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**PUBLIC NEEDS, PRIVATE MARKETS: LESSONS FROM INTERNATIONAL EXPERIMENTS AND EXPERIENCE WITH POLICY FOR THE HEALTH SECTOR**

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Paper proposed for presentation at the 10<sup>ème</sup> Congrès de l'association française de science politique et le 3<sup>ème</sup> Congrès international des associations francophones de science politique

September 7, 8 and 9, 2009  
Grenoble, France

**EXTENDED ABSTRACT**

Industrialized countries and the global community face increasing challenges regarding welfare policies and especially health policy. Predetermined intellectual orientations and elaborate philosophical preferences make any easy application of state-of-the-art social science extremely difficult. However, the paradigm of *l'efficacité* weighs heavily. Limited resources require that best-practice policy, grounded on evidence, be brought to the fore. If outcomes on cost, quality, and access count, then which health policy approach is best in terms of the most efficient? Is it the market (*privatisation via un système libéral ou néolibéral*), public programs (*l'Etat-providence*), or outsourcing some public responsibilities to the private sector (public-private partnerships)?

After several decades of informal “testing,” specific policies are associated with known outcomes in health policy across a range of culturally varied national contexts. Certain limited conclusions are compelling. There is no clear evidence that market competition has reduced overall health system costs, improved quality, or increased access to health services in most countries where it has been tried. Market competition may reduce access but this result can be moderated with close regulation.

Among the reasons why market competition has performed poorly in the health sector, despite high expectations, are the following: i) the individual players are not qualified for the roles assigned to them under demand-side market competition, ii) marketing and advertising associated with market competition increase the utilization of health services, iii) expenses related to maintaining a “level playing field” for competition are very high, iv) high administrative costs of multi-payer systems are intrinsic to the competitive private markets, v)

reduced cooperation between providers in highly competitive markets leads to duplication of services in communities.

In some cases, the market incurs unexpected externalities and some of these fall on insurers. Reduced financial returns to private health insurers may be one. In addition, implicitly and without much reflection, market systems impose responsibility for social solidarity programs on the private sector, a task for which these organizations are poorly prepared. Finally, it implies structural conflicts of interest on insurers.

The question for political science is this: Why do policy makers, in so many different countries continue to support market competition in the health sector in the absence of better evidence for its success? Several explanations exist, beyond the oft-mentioned immediate politico-economic rationale of self-interest. Two are analyzed here: first, some experts contend that the market approach in the health sector has not been given a “fair test” and that the experiment should be continued with less government regulation, because only then will optimal results be observed. There is little data to support this case, however. Second, the market is said to reflect a *preference* to pay more for an increased *choice of insurer*.

Lessons from comparative, international public policy research suggest that continuing experiments with **market competition in the health sector is only justifiable as a normative option, not as evidenced-based policy.**

# **Public Needs, Private Markets: Lessons from International Experiments and Experience with Policy for Health Insurance**

In recent decades, the health insurance sector has come to be considered the same as any other merchandise in many industrialized countries –with products best produced, priced, and distributed through the free market where self-interested, rational, individuals are free to purchase goods and services on the basis of personal choice with little government interference. This, it is said, assures equilibrium as consumers and producers enter and leave the market depending on the price of services, which vary according to supply and demand (Parkin, 1999). Expected benefits include lower overall health system costs, increased accessibility, and higher quality health care. While the market model prevails more in some countries than others, many developed countries have experimented with it in one form or another over the last two or three decades. The list includes the U.S., the Netherlands, Switzerland, Italy, New Zealand, Spain, Sweden, and the United Kingdom (Laugesen, 2005).

It is time to ask if there is any evidence or experience related to market competition in the health sector that can guide policy. Should policy makers act to preserve it or is it time to move in another direction?

## ***I. What Evidence Exists about Market Competition in the Health Sector?***

Translating evidence into policy is a popular idea in the health sector today and it makes good sense. If policy makers are armed with research results, they might produce better legislation, at least in theory. Policy success depends on the availability of solid data to support action. But there are few carefully controlled studies of the effects of market competition in the health insurance sector. Randomized clinical trials are very difficult and expensive to carry out. The Rand experiment in the U.S. illustrates how even with the best of efforts, results will be questioned (Nyman, 2008).

Why is there so little good evidence about market competition in the health insurance sector? One reason is that there are so many factors that influence the performance of market competition in the this sector. These variables continually interact with one another (Buss, 2000). Practicality, in any case, precludes manipulation of variables at the level of societies even if it were theoretically possible. In addition, there are ethical implications involved in macro research that prohibit assigning individuals, regions or states on the basis of randomization. Finally, findings might not be applicable to other societies because human behavior is affected by culture. Along with cultural conditions there are the “secular trends” (long term trends) involved with the health insurance sector and the timing of the introduction of the market could well be affected by them.

In many industrialized countries, experiments with market competition in the health insurance sector have been implemented together with other policy innovations which complicates coming to any conclusion about the market itself. These innovations include privatization (OECD, 2004), the transformation of nonprofit insurers into for-profit entities (P.

V. Rosenau & Linder, 2003), and the introduction of demand-based cost containment policies or supply-side measures that affect insurance products.

The fact that there are few high quality research projects does not mean that there is no relevant information available to policy makers about the performance of market competition in the health insurance sector. Less complicated, policy-relevant interventions have been tested, producing useful results. “Non-experimental designs such as international comparisons and time trend studies,” have been carried out. These provide a basis for policy interventions despite the presence of confounding factors (Hardt, 2008; Stronks & Mackenbach, 2005). Gross associations between implementation of market competition and system level changes on variables of interest must suffice, by default, in the absence of better information. In addition, country level case studies are available; these may inform policy though the links between results and expectations cannot be tightly drawn. Case studies do not always provide evidence that is so convincing that policy makers are compelled to take action. But case study methodology is improving and it can be employed, today, to test deterministic propositions such as those expressing a necessary condition, case by case (Dul & Hak, 2007).

## ***II. The Goals of Market Competition in the Health Sector***

Market competition in the health insurance sector has been justified because it is assumed to lower costs, improve quality and increase access for all. Three countries provide evidence regarding market competition today- the Netherlands, Switzerland and the U.S., with its several independent and different health systems and subsystems including Medicare, Medicaid, employer based insurance, the Veteran’s Administration , the prison health system, the military health system, etc. In the Netherlands and Switzerland, the goal of market competition for health insurance was to reduce overall health insurance costs. Both countries sought to assure a “level playing field” for competition. This was accomplished by setting the rules to regulate competition and provide fairness to insurers, patients and taxpayers. These rules included: that everyone be required to buy insurance, that the basic health insurance policy be standardized, that all insurers be required to offer this basic policy to everyone (regardless of their health status) at the same price, and that those insurers that ended up with a sicker pool of patients be compensated for the greater risk that they had assumed via a “risk pool”.

### ***Does the Market Reduce Costs?***

Case studies of market competition for health insurance in U.S., Switzerland, and Netherlands shed light on whether the market approach can control costs. These countries are, today, among the most expensive per person, per year, health systems in the world. In none of these countries, or the various sub-systems in the U.S. health system, has the introduction of market competition coincided with lower health sector costs (Scanlon, Swaminathan, Chernen, & Lee, 2006). On the contrary, increased market competition has coincided with increased health system costs (Callahan & Wasuna, 2006; Schoen et al., 2005). Competition has been found to reduce hospital cost-growth in the short-term, but effects diminished in the long term and cost roll-backs were not observed in either time period (Shen & Melnick, 2006). In the Netherlands business groups argue that government regulation is required, in addition to market competition, to contain costs, especially if a high level of quality is to be maintained (Commentary, 2008).

Market competition is not associated with reduced overall health system cost reduction and yet health insurance companies are not making a profit on basic health insurance in the Netherlands and Switzerland. Costs have continued to increase every year in the Netherlands after the health reform that introduced a private market for health insurance despite the fact that this experiment with market competition conforms closely to what economists consider theoretically optimal economics structures (De Nederlandsche Bank, 2009; Enthoven & Van de Ven, 2007; P. Rosenau & Lako, 2009a). Switzerland prohibits insurance companies from making a profit on basic health insurance and even so, overall healthcare costs have still not been controlled by expanding the role of market competition for health insurance (Colombo, Zurn, & Oxley, 2006). In the U.S. insurers are having problems making a profit on health policies that are affordable for consumers/patients though they seek to do so in the individual health insurance market: the insurers' problems are also attributable to the economic recession that began in 2008.

U.S. Medicare is an important case study of the effect of market competition on costs. This universal health care system, for those over 65, was transformed by the Balanced Budget Act of 1997 to permit market competition between traditional government Medicare and Medicare Advantage, private-sector Medicare. The goal was to lower overall costs and force the government part of the program to be more efficient because it would have to compete with the private sector.

Results with the Medicare Advantage experiment with market competition have been disappointing though it is still supported by business groups (Kaiser Family Foundation, 2008a). The U.S. government has subsidized Medicare Advantage companies with payments 10-15% above those paid to traditional Medicare. In addition, the Medicare Advantage program has been plagued by improper, even illegal and fraudulent sales practices (Pear, 2007). Medicare Advantage (private sector) patients are often encouraged to return to traditional Medicare if they become seriously ill or if their health care is costly (OECD, 2004; Walsh, 2008; Woolhandler & Himmelstein, 2007). But even this has not improved Medicare Advantage's cost performance.

In the end, market competition has failed to reduce the cost-growth of the Medicare program (Kaiser Family Foundation, 2008e; Woolhandler & Himmelstein, 2007). There is substantial political pressure on the U.S. government to eliminate subsidies to Medicare Advantage providers (Kaiser Family Foundation, 2008d), but because Medicare Advantage constitutes 31% of the "revenue for health insurers that offer such plans" it will be very difficult for policy makers to remove these extra payments (Kaiser Family Foundation, 2008b).

The entirely private sector Medicare Part D a pharmaceutical benefit for the over 65 years of age population in the U.S. provides another natural experiment with market competition. *Premium cost-sharing* has increased since its establishment and *overall costs* have also increased since its inauguration in 2006 (Hargarve, Hoadley, Cubanski, & Neuman, 2009).

### ***Can Market Competition for Health Insurance Expand Access?***

The U.S. is the best test of the effects of market competition for health insurance on access. Switzerland and the Netherlands and most other countries employing market competition in their health insurance markets, already had close to 100% access before the experiment with the market began. Because insurance translates directly into access, whether an

individual is insured or not has an important impact on his or her health status in the U.S. Access, in turn, is directly related to improved health status and quality of life (Dorn, 2008; Institute of Medicine, 2004). The percent of the population lacking health insurance has increased in recent years and the expansion of market competition has not improved this situation (Consumer Reports, 2007). Access has also reduced because employers are passing on the increased costs of insurance to employees by way of increased co-pays, deductibles, etc. (Mishel, 2006; Regopoulos & Trude, 2004). This may be as much a result of economic hard times as it is the result of increased market competition.

Mandating individuals to buy health insurance and encouraging employers to provide it should increase access in a private health insurance market. The state of Massachusetts in the U.S. has taken this approach to improving access in their markets with some success, achieving near universal health insurance. But this has turned out to be a test of the success of regulation as much as a test of the market competition in increasing access. State subsidies are required so that those with lower incomes can afford to purchase insurance (Kaiser Family Foundation, 2008c). In addition, enforcement of this obligation to purchase health insurance has not been entirely effective (Abelson, 2007). In addition the legislation in Massachusetts did not include a systematic plan to control costs. After two years policy experts conclude that the biggest challenge to access is rising costs (Kaiser Family Foundation, 2008f). The Netherlands also employed a mandate to purchase insurance with the introduction of the market for health insurance. The number of individuals who fail to comply with this requirement is very low, 1%-2%, and the market cannot be said to have reduced access to any great degree. This is in good part due to the fact that government subsidizes the purchase of insurance for the lower socio-economic groups (Centraal Bureau voor de Statistiek Persbericht - Statistics Netherlands, 2009).

Is reduced access an inevitable outcome of increases in market competition in the health sector? The results from international experience are mixed. Market competition's influence on access may be a function of the presence or absence of regulation. Few policy experts suggest that increasing market competition reduces access. Solidarity values in Europe have meant that subsidies to the poor to purchase health insurance have accompanied increased market competition. This has been the case in both the Netherlands and Switzerland as well as in Massachusetts (Morone, 2000; Saltman, 2002b; Sanmartin et al., 2006).

### ***Can Market Competition for Health Insurance Improve Quality & Efficiency of Health Services?***

Policy makers expect that market competition for insurance, combined with making quality information about providers available to consumers (transparency), should lead to better quality of health services. Consumers/patients, it is assumed, will then choose their health insurance and providers on the basis of publicly available quality ranking information. However, not all forms of market competition systems include incentives for insurers to focus on quality (Callahan & Wasuna, 2006; Custers, Arah, & Klazinga, 2007). Quality is difficult to measure and in many health systems, including the Swiss health system, measures of quality are not available to consumers (Leu, Rutten, Brouwer, Matter, & Rutschi, 2008).

The general conclusion of policy experts is that “there is no clear international evidence that increased competition amongst insurers would improve the quality or efficiency of care” (Colombo et al., 2006). One major study reports that market competition among health insurance plans has not been found to be associated with better quality performance, measured by improved HEDIS scores on chronic care measures (Scanlon et al., 2006).

### ***III. Why Market Competition in the Health Sector Performs Poorly***

There is little direct evidence as to why market competition in the health sector has not achieved its goals. But some hypotheses can be offered based on relevant research results carried out in several different countries. The logic emerging from economic theory about supply and demand, advertising and marketing, and the performance of monopolies also suggest answers to this question. The health sector involves what economists call imperfect competition because of its special characteristic. These include: the fact that consumer tastes are not predetermined, sometimes individuals are not good judges of what is best for them as regards health services, individuals are not always rational, the general social welfare does not necessarily result from each individual pursuing his or her self interest, monopoly power exists in the health sector, etc. These are explained in some detail in Thomas Rice’s *The Economics of Health Reconsidered* (Rice, 2002). While optimists are convinced that the market can be made to work, Wells, Ross and Detsky argue that “it is impossible to develop policy initiatives that correct market distortions and produce a truly efficient health care market...”, (Wells, Ross, & Detsky, 2007) p. 2787. Public opinion polls across many nations find that the health sector is not viewed as a legitimate area for market competition (Laugesen, 2005).

#### ***i) The Players Are Not Qualified***

There are two types of market competition in the field of health: supply side and demand side. The poor performance of market based health systems may be due to the fact that so many countries emphasize demand side competition, which *makes unrealistic requirements on patients/consumers and providers*. Supply side and demand side market controls are organized differently. Demand side market competition in the health sector emphasizes cost-sharing in the form of co-pays and deductibles, and it puts the patient/consumer in charge, requiring that the individual “shop” for the best quality provider, the lowest cost insurance policy, etc.

Supply-side market competition emphasizes government regulation and incentives for providers (doctors and hospitals). It requires that insurance companies to compete with each other, often as representatives of their patients. This takes the form of capitation payments to providers, DRGs for hospitals, and HMO style features such as utilization review, case-managers, practice guidelines, gatekeepers, technology rationing, global budgets and waiting lists/times (Rice, 2002)

Patients and providers may not be qualified to play the role assigned to them in a *demand driven* markets and health policy experts have long cautioned that it is ineffective in containing costs (Mossialos, 2004). Demand side market competition is the basis of market competition in the health insurance market in the U.S. (the independent market), Netherland, and Switzerland where theoretically rational patient/consumers’ seek to purchase insurance policies offered in the marketplace. Where consumers have not done this in the past, as in the Netherlands, they have

to acquire these skills quickly because the success of market competition depends on their playing this role (Nyman, 2007). For example, if the market is to improve quality of care, good quality health care must be identifiable to the consumers/patients must then seek it out and choose it on the basis of value for insurance dollar. Consumers/patients must factor in comparative price information and remain vigilant enough to aggressively “shop” for health insurance over time, switching insurance policies if price or quality changes. “Without the threat of consumers switching to better performing competitors insurers would have no incentives to be as efficient as possible” (Leu et al., 2008) page 93 .

Even if consumers/patients have the skills to play their role in the health marketplace, do they have the information they need to make decisions? Transparency as to cost and quality need to be made available to individual and group purchasers of services and insurance, if the expectations about the performance of market competition are to be achieved. This means that patients have to be able to compare the relative performance of providers on quality and they need to know the price of various medical procedures and provider charges in advance.

These requirements are seldom met in the real world of demand-driven health care marketplace. Even when consumers rise to the challenge and perform well in making purchases of health insurance, they cannot be counted on to do so going forward (Leu et al., 2008). Initially in the Netherlands consumers were critical customers when purchasing health insurance but they did not continue to shop critically after the first year of the market reform. Evidence suggests as well, that some individual patients are not capable of making informed choices for various other reasons (Lako & Rosenau, 2008).

Under the terms of demand-driven market competition, health care providers – including physicians need to be good business managers. They are not taught this skill-set and are ill prepared for it. This means they must learn to estimate their costs and benefits without compromising quality. Holding physicians and insurers to these fiduciary responsibilities vis-à-vis patients in the current competitive environment may be unrealistic. Few physicians fully understand their role in the health system in these terms. They are more knowledgeable about quality than costs. But the bottom line is that they must make a living and cover their costs. Many health care providers are focusing on how to merely survive in the heavily market-driven health sector. While they may learn to “bid” for health services eventually, some of them are conflicted by deeply held beliefs that health services have a social component that is not present in other business and economic sectors.

Efforts to get around the fact that most providers are inadequately prepared for market competition include pay-for-performance to align incentives for reducing costs and improving quality . The National Health Service in Britain uses pay-for-performance, *supply side models* to change providers behavior. In Britain competition is “internal” to provider groups and financial incentives encourage competition on price and quality in local markets. Some evidence indicates that physicians are much more likely to respond to pay-for-performance financial incentives once competition between providers is established (Campbell et al., 2007). Another study, however, found that market incentives were not nearly as effective at improving performance as were direct and stern sanctions for failure to improve performance , for example with respect to waiting times (Propper, Sutton, Whitnall, & Windmeijer, 2008). In short, the

evidence is mixed on pay-for-performance as a way to get around the fact that providers are poor performers in the marketplace (P. Rosenau & Lako, 2009b).

### ***ii) Marketing and Advertising Increase Demand in the Market-Based Health Sector but Undermine Cost Control***

Through marketing and advertising insurers and providers expand the customer base, increase demand, and use knowledge about consumption and purchasing patterns to increase sales. But this adds to the overall health system costs. Increasing demand is *not* about movement along the demand curve; it is *not* about an increase in quantity or change in the price of a service or good. It is about shift in the demand curve “to the right,” an increase in the quantity for a good or services at every price on the curve. This raises the curve but does not change the slope; it’s a new and more expensive marketplace.

Health policy makers do not always anticipate the ability of advertising and marketing to shift the demand curve with the effect of increasing total health system costs when they design health reform. The Netherlands health insurance reform of 2006 is a case in point. Here many believe that marketing and advertising by private insurance companies has increased the demand for services within the system (Commentary, 2008; Rosenberg, 2008). Marketing and advertising do this by bringing “new information” to consumers and by convincing patients that they “need” a product that they did not know existed and for which they had no desire in the past. This effect has been documented in a study of antidepressants in the U.S., where ads brought medication to the consumer’s attention and increased the number of new users (Meyerhoefer & Zuvekas, 2008) The cost of pharmaceuticals is highest in the U.S., one of only a few industrialized country where advertising for medication is permitted.

Marketing and advertising are generally viewed as essential to successful business enterprises and to the functioning of the market. But they may also undermine efforts to achieve cost containment and quality improvement. There is a contradiction in emphasizing consumer choice and encouraging the consumption of services in health sector markets where as much as a third of health services do not benefit the patient (Anderson & Chalkidou, 2008; Kuttner, 2008; Laugesen, 2005; Phelps, 2003; J. Wennberg, 1996; J. E. Wennberg, Fisher, Goodman, & Skinner, 2008; Wilensky, 2003). Market competition is a poor mechanism for sorting out needed from inappropriate health care and marketing does not help.

Marketing and advertising are viewed by economists as both “a cause and a consequence of imperfect competition”. Under conditions of perfect competition, where many producers make identical goods, advertising shifts the demand curve out but the effect on the individual advertiser’s sales is negligible. However, competition in the health sector is imperfect competition and here marketing and advertising appear to be more effective in increasing costs without improving quality, especially when only one producer or provider advertises (Stiglitz, 1997).

A qualification to this analysis is needed. The ability to increase profits by increasing demand assumes that the sale of each unit of product results in increased profits. This has not been the case in the Netherlands and Switzerland where sales of the basic health insurance policy are closely regulated. In the Netherlands selling more health insurance policies has translated

into greater losses because insurance companies have registered a loss, not a profit, on the basic health policy for since the health reform put the market in charge in January 2006 (De Nederlandsche Bank, 2008).

### ***iii) Maintaining a Level Playing Field for Competition in the Health Sector Is More Expensive than Anticipated***

Another reason that market competition may not contain costs is that maintaining a level playing field for competition in the health sector is expensive and this is not always anticipated. Policy makers in many industrialized countries agree that because market competition is imperfect in the health sector, intervention is necessary to avoid externalities. However, the costs of intervening to achieve a level playing field for competition in the health sector are high. The Netherlands and Switzerland have actively intervened to hold competitors to fair competition standards. They sought to control the gaming in the marketplace that reduces access to health insurance for the most vulnerable populations, or permit insurers to cancel health insurance for those who become severely ill (Girion, 2009).

Regulation and monitoring can be used to assure access, requiring insurance companies to sell insurance to all who seek to purchase it, regardless of health status. This is called guaranteed issue and it is another solution to market dysfunction, but it involves regulations that are expensive to implement. Government organizations must be established to determine the risk adjusted compensation to be given to the various health insurance companies shifting funds to those that ended up with less healthy patient populations from those with healthier insured populations. Even then, guaranteed issue is meaningless without community rating. Community rating means insurance premiums are the same for all and based on the anticipated overall costs of the large group, not the individual. Without community rating, insurers would be tempted to make the premiums unaffordable for high risk patients discouraging them from acquiring health insurance (P. Rosenau & Lako, 2009a). Another government organization has to monitor the price charged by insurance companies to be sure that community rating rules are being respected.

In a fair competitive market for health insurance consumers/patients need information about provider quality. This data must be gathered, verified, and made available to consumers – at substantial expense to the health system. In addition, the content of basic health insurance policies offered for sale in the competitive market must be monitored to be sure that they meet minimum standards required by law and are presented without deception to consumers/patients. Compliance with laws requiring that all purchase health insurance must also be monitored and the means to enforce compliance with such mandates established. Finally, the fiscal viability of all insurance companies participating in the competitive market also needs to be supervised (Saltman, 2002a)

### ***iv) Administrative Costs Are Higher in Competitive Markets with Multiple Payers***

Market competition by definition requires multiple participants compete with each other. Generally, multiple payers increase administrative complexity consuming between 15 and 30% of expenditures (Woolhandler & Himmelstein, 2007; Woolhandler & Himmelstein, 1997). Might this be one reason why market competition is associated with increased administrative costs? In

fact, there is some evidence that administration costs are greater in market-based multi-payer health systems (Colombo et al., 2006; OECD, 2004; Rice, 2002) and this appears to be the case for those that involve private insurers (Mossialos, 2004). Administrative costs are high because the economies of scale and simplified billing opportunities are missed and increased complexity of payment adds to costs. Each payer has its own way of doing business. Internal compliance and audits add to costs too. There are few incentives for standardized procedures though regulation.

Management costs in general are still higher in health systems that use highly regulated market competition (Buss, 2000). For example, the Dutch health insurance reform of 2006 is based on market competition, and the bureaucracy that sustains it is extensive and expensive. It includes the Dutch Central Bank that monitors the financial viability of insurers, the Dutch Healthcare Authority (NZa) that regulates the market to assure that it is functioning properly, the Health Insurance Ombudsman that takes complaints on the health insurance industry and the supplementary health insurance policies, the Health Care Insurance Board (CVZ) that coordinates the Health Insurance Act, the Health Care Inspectorate (IGZ) that assures quality of care and checks on provider errors, and the Netherlands Competition Authority (NMA) that “enforces fair competition, takes action in case of unfair competition, and approves mergers and acquisitions” (Leu et al., 2008).

Economic theory also provides an understanding as to why health systems that are based on a more limited number of payers (or even a single payer) cost less. These systems function as do monopolies or near monopolies, and they are highly efficient. Monopolies can produce large quantities of goods quickly and this makes for cost savings because of volume as well as low administrative costs. For example monopolies during public emergencies and for war time production during World War II proved highly efficient and dependable, much more efficient than competitive markets (Samuelson, 1967; Schumpeter, 1984). Historically, water and public utilities were considered to be “natural monopolies”.

The problem with monopolies is they can charge anything they wish for their product and restrict productivity if they set output too low. The mechanisms employed for controlling the price of patent-protected (monopoly) brand name drugs in many countries today (not the U.S.) protect innovation but do not allow the patent holders to set their own prices (Abel-Smith, 1992a, 1992b) (Ess, Schneeweiss, & Szucs, 2003). It is more difficult to solve the problem of pharmaceutical companies that hold patents on needed medication (monopolies) but choose not to produce these needed pharmaceuticals. This happens with vaccines, usually because of low profit margins associated with these products (Light, 2007).

### ***v) Competitive Markets Lead to Lower Cooperation among Providers and Duplication of Services***

In the Netherlands competitive markets among insurance companies has been observed to give providers, both hospitals and doctors, an incentive to cease cooperating with colleagues in the same geographical area. This leads to an expensive duplication of services. Prior to the 2006 reform, doctors report having referred patients, largely for quality reasons, to other doctors who had a reputation for success or were know to specialize in treating certain illnesses. Insurers restrict such referrals today by encouraging the use of doctors with whom they have contracts.

The introduction of market competition ended an informal division of labor among hospitals and replaced it with a multiple points of duplication of services at increased system level costs and perhaps with decreased quality. At the community level, hospitals in the Netherlands generally practiced specialization as to procedures that were offered in a geographical area with one hospital purchasing an expensive piece of equipment. Providers referred patients to the hospital note for a specific test or procedure to the appropriate hospital. Other hospitals would purchase different equipment to avoid duplicating services in the area. These practices would likely improve performance if the principal that volume increases quality were at work. After the introduction of market competition, each hospital felt it was required to purchase and offer all test services to effectively compete with other hospitals and attract business.

#### ***IV. Externalities for Insurers: Reduced Returns and Responsibility for Social Solidarity***

The unintended result of reassigning roles and increasing market competition for health insurance has been little studied. Latent and manifest consequences exist and these are quite surprising despite the fact that they are taken for granted and have received little discussion

In both the Netherlands and Switzerland insurers have experienced reduced returns since market competition for insurance was fully implemented. By law in Switzerland insurers do not make a profit on the basic health insurance policy that they must make available to the public. Legislation actually prohibits insurers from registering profits on basic insurance though they may do so on the supplementary policies that they sell to go along with the basic insurance. However, in the Netherlands, insurers have failed to register a profit, though they are encouraged to do so

In highly regulated markets for health insurance in the Netherlands and Switzerland, another externality is that insurers appear to be substituting for government in the sense that they have assumed responsibility for social solidarity functions. The Dutch health care reform legislation states that insurers have a fiduciary responsibility for those they insure, but there is little monitoring or enforcement of this assignment. Nevertheless private insurers are managing, organizing, and implanting basic health insurance for the population, substituting for what was previously a government responsibility. Interviews in Switzerland suggest that insurance company executives do not see this as unfair (P. Rosenau & Lako, 2008).

The unexpected consequences of asking private insurers to substitute for government on social solidarity projects, and to do so without remuneration for this function (zero profits on basic insurance), raises questions and topics for new research. Is there a conflict of interest due insurers' fiduciary responsibility to their patient/customers as well as their stock holders? Should stock holders be expected to subsidize these functions --which they end up doing because the dividends distributed to investors are lower (in publically traded companies). Do these companies make up for lost revenue on the basic insurance policies by other means – through the sale of other products? How well do private sector companies fulfill this social solidarity function compared to government?

## ***V. Why Policy Makers Continue to Support Market Competition in the Health Sector***

### ***i) Arguing that More or Different Types of Market Competition Would Work Better***

Why has market competition in the health sector has not been entirely abandoned given its poor performance (Cassil, 2005)? Some policy makers are hopeful that with a few changes the expected benefits of the market for the health sector will be realized (Enthoven & Van de Ven, 2007). They feel that market competition has not yet received a fair test in the health sector (Cannon & Tanner, 2005; Conover & Wiechers, 2006). It will be a success, they argue, only when it is freed from government regulation – in short, there has *not been enough competition* to adequately test the model to date. For an adequate test, these experts contend, regulations must be dramatically reduced or eliminated because the health sector marketplace is, today, too restrained. More, not less, market competition is needed to achieve expected benefits (de Jong & Mosca, 2006). One way to achieve this is for insurance companies to increase selective contracting with providers (Gress, 2006) and this is being tested in the Netherlands (Enthoven, 2008; Enthoven & Van de Ven, 2007).

These market advocates believe the relationship between market competition and health system performance is not a linear function but rather will exhibit plateau effect that is yet to be reached. Market competition must be increased, regardless of experience and the absence of progress because at some undetermined level, improvement will be observed. The assumption of a plateau effect, the belief that it will be observed eventually, that less regulation will suddenly yield a positive result, is counterintuitive. It has yet to be observed in the real world (Commentary, 2008; Leemhuis & Wiegel, 2008). Under a different model, a dose-response step-function scenario, incremental change should yield observable improvement, and more change in the same direction might be expected to yield a greater improvement. This is not the case with market competition in the health sector because a little competition has not yielded any improvement defined as reduced costs or improved performance.

### ***ii) Redefining Market Success as Preference, Choice, and Perspective***

If new and different criteria for the policy success of market competition for health insurance is being substituted for the usual criteria (cost containment, higher quality, and greater access performance), different policy recommendations might result. If the criteria for “success” are changed, then market competition may be defined as successful. This helps explain why the “experiment” with market competition goes forward despite little evidence to support it.

Market competition remains a legitimate choice if justification for it is based on normative criteria that involve personal preference or, philosophy, and the perspective of the individual rather than of the society (P. Rosenau, 2003). The market is a legitimate choice if one argues that paying more is an acceptable "preference" (Colombo et al., 2006) because it increases a patient's choice of health insurance plan. But while such preferences are a legitimate basis for

policy choices, they have consequences. For example, the unregulated market for health insurance is associated with lower rates of insurance for vulnerable populations.

Preference-as-criteria-for-success in the health sector suggests that: “It’s our choice where we spend our money”. Within this frame of mind spending levels are not a problem (Cutler & McClellan, 2001). If the U.S. is spending twice as much as most other countries, that is its prerogative. Swiss policy experts also conclude that the “high cost may reflect, in part, societal choice, i.e., a willingness to pay for unconstrained choice and generous supply. However, there is no guarantee that this social consensus will persist in the future in the face of unrelenting cost and insurance premium increases.” (Colombo et al., 2006) p. 154.

Here choice is understood, as an inherently desirable outcome and it is associated with private financing and competitive markets in the health sector (OECD, 2004). *But choice here means choice of an insurance plan, not choice of a doctor or hospital.* Insurance plans in a free market often restrict choice of provider to those with whom they have negotiated a discount and this is not what advocates of market “choice” are talking about.

Challenges to the preference-for-choice-model in the health sectors are empirical. It is commonly argued, especially by elected officials, that offering consumers a choice makes them feel participatory, empowered, happier, and more in control. However greater choices do not always produce better market results than fewer choices, Schwartz, employing experimental data, reports that greater consumer choice can lead to stress, frustration, and disappointment. In the end confronted with too much choice, consumers simply give up and pick at random (Schwartz, 2005).

Deeming the experiment with market competition for health sector a success or failure is also about perspective or the unit of analysis. Assessments about market competition may differ, depending on whether one’s point of view is that of a particular individual or that of the society. Even when the individual actors behave rationally, the results may be an irrational outcome for society, one that is the opposite of what is intended when policy is formulated. From the point of view of enhanced freedom for the individual, for example, it may mean more timely access to health services. From the perspective of the individual producer of goods and services, marketing and advertizing to increase demand is fair play even if this leads to higher societal costs and a potential increase of inappropriate care.

## ***VI. Conclusion and a Dilemma***

On balance, after several decades of unsystematic experimentation with market competition in many industrialized countries it can be said that market competition is not associated with cost containment, improved quality or increased access. There are several explanations as to why the expected benefits of market competition in the health sector have not been observed and these have been reviewed above.

For some policy experts, faith in the market is waning (Fuhrmans, 2004). Some employers, policy makers, and private business executives in the U.S. appear ready to accept a broader role for the government and for regulation, instead of continuing to tinker with less regulated market competition to make it work (Nichols, Ginsburg, Berenson, Christianson, &

Hurley, 2004). Others conclude that market competition in the health sector is a failure and should be abandoned (Ranade, 1998).

From a methodological point of view there is little evidence that qualifies as meeting the “gold standard” about the performance of market competition in the health sector and this opens the door to policy-subjectivity. Methodologically, much of what is taken as evidence is based on correlations between the market and concurrent system level performance. But correlation is not causality.

Ultimately evidence regarding *market competition in the health sector is about more than methodology*. Political aspects of this topic mean that unbiased assessment is not easy. Evidence when it is available, may not be incorporated into policy because of the nature of the political process itself. Policy makers, understandably, focus on political priorities even when empirical data and findings are clear, so it is not surprising that they do so in the absence of unequivocal evidence.

*Accuracy of the premises*, a minimal methodological standard, and the answer to the question: “*does it work?*” could be brought to bear on policy decisions as one remaining option. But the accuracy of the premises is in doubt, and market competition cannot be said to be attaining its performance goals, defined in standard terms. Criteria of success based on pure preference or a greater-choice-of-insurer are not convincing from an evidence-based view. It is hard to justify prolonging the experiment with the market in the health sector at this point. Policy makers who continue to pursue market based policy in the health sector are implementing “essentially speculative schemes” and they should be understood to be little more than this (Callahan & Wasuna, 2006).

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