# Chapter 7

## 병원 및 병원산업

# A. 급성기질환 병원: 특징

Most hospitals in the United States are:

- Private, community based
- Non-profit
- Often either local monopolies or oligopolies (duopolies)
- 한국의 경우는**?**

What is the legal difference between a for-profit and non-profit firm?
(의료기관 영리법인화 혹은 투자개방형 병원 도입의 문제?)

- Can non-profits make profits (surpluses)?
- Are surpluses (profits) distributed to owners?
- Non-profits may be legally required to provide pro bono care

# B. 병원관리의 모형

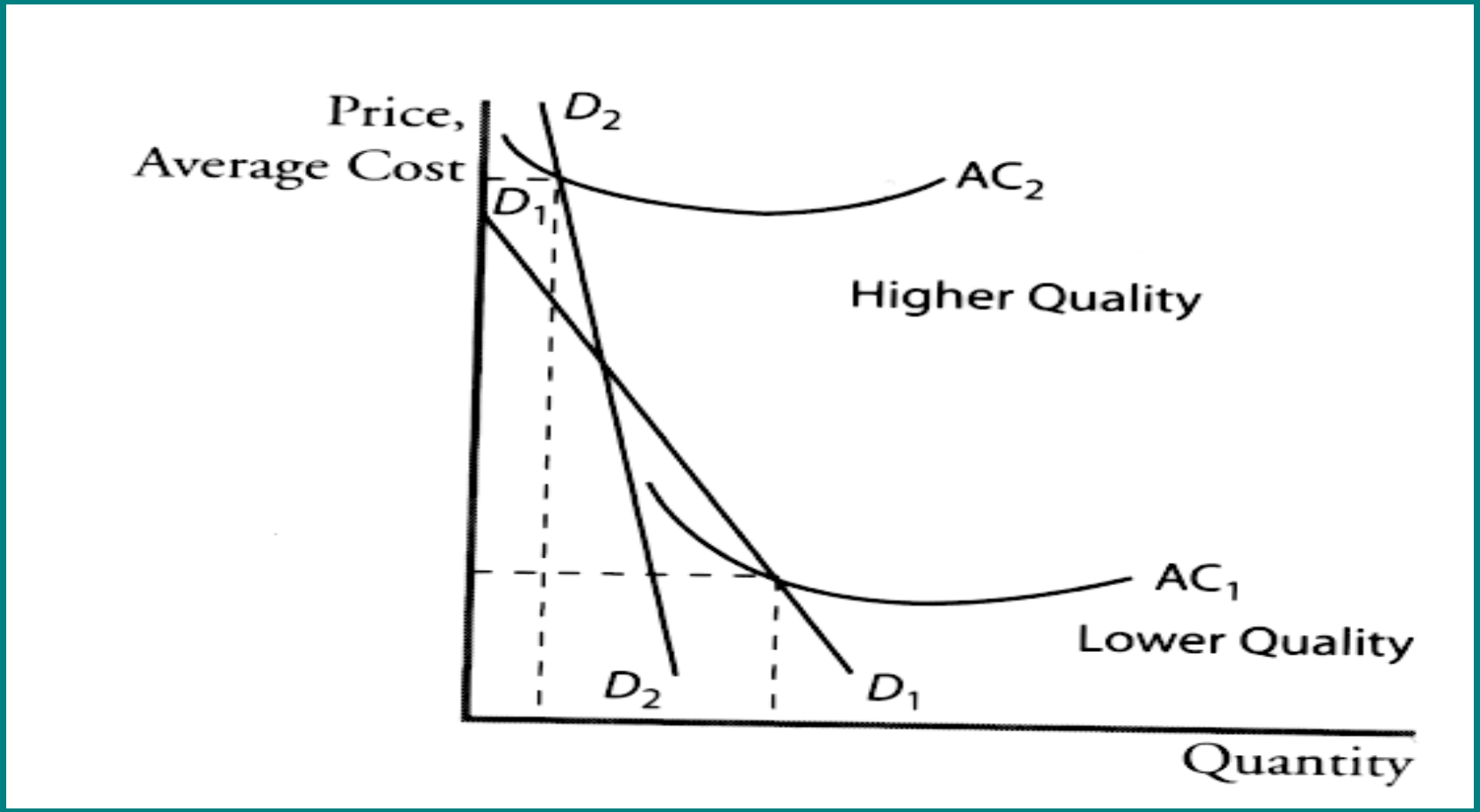
1. Utility maximization on the part of hospital managers. (Newhouse)

2. Utility maximization of the physicians associated with the hospital. (Pauly and Redisch)

3. A tug of war between physicians and management for control. (Harris)

# B(1). 병원관리자의 효용극대화

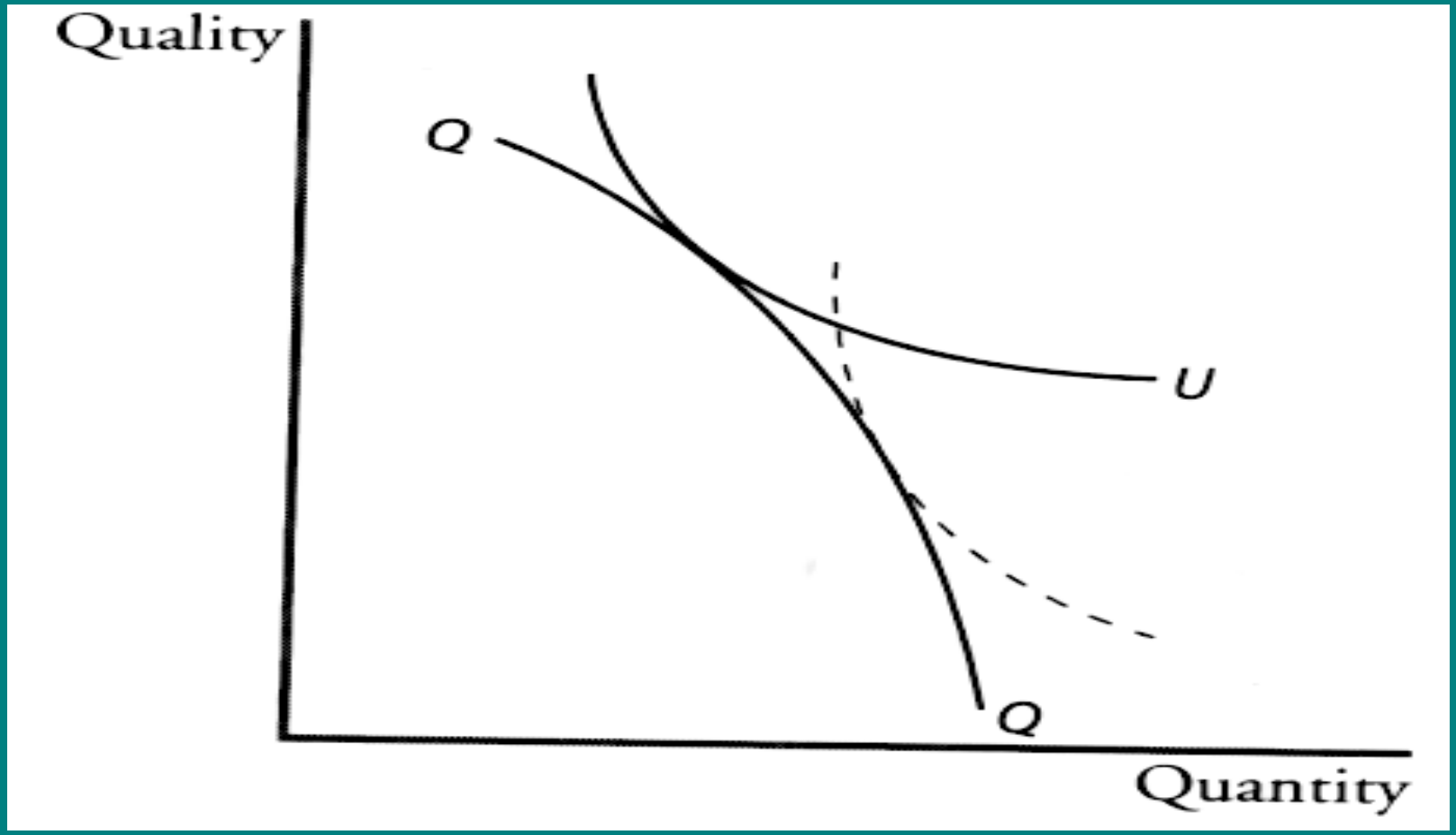
Cost and Demand Curves for Two Quality Service Levels



# B(1). 병원관리자의 효용극대화

## A Quality/Quantity Frontier

Managers of non-profit hospitals are likely to opt for higher quality.



# B(2). 의사의 효용극대화

(a) Physicians can only determine the number of affiliated physicians. **Then they will choose the quantity of physicians that will maximize net revenue per physician.**

(b) **Physicians can modify other inputs as well.** They will choose a production function that maximizes average physician earnings:

- If non-physician hospital costs to patients are 0, they will want the highest possible level of complementary inputs.
- If patients also pay a hospital bill, physicians will want to economize on the amount of complementary inputs.

# B(3). 의사와 병원관리자간의 경쟁

Consider this model a kind of **bilateral monopoly (쌍방독점) model.**

Think of the physicians as the “buyers” of the hospital services and the managers as the “suppliers” of services.

The balance of power may lead to both efficiency and quality control.  (Jeffrey Harris)

# C. 병원시장내의 경쟁모형

**1.** 비가격경쟁**(Non-price competition)**

Since most hospitals operate in imperfectly competitive markets (oligopolies or local monopolies), and are also non-profit in structure, they tend to compete on the basis of quality, not price of services.

The "Medical Arms Race": Historically, this model has been a plausible explanation when competition has been over quality and not price.

- It can be viewed as a response to imperfect information in a market that is a non-collusive oligopoly (다음의 표).

# C. 병원시장내의 경쟁모형

## The Medical Arms Race Game Theory Problem

| | | B 병원 | |
|---|---|---|---|
| | | 새 MRI 도입 | 도입보류 |
| A 병원 | 새 MRI 도입 | - $2,500,000<br>- $2,500,000 | - $5,000,000<br>+ $2,500,000 |
| | 도입보류 | + $2,500,000<br>-$5,000,000 | 0<br>0 |

# C. 병원시장내의 경쟁모형

**2.** 가격경쟁**?**

Today, since third-party payers, both governmental and private, have the power to negotiate prices for services, there now appears to exist a certain level of price competition. This has been true at least since the mid-1990s when managed care became so predominant in markets throughout the United States. However, prices paid for services administered to Medicare patients are set by the DRG system.

# D. Provision of Charity Care by Hospitals

What determines the quantity of charity services a hospital provides?

Some hospitals may be required by law to provide a certain amount of charity care, but most have a good amount of discretion with respect to the amount of charity care they provide.

The motives for the provision of discretionary charity care may vary.

# D. Provision of Charity Care by Hospitals

Frank and Salkever have developed a model of hospital altruism. The model differentiates between pure and impure altruism on the part of hospitals.

Pure altruism involves providing care on the basis of community need.

Impure charity: charity care is provided for the purpose of public relations.

How can we differentiate between the two types of charity? [Hint: How would a hospital respond to another hospital in the same region increasing the quantity of charity care it provides?]