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The Elusive Ideal of Market Competition in U.S. Health Care

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Chapter 15
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15.1 Introduction

What role does market competition play in the United States' health care system, and what might the United States (US) and the European Union (EU) learn from each other's experiences? Market competition remains a persistent but elusive ideal in American health care. More than its peers, the US health care system looks to market-inspired theories and policy instruments to solve its problems. But decades of policies promoting this ideal have not given Americans the health system they

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desire.[1] Most recognize that equity is not what markets provide,[2] yet markets have also failed to produce a more efficient US health care system. Ironically, the ideal of market competition has both driven and undermined contemporary health reform efforts in the United States. Even reforms designed to stimulate more competitive markets have faced considerable resistance because the political branches could not agree how to balance the public and private sectors.[3]

Markets versus government remains the 'basic dividing line and dominant theme in American health policy'.[4] Academics and policymakers have long struggled to identify the appropriate role for markets in health care.[5] And there remains 'deep social ambivalence about whether health care should be considered a public good or a commodity'.[6]

Of course, the United States is not alone in this struggle. Because there has never been a purely public or private health care system,[7] every country must determine the appropriate relationship between markets and government in health care. Even countries with robust public health care systems are trying to use markets to squeeze more efficiency out of their systems without jeopardizing other priorities, such as universal coverage or solidarity. For example, Canada recently considered whether to open its public system to more private sector participation.[8] Most countries labor to find the appropriate role for market competition in health care.

This chapter explores how the ideal of market competition both drives US health policy and sets it apart. I begin by reviewing how the US health system remains an international outlier, examining so-called 'American exceptionalism' in health care. Second, I discuss how several EU Member States have embraced market instruments, and explain how these efforts qualitatively differ from US efforts. Third, I evaluate notable market-based trends in the United States, such as managed competition, privatization, and consumer-driven health care, and describe how these models have failed to live up to their promises. Fourth, this chapter discusses how contemporary health reform in the United States has been both driven and undermined by market ideals. I conclude by considering the appropriate role for competition in health care, given its many limitations.

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[1] White (2007), pp. 395, 434.

[2] Pauly (1998). On the whole, US economists seem less comfortable than economists in Europe talking about justice and equity in health care. Callahan and Wasunna (2006), p. 10.

[3] Cutler and Keenan (2008), p. 472.

[4] White (2007), at pp. 395, 396; Hyman (2006), p. 265. Of course, the 'market' and 'market mechanisms' can mean many things, including different instruments that bear on the behavior of different health care actors and institutions. See Callahan and Wasunna (2006), at p. 4.

[5] For a particularly insightful analysis nearly thirty years ago, see Rosenblatt (1981), p. 1067.

[6] Hunter (2008), p. 20.

[7] Chernichovsky (1995), p. 340; Callahan and Wasunna (2006), at pp. 41, 92.

[8] *Chaoulli* v. *Quebec* (Attorney General), [2005] 1 S.C.R. 791 (Can.); Bobinski (2008), pp. 355–369; Flood, et al. (2005), pp. 257–277.

15.2 American Exceptionalism in Health Care

The US health care system is exceptional. So-called 'American exceptionalism', the idea that the United States is unique in the world, has been controversial since Alexis de Tocqueville published his observations in the 1830s.[9] But the health policy world generally agrees that the US health care system is singular.[10] Among developed countries, the United States is the only one without a single health care system organized around 'a common philosophy about coverage, access, and cost'.[11] Ours is a fragmented pastiche of health insurers, providers, and facilities, each of which is regulated primarily by states rather than the federal government.[12] Indeed, calling ours a 'system' is charitable; its defining feature may be its extreme decentralization.[13]

So precisely how is the US health care system exceptional? Health care systems are generally evaluated along three dimensions: cost, quality, and access.[14] As one scholar notes, 'enhancing quality, lowering cost, and broadening access' is the 'holy grail' or 'holy trinity' of health care policy.[15] Compared to its peers, the US health care system does not fare particularly well along any of these three dimensions.

The first and increasingly central criterion is cost. How expensive is the health care system? What does it spend *per capita*, and what percentage of the economy does health spending occupy? The US health care system is by far the most expensive in the world, both in aggregate and *per capita* terms. In aggregate terms, the United States spends as much on health care as every other nation in the world *combined*. In 2007, worldwide health care spending reached around $4.1 trillion, and the United States alone accounted for over *half* of that amount ($2.3 trillion).[16] Moreover, most predict that US spending will continue to rise, potentially to as much $4.3 trillion by 2018—equal to *total* worldwide health spending today.[17] Unsurprisingly, the United States spends a much larger portion of its gross domestic

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[9] See, e.g., Schuck and Wilson (2008), p. x.

[10] 'Volumes have been written on the topic of American exceptionalism in health policy'. Jost (2004), p. 437.

[11] Cutler and Keenan (2008), at p. 449.

[12] Bloche (2009), pp. 452–454. Of course, the same might be said about the EU, as health care remains a competency of the Member States.

[13] Brown (2008), p. 325; Cutler and Keenan (2008), at p. 451.

[14] Cortez (2008), p. 95.

[15] Hyman and Silver (2001), p. 1452.

[16] World Health Organization (2007); Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960–2008* (2008), at Table 1.

[17] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, *National Health Expenditures and Selected Economic Indicators, Levels and Annual Percentage Change: Calendar Years 2003–2018* (2008), at Table 1.

product (GDP) on health care than other countries. In 2008, health care spending accounted for 16.2% of the US economy, and experts predict it could reach 20.4% by 2018.[18] By contrast, health spending occupies significant but much more modest portions of the economies in Germany (10.6% of its GDP), Canada (10.1%), the Netherlands (9.8%), Denmark (9.8%), Spain (8.5%), and the United Kingdom (8.4%).[19] Moreover, US health care is exceptionally expensive in *per capita* terms. In 2007, US residents spent an average of $7,290 on health care, roughly twice what their counterparts spent in Canada ($3,895), Germany ($3,588), the Netherlands ($3,837), Denmark ($3,512), the United Kingdom ($2,992), and Spain ($2,671).[20] Again, experts largely project US spending to rise,[21] though other countries certainly also struggle with rising costs.

The second criterion for evaluating health systems is quality. Does the health care system provide necessary, appropriate, and high quality care? Does it ensure that health care professionals, facilities, and products meet minimum quality standards? What results does the system generate, and how healthy are residents? The US system does not provide high quality care commensurate with its spending. Although the 'quality' of health care is notoriously difficult to measure, most metrics show that the United States lags behind its peers. For example, in 2000 the World Health Organization (WHO) famously and somewhat controversially ranked 193 countries by the quality and performance of their health systems.[22] The United States ranked 37th in overall performance[23] and 24th in the overall health of its population.[24] More specific comparisons show that the United States does not score well compared to other developed countries on several health-related metrics, such as life expectancy and infant mortality rates, which are admittedly imperfect barometers of quality.[25] Yet, virtually every comparison of

[18] Centers for Medicare and Medicaid Services, *supra* n. 16, at Table 1; Centers for Medicare and Medicaid Services, *supra* n. 17, at Table 1.

[19] Organization for Economic Cooperation and Development, *OECD Health Data 2009: Statistics and Indicators for 30 Countries* (2009) (citing 2007 data).

[20] Ibid.

[21] The potential causes for high health care spending in the United States are many, and are beyond the scope of this chapter. For excellent discussions, see Jost (2007), pp. 174–177, and Cutler and Keenan (2008), at pp. 450–454.

[22] WHO (2000).

[23] Ibid., at p. 155. The WHO measured 'performance' through eight criteria, including how responsive and fair the health system is, how healthy residents are, and health spending per capita. Commentators from the United States often criticize these criteria as being unfairly weighted against the US health care system.

[24] Ibid. at p. 176. The WHO measured 'health attainment' by comparing disability-adjusted life expectancy (DALE) years between countries.

[25] Cutler and Keenan (2008), at p. 452, 453 (noting that the United States ranked 23rd out of 30 countries measured in life expectancy at birth).

'quality' shines an unfavorable light on the US health care system.[26] The US system does certain things very well. It is good at providing innovative, extraordinary, life-saving treatments. But it struggles to provide basic care and prevent common illnesses.[27] As two notable scholars conclude, 'there is precious little evidence that the United States does better than other countries in any material outcome'.[28]

The third criterion is access to care. How difficult is it for people of ordinary means to access health care goods and services? What percentage of the public has health insurance, and what percentage can obtain basic care? How long must patients wait for care? Does the system make care reasonably available to those who need it? Again, despite ample spending, access to health care in the United States is exceptionally erratic. In 2008, 46.3 million people lacked health insurance in the United States,[29] and undoubtedly more have lost insurance during the recent recession. Another 25 million Americans are 'underinsured', defined as those with insurance that requires relatively high cost-sharing obligations (such as premiums, deductibles, and other out-of-pocket spending) relative to income.[30] Although some argue that the uninsured can always get care somewhere, the uninsured do face consequences—in 2002 the Institute of Medicine estimated that 18,000 adults aged 25–64 die each year from treatable conditions because they lack insurance.[31] The United States is the only modern industrialized democracy that relies primarily on private, voluntary health insurance[32]; every other such country approximates universal coverage.[33] United States' residents who are not offered or cannot afford health insurance typically go uninsured. Although it is true that the uninsured do not lack access to all necessary care,[34] they must rely on an unorganized patchwork of 'safety net' providers with precarious funding.[35] Moreover, there are significant disparities in access to care and the quality of care received depending on one's race, ethnicity, and socioeconomic status.[36] Even among the insured, there is

[26] See, e.g., Hussey et al. (2003), pp. 89–99 (comparing the US health care system to four others using 19 quality criteria, such as survival rates from common procedures); American College of Physicians (2008), pp. 1–21; Docteur and Berenson (2009); Commonwealth Fund Commission on a High Performance Health System (2008).

[27] Nolte and McKee (2008), p. 58.

[28] Cutler and Keenan (2008), at p. 453.

[29] DeNavas-Walt et al. (2009), pp. 20, 21 (Table 7).

[30] Schoen et al. (2008), p. w298 (web exclusive). Moreover, Families USA (2007) estimated that during 2006–2007, up to 89.5 million people under age 65 lacked health insurance for at least one month. Families USA (2007).

[31] Institute of Medicine of the National Academies (2002), p. 165.

[32] Jost (2004), at p. 433.

[33] Jost (2007), at p. 178.

[34] Ibid., at p. 2.

[35] See Institute of Medicine of the National Academies (2000).

[36] American College of Physicians (2008), at p. 2.

significant variation in health care costs, quality, and access.[37] Although no country's health care system is completely equitable—wealthier residents tend to access higher quality care more quickly than non-wealthy residents virtually everywhere, the United States is alone among developed countries in allocating health care *primarily* based on one's ability to pay.[38] For decades, US policymakers have tried unsuccessfully to approximate universal insurance coverage.

The US health care system is exceptional in countless other ways. It spends markedly more on administrative costs than any other system.[39] Its medical malpractice compensation system is notorious for being excessive and punitive.[40] And it uses 'one of the most regressive approaches to financing of any country in the world'.[41]

In sum, the US health care system is exceptional: exceptionally expensive, exceptionally inefficient, and exceptionally uneven in distributing care to its population. As Jost concludes, other countries demonstrate that they can 'provide universal access at much lower cost without sacrificing quality'.[42] Indeed, the experience of other countries 'tends to show that in this one particular corner of the economy, government often outperforms the private sector'.[43] Yet the US health care system still clings to the ideal that market competition can solve its problems.

15.3 Market Competition in Europe: Proceeding from a Different Baseline

Despite its exceptional nature, the US health care system is far from the only one to embrace market competition. Virtually every health care system in the EU relies on at least *some* market-based tools and incentives, typically to reduce costs, enhance efficiency, and give patients greater choice.[44] Indeed, health reforms in

[37] Ibid., at p. 1.

[38] Jost (2007), at p. 178, 182 (noting that in most other countries 'health care resources are distributed primarily on the basis of other criteria, though rarely is wealth irrelevant'.).

[39] American College of Physicians (2008), at p. 9; Cutler and Keenan (2008), at p. 452; Jost (2007), at pp. 175–176.

[40] Studdert et al. (2004), p. 283; Leflar (2009), p. 3. Note that despite repeated declarations that the US medical malpractice system significantly contributes to high health care spending, most studies suggest that it contributes no more than 5% to overall spending, even when factoring in the costs of defensive medicine (e.g., ordering tests and procedures motivated by the fear of malpractice liability rather than a judgment that the procedure is medically appropriate or necessary). Cutler and Keenan (2008), at p. 453; Jost (2007), at p. 175.

[41] Jost (2007), at p. 191.

[42] Ibid., at p. 188.

[43] Ibid., at p. 201.

[44] Callahan and Wasunna (2006), at p. 90, 92.

Member States have generally converged around the common trend of introducing market-based incentives.[45]

Of course, some Member States embrace market incentives in health care more than others. For example, Callahan and Wasunna have identified certain States as 'market rejectors' (Denmark, France, Ireland, Italy, Sweden, and the United Kingdom), and others as 'market accommodators' (Belgium, Germany, Israel, the Netherlands, and Switzerland), with others falling in between.[46] Market 'accommodators' generally try to utilize market instruments without sacrificing principles of solidarity or universal coverage.[47] But even the market 'rejectors' (States that historically reject broader, more invasive market mechanisms in health care) generally 'accept some limited role for the market'.[48]

The 'accommodators' have embraced market instruments in several ways. Most notably, the Dutch health care system relies on individual insurance mandates and competition between private insurers (often referred to as 'regulated competition'), building on theories of managed competition developed originally by American economist Enthoven.[49] The Dutch Health Insurance Act, which entered into force on 1 January 2006, requires private managed care organizations to compete annually for individual patients, implementing concepts like selective contracting, using general practitioners as gatekeepers, and vertically integrating with providers.[50] The Dutch system is also notable for the government's efforts to provide objective price and quality information to consumers.[51] Likewise, reforms in Germany, with one of the most expensive health care systems in the world, have tried to encourage competition among both providers and the sickness funds that pay for them.[52] Switzerland, another expensive system, has also encouraged competition among its insurance funds.[53] In fact, the Dutch and Swiss health care systems both have inspired US reform discussions.[54] Thus, although only the

[45] Ibid., at p. 91.

[46] Ibid., at pp. 91–108.

[47] Ibid., at p. 92.

[48] Ibid., at p. 91.

[49] Ven, van de and Schut (2008), pp. 771, 773–774 (noting that the Netherlands 'is the first country that is consistently implementing Alain Enthoven's model of national health insurance based on managed competition in the private sector'); Callahan and Wasunna (2006), at pp. 43, 101–103. Enthoven originally presented his views in a 1977 memo to the US Secretary of Health, Education, and Welfare, subsequently published in two parts in *The New England Journal of Medicine*. See Rosenblatt (1981), at p. 1076 n. 34. See also the chapter by Sauter in this book.

[50] Ven, van de and Schut (2008). Importantly, the Dutch government finances many of the most expensive and least affordable health care goods and services, such as long-term nursing care, hospitalizations over a certain duration, and inpatient mental health care. Jost (2007), at p. 193.

[51] Ven, van de and Schut (2008), at p. 780 (noting that the Dutch government established a website to provide consumers information about insurers, at http://www.kiesbeter.nl).

[52] Freeman (1998b), pp. 179–191; Callahan and Wasunna (2006), at pp. 100, 101. See the chapter by Welti in this book.

[53] Callahan and Wasunna (2006), at 103, 104.

[54] Harris (2007).

Dutch system relies primarily on private insurers, other systems in the EU implement market-inspired policies.

Even the market 'rejectors' have experimented with market instruments in health care. Sweden—with its robust welfare state and general wariness of market influences in health care—has tried easing cost pressures by (i) encouraging hospitals to compete with one another, (ii) utilizing private providers, and (iii) shifting costs to patients via co-payments.[55] Italy has tried to encourage equal competition among public and private providers and, like other countries, has tried to use co-payments to contain costs.[56] Denmark, which has one of the most comprehensive health systems in Europe, increasingly relies on private supplemental insurance.[57] Likewise, 80% of the population in France relies on supplemental private health insurance.[58] Even the United Kingdom's National Health Service (NHS), a well-known paradigm for public, centralized health care, has implemented market-based reforms. Prime Ministers Thatcher and Major both encouraged 'internal competition' among NHS hospitals.[59] The NHS has also tried to encourage managed competition by introducing primary care trusts to pay for care.[60]

Despite these examples, and there are many more, the United States and EU Member States have implemented market-based tools from very different baselines. While the United States is alone among developed countries in relying primarily on private, voluntary health insurance, Member States generally cover everyone, usually through national or social health insurance.[61] Historically, the arguments for more competition in European health care systems 'overwhelmingly took for granted that universal entitlement to health insurance was a given'.[62] Even the Netherlands, with its entrepreneurial traditions and reliance on private insurers, operates from the baseline of solidarity.[63] In contrast, there has been significant disagreement in the United States whether universal coverage is 'desirable and implementable'.[64]

These baselines derive from different priorities. Although every country generally aims to provide quality care to everyone for a reasonable price, the US

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[55] Diderichsen (2000), pp. 931–935; Saltman (1998), pp. 164–178; Callahan and Wasunna (2006), at pp. 95–96.

[56] Callahan and Wasunna (2006), at p. 98 (noting that Italy has some of the highest co-payments in the EU (30%), although nearly half the population does not have to pay them).

[57] Callahan and Wasunna (2006), at pp. 98–99.

[58] Ibid., at p. 99.

[59] White (2007), at p. 401. The NHS 'survived the Thatcher years', when railroads, airlines, and other public services were privatized. Callahan and Wasunna (2006), at p. 93.

[60] Callahan and Wasunna (2006), at p. 94 (noting that market-based reforms in the United Kingdom have ebbed and flowed with Labour party); Ranade (1998b), pp. 101–118.

[61] Jost (2006), at pp. 433–434. Note, however, that like the United States, the Dutch system relies primarily on private insurers.

[62] Marmor (1998), p. 68.

[63] Callahan and Wasunna (2006), at p. 103; Robinson (1998), pp. 147–162.

[64] Marmor (1998), at p. 68.

health care system places a higher priority on independence and entrepreneurship than its peers.[65] Patients are responsible for themselves. Americans generally trust private industry and distrust the government to solve problems.[66] Unsurprisingly, our health care system reflects these values.

In contrast, health systems in the EU are generally based on social solidarity, the belief that citizens are responsible to each other, not just themselves, and that all citizens should have equal access to care, regardless of their ability to pay.[67] There is less distrust of government and less faith that the market can solve all problems. Indeed, '[s]olidarity is fundamentally a rejection of markets as the best means to distributing health care goods and services'.[68] Logically, EU health systems reflect these values.[69]

Among Member States, market-based reforms are intended to reduce costs, increase efficiency, and give patients greater choice—all pragmatic goals. In the United States, proponents tout the same pragmatic goals, but also cling to market-based solutions on ideological grounds, seeking to increase the private sector's role at the expense of the public sector. Thus, market-based solutions are propelled in the United States much more by ideological forces.[70]

Yet, as in the United States, health care systems in the EU (varied as they are) must determine the extent to which health care is an economic, commercial endeavor versus a non-economic, public good. Article 168 of the Treaty on the Functioning of the European Union (TFEU) states that health care is the responsibility of Member States. However, EU law, enunciated through Treaties, Directives, Regulations, and landmark decisions by the European Court of Justice (ECJ), prohibits Member States from restricting the free movement of goods, services, persons, and capital within the internal common market, and bans anti-competitive or protectionist arrangements.[71] Thus, EU law sometimes requires

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[65] Gawande (2009); Jost (2007), at p. 15 (noting that the US health care system typically scores high when evaluating creativity and innovation).

[66] Jost (2007), at p. 117.

[67] Newdick (2008), pp. 844–845 ('Solidarity animates the European idea of health care to this day'.)(internal quotations omitted); Callahan and Wasunna describe 'solidarity' as 'a communal or communitarian moral promise' rather than a publicly recognized right expressed in more individualistic terms. Callahan and Wasunna (2006), at pp. 90, 105. Newdick also contrasts solidarity from 'a modern rights based approach'. Newdick (2008), at p. 845.

[68] Jost (2007), at p. 172.

[69] Callahan and Wasunna (2006), at p. 87.

[70] Ibid., at p. 109.

[71] Several articles of the Treaty on the Functioning of the European Union prevent Member States from restricting the free movement of goods (Articles 34–36 TFEU), persons (Articles 45–48 TFEU), services (Articles 56–62 TFEU), and capital (Articles 63–66 TFEU). Two Articles prohibit anti-competitive arrangements (Articles 101 and 102 TFEU). See Treaty of Lisbon amending the Treaty on the European Union and the Treaty Establishing the European Community, 13 December 2007, *OJ* (C 306) 1, 10, 42; see also Gronden, van de (2008), pp. 705–760.

Member States to consider whether internal health policy decisions restrict free movement or are otherwise anti-competitive.

However, as van de Gronden notes:

> it is difficult and sometimes nearly impossible to draw a distinction between elements of the internal market and features connected with the organization and delivery of health care.[72]

Although EU law dictates that States shall retain responsibility for managing services of general interest like health care and social security, judicial opinions have circumscribed this authority in several high-profile cases by applying free movement and competition requirements.[73] For example, a series of landmark court rulings by the ECJ has held that Member States have limited authority to prevent their residents from traveling to other Member States for non-hospital care, or even to require prior authorization before reimbursing residents for that care back home.[74] These rulings are affecting the basic tradeoffs Member States make in their health care systems, including decisions regarding hospital capacity, waiting lists, and even whether to cover new treatments.[75]

The ECJ is drawing some fine lines here by developing a complicated and technical set of tests for determining the circumstances under which national health care systems violate free movement and competition law. Indeed, in the competition cases, it seems that the more Member States embrace principles of market competition, rather than solidarity, in their health systems, the less claim they have that health care is a non-economic activity not subject to the EU's competition laws.[76] This distinction is the biggest grey area for EU health care systems,[77] reflecting perhaps the broader tensions between economic and social integration in Europe.

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[72] Gronden, van de (2008), at p. 707.

[73] Ibid.; Hatzopoulos (2008), pp. 761–803; Newdick (2008), at pp. 844−867.

[74] ECJ, Case C-158/96 *Kohll* v. *Union des Caisses de Maladie* [1998] *ECR* I-1931; ECJ, Case C-120/95 *Decker* v. *Caisse de Maladie des Employés Privés* [1998] *ECR* I-1831; Case C-157-99 *B.S.M. Geraets-Smits* v. *Stichting Ziekenfonds VGZ and Peerbooms* v. *Stichting CZ Groep Zorgverzekeringen* [2001] *ECR* I-5473; ECJ, Case C-385/99 *Müller-Fauré* v. *Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA, and E.E.M. van Riet* v. *Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen* [2003] *ECR* I-4509; ECJ, Case C-372/04 *Watts* v. *Bedford Primary Care Trust* [2006] *ECR* I-4325; ECJ, Case C-368/98 *Vanbraekel* v. *Alliance Nationale des Mutualités Chrétiennes* [2001] *ECR* I-5363.

[75] Gronden, van de (2008), at pp. 717, 724–725; Newdick (2008).

[76] Gronden, van de (2008), at pp. 740–742, 751 ('[The ECJ has] scrutinized how much room a national social security scheme leaves for competition in the implementation of a social security scheme, and what role the principle of solidarity plays. When a social security scheme is almost completely based on solidarity, the institution managing the scheme cannot be regarded as an undertaking [subject to competition law]. In contrast, if the implementation of a social security scheme is based on a mix of competition and solidarity elements, the institutions concerned do perform an economic activity and can, as a result, be seen as an undertaking [subject to competition law]'.); Hatzopoulos (2002), pp. 710–713.

[77] Hatzopolous (2008).

Thus, although health care systems in the United States and EU both rely on market instruments, these jurisdictions generally proceed from very different baselines. In Europe, market competition enhances more cohesive, comprehensive systems; in the United States, it forms the philosophical foundation. Nevertheless, the United States need not look to Europe or even Canada for examples of efficient, 'government-run' health care (the US Veterans Health Administration) has been hailed as our most successful health care system after major reforms over the past 10–15 years,[78] providing perhaps the most recent domestic example of how non-market alternatives can outperform market instruments in health care.

15.4 Market-based Instruments and Their Limitations

Over the past few decades, the United States' health care system has embraced several market-based techniques to address its problems.[79] However, these tools generally have failed to reduce spending or the number of uninsured.

First, the United States' health care system was transformed in the 1980 and 1990s by 'managed competition', which shifted away from incentives provided by traditional indemnity insurance and fee-for-service medicine, relying instead on competition among insurers to incentivize physicians and other providers to make wiser, more prudent spending decisions.[80] Managed care organizations such as health maintenance organizations (HMOs) began using several tools to lower spending, including: selective contracting with providers; using primary care physicians as gatekeepers to limit access to more expensive specialty care; shifting more financial risks to patients and providers; and using utilization reviews to verify that treatments were 'medically necessary'.[81]

In the 1990s, HMOs, PPOs, and other incarnations gradually supplanted conventional indemnity insurance.[82] Evidence suggests that managed competition actually helped control spending in the United States between 1993 and 1997, although some argue that this was due more to panic by providers anticipating managed care reforms than to organizations actually managing care.[83] But despite

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[78] Longman (2007); Jost (2007), at p. 192.

[79] Callahan and Wasunna (2006), at p. 35 ('Market thought made a great political leap in the 1980s and 1990s. Health care had become an obvious arena to test its applications and implications').

[80] Jost (2007), at p. 18; White (2007), at p. 398; Ranade (1998a), pp. 6, 7.

[81] White (2007), at p. 402, 403; Ranade (1998a), at pp. 6, 7; Cutler and Keenan (2008), at p. 469–470.

[82] White (2007), at p. 410 (Table 2).

[83] Ibid., at pp. 430, 431; Callahan and Wasunna (2006), at pp. 75–77, 206, 207 (managed care was 'an economic success and a political failure', meaning that it successfully suppressed costs, but was unpopular politically, largely because it constrained patient choice) (quoting Robinson (2001), p. 2622).

the decade-long shift toward managed care, spending has continued to rise dramatically since 1997.[84] Moreover, the managed care 'revolution' also failed to reduce the number of uninsured in the United States, which jumped from 34.7 million in 1990 to 46.3 million in 2008.[85] Thus, although managed care introduced several market-based innovations to the US health care system, these innovations generally failed to lower spending or reduce the number of uninsured.[86] Finally, as policymakers and academics on both sides of the political spectrum acknowledge, managed 'competition' requires extensive government regulation and aggressive enforcement of antitrust laws to work.[87]

The second major market-based trend in US health care system has been privatization: increasing the private sector's role in health care and reducing the government's.[88] In most developed countries, health care is traditionally viewed as a public good rather than a commodity subject to the vagaries of the market. The US view differs. Indeed, the long history of American medicine has pointed toward the 'coming of the corporation'.[89] Proponents of privatization believe that private businesses can insure patients, run hospitals, and provide health care more efficiently than the public sector.

Many hospitals have transitioned from not-for-profit to for-profit enterprises.[90] Physicians have become more entrepreneurial, establishing physician-owned hospitals, surgery centers, and laboratories, all of which have proliferated in recent years.[91] But rather than reduce spending, privatization and entrepreneurialism have encouraged a complex web of financial relationships between physicians, hospitals, pharmaceutical companies, and other income-generating ventures. In fact, federal and state governments have sewn together a complicated patchwork of laws that govern financial conflicts of interest by providers, most notably the federal self-referral and anti-kickback statutes.[92]

Even Medicare, the federal health insurance program for the elderly and chronically disabled,[93] has become more privatized in recent years, despite evidence that Medicare generally outperforms private insurers.[94] Indeed, Medicare frequently finds itself as 'the battleground of the market versus government

[84] White (2007), at p. 407 (noting that except between 1993 and 1997, managed care reforms failed to control costs as well as Medicare); Cutler and Keenan (2008), at p. 470.

[85] DeNavas-Walt et al. (2009), at p. 59 (Table C-1). The percentage of uninsured went from 13.9% in 1990 to 15.4% in 2008.

[86] White (2007), at p. 407, 416.

[87] Marmor (1998), at pp. 56, 57.

[88] However, as Richard Freeman notes, 'privatization' and 'marketization' can be distinct phenomena. Freeman (1998), at p. 190.

[89] Starr (1982), pp. 420–449.

[90] Callahan and Wasunna (2006), at pp. 78, 79.

[91] White (2007), at p. 425; Gawande (2009).

[92] 42 U.S.C. §§ 1320a-7b(b), 1395nn.

[93] Cutler and Keenan (2008), at p. 455.

[94] White (2007), at p. 432.

struggle'.[95] Since its inception in 1965, Medicare has delegated responsibilities to private insurers, and Congress has explicitly incorporated private insurers into Medicare.[96] For example, Congress has tried to encourage beneficiaries to receive their Medicare benefits through a private HMO, first through Medicare Part C, then through Medicare+Choice, and later Medicare Advantage.[97] Although private HMOs were supposed to control costs better than traditional Medicare's fee-for-service model, these efforts have proven to be incredibly expensive and almost complete failures.[98]

More recently, when Congress created a new Medicare prescription drug benefit in 2003, it entrusted private companies to run these new plans, believing that elderly Medicare beneficiaries would shop online and compare plans that competed for customers.[99] The thinly-veiled goal was 'to privatize as much of the drug benefit as possible'.[100] Today, Medicare beneficiaries have to choose between more than 2,400 plans offering a staggering variety of co-payments, drug prices, and formularies.[101] Relying on the private sector has not saved Medicare money: the prescription drug legislation gave private insurers $46 billion in incentives to participate, and cost $134 billion over initial estimates.[102] Thus, privatization has also failed to reduce spending.[103]

Third, free-market advocates have touted consumer-driven health plans (CDHPs) as a panacea for the US spending crisis. Consumer-driven theorists claim they can cut spending by requiring patients to spend their own money more wisely (rather than insurers'), thereby reducing demand for care and eliminating waste.[104] CDHPs generally use high deductibles that require patients to pay for most routine care until the high deductible has been met. For example, a family may have to spend $5,000 out-of-pocket before the insurance policy begins to cover expenses. These CDHPs are usually combined with tax-exempt health or medical savings

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[95] Oberlander (2003); Callahan and Wasunna (2006), at pp. 83–85.

[96] Hess (1968), pp. 119–122; Field and Stefanacci (2007), pp. 208–210.

[97] Field and Stefanacci (2007), at pp. 208, 209. Note that enrollment among Medicare beneficiaries was never particularly high, beginning with 8% of beneficiaries in 1995 and peaking at 16% in 1999-2000 before declining back to 11% in 2003. Callahan and Wasunna (2006), at p. 84.

[98] Callahan and Wasunna (2006), at pp. 207, 208; Jost (2007), at p. 201 (noting that the government has dumped billions subsidizing uncompetitive private Medicare Advantage plans).

[99] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, 117 Stat. 2066.

[100] Callahan and Wasunna (2006), at p. 84.

[101] Centers for Medicare and Medicaid Services (2009); Schneider and Hall (2009), pp. 25, 26 (citing a Medicare expert struggling to help an elderly parent select a prescription plan).

[102] Jost (2006), at p. 439; Callahan and Wasunna (2006), at p. 167.

[103] There is also evidence that increased commercialization within Medicaid, the federal-state insurance system for the poor, is problematic and has failed to reduce spending. See Watson (2001), p. 53.

[104] Jost (2007), at pp. 17, 32; Cutler and Keenan (2008), at pp. 470, 471; Marmor (1998), at p. 56.

accounts (HSAs or MSAs).[105] The rationale behind consumer-driven health care is that patients can be turned into consumers if they are forced to pay a larger share of their own health expenses.[106] Today, many insurers offer some form of high-deductible plan in conjunction with health savings accounts. But again, consumer-driven health care has failed to reduce spending, and has not proven to be a viable option for the uninsured.[107]

Thus, none of these market-based innovations (managed competition, privatization, or consumer-driven health care) has reined in spending or solved the problem of the uninsured in the United States. But why? Though the answers are many and complex, the bottom line is that health care is not like other goods and services.

First, market-based innovations in health care depend heavily on principles of neoclassical microeconomics that do not work particularly well in health care.[108] Taking one example, advocates of consumer-driven health care assume that patients can and will make rational, utility-maximizing decisions when spending their own money.[109] But research shows that most patients often do not—and indeed cannot—make perfectly rational decisions about their own health care. Patients' rationality is 'bounded' rather than perfect.[110] Patients' decisions derive as much from behavioral, historical, sociological, and psychological factors as from economic ones.[111] Decisions about diagnoses and courses of treatment are mired in uncertainties.[112] Most patients are not capable of evaluating complex medical information, so they often rely on physicians and other professional intermediaries to make decisions for them.[113]

Health care markets are also saddled with information asymmetries between payers and providers.[114] Information about the price and quality of health care goods and services is scarce.[115] Providers have little incentive to produce unbiased

[105] Federal laws in 1996 and 1997 encouraged these plans, but it was not until Congress passed the Medicare Modernization Act in 2003 that they proliferated. See Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104–191, 110 Stat. 1936; Balanced Budget Act of 1997, Pub. L. No. 105–33, 111 Stat. 251; Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, 117 Stat. 2066.

[106] Jost (2007), at pp. 31, 32.

[107] For a devastating critique of the consumer-driven movement, see Jost (2007).

[108] Jost (2007), at pp. 86–118; Cutler and Keenan (2008), at p. 459.

[109] Jost (2007), at pp. 87, 93.

[110] Madison (2007), p. 1584; Simon (1979), p. 502.

[111] Jost (2007), at p. 31.

[112] Ibid., at p. 93; Appleby (1998), p. 39.

[113] Schneider (1998), pp. 35–46; Jost (2007), at pp. 98–100; Gawande (2009) ('Any plan that relies on the sheep to negotiate with the wolves is doomed to failure', quoting a doctor).

[114] White (2007), at p. 419; Jost (2007), at pp. 97, 98.

[115] Jost (2007), at p. 90.

information and may often have an incentive to conceal it.[116] And many segments of the health care industry still frown upon price advertising.[117]

Predictably, transaction costs are significant in health care.[118] Health insurance serves a valuable function, but it complicates transactions, particularly because most Americans purchase it through yet another intermediary: employers.[119]

Finally, health insurers and providers often enjoy local or regional monopolies, which leads to anticompetitive behavior.[120] For example, there are considerable concentrations of market power in the pharmaceutical, medical device, hospital, physician, and insurance markets.[121]

In summary, neoclassical microeconomics depends on so-called 'perfect' markets, but markets are far from perfect in health care.[122] Health care simply is not like other industries.[123]

Second, several market-based innovations in health care are geared toward discouraging 'moral hazard'—the concern that patients with insurance will over-consume health care precisely because they are insured.[124] Indeed, many market advocates believe moral hazard is the primary problem in health care, and that insurance 'is the problem, not the solution'.[125] But again, health care is not like other goods and services. Seeking health care is often 'time-consuming, inconvenient, unpleasant, uncomfortable, and sometimes just plain painful'.[126] Most insured patients have better things to do than consume health care.[127] Thus, market-based innovations like consumer-driven health care that seek to limit patient demand are not likely to rein in spending.

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[116] Ibid., at p. 90.

[117] Ibid., at p. 98.

[118] Ibid., at p. 91.

[119] As Cutler and Keenan aptly note 'Employers writing checks to health insurance companies fear that they will be made to bear the cost; workers are afraid to leave their jobs because health insurance is tied to work; and everyone is a pink slip away from losing coverage'. Cutler and Keenan (2008), at p. 459.

[120] Jost (2007), at p. 91.

[121] Ibid., at pp. 100, 101; White (2007), at p. 415 ('Overall, a period of market-led transformation of American medical care resulted in the consolidation of both insurers and hospital systems …').

[122] Of course, noted health economist Mark Pauly has argued that the correct comparison is not perfect markets versus perfect government, but imperfect ones. See Pauly (1997), p. 470. See Rice (2002), for a criticism of how market competition works in health care *vis-à-vis* government.

[123] Jost (2007), at p. 32.

[124] Appleby(1998), at p. 39; Gladwell (2005); Jost (2007), at p. xv.

[125] Jost (2007), at pp. 34, 35, 70.

[126] Ibid., at p. 35; Gladwell (2005).

[127] Jost (2007), at p. 35.

In summary, market-based innovations in health care often underestimate how different health care is from other industries.[128] Market incentives are limited, particularly demand-side incarnations like consumer-driven health care. Patients are not 'consumers' in any true sense and providers are not true 'sellers'. The economics of health care is unconventional, and market-based incentives are often a crude and imperfect tool for allocating scarce health care resources. As Joseph White notes, '[t]he market did not control costs, increase access, or help rationalize the American health care system'.[129] Indeed, 'market theory' has been called an 'intellectually spent explanatory paradigm' for health care policy.[130]

But this has not deterred free-market advocates. When the approaches above fail, they argue that it is because we have not created perfect enough markets,[131] or that government regulation still impedes the market. Recognizing the limitations of market-based tools in health care is paramount. But there continues to be a strong pro-market slant among health economists and policymakers in the United States.

15.5 The Ideal of Market Competition in United States Health Reform

Contemporary reform efforts in the United States reveal the extent to which market ideals retain their vigor. Ironically, market ideals have both driven and obstructed recent health reform proposals. Both the 1993 Clinton plan and the 2009 Obama plan took pains to promote competition between insurers and increase patient choice, but each was heavily criticized by market advocates and others concerned that the plans would irreversibly amplify the government's role in health care, perhaps even leading to 'socialized medicine' (a frequently voiced but frequently misunderstood criticism).[132] It is notable that the defeat of the Clinton plan and the significant resistance encountered by the Obama plan both occurred in otherwise favorable political settings: both were championed by Democratic lawmakers that enjoyed a Democratic House, Senate, and Presidency. Yet both plans were bogged down and heavily influenced by criticisms animated by free-market rhetoric. And though reasons for the intense resistance to these plans are numerous and complex,

[128] Cutler and Keenan note that '[e]conomic transactions can happen smoothly or with rough edges. [Health care] is as rough as it gets'. Cutler and Keenan (2008), at p. 459; Jost (2007), at p. 189.

[129] White (2007), at p. 426.

[130] Hunter (2008), at p. 18 (citing Symposium, 'Rethinking Health Law', 41 *Wake Forest Law Review* (2006), p. 341) (internal quotations omitted).

[131] White 2007), at p. 399.

[132] Jost (2006), at p. 99 (citing fears over the Clinton plan); Bobinski (2008), at pp. 372, 373.

many derive from the basic disagreement over the appropriate balance between markets and the government in health care.

In 1993, the Clinton plan relied heavily on theories of managed competition to control costs and improve access to insurance[133] (though as noted above, fostering such competition generally requires extensive government regulation).[134] The legislation was long and complex, in part because of the nature of health reform, but also in part because of 'the lengths to which it went to appease all possible political constituencies', including market advocates.[135] Despite these overtures, opponents won the political debate by seizing on two firmly held beliefs in the United States: first, that achieving universal coverage will require significant government expenditures; and second, that the private sector can more efficiently provide health insurance than the government.[136] However, as several American commentators have noted, 'international evidence in fact provides striking proof that the opposite can be true'.[137] Thus, despite relying on a framework of managed competition, the Clinton plan failed spectacularly. In fact, some speculated that its demise might preclude future reform efforts in the United States.[138]

Sixteen years later, health reform continued to be both driven and shackled by the ideal of market competition. In September 2009, President Obama convened a special joint session of Congress to push for health reform and answer criticisms that the proposed bills would sacrifice competition for government control. His speech mentioned 'competition' four times, reaching the following crescendo:

> My health care proposal has also been attacked by some who oppose health reform as a 'government takeover' of the entire health care system. … So let me set the record straight. My guiding principle is, and always has been, that consumers do better when there is choice and competition. … Without competition, the price of insurance goes up and the quality goes down.[139]

In March 2010, after nearly a year of rancorous debate, President Obama finally signed into law landmark health reform legislation, the Patient Protection and Affordable Care Act.[140] The Act is more accurately cast as health *insurance* reform rather than health *system* reform, as it generally targets access to health

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[133] Health Security Act, H.R. 3600, 103d Cong. (1st Sess. 1993).

[134] Skocpol (1995), pp. 66, 69; Jost (2006), p. 580; Marmor (1998), at pp. 60–61.

[135] Jost (2006), at p. 609 note 411.

[136] Marmor (1998), at p. 67.

[137] See, e.g., ibid., at p. 67; Jost (2006).

[138] See, e.g., Marmor (1998), at p. 62.

[139] President Barack Obama's Remarks to a Joint Session of Congress (9 September 2009), at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care/.

[140] H.R. 3590, 111th Cong. (2nd Sess. 2010), codified as Public Law 111–148. On 30 March 2010, President Obama also signed the Health Care and Education Reconciliation Act of 2010, H.R. 4872, 111th Cong. (2nd Sess. 2010), which makes several amendments to the Patient Protection and Affordable Care Act.

insurance, rather than reforming how the system organizes or delivers care.[141] The Act includes several major reforms that should significantly expand access to health insurance in the United States.

First, beginning in 2014, the Act requires uninsured individuals to purchase health insurance, and those who remain uninsured must pay an additional tax based on their income. In return, the Act outlaws some of the more controversial insurance company practices, such as rescinding policies when patients become sick, imposing lifetime dollar limits on coverage, and denying policies based on preexisting medical conditions.[142]

Second, also beginning in 2014, the bill expands eligibility for Medicaid (the joint federal-state health insurance program for the poor) particularly to uninsured individuals without dependent children who previously were ineligible despite meeting income limits.[143] The bill thus turns Medicaid into a genuine insurance program for the poor, as only half of all poor residents are currently eligible under diverging state eligibility requirements.

Finally, the bill creates state-based health insurance 'exchanges' that allow uninsured individuals to purchase policies that meet minimum coverage requirements.[144] States will receive money from the federal government to establish these exchanges, or states can rely on the federal government to establish a multi-state exchange. Individuals will receive tax credits to pay for insurance premiums, as well as federal subsidies to pay for cost-sharing obligations such as deductibles and co-payments. The bill creates separate insurance exchanges for smaller, self-insured businesses to purchase plans for employees, and these plans are also subsidized federally.

Together, these reforms are expected to reduce the number of uninsured by 32 million over ten years, leaving roughly 23 million uninsured, 'about one-third of whom would be unauthorized immigrants'.[145] Thus, the Act would raise the percentage of 'legal non-elderly residents' with insurance coverage from roughly 83 to 94% nationally.

The Act specifically targets competition in the insurance market. One of the Act's major features is creating health insurance exchanges in which individuals and smaller employers can shop among competing plans.[146] Realizing that health

[141] Although the Act includes provisions that do target the delivery system (e.g., Title III, Subtitle A, 'Transforming the Health Care Delivery System'), few believe that the Act will in fact fundamentally change how health care is delivered in the United States.

[142] H.R. 3590, *supra* note 140, at Title I, Subtitle A, Part A ('Individual and Group Market Reforms').

[143] Ibid., at Title II, Subtitle A ('Improved Access to Medicaid').

[144] Ibid., at Title I, Subtitle D ('Available Coverage Choices for All Americans').

[145] Letter from Douglas M. Elmendorf, Director, U.S. Congressional Budget Office, to Hon. Nancy Pelosi, Speaker of the U.S. House of Representatives, 20 March 2010, at http://www.cbo.gov/.

[146] H.R. 3590, *supra* n. 140, at Title I, Subtitle D.

insurers dominate local markets,[147] the Act tries to subject these markets to regional or even national competition to encourage insurers to offer more generous benefits for lower prices. The Congressional Budget Office estimates that roughly 24 million residents would purchase individual insurance through the exchanges by 2019.[148]

Throughout the legislative process, Republicans and Democrats generally agreed that more competition in the insurance market would improve the price and perhaps the quality of insurance. But unsurprisingly, the parties disagreed pointedly over the precise role the government should play to promote such competition. Most Democrats argued that a public insurance plan (the so-called 'public option') would force private insurers to offer better plans at better rates; most Republicans countered that a public plan would ultimately drive private insurers from the market, inevitably leading to a single payer system. Thus, although both parties generally agreed in principle that reforms should try to make the insurance market more competitive, they disagreed significantly about how to do so. Moreover, many Americans broadly support universal insurance coverage in theory, but there has never emerged anything close to a public consensus on how to achieve it.[149] A single payer system has never seriously been considered.

As a compromise, the Act replaced the so-called 'public option', which generated fierce debate and threatened to undermine passage of the legislation, with a series of alternatives. First, the Act creates local, non-profit health care 'cooperatives' called 'Consumer-Oriented and Operated Plans' (CO-OPs) that will offer insurance.[150] The Act would have created a state-based 'community health insurance option', but this provision was later stricken from the bill.[151] Finally, the Act allows the US Office of Personnel Management to contract with health insurers to offer 'multi-state' health plans in each state exchange.[152] These three programs seem designed to offer consumers alternatives to plans offered by private health insurance companies—without creating anything that could be cast as 'public option'. Nevertheless, not a single Republican Representative or Senator voted for the Patient Protection and Affordable Care Act or the Reconciliation Act that finalized the legislation.

Thus, despite major insurance reforms, the US health care system continues to tether itself to private health insurance, even though this has not and will not produce universal coverage. Indeed, some argue that the ideal of market competition in American health care has 'siphoned energy away from more appropriate

147 Robinson (2004), pp. 11–24.

148 Letter from Douglas M. Elmendorf, *supra* note 145, at p. 9.

149 Cutler and Keenan (2008), at p. 472; Blendon et al. (2003), pp. W3-405-09 (noting that roughly half of Americans surveyed would support single-payer insurance and half would oppose it).

150 See H.R. 3590, *supra* n. 140, at § 1322.

151 Ibid., at § 1040 (amending Title I, Subtitle D, § 1323).

152 Ibid., at § 10104 (amending Title I, Subtitle D, § 1334).

strategies of reform'.[153] Ironically, the ideal has both animated and burdened contemporary health reform efforts.

15.6 Markets in Health Care: Toward a More Perfect Union?

What is the appropriate role for market competition in health care? For the United States, this is the $2.3 trillion question. Unfortunately, given the nature of health care, there are no reliable formulae that might guide us. And the experiences of peer countries, most of which seem to have found a better balance, are so varied and complex that it is difficult to extract many useful lessons.[154] In each system, the goal is to use the market 'without doing harm to the moral values of medicine, most notably the primacy of patient welfare and professional integrity'.[155] But in the United States, another, more basic goal continues to elude us: using the market not only to control spending, but to increase access to care.

Fortunately, there seems to be relatively broad support to pursue the following principles, even though there remains significant and possibly even intractable disagreement over precisely how to implement them.

15.6.1 Insurers Should Compete

Data reveal that there is not much local competition between health insurers in the United States, and many locales show significant concentrations of market power.[156] Thus, contemporary reform efforts have often placed a high priority on stimulating competition between insurers, or least removing existing barriers to it. To some, this means shifting away from employer-based insurance toward a more flexible individual market, as in the Netherlands.[157]

Regardless of the tactic, both domestic and international experiences suggest that creating a competitive insurance market requires significant government involvement. For example, the Patient Protection and Affordable Care Act would create state insurance exchanges for those without access to affordable group insurance.[158] The Act relies on significant government oversight to achieve the dual purposes of controlling costs and expanding access to coverage, recognizing that a less encumbered insurance market does neither. Regulators can facilitate the

[153] Marmor (1998), at p. 69.

[154] Callahan and Wasunna (2006), at pp. 4, 203.

[155] Ibid., at p. 36.

[156] American Medical Association (2006); Jost (2007), at pp. 100, 101; White (2007), at p. 415.

[157] Ven, van de and Schut (2008).

[158] See *supra* n. 140.

market by addressing various market failures, for example by requiring risk pooling, community rating, guaranteed issue, portability, renewability, and limiting rescissions.[159] Some of these interventions are more controversial than others, but none generate as much intense debate as the proposal to provide a public, government sponsored insurance plan to compete with private insurers.

15.6.2 Providers Should Compete

Data also reveal significant concentrations of market power among health care providers.[160] As with the insurance market, there is no easy solution. But the following two philosophies might create a more transparent, competitive market. First, because price advertising is still taboo in much of the health care industry, many recommend that we require providers to list their prices publicly in order to facilitate comparison shopping.[161] Indeed, encouraging price transparency has been perhaps the most important and realistic contribution of the consumer-driven movement.[162] Second, a growing contingent calls for financing reforms like 'pay-for-performance' that could better align the incentives of providers with those of patients and payers by explicitly linking payments to outcomes and quality benchmarks.[163] Providers that improve the health of their patients would receive higher payments than those who did not, particularly providers with higher complication or hospital readmissions rates.[164] The goal is to use financial incentives to improve care, encouraging quality over quantity (the bane of fee-for-service models).[165]

15.6.3 Competitive Markets Require Accurate, Objective Information

Competitive health care markets require not only better price information, but also better information about quality than these markets currently provide. For example, in an ideal world, patients and insurers could access a database or website that

[159] See, e.g., Arrow, et al. (2009), p. 493; Marmor (1998), at p. 67.

[160] Jost (2007), at p. 100.

[161] See, e.g., American College of Physicians (2008), at p. 13; Jost (2007), at p. 194.

[162] Jost (2007), at p. 85.

[163] Cutler and Keenan (2008), at p. 464.

[164] Ibid.

[165] Ibid.; Arrow et al. (2009), at p. 493; Gawande (2009) ('As economists have often pointed out, we pay doctors for quantity, not quality').

would allow them to compare the quality of service providers.[166] There is little disagreement in principle that we need better quality information.[167] On the other hand, recent efforts to generate better information about the quality of health care goods and procedures have generated controversy. Comparative effectiveness studies and technology assessments cure at least some information asymmetries by allowing patients, professionals, and payers to compare goods and services.[168] The market alone does not reliably produce this information,[169] which may be why many countries seem to be embracing these studies.[170] In the United States, comparative effectiveness research has generated controversy, in part because some believe that it leads to government 'rationing',[171] despite evidence that governments rarely use such research to deny coverage for effective technologies.[172] Thus, although the Patient Protection and Affordable Care Act would support comparative effectiveness research, it would not allow the government to make coverage or reimbursement decisions based on these findings.[173]

15.6.4 Modest Cost-sharing

Many countries have found that modest cost-sharing can be an effective method of controlling costs and encouraging more responsible, cost-sensitive consumption of health care—but only if it does not deny access to care for poorer populations or deter patients from obtaining necessary care.[174] For example, tiered pharmaceutical plans with varying co-payments can encourage patients to use less expensive generics in appropriate circumstances, and co-payments also encourage more judicious visits to physician offices and emergency rooms.[175] But cost-sharing is not very effective for services like hospitalization, over which patients exercise very little control.[176] Thus, modest cost-sharing with payments based on income

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[166] Jost (2007), at p. 200.

[167] For a discussion on the limits of this approach, see Schneider and Hall (2009), at pp. 7–65.

[168] Arrow et al. (2009), at p. 493. For a critique of technology assessments, see Elhauge (1996), p. 1525.

[169] Callahan and Wasunna (2006), at p. 173 (citing studies); Jost (2007), at p. 198 (noting that political pressure hampers Medicare payment and coverage determinations).

[170] Callahan and Wasunna (2006), at pp. 172, 173; Dickson et al. (2003), p. 3; European Network for Health Technology Assessment, at http://www.eunethta.net/.

[171] See, e.g., Gottlieb (2009), p. A15.

[172] Jost (2007), at p. 185.

[173] H.R. 3590, *supra* n. 140, at § 6301(j).

[174] Hall and Schneider (2009), p. 743; American College of Physicians (2008), at pp. 13-14; Jost (2007), at pp. 130, 131, 191.

[175] Jost (2007), at pp. 196, 197.

[176] Ibid., at p. 197.

can encourage patients to consume certain health care goods and services responsibly.

It is important to keep in mind that not all health care goods and services are created equal. For example, expensive acute and longer term care can be financially catastrophic for patients, and it is this type of capricious risk that health insurance is well designed to handle.[177] We should subsidize this type of care for those who cannot afford it and be wary of market mechanisms, particularly demand-side incarnations like consumer-driven health care, that promise to reduce costs here. On the other end of the spectrum, more predictable, low-cost health care goods and services seem to be more responsive to demand-side incentives, at least for those with sufficient income.[178] Other services that are more susceptible to moral hazard, such as cosmetic surgery, also seem to respond to cost-sharing incentives and provider competition.[179]

There is evidence that supply-side competition works best 'with the help of demand-side control imposed by government monopsonistic purchasing clout',[180] reflected in efforts to introduce a public health insurance option to compete with private insurers.[181] The United States uses both supply-side and demand-side incentives, 'perhaps the worst of both worlds' because cost-sharing is not complete enough to restrain demand, and care is not managed systematically enough to restrain supply.[182] Supply-side limits are much more common in other countries, but demand-side limits like consumer-driven health care seem to be the device *du jour* of the pro-market crowd.[183] Nevertheless, there seems to be a growing consensus that market-based incentives work better on the supply side (where, for example, they can encourage providers to offer better prices and higher quality care) than on the demand side (which relies, for example, on patients to make wise spending decisions).[184]

15.6.5 Retail Care

There has been a proliferation of private retail clinics in the United States that provide basic care in retail chain pharmacies, supermarkets, and discount stores.[185]

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[177] Ibid., at pp. xii, 192, 193.

[178] Ibid., at pp. 193–194.

[179] Ibid., at pp. xvii, 193.

[180] Callahan and Wasunna (2006), at p. 209.

[181] The legislation passed by the US House of Representatives included such an option. See Affordable Health Care for America Act, H.R. 3962, 111th Cong. (1st Sess. 2009); Jost (2007), at p. 195.

[182] Cutler and Keenan (2008), at p. 470, 471.

[183] Ibid., at p. 471.

[184] Saltman and Figueras (1996), p. 20; Schneider and Hall (2009), at pp. 10, 11.

[185] Sage (2007), pp. 1233–1334.

These clinics employ a number of market-based innovations that make them attractive to the uninsured and under-insured, thus potentially expanding access to care. For example, retail clinics typically accept cash payments rather than insurance; openly post prices; have low overhead and maintain expansive hours; provide basic care for common ailments; employ mid-level practitioners such as physicians assistants and nurse-practitioners; make use of electronic medical records and computerized practice guides; and focus on customer service.[186] Retail clinics generally expand access to care and introduce a modicum of competition in the *delivery* of care.[187] The retail movement has delivered several innovations, though the government should still cover routine health care for the poorest among us.[188]

Together, these market-facilitating philosophies underscore the reality that competition in health care works best when coupled with relatively strong government regulation to guide it.[189] Competitive insurance markets require extensive government regulation to combat market failures like adverse selection and moral hazard. Competitive provider markets require robust enforcement of antitrust and fraud and abuse laws.[190] Markets alone do not provide reliable comparative information about the price or quality of health care goods and services. Indeed, some argue that for any market-based reforms to successfully improve cost, quality, and access in the United States, they 'would have to include such substantial restrictions on the normal ways of doing business in US markets that it would be barely recognizable as market-oriented in the American context'.[191] White echoes this sentiment, arguing that '[e]ffective reform will require restraining the market, not relying on it'.[192] Finally, facilitating competition is not costless: the 'transaction costs' of regulating and promoting competition can often 'mean that the efficiency gains of competition are used to sustain the system of competition itself'.[193]

In short, the logic and goals of markets do not produce the type of health care system that most Americans want.[194] The basic market for health care in the United States gives providers wide latitude to pursue profits, requires patients and payers to shop intelligently for health care goods and services, and grants entrepreneurs broad access to capital.[195] But these features 'do not appear to be helping

[186] Ibid., at pp. 1238–1242.
[187] Ibid., at p. 1235.
[188] Jost (2007), at p. 194.
[189] Callahan and Wasunna (2006), at p. 209.
[190] Haas-Wilson (2003).
[191] White (2007), at p. 399 (internal quotations omitted).
[192] Ibid., at p. 436.
[193] Freeman (1998a), p. 400.
[194] White (2007), at pp. 395, 434.
[195] Ibid., at p. 434.

the health care system attain its goals'.[196] The United States' health care market does provide a wide array of choices and does offer sophisticated, high-end care.[197] But it does so at a significant cost. Our system encourages innovation, but the immense innovation over the last twenty years has not markedly improved our system.[198]

Markets alone will not adequately insure the elderly or sick among us. Universal coverage requires some people to subsidize others, and no country provides universal coverage without the government compelling such subsidies.[199] Equity is not what markets provide, and markets have failed to provide a more equitable and efficient system.[200]

15.7 Conclusion

The United States remains an international outlier in health care, both functionally and philosophically. Though EU Member States also rely on market instruments in health care, and similarly struggle to locate the appropriate boundaries, these nations generally implement market-based policies from a baseline of universal coverage that the United States does not enjoy, even after major health insurance reform. The ideal of market competition in the US health care system persists, but continues to elude us, as demonstrated by contemporary reform efforts. The evidence suggests that market theories and policy instruments have yet to produce the health care system most Americans want. Recognizing the limits to market competition in health care—including learning to distinguish where it is helpful from where it is not—will be necessary to further improve our system.

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