

WHY SHOULD THE ECONOMICS OF HEALTH BE RECONSIDERED?

1.1 Context

Recent years have seen a surge of interest in reforming the organization and delivery of health systems by replacing government regulation with reliance on market forces. Although much of the impetus has come from the United States, the phenomenon is worldwide. Spurred by ever-increasing costs coupled with competing priorities such as education, welfare, and—much more recently—environmental concerns, analysts and policymakers have embraced the competitive market as the means of choice for reforming medical care systems. To a great extent, this belief stems from economic theory, which purports to show the superiority of markets over heavy government involvement.

In the United States during the middle and latter part of the 1990s, increased competition in the healthcare sector helped control the rate of increase in costs. The main manifestation of this competition was the increase in managed care enrollment and concomitant decline in fee-for-service. Between 1993 and 2001, for example, the percentage of workers covered by conventional fee-for-service insurance declined from 49 percent to just 7 percent (Jensen et al. 1997; Gabel et al. 2001). The second half of the 1990s also saw less use of hospital care and much lower inflation in health costs than in previous decades. Average per capita health expenditures rose only 5 percent annually, approximately the same increase as the economy as a whole, and far less than in previous years (Centers for Disease Control and Prevention 2001). Studies showed that the geographic areas with the highest managed care penetration experienced the smallest increases in health costs (Zwanziger and Melnick 1996; Bamezai et al. 1999). Whether this meant the market was operating more efficiently was less clear, however, as improved efficiency depends not only on costs but also on access to care and quality of care received.¹ Access has been declining; the number of uninsured Americans increases nearly every year. Definitive conclusions about trends in quality are harder to make (Miller and Luft 1997).

But heavy-handed managed care had severe side effects. Talk of a backlash began as early as 1997 (Blendon et al. 1998) and a special issue of a leading health policy journal, the *Journal of Health Politics, Policy and Law*,

was devoted to the topic in 1999. Since that time, softer forms, sometimes dubbed “managed care light,” have become more prominent. Preferred provider organization (PPO) enrollment has increased, and health maintenance organization (HMO) enrollment has decreased, and within HMOs, access to specialists is less restricted.

A resurgence of rising costs accompanied the managed care backlash. These pressures are now primarily being addressed not through regulation, but through higher prices—a classic market (as opposed to regulatory) response. Annual growth in premiums for job-based health insurance coverage increased at rates well into the double digits from 2001 to 2004, although the rate began to decline in 2005 and continued to do so through 2007 (Claxton et al. 2007). One reason the pressure on premiums has lessened is the substantial growth in patient cost-sharing requirements, such as deductibles and copayments. Between 2001 and 2006, average PPO deductibles rose by 60 percent, and copayments for preferred, brand-name drugs, by 50 percent (Claxton et al. 2006). Consumer prices in the economy as a whole rose by only 14 percent during this five-year period (Bureau of Labor Statistics 2008). This underlies a larger change: the movement toward health insurance policies with high deductibles in general and consumer-directed health plans in particular.

Three strategies exist for confronting growing costs: government regulation (e.g., limiting reimbursements or resources), private regulation (e.g., managed care restrictions), and the price mechanism. The United States has moved from the first to the second, and now moves toward the third.

The perceived success of this increasingly competitive marketplace in healthcare sectors is part of a broader trend in the United States, in which markets are viewed as efficient and government is viewed as inefficient. As Robert Kuttner (1997) wrote, “America . . . is in one of its cyclical romances with a utopian view of *laissez-faire*.” The relevance of this statement persists more than a decade later because the cycle has not yet ended. This does not imply, either in the health sector or in the economy as a whole, that policymakers have eschewed government involvement. Our concern is that healthcare markets are moving in this direction, and that economic theory is used—inappropriately, we will argue—in support of market-based health policies.

Practically all health economists—even those favoring a more competitive marketplace—recognize the need for government to play a significant role in the health system. Much of the work in this area is based on the writings of Alain Enthoven (1978a, 1978b, 1988, 2003; Enthoven and Kronick 1989a, 1989b), who advocates reliance on consumer choice and competition to improve the efficiency of healthcare markets. Nevertheless, he still believes that government has two key roles: ensuring that competition is based on price rather than selection of the healthiest patients, and providing subsidies to low-income persons.

The corollary to this viewpoint is that government should confine itself to these two roles. Health services policy should be based on competition, with government ensuring that markets operate fairly and helping disadvantaged people. A careful review of economic theory as applied to health, however, does not permit government such a limited role.

This book contends that one of the main justifications for the superiority of market-based systems stems from a misapplication of economic theory to health. As we will show, this application is based on a large set of assumptions that are not met and cannot be met in the healthcare sector. This is not to say that competitive approaches in this key sector of the economy are inappropriate; rather, their efficacy depends on the policy being considered and the environment in which it is to be implemented. Stated more colloquially, it works well in some instances but not in others. There is, however, no reason to believe market-based systems will operate more efficiently or provide a higher level of social welfare than alternative systems based on governmental financing and regulation. This argument is further bolstered by the deviation of many other developed countries from market-based health systems.

Although economists know that claims about the superiority of competitive approaches are based on fulfillment of assumptions, the healthcare literature rarely mentions the large number of such assumptions or their importance. One should not put undue blame on health economists, however; this problem pervades the entire economic discipline. In this regard, Lester Thurow (1983) has written that “every economist knows the dozens of restrictive assumptions . . . that are necessary to ‘prove’ that a free market is the best possible economic game, but they tend to be forgotten in the play of events.” Chapter 3 provides the authors’ list of these assumptions, and in subsequent chapters we show their implications in the fields of health economics and health policy.

The book thus centers on a description, analysis, and application of the assumptions upon which the superiority of competition is based—and in particular, what happens in markets for health services if they are not met.

1.2 Purpose of the Book

The purpose of this book is to reconsider the economics of health. It does so by examining the assumptions on which the superiority of competitive approaches is based, and how failure to meet those assumptions affects health policy choices.

Although each chapter provides applications, the book is also about theory—its use and its misuse. The book will attempt to show that economic theory does not support the belief that competition in the health services sector will necessarily lead to superior social outcomes.

If economic theory does not demonstrate the superiority of market forces in health, questions must be answered empirically. To a large extent,

that is exactly what health economists and health services researchers are trying to do. The authors have few reservations about the kinds of research studies being conducted. Our concern is that the work will suffer if researchers approach it with preconceived notions of what the results ought to be.

Some readers will be disappointed to see that although the book critiques the competitive model, it does not explicitly offer a theoretical alternative. It does, however, compare the health systems of countries that use varying ratios of government and markets. Unfortunately, there is little useful data for drawing conclusions about the success of alternative systems, although this is improving. Ultimately, readers must draw their own conclusions about the most desirable system using theory and the extant empirical literature. We hope this book can help them do so.

Unlike the two previous editions, the third is designed to serve as a stand-alone text for courses in health economics. Chapter 2 provides the microeconomics basis necessary for understanding the rest of the book, and we have included several topics not addressed in the previous editions—specifically, material on workforce (e.g., physicians and nurses), institutions (e.g., not-for-profit organizations), and products (e.g., pharmaceuticals). Needless to say, supplemental material, especially articles in professional journals, is always helpful to round out one's understanding of an issue.

The book is also addressed to non-economics professions. Because students and practitioners in these disciplines obviously tend to be less schooled in the details of economic analysis, they often have to take health economists at their word when the latter speak about the policy implications of economic analysis in general, and the superiority of markets in particular. (In this regard, Joan Robinson has been quoted as advising, “Study economics to avoid being deceived by economists” [Kuttner 1984].) We hope this book will help put those in disciplines other than economics on a more level playing field when it comes to discussions of health policy.

1.3 Outline of the Book

The book is divided into ten chapters and a conclusion. Chapter 2 covers nearly all of the major topics a course in microeconomic theory would cover. A few remaining topics (e.g., externalities, labor economics) are discussed later in the book. Those who are already familiar with intermediate microeconomic theory can proceed directly to the other chapters. Others may want to refer back to Chapter 2 when reading the subsequent material.

Chapter 3 provides a list of the assumptions upon which the superiority of market competition is based, as well as an overview of the role of government. We critique those assumptions in the chapters that follow.

The next five chapters provide the core of the book. Chapter 4 focuses on the theory of demand, and Chapter 5 applies the theory of demand to

health, insurance, and particular health services. Chapters 6 through 8 focus on supply: issues of competition and market power in healthcare supply and demand, for-profit medicine, and workforce issues, respectively. Chapter 9 explores equity and redistribution, a topic of tremendous importance to policy but one that has received insufficient attention from health economists. Chapter 10 discusses different ways developed countries can and have organized their healthcare systems, and includes cross-national empirical evidence on outcomes and costs and tentative lessons from this evidence. The conclusion offers some final thoughts concerning the role of competition in health services. The appendix, the writing of which was led by Miriam Laugesen, provides a brief overview of the health services systems in ten developed countries, to support the material in Chapter 10.

Note

1. Alain Enthoven (1988) makes this point nicely, writing, “An efficient allocation of healthcare resources to and within the healthcare sector is one that minimizes the social cost of illness, including its treatment. This is achieved when the marginal dollar spent on healthcare produces the same value to society as the marginal dollar spent on education, defense, personal consumption, and other uses. Relevant costs include the suffering and inconvenience of patients, as well as the resources used in producing healthcare. This goal should not be confused with minimizing or containing healthcare expenditures. Policymakers focus much attention on the total amount of spending on healthcare services, often as a share of gross national product (GNP). But a lower percentage of GNP spent on healthcare does not necessarily mean greater efficiency. If the reduced share of GNP is achieved by denial or postponement of services that consumers would value at more than their marginal cost, then efficiency is not achieved or enhanced by the cut in spending” (11).