Healthcare Cost and Utilization Project (HCUP) website at <http://www.ahrq.gov/data/hcup>. Under "Tools and Software," you can access Instant Access Hospital Statistics that provides average hospital charges by diagnosis. Look up the 2004 NIS average hospital charges stratified by hospital teaching status for ICD-9-CM code 487.0 (Influenza with Pneumonia). Use the Z-test calculator to determine if there is a statistically significant difference in the average charge incurred by patients treated in teaching versus non-teaching hospitals (i.e., is the p-value less than 0.05?).

Lecture 3

topic: demand for health (I)

prerequisites: indifference curves and budget constraints, and the effects of rationing (e.g., quotas) and externalities in consumption. (Suggested optional reading: P&R, sections 2.4 (elasticity), 3.1-3.3 (utility curves, budget constraints, and demand), 4.1, 4.4 and 4.6 (demand equations and consumer surplus)).

objectives: 1) the student should recognize what factors affect the demand for health care and understand that the demand for health care is derived from the demand for health;
2) the student should be able to interpret an estimated demand equation and derive appropriate demand elasticities from it to guide policy.

readings:

Phelps (2003), chap 4

- focus on indifference curves (which show preferences or objectives), and budget constraints (which show opportunities); the upper right hand quadrant of the diagram used in class corresponds to Figures 4.2a, 4.3a
- also use this chapter to understand actual consumer health care prices (e.g., deductibles, copayments) and their relationship with insurance

Phelps (2003), chap 5

- focus on the price (both money and time) elasticity and income elasticity results (p 136-149 and 155-157); feel free to ignore the appendix

Rice, T., and Matsuoka K.Y. (2004). The impact of cost-sharing on appropriate utilization and health status: a review of the literature on seniors. **Medical Research and Review**, 61(4), 415-452. (available through Online Resources A-Z: <http://www.medlib.iupui.edu/>)

- skim, particularly the discussion of effects on health (p. 420, 427-8), on inappropriate use (p. 428, 441-5), and effect by type of copayment (p. 445-7).

questions:

1. The copayment for IU Health Care has increased from \$15 to \$20 per visit. What happens to the quantity demanded of health care? of health? Explain the connection between the demand for health and the demand for health care using the Grossman model.

2. Suppose the demand equation is

$$\text{Visits} = 100 - 2 \text{ price/visit}$$

What does it look like? How much would be demanded when price is \$15? At this price, what is the price elasticity? If this is the demand curve for your hospital and you want to increase revenues, do you increase or decrease the price per visit?

web exercise:

Visit <http://www.pohly.com/admin1.html> for a glossary of managed care terms (see page bottom). Find out how deductibles and copayments differ. In preparation for the next lecture, also look up the definitions of “adverse selection” and “community rating.”

Lecture 4

topic: demand for health (II): insurance

prerequisites: consumer surplus and welfare analysis

(Suggested optional reading: P&R, sections 5.1-5.3 (risk, aversion and insurance), 9.2 (social optimum), 17.1 and 17.3 (asymmetry of information). Older texts may not cover this material.)

objectives: 1) the student should understand why insurance is demanded by risk-averse individuals and what sorts of health care are most apt to be covered;
2) the student should be able to distinguish between moral hazard and adverse selection (hidden action and hidden type) and why they lead to market failure;
3) the student should be familiar with possible remedies of partial insurance (e.g., coinsurance, deductibles), and compulsory insurance.

readings:

Phelps (2003), chap. 10

- focus on the graphs depicting expected utility and risk premiums (p 318-324), the welfare loss from moral hazard (p 326-329), and the discussion of adverse selection (p. 334-44).

Committee on the Consequences of Uninsurance. **Hidden Costs, Values Lost: Uninsurance in America.** Washington, D.C.: National Academy Press; 2003.

- Review the “Executive Summary” for problems related to health insurance gaps.
<http://search.nap.edu/books/030908931X/html/>

questions:

1. Define an actuarially fair premium. An insurance company that charges such a premium makes how much profit?

2. You work for an insurance company and you have to recommend coverage of either (1) schizophrenia which affects .1% of the population and costs \$50,000/person a year to treat, or (2) mild depression which affects 10% of the population and costs \$500/person a year to treat. In a risk averse world, which insurance coverage would be in greater demand?

3. Explain how a health plan that offers a choice of three packages with varying degrees of coverage (like at IU) might make all enrollees worse off than if we forced everyone to subscribe to one plan.

web exercise:

Visit <http://www.medicare.gov/mphCompare/home.asp>. What Medicare insurance options are available in your area? Would you choose Original Medicare or a Medicare Advantage Plan (e.g., Anthem Medicare Preferred)? Consider premiums and copayments as well as coverage. Would you suggest an ailing or frail elder relative choose a different plan? Under what conditions should your relation consider a plan with prescription drugs coverage?

Read the memo <http://walmartwatch.com/memo> and identify the various strategies this employer considered to “improve” risk-selection of their insurees.

Lecture 5

topic: Supply I (physicians)

prerequisites: perfectly competition, monopoly, monopsony; average and marginal product and costs (Suggested optional reading: P&R, sections 10.1 to 10.6 (market structure), 14.1 to 14.4 (agency relationships) and 15.2 (discounting). Older texts may not cover agency relationships.).

objectives: 1) the student should understand how market structures, especially monopolies (e.g., unions) and monopsonies (e.g., sole employer), affect wages and employment;
2) the student should understand how professional firms differ from other firms, particularly the professional-agent relationship;
3) the student should understand why supplier-induced demand is thought to exist, and why it cannot be empirically verified.

readings:

Phelps (2003), chap. 7
- focus on the discussion of induced demand (p 237-48)

questions:

1. Would you expect fees to be higher or lower, *ceteris paribus*, in a single payor system or a multi-payor system where several insurance companies each negotiate a separate fee schedule? If we are able to force physicians to accept a lower fee schedule, would we reduce health care costs?

web exercise:

1. Compare the two positions presented in the following articles:

Milgate, K., Hackbarth, G. (2005). Quality in Medicare: from measurement to payment and provider to patient. **Health Care Financing Review**, 27(2), 91-101. (available through Online Resources A-Z: <http://www.medlib.iupui.edu/>)

Weber, D.O. (2005). The dark side of P4P. **The Physician Executive**, 31(6), 20-25. (available through Online Resources A-Z: <http://www.medlib.iupui.edu/>)

Lecture 6

topic: Supply (II): hospitals

prerequisites: economies of scale, economies of scope

(Suggested optional reading: P&R, sections 7.1, 7.2, and 7.7 (cost curves and average and marginal cost concepts).

objectives: 1) the student should be able to identify different hospital types according to their objective functions and their implications for the impact of reimbursement and regulation changes (particularly in controlling costs);
2) the student should be able to identify how to influence a non-profit hospital's behaviour by manipulation of financial and other constraints facing the hospital;
3) the student should be able to interpret hospital cost functions for policy purposes and identify problems with their estimation.

readings:

Phelps (2003), chap. 8

- focus on the discussion of hospital objectives and/or preferences (p 256-66) since these are the basis of the indifference curves used in the model in class;
- use the material on p 267-75 as background for the class discussion of cost curves

Phelps (2003), chap. 9

- focus on p 288-301 (which is the model of hospital behaviour used in class), but also consider the interactions between health care players discussed at the beginning of the chapter (these are the focus of lecture 7)
- feel free to ignore the appendix

Optional reading: Ginsburg, P.B., and Grossman, J.M. (2005). When the price isn't right: how inadvertent payment incentives drive medical care. **Health Affairs – web exclusive**, 9 August 2005. (getting this article through IUPUI is a bit tricky, but can be done: Find "Health Affairs" through Online Resources A-Z: <http://www.medlib.iupui.edu/>, choose "HighWire Press" and search under the authors' names at the Health Affairs website; or you can just make a copy from the copy in BS4032T).

- a thoughtful commentary on the problems of setting prices to reflect costs

questions:

1. If the hospital cost equation is given by

$$\text{Total cost} = 50,000 + 500 \text{ beds} + 5 \text{ beds}^2$$

what is the average cost of a hospital that has 25 beds? 50 beds? Which hospital is more efficient? Why? Graph the average cost curve. What bed size is optimal?

web exercise:

Read the issue brief by Berenson et al., "Do Specialty Hospitals Promote Price Competition?" (available from the Center for Studying Health System Change, <http://www.hschange.com/CONTENT/816/>). Explain how specialty hospitals may affect the general hospital sector.

Lecture 7

topic: Integration (I): vertical integration and system dynamics

prerequisites: review lectures 5 and 6

objectives: 1) students should understand the health care sector is made up of for-profit and not-for-profit firms and how they respond differently to policy stimuli;
2) students should understand the multilateral nature of health care transactions creates incentive problems because of imperfect integration;
3) students should know various proposals for solving such problems by adopting "integrated" structures (e.g. HMO's, IPA's);
4) the student should understand how technology can aggravate these problems.

readings:

Phelps (2003) chap. 2

- consider the various possible interactions among health care players (p 28-39)
- focus on the shocks to the system that can drive costs upwards (p 39-58)

Phelps (2003) chap. 11

- focus especially on payment mechanisms and relative performance (p. 376-80)

Ginsburg, P.B. (2005). Competition in health care: its evolution over the past decade. **Health Affairs**, 24(6): 1512-1522. (available through Online Resources A-Z (HighWire Press: <http://www.medlib.iupui.edu/>)

- an interesting article that suggests efforts to improve the efficiency of FFS/indemnity insurance health care market through managed care may have backfired.

questions:

1. Prospective payment systems (e.g., capitation in PPO's) are, according to our model of individual supplier behaviour, supposed to increase incentives to treat more people relative to fee-for-service. Does it follow that if the health care system as a whole moved to capitation (like Indiana's mental health care system) that more people receive care?

2. Identify 2 ways in which the doctor-hospital relationship increases overall health care costs.

Lecture 8

topic: Integration (II): regulation versus competition

objectives: 1) the student should now be able to assess the impact of market failures and inherent characteristics of health care (discussed in Lecture 2) in this system;
2) the student should be able to discuss the effects and relative merits of government interventions, including regulation, reimbursement, and competition strategies;
3) the student should be able to discuss the ethical as well as the efficiency effects of these interventions.

readings:

Phelps (2003), chap. 15

- pages 498-521 give you an idea of the types of regulations that have been applied to different players in the system and their effectiveness (try to identify factors about the players and the regulations that contribute to success)
- pages 521-43 provide additional material on the drugs and devices market discussed last week

questions:

1. Which inherent characteristic creates the need for protection of consumers from providers? Which other inherent characteristic necessitates this protection be in the form of licensure rather than, say, warranties?
2. Which inherent characteristics are exacerbated by technology development?
3. What is required for regulation to be more effective than competition for changing behaviour? Do you think Clarian Hospital's behaviour can be changed more easily through regulation or competition?

web exercise:

Read "Judge Strikes Down Morgan County Ordinance on Health Care Facilities" (available at <http://www.insideindianabusiness.com/newsitem.asp?id=15744>).

Lecture 10

topic: Cost-Benefit Analysis I - Costs

prerequisites: review lectures 1, 2, and 3

objectives: 1) the student should be able to identify the four basic types of economic evaluation and the differences in the information they provide;
2) the student should be able to distinguish between marginal and average costs, and between opportunity costs and charges;
3) the student should be able to identify shared inputs and durable inputs and identify how they should be handled in the costing exercise.

readings:

Phelps does not include much material on economic evaluation, so the next two lectures will draw on two, freely available, Internet sources. Together, they amount to 135 pages of information. I have provided an additional optional reading that you may download if interested.

Guidelines for the Economic Evaluation of Health Technologies: Canada, 3rd ed. Ottawa: CADTH, 2006. (visit <http://www.cadth.ca/>, select English, and enter “Guidelines for the economic evaluation of health technologies” in the search box in the upper right corner.)

- focus on sub-sections 1-5, 7, 10 and 11 this week

Optional reading: Baladi J-F. **A Guidance Document for the Cost Process. Version 1.0** Ottawa: Canadian Coordinating Office for Health Technology Assessment (CCOHTA); 1996

Can also be obtained from the CADTH website.

Zöllner, H., Stoddart, G., Smith, C.S. (2003). Useful economic tools. In **Learning to Live with Health Economics**. Copenhagen: WHO, 2003.

- focus on section 5.2 this week

questions:

1. Define two types of efficiency about which economists are concerned.
2. Identify 4 types of economic evaluation. Which indicate projects that are allocatively efficient?
3. Name two types of inputs that require special handling when finding the cost of an intervention.
4. When does cost minimization analysis identify technically efficient treatments?

web exercise:

Pick a medical procedure you or a family member has undergone in a hospital. Visit AHRQ’s HCUPnet website (<http://www.ahrq.gov/data/hcup>) and find the average charge of this procedure. Would you say this is a good estimate of the economic cost of this procedure? Why or why not?

Pending web exercise:

For next week: find your SF-36 scores using the on-line survey (use the demo facility at <http://www.sf-36.org/demos/SF-36.html>). Were you unsure how to score yourself on any particular category? What impact did this have on your overall score?

Lecture 11

topic: Cost-Benefit Analysis II - Benefits

prerequisites: review lectures 1, 2, and 3

objectives: 1) the student should be able to distinguish between outcome and process measures of benefit;
2) the student should be able to discuss how (a) clinical units, (b) health status indices, and (c) health state utilities are used in economic evaluation;
3) the student should recognize ethical implications of decision statistics used to evaluate projects

readings:

Guidelines for the Economic Evaluation of Health Technologies: Canada

- focus on sub-sections 6, 8, 9, 12-15 this week

Zöllner, H., Stoddart, G., Smith, C.S. (2003). Useful economic tools. In **Learning to Live with Health Economics**. Copenhagen: WHO, 2003.

- focus on sections 5.1 and 5.3 this week

Malek, M. (2000). **Implementing QALYs?** Hayward Medical Communications. (available at <http://www.jr2.ox.ac.uk/bandolier/painres/download/whatis/whatis.html> - choose “implementing QALYs”)

- focus on how QALYs are used in economic decision making

For your critiques, refer to:

National Information Center on Health Services Research and Health Care Technology,
Drummond’s Check-list for Assessing Economic Evaluations (available at http://www.nlm.nih.gov/nichsr/edu/healthecon/drummond_list.html)

questions:

1. Show that the present value of a payment of \$50 today and \$50 next year is the same as \$97.62 paid today (use a 5% discount rate).
2. Which condition do you think is worse: being blind or being in a wheelchair? How many years of life (assume you'll live to be 75) would you give up to be cured of blindness? Paraplegia?

Lecture 12

topic: System evaluation (I): international comparisons of performance

prerequisites: review lectures 4 and 8

objectives: 1) the student should be familiar with delivery systems in other countries;
2) the student should be familiar with the cultural and institutional forces that drove the evolution of these systems (in particular, the objectives and cultural, political and economic constraints which policy makers faced);
3) the student should be familiar with the relative performance of these systems and the problems in measuring such performance.

readings:

Phelps (2003), chap. 16

- review the material regarding difficulties in making cross country comparisons (particularly Box 16.4) and the discussion of changes over time (p. 578-83).

Anderson, G. and P. Hussey (2001). Comparing health care system performance in OECD countries. **Health Affairs**, 20(3), 219-232.

(available through Online Resources (HighWire Press): <http://www.medlib.iupui.edu/>)

- check how the countries discussed in class compare in terms of spending on health care and health outcomes
- consider how performance has changed over time

Reinhardt, U., Hussey, P., and G. Anderson (2004). U.S. health care spending in an international context. **Health Affairs**, 23(3), 10-25.

(available through Online Resources: <http://www.medlib.iupui.edu/>)

- consider the factors that explain differences in prices

Optional reading. Anderson, G.F., Frogner, B.K., Johns, R.A., Reinhardt, U.E. (2006). Health care spending and use of information technology in OECD countries. **Health Affairs**, 25(3), 819-831.

(available through Online Resources: <http://www.medlib.iupui.edu/>)

- for those who hope IT can save the US health care system

questions:

1. What are the factors that influence whether a nation has public/universal health insurance?
2. What cost containment strategies have proven effective in Germany, the United Kingdom and Canada?

web exercise:

Strictly optional: If interested, the OECD provides information on the methods and definitions used to collect/construct the data on which the above papers are based

(<http://www.irdes.fr/ecosante/OCDE/13.html>).

Lecture 13

topic: Case studies

objectives:

- 1) to familiarize the student with actual evaluations;
- 2) to reinforce how this information is used in health policy.

readings:

1. You will be assigned to one of four or five groups (depending on class size). Each group will be given a published economic evaluation to critique. The final product should be a two page written document (point form is fine). Copies of this document should be made available to other members of the class by November 13th (so that they may read it prior to your presentations on the 15th). You may find it helpful to refer to Drummond checklist. You will be evaluated on the thoroughness of your critique.
2. Each group will also be given readings on some aspect of economic analysis that is relevant to the article. Each group will be asked to give a short "mini-lesson" on this topic during the November 15th lecture. Review the materials provided and devise a strategy for effectively presenting your topic to the rest of the class. You will be evaluated on the effectiveness of your instruction, including your ability to incorporate examples from your critiqued articles to make the subject matter more salient.

Lecture 14

topic: System evaluation (II): the United States

objectives: 1) the student should be aware of the performance of the United States' system in terms of costs, outcomes, and distribution relative to that of other countries;
2) the student should be aware of the objectives and constraints which explain the evolution of the U.S. health care system;
3) the student should be familiar with the various reform proposals at the federal level.

readings:

Davis, K. (2004). Consumer-directed health care: Will it improve health system performance? **Health Services Research**, 39(4, Part II), 1219-1233
(available through Ovid database: <http://www.medlib.iupui.edu/>)
- Focus on the material from p. 1224 onwards

Arnst, C. The best medical care is the US. **Business Week**, June 29, 2006.
(http://www.businessweek.com/magazine/content/06_29/b3993061.htm?chan=search)

Symonds, W.C. (2006). In Massachusetts, care for all? **Business Week**, April 4, 2006.
(http://www.businessweek.com/investor/content/apr2006/pi20060404_152510.htm)

questions:

1. The U.S. reform movement to universal coverage has failed. Is this because (a) society doesn't want reform, or (b) we can't get the reform we want?
2. Explain why managed care might be cheaper than a standard fee-for-service indemnity plan? Discuss using the model from Lecture 8.

web exercise:

Review the following Kaiser Family Foundation Fact Sheets:
Medicare (<http://www.kff.org/medicare/upload/1066-09.pdf>)
Medicaid (<http://www.kff.org/medicaid/upload/7235.pdf>), and
Uninsured (<http://www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-Fact-Sheet-6.pdf>).
The Massachusetts Reform Plan (<http://www.kff.org/uninsured/upload/7494.pdf>)
Medicare Prescription Drug Benefit (<http://www.kff.org/medicare/upload/7044-04.pdf>)

Lecture 15

topic: review