Reconsidering the Role of Competition in Health Care Markets: Introduction

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In recent years there has been a surge of interest in reforming the organization and delivery of health systems by relying more on market competition. Although much of the impetus has emanated from the United States, the phenomenon is worldwide (Brown 1998). Recognizing the significance of these trends, in May 1998 we organized an international conference in Berlin on “Reconsidering the Role of Competition in Health Care Markets.” The two-day meeting was jointly sponsored by the UCLA Center for Health Policy Research, the Karolinska Institutet in Sweden, and the Wissenschaftszentrum Berlin für Sozialforschung (WZB; in English, the Berlin Science Center for Social Research). The conference, which was hosted by the WZB, included thirty-one individuals from ten countries. This special section presents a summary of the main issues on which the meeting focused, followed by ten brief reports on the interplay of markets and government in specific developed countries. It concludes with a short analysis of the implications of the forgoing material on health care policy internationally and two commentaries that bring additional perspective to these issues.

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The WZB room in which the meeting was held had special significance for the conference. It was originally built as the administrative courtroom for the world’s first social insurance system, under Chancellor Otto von Bismarck. Although damaged in World War II, the meeting room has since been reconstructed. Preserved from the original structure and overseeing the room are four sculpted heads, one on each side: one of a boy, another of a young man, another of a full-grown man, and the fourth, an old man. It was hoped that the rulings made in the venue would reflect the intergenerational social solidarity on which the German social insurance system was founded.

Social insurance systems worldwide are now under stress. The purpose of the conference was to stimulate dialogue and debate among scholars from developed countries about the appropriate mix of government and markets in health care systems. Participants came from universities, research institutes, foundations, government, and the private sector from three continents and represented such fields as economics, sociology, political science, public health, medicine, business, and journalism (see participant list in Table 1). The countries represented a mix of those moving toward more competitive systems and those that continue to rely more on government organization and financing.

Table 1  Conference Participant(s)

<table>
<thead>
<tr>
<th>Country</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>Robert G. Evans</td>
</tr>
<tr>
<td>France</td>
<td>Jean-Pierre Poullier, Simone Sandier</td>
</tr>
<tr>
<td>Germany</td>
<td>Heiner Ganssmann, Hagen Kuehn, Martin Pfaff, Hartmut Reiners, Rolf Rosenbrock</td>
</tr>
<tr>
<td>Ireland</td>
<td>Miriam M. Wiley</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Eddy van Doorslaer</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Todd Kriebel</td>
</tr>
<tr>
<td>Sweden</td>
<td>Finn Diderichsen, Roland Grandqvist</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Peter Zweifel</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Alan Maynard, Clive Smee, Alan Williams</td>
</tr>
<tr>
<td>United States</td>
<td>Abdelmonen A. Afifi, Gerard Anderson, Brian Biles, E. Richard Brown, Judith Feder, Stefan Gildemeister, John Iglehart, Gerald Kominski, Harold Luft, James A. Morone, Thomas Rice, Diane Rowland, Bruce Siegel, Deborah A. Stone</td>
</tr>
</tbody>
</table>
Table 2  Assumptions of a Competitive Marketplace

<table>
<thead>
<tr>
<th>Market competition</th>
<th>Demand theory</th>
<th>Supply theory</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no negative externalities of consumption.</td>
<td>A person is the best judge of his or her own welfare.</td>
<td>Supply and demand are independently determined.</td>
<td>The distribution of wealth is approved of by society.</td>
</tr>
<tr>
<td>There are no positive externalities of consumption.</td>
<td>Consumers have sufficient information to make good choices.</td>
<td>Firms do not have any monopoly power.</td>
<td></td>
</tr>
<tr>
<td>Consumer tastes are predetermined.</td>
<td>Consumers know, with certainty, the results of their consumption decisions.</td>
<td>Firms maximize profits.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individuals are rational.</td>
<td>There are not increasing returns to scale.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individuals reveal their preferences through their actions.</td>
<td>Production is independent of the distribution of wealth.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social welfare is based solely on individual utilities, which in turn are based solely on the goods and services consumed.</td>
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Context

Background material for the conference was the recently published book *The Economics of Health Reconsidered* by Thomas Rice (1998). The book questions the belief that economic theory demonstrates that market competition provides a preferred set of policies in health care. It examines four key aspects of economic theory: competition, demand, supply, and redistribution. In each of these areas, it presents and analyzes the assumptions that need to be fulfilled in order for markets to necessarily produce the most desired set of social outcomes. These assumptions are listed in Table 2.

The book critiques each of these assumptions and provides a number of applications to health care policy. One of the main implications of Rice’s book is that there are a wide range of policy tools available to improve social welfare that are not suggested by traditional economic theory. In the conventional market model, there are actually very few levers available to health care policy makers. Because the model is driven by consumer demand, the primary tools involve influencing
demand, either by changing out-of-pocket price or by providing additional information to consumers. There is no place to influence supply because it is presumed that suppliers will simply produce those things that are demanded.

What we actually see in health policy throughout the world, however, is the reliance instead on supply-side policies. These include using such policy tools as capitation, diagnosis-related groups (DRGs), utilization review, practice guidelines, technology and manpower controls, and global budgets — to name just a few. These policies are aimed primarily at influencing the behavior of the suppliers of care rather than the demanders. As a result, none of these policies directly arises out of the competitive model, nor, according to conventional economic theory, would any result in superior outcomes compared to purely demand-based policies. Nevertheless, many would argue that these policies have resulted in superior outcomes in the health care marketplace.

The book, however, does not take the next step and show where market forces will be most effective in health care, and where it is preferable to rely on government. Equally important, it does not explore the many ways in which markets and government can work together to bring about a preferred set of health policies. These were the types of issues that the conference was designed to address.

Care Issues in Health Care Policy

The conference focused primarily on three broad policy-relevant issues: (1) the relative advantages of markets versus government in bringing about efficiency in health care; (2) alternative ways of achieving equity in the distribution of health and health services; and (3) how markets and government can work together to achieve a more optimal health care system. Here we will not attempt to explore these issues in detail; rather, we will characterize some of the main themes about them that were discussed in Berlin.

Efficiency

On the topic of efficiency, it was generally agreed that the choice of government versus markets is a false dichotomy (Health Care Study Group 1994). In particular, participants pointed out that markets need government in order to function properly because of the strong incentive of providers to profit from the selection of healthier enrollees (for insurers)
and patients (for providers). In fact, when markets are relied upon, government must be especially dynamic, responding quickly to new and innovative ways that competitors devise to achieve favorable selection. Governments must also continually be aware of and ready to act on the consequence of greater reliance on market forces in the delivery of care that produces the erosion of cross-subsidies from wealthier and healthier members of society to the poor and sick.

Participants tended to agree that markets had a much stronger role—and potential to improve social welfare—in the delivery than in the financing of health care. Indeed, a study of European health care systems has shown that almost all such countries rely on ability to pay rather than use services in financing health care (Wagstaff and van Doorslaer 1992). The key issue, then, is the appropriate mix between markets and government in health care delivery, and most of the discussion focused on this topic. Many of the policy specialists at the conference pointed out that in most countries, including the United States, government involvement was originally predicated on a failure of markets to provide necessary health care coverage to the elderly and poor. Furthermore, although government is often considered cumbersome, it has achieved much success through such administered pricing systems as global budgets (Europe and Canada) and DRGs (United States).

Finally, everyone at the conference agreed that government offers no panacea, in part because of the workings of the political process. Just as markets tend to reward firms that seek to maximize profits more than patients’ health, government is also beholden to special interests, such as associations representing providers of care. Thus, while critics of policies that rely on market forces focus on the motives inherent in market competition, one must also consider the motives and actions of interest groups in a health care system governed primarily by political muscle.

Achieving Equity

The second main issue addressed was solidarity and the dangers that a market-reliant health care system poses through its focus on individuality. Most of the discussion, however, focused on equity, and in particular, on what one is trying to equalize and how one can best achieve the various definitions of equity. In considering these issues, one must distinguish between equality, a state in which everyone has the same amount of something, and equity, in which distributions may be uneven in order to achieve a fairer ultimate distribution (Stone 1996).
Participants noted that there are at least four things a society can equalize in order to improve social welfare with regard to health: (1) initial resources, (2) access to care, (3) use of service, and (4) health itself. Traditional economic theory tends to focus on the first of these attributes. Society can, if it wishes, equalize the distribution of incomes through taxation and subsidies, but then allow people subsequently to make their own purchasing decisions. Problems with this approach include the difficulty in actually achieving an equal distribution of initial resources, and even if it were accomplished, the likelihood that people might make choices that do not reflect their best interests.

Equalizing access to care has been advocated by others; LuAnn Aday, Ronald Andersen, and Gretchen V. Fleming (1980: 26) argue for this strategy, which “is said to exist when need, rather than structural or individual factors, determine[s] who gains entry to the health care system.” One shortcoming is that even when economic factors are eliminated through comprehensive insurance coverage, sociodemographic inequalities in the use of health services remain.

There has been much debate on the advantages of equalizing utilization of services as opposed to the equalization of health itself (Culyer 1989, 1993; Mooney et al. 1991). Much of the discussion at the meeting focused on Alan Williams’s (1997: 119) notion of the “fair innings,” which “reflects the feeling that everyone is entitled to some ‘normal’ span of health. . . . The implication is that anyone failing to achieve this has in some sense been cheated, whilst anyone getting more than this is ‘living on borrowed time.’” One implication is that more medical resources should be devoted to the young, who have not yet had their fair innings, with correspondingly less spent on the elderly. Although some participants were enthusiastic about this notion of equity, others expressed concerns, one of the main ones being that we know little about how to equalize the health status of different population subgroups in a cost-effective manner.

How Markets and Government Can Work Together

The third main topic of the conference focused on how markets and government can work together to achieve more optimal health care systems. Discussion during this session was quite free-ranging and perhaps more difficult to summarize than the others. In addition, several participants noted that terms such as “markets” and “competition” have very different connotations on different sides of the Atlantic, so it is necessary to be precise.
There was general (although not universal) agreement that the dichotomy between markets and government is a false one; both are needed and both need each other. Government often needs markets to help ensure that the services produced are the ones that are wanted, and that resources are not unnecessarily squandered. Markets need government to ensure that pricing is fair, that all segments of the population are served, and that objective information is disseminated. The key issue, then, is determining the blend of the two that should be utilized, and to do that, empirical evidence is fundamentally important. Participants felt that in spite of the policy discussions on the role of competition that have taken place for decades, information on the optimal mix of government and markets is still scarce, and researchers and policy makers should look at other countries as well as their own to find the appropriate knowledge base.

Comparing Health Care Systems

The core of this special section are ten short reports on eleven countries. We asked the authors to write a brief essay on the health systems in their country, focusing on three issues:

- the role of government in financing and delivering health services, including successes and problems;
- the introduction of markets into the financing and/or delivery of health services, and its successes and problems; and
- how the roles of markets and government may change over the next decade; policy options now being considered; and the perceived advantages and disadvantages of such changes.

The reports on the eleven countries provide a fascinating view of how different societies view competition and regulation and indicate some very different trends in health care policy. As Deborah A. Stone reports, nearly any way one measures market versus government involvement in health care, the United States has relied primarily on markets rather than government. More significantly, she points to a trend in which markets gaining greater significance, as more patients in publicly funded programs are funneled through private managed care organizations, and as both federal and state governments become increasingly shy about exerting their regulatory powers. In reading the reports on the eleven countries, it is clear that the United States relies more on markets than the other countries, but also that recent developments are resulting in an even stronger role for markets.
On the other end of the spectrum, some countries have not (yet) embraced markets to any meaningful extent. Miriam M. Wiley reports that Ireland is such an example. The Irish have been unusually successful over the past two decades in reducing the proportion of national income spent on health, but this has largely been the result of their country’s fast-growing economy rather than successful expenditure control. Although she states that “there are no indications currently that any form of market-based model is likely to emerge in the foreseeable future as the dominant framework,” inability to control future expenditure growth could create such pressures. Although the lack of historical reliance on markets is also true in Canada, Robert G. Evans points out that there are many forces that seek much greater reliance on markets—including provider groups, insurers, certain political figures, and some wealthier citizens who would prefer a system in which they do not cross-subsidize other population groups. Thus far, however, these appear to be threats to the current system that largely have not been actualized.

The area in which market involvement has been the highest in Canada is for services not covered by the provincial health plans, which, depending on province, may include dental care, prescription drugs, and noninpatient institutional care. Jean-Pierre Poullier and Simone Sandier report on a similar system in France, where “it is only in dental care, eyeglasses, and over-the-counter drugs that the market prevails.” France differs greatly from Canada and several other countries reported on here in the extent to which patient copayments are required, as well as in the availability of privately funded supplemental insurance that covers these expenses. The authors indicate, however, that there is no strong movement toward more market involvement, as “public opinion stands massively against devolution of responsibility to private insurance or reduction in coverage.”

Most of the other countries examined in this special section have experimented with increased market involvement in recent years, although in a few the pendulum has begun to swing back to a more government-oriented system. The country that has received the most attention in this regard is the United Kingdom, where the Thatcher government introduced “internal markets” to health care in 1991. As described by Clive Smee, this infusion of competition was generally among providers, not among the funders or health plans. Unfortunately, there are few good evaluations of these changes; what does seem clear, according to Smee, is that although some improvement in hospital productivity did occur, “there was no sustained improvement in public satisfaction, no sustained decline in waiting lists or waiting times, and no measurable improvement
in the clinical quality of care or in health outcomes.” But the resulting increase in administrative costs, and the increasing perception that the British medical system was becoming more “two-tiered,” led the current government to move away from this model.

Other countries considered following Britain’s lead. As reported by Todd A. Krieble, New Zealand was also on the verge of introducing internal markets in 1993, soon after Britain, with a system that would have been even more marketlike because “individuals were to be able to choose among competing health plans that would contract with competing providers.” This idea was quickly abandoned, and the system reverted to one where government retained its dominant role in financing and delivery. Sweden went further in following Britain’s lead, including splitting the roles of purchasers and providers, giving financial incentives to general practitioners through capitation payments, and introducing more patient copayments. However, as Finn Diderichsen notes, any resulting increase in efficiency was matched by a reduction in the equity of the system. Continued financial strains, however, make it too early to know which path Sweden will ultimately choose.

Outside of the United States, the countries that have perhaps gone the furthest in introducing markets and managed competition are Switzerland, the Netherlands, and Belgium. The Swiss reforms discussed by Peter Zweifel were enacted in 1996 and included both competition among sick funds that purchase coverage (which in turn has led to the development of both PPOs and HMOs), to help defray potentially high costs for those with low incomes, and a means-tested health insurance purchase. However, because uniform premiums are required for all adults, there is still an incentive to cream-skim, which can perhaps someday be ameliorated by more effective risk-adjustment of premiums. Although Zweifel notes other obstacles that need to be overcome for managed competition to be a strong success, he notes that “at the very last, there is a willingness to try out new solutions that had not been known for decades in Swiss health care.” There are some similarities between the Swiss experience and those in the Netherlands and Belgium. The Netherlands in particular has tried to embrace managed competition in a framework ensuring universal access while empowering sickness funds to selectively contract with providers, negotiate prices, and compete for enrollees. More recently, the funds are beginning to engage in various utilization management activities. Belgium has, since 1995, also given sick funds incentives for efficiency through risk-adjusted capitation payments, albeit for only a small portion of their total revenue. Eddy van Doorslaer and Frederik T.
Schut report that there are still a number of impediments facing both countries—both technical and political—in the quest to implement more effective reforms based on managed competition.

In some ways, the hardest of the countries to categorize is Germany, the setting of the conference. As Martin Pfaff and Dietmar Wassener indicate in the beginning of their essay, “the principle of solidarity rather than competition is considered the basic constituent element of Germany’s health care system, but competition de facto has always existed. . . . among private health insurance funds, among private and social health insurance funds, and among . . . ambulatory care physicians.” In general, the German system involves little direct government financial involvement but much explicit oversight of both supply- and demand-side organizational relationships.

In summary, the countries examined in this special section exemplify both varying degrees of market and government involvement in health care and different trends. Each of the essays has much to offer in both its overall description of the respective systems, as well as an analysis of the factors that are likely to spur future change. Clearly, there is no model in the developed world on the advisability of introducing more market forces into national health care systems, but the capstone essay by James A. Morone, and the two commentaries by Donald W. Light and David Wilsford, help us to explore the larger implications for health care and health care policy. The material in this special section is intended to spur greater thought on this most key health policy issue.

References


