

6-3-2020

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### Recommended Citation

DeGenova, E. (2020). Healthcare: Public or Private. *D.U.Quark*, 4 (2). Retrieved from <https://dsc.duq.edu/duquark/vol4/iss2/6>

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# Healthcare: Public or Private

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*D.U. Quark* Year. Volume 4(Issue 2) pgs. 38-49

Published June 3, 2020

Staff Article

The status of the United States health care market has been the source of one of the longest ongoing battles amongst the American people. Today, Americans are at odds, and little gray area exists within the arguments. Some people hold signs in the streets reading "Medicare for All", while others condemn the Affordable Care Act entirely. A popular debate focuses on whether "health care is a human right"; however, on each side of the argument, the beliefs are rooted far too deeply in culture, religion, politics, etc. Therefore, in order to analyze this topic apolitically, one must consider the cost/financing, quality, access, tax structures, and investments associated with new procedures/technological advancements in both socialized and free market health care systems. This will help decide which health care system is best for the United States.

## **Cost and Financing of Care:**

In a free market healthcare system, patients battle two types of uncertainties: (1) the amount of health care they will need, and (2) receiving the best quality of healthcare for its price. This leads consumers to fear the unknown and purchase insurance to cover the cost of health care they may need in the future. Due to this cost shielding (i.e. insurance covering costs), another problem arises known as "moral hazard". Moral hazard is a term used to describe two events resulting in excessive healthcare: (1) patients usually opt to receive more

care than they normally would if they had to pay for it out-of-pocket, and (2) health care consumers are more likely to engage in risky activities because their healthcare costs are covered by insurance. Therefore, health insurance companies devised three ways to incentivize patients to demand less care: (1) sharing the cost of insurance (i.e. co-payments, deductibles, coinsurance), (2) altering tax incentives related to the purchase of insurance (i.e. Health Savings Accounts), and (3) increasing the incentives for the insured to prevent illness (i.e. Value-based insurance design) by making preventative cost-sharing cheaper than the latter (i.e. following the recommended, preventative, vaccine timelines, versus paying the full-costs of treating the contracted virus) [6].

However, this creates a problem where private insurers have incentives to deny coverage to individuals whose costs are likely to exceed their premium payments and only provide coverage to the lowest-risk patients, known as “cream-skimming.” Thus, insurers charge extremely high prices to higher-risk patients, leaving the group most in need of health care services uninsured [6]. Federal and state governments often step in to help insure high-risk patients that cannot afford care, providing insurance for the elderly, chronically ill, poor, and disabled [6]. By doing so, it is obvious neither public nor private healthcare systems can operate without each other. As private insurance cares for and assumes the risk for patients that can afford it, public insurance cares for the patients that cannot.

The year 1965 marks a major turning point in U.S. health care. Up to this point, middle class working Americans were the only insured group, as private health insurance was the only widely available source of payment for health care. This led the elderly, unemployed, and poor to rely on their own resources (i.e. limited public programs, or charity from hospitals) [5].

Today, the six major government healthcare programs—(1) Medicare, (2) Medicaid, (3) State Children’s Health Insurance program, (4) Department of Defense TRICARE, (5) Veterans Health Administration program, and (6) Indian Health Service program—provide health care services to about one-third of Americans. The federal government has a responsibility to ensure that more than \$500 billion of annual investments into these programs are used wisely to reduce illness, injury, and disability and improve the health of the population. Almost all health care services are delivered through private health care providers, managed care plan arrangements, and community health centers and, to a lesser degree, state, county, or other publicly owned facilities or programs [7]. Therefore, as public health care relies extensively on private health care providers by negotiating contracts for care with them, it is easy to see how these systems work together to provide care to all Americans alike.

When looking at the length of stay (LOS) and cost of hospital stays in 2016 per primary payer, it is easy to understand why one healthcare system cannot exist without the other.

### Cost of hospital stays, 2016

<b>Expected primary payer</b>	<b>Hospital stays</b>	<b>Percent</b>	<b>Mean length of stay</b>	<b>Mean cost per stay</b>	<b>Aggregate cost, millions</b>
Medicare	14,100	39.5%	5.3 days	\$13,600	\$192,784
Medicaid	8,200	23%	4.6 days	\$9,800	\$81,153
Private insurance	10,700	30%	3.9 days	\$10,900	\$115,852
Uninsured	1,500	4.2%	4.1 days	\$9,300	\$13,781
Other	1,100	3.1%	4.6 days	\$12,600	\$13,354

Table 1: Presents statistics on LOS and cost for hospital inpatient stays in 2016 [2].

According to Table 1, patients covered by Medicare have the longest mean length of stay (5.3 days vs. 3.9-4.6 days for other payers) and the highest mean cost per stay (\$13,600 vs. \$9,300-\$12,600 for other payers) [2]. It would be nearly impossible for the government to assume the cost of all other types of primary payers due to its limited budget. Therefore, both public and private health care systems can work together to improve cost sharing and increase healthcare coverage for all.

**Quality of Care:**

As mentioned above, the second uncertainty facing patients is “receiving the best quality of healthcare for its price.” One of the main differences between the quality of care in public and private hospitals can be analyzed through length of stay (LOS). For example, according to the Center for Disease Control, in 2014 the average length of stay varied drastically between hospitals.

Average Length of Stay - 2014

<b><u>Public/Government</u></b>	<b><u>LOS (days)</u></b>	<b><u>Private/Free-Market</u></b>	<b><u>LOS (days)</u></b>
Federal	10.3	Non-federal	6
State-local government	6.4	Community	5.5
		For-profit	5.5
		Non-profit	5.3
Average LOS	8.35	Average LOS	5.575

Table 2: Presents data of average LOS in 2014 [3].

In 2014 the average length of stay in a public/government hospital was 8.35 days, while private/free-market hospital was 5.575 days [3]. This significant difference may be due to available staff and the size of the health care facility. Private hospitals tend to be smaller in size;

therefore, patients have more personalized care, increasing quality of care, and decreasing LOS. This decrease in LOS means beds become available faster, which decreases wait time for other patients needing care; this leads to an increase in the quality of care. Private hospitals are also given incentives to be efficient, while public are not, resulting in a shorter LOS for private patients.

Conversely, public hospitals have many beds, minimal staff due to budget constraints, and care for all patients regardless of insurance. The goal of a public hospital is to care for every patient with the same quality, because there are no financial incentives to do otherwise. However, due to the ratio between patients and healthcare staff members, care is less personalized and has a higher wait time and LOS per visit. However, due to the availability of private hospitals, the risk of public hospitals becoming overcrowded is prevented. This increases the quality of public care. Again, public and private health care systems can work together to improve quality of care for all.

### **Access to Care:**

Consumers from all over the world travel to America to receive care due to the vast access provided by private healthcare. According to the American Hospital Association, in the year 2018 there were 6,210 hospitals alone – which doesn't even take out-patient or long-term care facilities into consideration.

Number of Hospitals in the U.S., 2018

<b>Total Number of All U.S. Hospitals</b>	<b>6,210</b>
Number of U.S. Community Hospitals	5,262
Number of Nongovernment Not-for-Profit Community Hospitals	2,968
Number of Investor-Owned (For-Profit) Community Hospitals	1,322
Number of State and Local Government Community Hospitals	972
Number of Federal Government Hospitals	208
Number of Nonfederal Psychiatric Hospitals	620
Other 2 Hospitals	120

Table 3: Presents data on the number of Hospitals by type [1].

Looking at Table 3, private hospitals largely outnumber public hospitals [1]. As mentioned earlier, “about one-third of the population receives its health care through government programs with access to both public and private facilities” [7]. Therefore, the remaining two-thirds of the population attend private healthcare facilities. The benefit of this system is simple in the sense that all parties can receive care without having to wait on services like other entirely socialized healthcare systems around the world. Public and private health care systems can work together to improve access to care for all.

## Tax Structures:

Tax structures must be considered between socialized and free-market healthcare. With an increasing elderly population, demand for health care is rising faster than economic growth can accommodate, because there are fewer people in the workforce. Increasing the role of private health care providers can help to close this gap by giving access to needed care, reducing the burden on government spending, and enabling lower tax rates [4]. An aversion to increased taxes for social programs is another reason already-insured middle class Americans have opposed expansion of health insurance coverage. While Americans may support the idea that the government ought to help people who are in financial need pay for their medical care, most Americans do not favor an increase in their own taxes to pay for such care [5]. Therefore, it is difficult for government programs to receive funding through simply increasing taxes on the American people. Thus, the government offers tax exclusion to incentivize a growth in the economy and community outreach instead.

The purchase of health insurance through an employer is tax free; therefore, a dollar in health benefits is more valuable to employees than a dollar in wages. This structure gives employees the incentive to demand more compensation in the form of benefits relative to wages, along with encouraging employers to provide better compensation [6]. As a result, more American people are insured through their employer, lessening the number of people on government programs and incentivizing the American people to work to receive better healthcare. This benefits the economy, which increases tax dollars that eventually funnel down into the budget of government healthcare programs. Therefore, by considering this chain

effect, it is easy to see how public and private healthcare use the tax structure to work together and serve the American people.

Another example of tax exclusion provided by the government is in the case of Not for Profit (NFP) companies. The main characteristic of an NFP company is in the name, meaning the company does not make an annual profit. Instead, the company operates exclusively for public, not private, interests; if liquidation occurs, those assets are relocated back into the company or its stakeholders (i.e. the community/charity). Due to this status, the government gives NFP companies large tax breaks, because they spend much of their profits helping the community. The tax code defines NFP companies as organizations operating exclusively for religious, charitable, scientific, public safety, literary or educational purposes. In healthcare, NFP companies provide some portion of free health care that the government would usually have to pick up. In this example, the use of tax exclusions is used to incentivize public and private health care systems to work together and share costs.

### **Investment in New Procedures/Technological Advancements:**

The biggest differences between private and public health care systems are funding and competition. Private hospitals are funded by investors and are not limited to a public budget provided by taxes; thus, private hospitals can afford expensive treatments, research, and technology, making patient visits more effective and efficient, reducing LOS, and increasing patient satisfaction. The lack of funding and competition in government health care systems produces a lack of innovation in health care procedures and technology. When comparing this

fact to other countries with innovative public healthcare systems, it is a difficult comparison due to the differences in available funding between the countries.

Although the health care market is more complex than any other business market, it still withholds the fundamentals of competition. However, because patients pay for care with insurance dollars, rather than out-of-pocket dollars, health care providers cannot attract customers by lowering treatment prices. As a result, providers must compete with other signals of quality they believe will be attractive to patients [6]. Therefore, private healthcare systems invest much of their resources into innovation of new procedures and technology advancements.

Due to the lack of finances, there are limited equipment and specialized treatment options available for public health care systems. However, as mentioned earlier, “almost all government health care services are delivered through private health care providers, managed care plan arrangements, and community health centers to deliver services and, to a lesser degree, state, county, or other publicly owned facilities or programs” [7]. Therefore, the advancements made by private healthcare systems are still available to patients insured by government programs. This is another example of how public and private health care systems work together to insure the health of the American people through investments in new health care procedures and technology advancements.

## **Conclusion:**

Healthcare as a human right has been debated for years. America stands divided between reform and repeal, based on strong opinions rooted in culture, religion, politics, and so on. Only after analyzing this topic apolitically through consideration of the cost/financing of care, quality of care, access to care, tax structures, and investments in new procedures/technological advancements in both socialized and free market health care systems can one decide which health care system is best for the United States. This research supports the conclusion that public and private health care systems work together to provide efficient and effective health care to all U.S. Citizens.

The American Free-Market, or private, healthcare system provides innovation in new procedures through research and technological advancements like no other country. As a result, America has leading quality and access to healthcare, not only through the sheer number of hospitals available, but also through personalized treatment for each patient. The American Socialized/Government, or public, health care system negotiates contracts with, and may provide tax exclusions for, private systems to increase access to care for the remaining one third of the government-insured population. By working together, public and private health care systems can provide access to cost efficient and quality healthcare to all U.S. Citizens.

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DeGenova, E. (2020). Healthcare: Public or Private. *D.U.Quark*, Volume 4(Issue 2).

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