CHAPTER

1

WHY SHOULD THE ECONOMICS OF HEALTH BE RECONSIDERED?

1.1 Context

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

The United States is a case in point. Two examples reflect the way in which health insurance has been extended to segments of the population. In 2006, the Medicare program, which serves Americans aged 65 or older and some people with disabilities, was expanded to include prescription drugs. This expansion was implemented by having the new benefits provided by competing private insurance companies. Similarly, when the Affordable Care Act was being debated in 2009 and 2010, President Barack Obama called for a public insurance option as an alternative to compete against private insurers, but this was ultimately rejected such that coverage for previously uninsured individuals can only be provided by the private sector.

Other countries have followed a similar path. Most notable is the Dutch healthcare system, which in 2006 implemented major reforms to its universal healthcare system by embracing the notion of competing private insurers. The Dutch system relies heavily on competition carried out through consumer choice among health insurance plans, but the system differs substantially from that of the United States. For example, in the Dutch system there is universal health insurance coverage, almost all insurers are nonprofit, government sets limits on the growth in hospital spending, and pharmaceutical prices are controlled by paying no more than in other countries (Rice 2021).

The perceived success of this increasingly competitive marketplace in healthcare sectors is part of a broader trend in the United States, in which markets are viewed as efficient and government is viewed as inefficient. As

Robert Kuttner (1997) wrote, "America . . . is in one of its cyclical romances with a utopian view of laissez-faire." The relevance of this statement persists more than two decades later because the cycle has not yet ended. We do not mean to imply, either in the health sector or in the economy as a whole, that policymakers have eschewed government involvement. Our concern is that healthcare markets are moving in this direction and that economic theory is used—inappropriately, we will argue—in support of market-based health policies.

The intellectual case for relying on markets in health is based in part on the writings of Alain Enthoven, who advocates reliance on consumer choice and competition to improve the efficiency of healthcare markets (Enthoven 1978a, 1978b, 1988, 2003; Enthoven and Kronick 1989a, 1989b). Nevertheless, Enthoven asserts that government has two key roles: (1) ensuring that competition is based on price rather than selection of the healthiest patients, and (2) providing subsidies to low-income persons.

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

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

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

chapters we show their implications in the fields of health economics and health policy.

1.2 Purpose of the Book

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

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

If economic theory does not demonstrate the superiority of market forces in health, questions must be answered empirically. To a large extent, that is exactly what health economists and health services researchers are trying to do. We have few reservations about the kinds of research studies being conducted. Our concern is that the work will suffer if researchers approach it with preconceived notions of what the results ought to be.

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

The fifth edition of this book updates and condenses earlier material, adds a new chapter, and expands another. The fourth edition's chapter 4 on the demand for health, insurance, and services, has been divided into two chapters. Chapter 4 now focuses on the demand for health, expanding the topic to include important new material on the social determinants of health, while the former chapter 4 content that covers the demand for health insurance and services now appears in chapter 5. (The previous chapter 5, on externalities of consumption, has been deleted.) Chapter 10 is new and presents a review of the field of behavioral economics. (Previous editions of the book gave considerable attention to this topic, but it was scattered throughout the chapters.) The fourth edition's chapters 10, 11, and 12 were revised and renumbered, appearing as chapters 11, 12, and 13 in the fifth edition.

The book is also addressed to noneconomics professions. Because students and practitioners in these disciplines obviously tend to be less schooled in the details of economic analysis, they often must take health economists at their word when the latter speak about the policy implications of economic

analysis in general and the superiority of markets in particular. (In this regard, Joan Robinson has been quoted as advising, "Study economics to avoid being deceived by economists" [in Kuttner 1984].) We hope this book will help put those in disciplines other than economics on a level playing field when it comes to discussions of health policy.

1.3 Outline of the Book

The book is divided into 12 main chapters (2 through 13) and a brief conclusion. Chapter 2 covers nearly all the major topics a course in microeconomic theory would cover. A few remaining topics (e.g., labor economics) are discussed later in the book. Those who are already familiar with intermediate microeconomic theory can proceed directly to the other chapters. Others may want to refer to chapter 2 when reading the later material.

Chapter 3 supplies a list of the assumptions on which the superiority of market competition is based, as well as an overview of the role of government. We critique those assumptions in the chapters that follow. The next two chapters focus on the theory of demand, including demand for health and its social determinants in chapter 4, and the demand for health insurance and for health services in chapter 5. Chapters 6 through 8 focus on supply: issues of competition and market power in healthcare supply, for-profit medicine, and workforce issues, respectively. Chapter 9 explores equity and justice, a topic of tremendous importance to policy but one that has received insufficient attention from health economists. Chapter 10 synthesizes contributions to health economics from the field of behavioral economics. Chapter 11 covers healthcare expenditures, and chapter 12 examines economic evaluation, including cost–benefit, cost-effectiveness, and cost–utility analyses. Chapter 13 discusses ways that high-income countries can organize, and have organized, their healthcare systems, and it includes cross-national empirical evidence on outcomes and costs and tentative lessons from this evidence. The conclusion offers some final thoughts concerning the role of competition in the healthcare sector.