Can the Healthcare Services Market be a Competitive Market?

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ABSTRACT

In this paper, is commented the view that health services can operate on a competitive model. Initially a reference is made to the famous article by Kenneth Arrow, which first raised the question of the special characteristics of health services provision. Some points that have raised disagreements on whether competition in the market for health services can result in efficient solutions and optimization of social welfare are then presented. Particular reference is made in the U.S. health system, which although is the most competitive in the western world does not seem to have achieved the targets, and this resulted in criticisms and call to avoid emulating this bad example.

Keywords: competition, health care services market

1. Introduction

In economics competitive is a market in which there are large numbers of buyers and sellers, each of whom has no power to influence prices, which are freely determined through supply and demand, there are no government restrictions on prices and quantities, and both sides, buyers and sellers, have full information about the conditions prevailing in the market, i.e. prices, quantities and qualities of products. The product of each producer is homogeneous, i.e. identical to that of other producers and there is free entry and exit from the market. Given some assumptions about preferences, income distribution and economies of scale, competition is the ideal model, in the sense that if it prevails in all markets it leads to socially optimal allocation of resources.

The question is whether the provision of health services can or should be a competitive market. The debate stems from the publication of the seminal[1] article by Nobel Laureate Professor Kenneth Arrow "Uncertainty and the Welfare Economics of Medical Care" in the American Economic Review in 1963.

2. Arrow's arguments

Arrow focuses on specific characteristics of the provision of health services (particularly medical care), which create gaps in the market and place the health sector at a distance from the competitive model.

These distinguishing characteristics are the following (Arrow, 1963:pp. 948-954):

- the nature of demand for medical services, which is unstable and unpredictable. The event of disease is a deviation from the normal state of affairs and the cost of the disease does not refer just to the costs for medical care but is also icluding the cost of having the risk of impairment or even death. Therefore, there is a peculiarity in medical care compared to any other usual commodity.
- the expected behavior of doctors, which is not the typical behavior expected of all other traders, who seek the maximization of their profit.
- product uncertainty, as the recovery from the disease is so unpredictable as it is the fact of its occurrence (1963:p. 951). Furthermore, there exists a significant difference in the uncertainty levels of the two sides, the patient and doctor.
- the information asymmetry, because the information the doctor possesses about the consequences of disease

1. It is a compact text that "demands from readers nothing less than the academic analogue of Talmudic scholarship", as Reinhardt notes (2001: p. 967). It is striking that the selective use of arguments serves both the proponents and opponents of free market of health services (Savedoff, 2004; Robinson, 2001).

and treatment options, is significantly higher than that of the patient, or at least, so believe both parties, as Arrow points out. Also, both parties are aware that there exists asymmetry of information and the fact of this knowledge colours their relationship in a special way (1963:p. 951).

- the limited availability of medical services, as there are significant entry restrictions[2] in the medical profession (this also happens in other professions as well). The cost of training students in a medical school is many times the cost of education at other schools. This fact, that the education of doctors is subsidized by society, should mean that prices for medical services would be low, because the doctor did not undertake the high cost of his education himself. However, doctors are the highest paid professionals. Finally, a characteristic of supply for a usual commodity is that it is offered at a wide variety of quality for respective prices, which is not the case with medical services.
- pricing practices, which for medical services can range from zero (for customers who are unable to pay), up to very high levels. Also, usually there is no price competition, as for usual commodities in other competitive markets.
- the issue of moral[3] hazard, i.e. the damage suffered by insurers from the overuse of medical actions[4]

Arrow concludes that "... we recognize the incomplete description of reality supplied by the impersonal price system" (1963:p. 967).

3. Can the health services market be competitive?

Arrow's article had enormous impact on health economics (indeed it marked the creation of the discipline) and established a framework for discussion which is still active for over 40 years.

Of course, during these years many things have changed and the health sector today is very different from 1963 (Chernew, 2001; Hammer et al., 2001; Sloan, 2001).

Thus, by a single doctor treating a single patient, we moved to a system based on the operation of very complex institutions. Medical technology has evolved rapidly. Public intervention has increased with programs such as Medicare and Medicaid[5] in the U.S. or National Health Systems in many European countries. An effort to promote competition (Pauly, 1988), took place in the U.S. by adopting in 1973 schemes such as the Health Maintanance Organizations (HMO), belonging to the so-called managed care.

When in the mid-70s the cost of Medicare has started to soar a possible solution was the encouragement of many elderly people to enroll in a private HMO. However, as Woolhandler and Himmelstein6 (2007) thoroughly explain, private contracts with the HMOs under the Medicare program have failed. Very quickly HMO executives realized that profit is in the attraction of healthy elderly, and by various marketing techniques they did exactly this, sending back to Medicare people who have severe health problems and, of course, a high cost for their care is required[7] . By acting thus, the HMOs managed to realize huge profits[8] and acquire strong political influence, which it is used to prevent efforts to end the practices they follow.

Arrow received strong criticism for his view that the market for health services is different from other markets. Robinson (2001:p. 1046) argues that many borrowed the

2. Friedman and Kuznets (1945:pp. 118-137) argue that entry restrictions to the medical profession is one of the reasons doctors have higher income. Arrow, however, questioned the assumptions underlying their calculations (1963:p. 955, fn 29). Friedman argues further (1962:p. 158), that "licensure should be eliminated as a requirement for the practice of medicine". Many authors question the relationship between licensure and quality of care (Svorny, 2004). Arrow himself (1963:p. 956), recognizes that certain medical procedures could be performed by a non-physician at a lower cost.

3. The term "moral" has a negative connotation, as it refers to immoral behavior, suggesting that there is some form of cheating or deception. It is often used in this sense by insurers or by politicians, especially in the U.S. where there is a highly charged debate on compulsory insurance and its social and economic effectiveness. However, in practice, economists by this term merely refer to the inefficiency and failure which may occur in the insurance market, and not something which is immoral (Hale, 2009). Indeed, as Pauly argues (1968:pp. 531, 535), moral hazard has nothing to do with ethics or morality, but is simply rational economic behavior, in which both the doctor and the patient have no incentive to cut the cost of medical care since it is undertaken by the insurance company. However, the logic of Pauly has led to the U.S. insistence on the moral hazard fear, which has led to the non-proliferation of health insurance for the entire population.

4. The existence of moral hazard was confirmed by the large (and unique) experimental study RAND Health Insurance Experiment, conducted in the U.S. from 1971 to 1982 under the direction of Joseph Newhouse (http://www.rand.org/health/projects/hie/).

5. These are two major public health programs in the United States signed by President Lyndon Johnson on 30/7/1965 in order to meet the health care needs of the elderly (over 65 years of age) (http://www.cms.hhs.gov/MedicareGenInfo/), and of the people of all ages with low income (http://www.cms.hhs.gov/MedicaidGenInfo/), respectively. Today these programs meet the health care needs for one third of the U.S. population.

6 Professors of the Medical School of Harvard University and co-founders of the organization Physicians for a National Health Program (http://www.pnhp.org), which since 1986 struggles for the establishment of a health system in the U.S., that will consider health care a public good accessible to all and not a commodity bought and sold like any other commodity.

7. The title of a relevant article is quite accurate: "The Medicare – HMO revolving door – The healthy go in and the sick go out" (Morgan et al., 1997). Angell (2008), points out that the U.S. is the only country in the world with a health system which is trying to avoid patients (p. 917). Comparing the U.S. with Canada, Angell concludes that the problem in Canada is not its health system but under-funding of the system, while the U.S. problem is exactly the opposite (p. 918).

8. Many HMOs have become gigantic organizations, with huge profits and very high administrative costs, thus removing resources from true health care (Woolhandler and Himmelstein, 2004).

ideas (and the authority) of Arrow to justify every singularity and inefficiency in the health market. However, there still exist many features that constitute a deviation from the competitive model. The failure of the competitive model can be clearly seen in the U.S. where even though the per capita expenditure on healthcare is around double the average of OECD countries[9], health indicators in many cases are modest and there are millions of uninsured[10] .

There was a lot of discussion around Arrow's view that the market gaps are covered by social institutions outside the market (1963:p. 947), meaning basically the trust which is supposed to be enjoyed by doctors (Arrow, 1963:pp. 949-951, 965-966). The criticism focused on the fact that the world was never as described by Arrow[11] (Pauly, 1988; 2001; Robinson, 2001). Admittedly, much of what Arrow said on the fact that the medical profession regulates itself has actually faded by the facts. The position and strength of the medical profession has been questioned because of examples of bad practice and the doctor and patient relationship has undergone significant changes. Moreover, the proliferation of the Internet, through the facilitation of the dissemination of information, breaks off the control of the flow of information on health issues that traditionally belonged to the doctor (Hardey, 2001:p. 404). Patients have the opportunity to become better informed and thus obtain more freedom of choice. However, regardless of how easily available information has become, it is questionable as to whether and to what extent patients can manage this information to make their own choices about their treatment regardless of their doctor's instructions (Haas-Wilson, 2001:p. 1042). The information asymmetry remains a central feature of the relationship[12] between doctor and patient, and therefore, as alleged by Fuchs (1988:p. 22), this relationship should remain a relationship of trust[13].

The high cost of market forces in the health sector is also a big problem. Woolhandler and Himmelstein (1997), show that the administrative costs[14] in private hospitals is 34%, compared to 22.9% in public hospitals. Woolhandler et al. (2003), indicate that the administrative costs of the entire health sector in the U.S. reaches 31% almost double the Canadian, 16.7%. High executives also drain resources from care with the huge salaries and bonuses (stock options, etc.) they get, even in the case their company is convicted for unlawful acts (Woolhandler and Himmelstein, 2004). The decision to "unleash" market forces in health diverts money from health care to the administrative bureaucracy (Woolhandler and Himmelstein, 2007:p. 1128) and this probably affects the quality of care[15] .

In the view of the opponents of the competitive model, the failure of competition to reduce costs stems from the fact that private companies in health care follow a profit-maximizing behavior rather than a minimizing-costs behavior. Moreover, to consider patients as "consumers of health services" may sound well in modern economics jargon, but a seriously ill person can not go for "shopping" for health services nor compare prices or reduce the quantity demanded when suppliers raise prices, or, finally, accurately assess the quality of the "product"[16].

Furthermore, in many cases there are monopolistic situations, as more than half of Americans live in areas where the population size would not allow the development of healthy competition[17]. For example, as Fuchs (1988:p. 21) asks, how many hospitals could we have in a population of 100,000 inhabitants; A maximum of two. How many cardiosurgery specialist teams can we have per million of population; A maximum of two as well. Even in

9. In 2007 health spending in the U.S. was 16% of GDP, while the average health spending in the other OECD countries were at 8.7% (OECD, Health Data 2009).

10. According to the latest figures published on 10/9/2009, in 2007 there were 45.7 million uninsured, while in 2008 the relevant figure was 46.3 million (US Census Bureau, 2009).

11. Robinson believes that "Arrow's article experienced the fate of many seminal writings, to describe as the presence a world that already was past" (2001:p. 1052).

12. Williams (1988), describes this relationship in a schematic way: In theory, the patient and doctor relationship is a principal (patient) – agent (doctor) relationship. If the doctor were a perfect agent their relationship would then be as follows:
The DOCTOR is there to give the PATIENT all the information the PATIENT needs in order that the PATIENT can make a decision, and the DOCTOR should then implement that decision once the PATIENT has made it.
However, reversing the words DOCTOR and PATIENT:
The PATIENT is there to give the DOCTOR all the information the DOCTOR needs in order that the DOCTOR can make a decision, and the PATIENT should then implement that decision once the DOCTOR has made it.
Obviously in practice we have the second case, therefore doctors are not a perfect agents and this is certainly a consequence of information asymmetry, which is responsible for the phenomenon of the physician-induced demand.

13. As Nobel Laureate Professor Paul Krugman noted recently (25/7/2009) in his regular column in New York Times, "…you can't rely on experience or comparison shopping. That's why we expect more from doctors than from bakers or grocers" (http://krugman.blogs.nytimes.com/2009/07/25/why-markets-cant-cure-healthcare/).

14. "... I am not sure we have a nurse per (each) bed, but we have a billing clerk per bed…it's obscene" (Dr. Uwe Reinhardt, hearing on healthcare reform, U.S. Senate Finance Committee, 19/11/2008).

15. A large meta-analysis (Deveraux et al., 2002), with data on 38 million patients in thousands of U.S. hospitals for the period 1982-1995 shows that the treatment at a private hospital has a higher risk of death compared with treatment in a public hospital.

16. These are essentially the points made by Arrow (1963). As Paul Krugman notes satirically: "…you can't rely on experience or comprison shopping. ('I hear they've got a real deal on stents over at St. Mary's!')", Krugman, op. cit.

17. The organization Health Care for America Now, using data from the American Medical Association for 2008, estimates that 95% of the U.S. insurance market is concentrated to a point that requires the activation of the antitrust law (http://healthcareforamericanow.org/).

large populations, it is doubtful that public interest is served by having doctors and hospitals compete. "Patients can benefit from cooperation among physicians and hospitals, in both reduced costs and better service" (Fuchs, 1988:p. 21).

Moreover, the production function of health services is a "peculiar" function: usually requires the cooperation of patients and health professionals, rather than acting as buyers and sellers who have opposing interests. Mutual trust contributes to the effectiveness of the "production", i.e. to the therapeutic effort.

In conclusion, many believe that the views expressed by Arrow are still relevant and strong. For example, Krugman writes: "... Arrow has demonstrated that ... ... the health care can't be marketed like bread or TVs"[18] , while Joseph Stiglitz says, "what we've seen is that the private healthcare insurers do not know how to deliver an efficient way"[19], and Fuchs (1988:p. 22), concludes that "the model of atomistic competition usually set as the ideal in economics textbooks often is not the right goal for health".

4. Conclusion

The issue of the operation of the competitive model in the provision of health services creates controversy. This is natural, as it is an issue that can not be analyzed by positive economics, but belongs to normative economics, i.e. it is not a question of the type "how" but a question of the type "how well". The answer, therefore, at to whether the market forces in health provision can lead to optimal resource allocation and efficient solutions and optimization of social welfare depends largely on the subjective value judgments made by the researcher, his overall political and philosophical values and beliefs. It is also obvious that the answer that the society gives and the decisions it makes on issues of this type can be changed over time, as the institutional, political and economic framework in which the issues are raised, alters radically.

It seems however that recently the dominant view is that the competitive model can not work in the health sector. The special characteristics of the sector are many and inequality[20] is one of the major problems arising from the entry of competition in the health sector. The poor performance of the U.S. health care is attributed to reliance in market mechanisms (Woolhandler and Himmelstein, 2007:p. 1129), and so other nations should avoid emulating this bad example[21]. This is why U.S. President Barack Obama made clear his intention to adopt policies designed to control markets[22] from the first moment of assuming Office[2] .

For Europe, which under the European Social Model[24] is the only part of the world where social justice and competitiveness are treated as mutually achievable goals and not as mutually exclusive, the answer to the challenges can not be the unconditional surrender to market forces, but should be the strengthening of the active and dynamic welfare state, leading to a New Social Europe (Giddens, 2008; Rasmussen and Delors, 2007).

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18. Krugman, op. cit.

19. Interview to Amy Goodman, 25/2/2009, http://www.democracynow.org/2009/2/25/stieglitz

20. Of all the forms of inequality, injustice in health care is the most shocking and inhumane" (Rev. Dr. Martin Luther King Jr., 25/5/1966, Second National Convention of the Medical Committee for Human Rights, Chicago).

21. Angell (2008) reaches a similar conclusion, arguing against efforts in Canada to privatize the health sector according to the U.S. paradigm.

22. "… without a watchful eye, the market can spin out of control", Barack Obama Inaugural Speech, (http://www.whitehouse.gov/blog/inaugural-address/).

23. As Epstein notes recently (25/9/2009) "...a year after he has not wavered one bit" (http://www.nejm.org/perspective-roundtable/health-care-reform-in-perspective/), and thus we recently (7/11/2009) had the pass of the bill on health care reform in the U.S. House of Representatives.

24. The European Social Model is essentially a political vision of a society that seeks progress and development without sacrificing any of its members, a society organized collectively against threats to the quality of life or life itself – such as sickness, unemployment, old age – a society which seeks anthropocentric ways for economic integration in the global economy.

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