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Competition in a publicly funded healthcare system

Are the UK and other countries right to adopt a market based model for improving their health services? **Steffie Woolhandler** and **David Himmelstein** believe that the appropriate response to the US experience with such policies is quarantine, not replication

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Why would anyone choose to emulate the US healthcare system? Costs per capita are about twice the Organisation for Economic Cooperation and Development average. Forty seven million people are completely uninsured. Many others with insurance face high out of pocket costs that hinder care and bankrupt more than a million annually.[1] Mortality statistics lag behind those of most other wealthy countries, and even for the insured population, clinical outcomes and patient satisfaction are mediocre.[2 3]

This dismal record arises, we contend, from health policies that emphasise market incentives. Even as the public share of health spending in the US has risen to 60% (box) investor owned firms have eclipsed the public, professional, and charitable bodies that previously managed the financing and delivery of care. The development and effect of US policies that mix public funding and private management has wider relevance because politicians in Europe and beyond are pushing analogous schemes.

Failure of private contracting in Medicare

The combination of tax funding and market oriented delivery is exemplified by the US Medicare programme, which has a budget more than double that of the entire NHS. Until 1965, many US employers offered private health cover, but elderly, poor, and disabled people were mostly uninsured and forced to rely on threadbare government institutions or charity. In 1965, Congress established the Medicare social insurance programme for elderly people. Private hospitals gained a vast new market, and investors soon took note, launching for-profit chains that now account for 15% of US acute care hospitals. Similarly, for-profit dialysis firms rushed in after the government made everyone with end stage renal disease eligible for Medicare in 1972.

Until the 1970s, private insurers (mostly founded and controlled by doctors and hospitals) and Medicare exerted minimal oversight of care and payment rates. But soaring costs prodded employers and government to assert more control. In the private sector, managed care and health maintenance organisations (HMOs)—most of which were controlled by investors rather than health providers and vigorously intervened in clinical care—rapidly gained a foothold.

In the mid-1980s, Medicare also began encouraging elderly people to enrol in private HMOs. Government paid the private plans a fixed monthly premium for each person who switched from traditional (fee for service) Medicare, with the HMO taking over responsibility for purchasing (or, rarely, providing) care. This arrangement was touted as a means to bring market efficiency to the public programme and to broaden patients' choices.

Unfortunately, the first crop of Medicare HMOs yielded mainly scandal—for example, a major political donor whose plan enrolled thousands of aged patients in Florida (and collected tens of millions of government dollars) but neglected to contract with doctors or hospitals to care for them. He fled prosecution, eventually seeking refuge in Spain.[4]

Subsequently, Medicare applied stricter regulations. The government set the HMOs' payment at 95% of the average monthly cost of care for a patient in traditional Medicare, with the expectation of 5% savings through improved efficiency. Patients who chose an HMO—attracted by free spectacles, lower copayments, and other benefits not covered under traditional Medicare—were free to return to traditional Medicare whenever they wished.

HMOs recognised an opportunity in the skewed distribution of health costs. Most patients use little care—indeed 22% of elderly people cost Medicare nothing at all each year—while the fraction who are severely ill account for the lion's share of expenditures. Astute HMO executives quickly realised windfall profits through cherry picking—recruiting healthier than average older people who brought hefty premiums but used little care—and returning sick patients, and their high medical bills, to the traditional Medicare programme—disrupting care for millions.[5]

HMO marketing departments devised selective

Tax financed health spending in US

- Official figures for 2005 peg government's share of total health expenditure at 45.4%, but this excludes:
  Tax subsidies for private insurance, which cost the federal treasury $188.6bn (£92bn; €129bn) in 2004 and predominantly benefit wealthy taxpayers
  Government purchases of private health insurance for public employees such as police officers and teachers. Government paid private insurers $120.2bn for such coverage in 2005: 24.7% of the total spending by US employers for private insurance
- Government's true share amounted to 9.7% of gross domestic product in 2005, 60.5% of total health spending or $4048 per capita (out of total expenditure of $6697)
- By contrast, government health spending in Canada and the UK was 6.9% and 7.2% of gross domestic product respectively (or $2337 and $2371 per capita)
- Government health spending per capita in the US exceeds total (public plus private) per capita health spending in every country except Norway, Switzerland, and Luxembourg

recruitment schemes to attract healthy people. These included free fitness club memberships, complementary recruiting dinners at times and places inaccessible to frail elderly people, and advertisements painted on the bottoms of swimming pools. HMOs used financial incentives to encourage doctors to persuade sick patients to leave the HMO—for example, deducting payments to specialists from the primary care doctor's own capitation payment. Hence, a general practitioner could raise her income by advising patients needing hip replacement to leave the HMO, and even convince herself that such advice might benefit patients by freeing them of HMO restrictions on the choice of surgeon and hospital.

HMOs concentrated on ensuring convenient and attractive care for the modest needs of healthy (and profitable) older people. Meanwhile, expensive, ill patients fared poorly. Stroke patients, those needing home care, and others with chronic illnesses got skimpy care, had bad outcomes, and fled HMOs.[5-8] And when all else failed and an HMO found itself saddled with too many unprofitably ill patients in a particular county, executives simply closed up shop in that area and returned the patients to traditional Medicare.

By the late 1990s, private HMOs' selective enrolment of healthy elderly people and removal of sick people had raised annual Medicare costs by about $2bn.[9] Yet despite this subsidy, HMOs couldn't effectively compete with traditional Medicare. The burden of administrative costs—about 15% in the largest Medicare HMO[10] compared with 3% in traditional Medicare—was too great to overcome. Many HMOs couldn't sustain the extra benefits they had offered at the outset to attract members.

As enrolment fell, HMOs lobbied hard for government rescue, and Congress upped their payments. Currently, Medicare pays private plans $77bn annually; the cost of caring for the eight million Medicare members who have switched to HMOs is 12% above the cost of caring for comparable patients in traditional Medicare.[11]

Medicare's HMO contracting programme, originally touted as a market based strategy to improve the public programme's efficiency, has evolved into a multibillion dollar subsidy for private HMOs. Moreover, the massive financial power amassed by these firms (largely at government expense) is a political roadblock to terminating this failed experiment.

Is private really better?

Other US experiments in using public money to buy care from private firms have also disappointed. Costs for the private insurance that government purchases for public employees have risen even faster than Medicare's.[12] According to comprehensive meta-analyses, investor owned renal dialysis centres (funded almost entirely by the special Medicare programme that covers everyone needing long term dialysis) have 9% higher mortality than non-profit centres despite equivalent costs[13]; and investor owned hospitals—which receive most of their funding from public coffers—have

By the late 1990s private health plans were selectively enrolling healthy people and removing sick ones

2% higher death rates and 19% higher costs than non-profit hospitals.[14 15] Despite spending less on nurses and other clinical staff, investor owned hospitals spend more on managers.[16]

If the failings of private contracting in the US are underappreciated, so is the major success story of recent US health policy: the Veterans Health Administration system. This network of hospitals and clinics owned and operated by government was long derided as a US example of failed Soviet-style central planning. Yet it has recently emerged as a widely recognised leader in quality improvement and information technology. At present, the Veterans Health Administration offers more equitable care, of higher quality, at comparable or lower cost than private sector alternatives.[17]

Costs of market forces

Health care's shift from a public service to a business model has raised costs, partly by stimulating the growth of bureaucracy. The proportion of health funds devoted to administration in the US has risen 50% in the past 30 years and now stands at 31% of total health spending, nearly twice the proportion in Canada.[18] Meanwhile, administration has been transmogrified from the servant of medicine to its master, from a handful of support staff dedicated to facilitating patient care to a vast army preoccupied with profitability.

Recent trends elsewhere indicate that the US experience is not unique. The advent of internal markets sharply increased administrative costs in the UK[19] and New Zealand.[20] The overheads of Canadian private insurers are 10 times higher than those of public provincial health insurance programmes.[18] In Australia, tax subsidies for private insurance have directed money through private firms, whose overhead is 12% (versus 3.5% in the public programme)[21]; the private hospitals favoured by current policies are about 10%

costlier than public ones.[22] As Germany's insurance plans have adopted an increasingly business-like mode of operation, administrative costs have soared, rising 63.3% between 1992 and 2003; meanwhile doctors complain about an avalanche of paperwork.[23]

Two factors are at work. Firstly, fragmenting the funding stream, with multiple payers rather than a single government one, necessarily adds complexity and redundancy. Secondly, high administrative costs are intrinsic to the commercial mode (in medical care as elsewhere). Each party to a business transaction must maintain its own detailed accounting records, not primarily for coordination but as evidence in case of disputes.[24] Moreover, investors and regulators demand verification by independent auditors, generating yet another set of records. Thus the commercial record replicates each clinical encounter in paper form before, during, and after it takes place in the examining room. The sense of mutual obligation and shared mission to which medicine once aspired becomes irrelevant, even a liability. Hence, the decision to unleash market forces is, among other things, a decision to divert healthcare dollars to paperwork.

Market failure

Market theorists argue that although competition increases administration, it should drive down total costs. Why hasn't practice borne out this theory?

Investor owned healthcare firms are not cost minimisers but profit maximisers. Strategies that bolster profitability often worsen efficiency. US firms have found that raising revenues by exploiting loopholes or lobbying politicians is more profitable than improving efficiency or quality. Columbia/Hospital Corporation of America (HCA)—the biggest US private hospital operator—deliberately submitted inflated bills and expenses to the government, structured business deals so that Medicare picked up the cost of corporate expenses, and paid doctors in return for patient referrals.[25] Tenet, the second largest hospital firm, has a long history of legal problems. In the 1980s (when the firm was known as National Medical Enterprises) it gave doctors kickbacks to boost referrals and improperly detained psychiatric patients in order to fill beds, resulting in legal settlements totalling nearly $700m.[26] More recently, Tenet paid hundreds of millions of dollars in fines to resolve claims that it offered kickbacks for referrals; claimed excessive sums from Medicare; and that its hospitals performed hundreds of unnecessary cardiac procedures.[27-29]

Overcrowded US emergency departments turn away an ambulance once a minute, on average

For-profit executives' incomes also drain money from care. When Columbia/HCA's chief executive officer resigned in the face of fraud investigations into the company, he left with $324m in company stock. Tenet's chief executive exercised stock options worth $111m shortly before resigning under pressure from investors in 2003. The head of HealthSouth (the dominant provider of rehabilitation care, mostly paid for by Medicare) made $112m in 2002, the year before his indictment for fraud (charges of which he was later acquitted) and four years before his conviction on unrelated bribery charges.[30]

Even chief executives of untainted firms have reaped enormous rewards. Former Harvard geriatrician John Rowe earned $225 000 a day (including Sundays and holidays) in his 65 months running Aetna health insurance company.[31] Bill McGuire made $1.6bn after giving up pulmonary medicine to run UnitedHealthcare.[32]

While private contracting has benefited executives and shareholders, it has increased costs and worsened quality because health care cannot meet the fundamental requirements for a functioning market. It is fashionable to view patients as consumers, but seriously ill people (who consume most care) cannot shop around, reduce demand when suppliers raise prices, or accurately appraise quality. They necessarily rely on their doctor's advice on which tests and treatments to "purchase."

Even for sophisticated buyers like government, the "product" of health care is notoriously difficult to evaluate, particularly since doctors and hospitals create the data used to evaluate and reward them. When Tenet hospitals did heart surgery on healthy patients, the surgical outcomes appeared first rate. Even for honest firms, careful selection of lucrative patients and services is the key to success. Conversely, meeting community needs often threatens profitability and hence institutional survival. In the past decade 425 emergency departments—magnets for both very sick and uninsured patients unable to pay—have closed. Overcrowded US emergency departments turn away an ambulance once a minute, on average.[33]

Finally, a real market would require multiple independent sellers, with free entry into the marketplace. Yet many hospitals exercise virtual monopolies; half of Americans live in regions too sparsely populated to support real medical competition.

What's driving privatisation?

Evidence from the US is remarkably consistent; public funding of private care yields poor results. In practice, public-private competition means that private firms carve out the profitable niches, leaving a financially depleted public sector responsible for the unprofitable patients and services. Based on this experience, only a dunce could believe that market based reform will improve efficiency or effectiveness. Why do politicians—who are anything but stupid—persist on this track?

Hallmarks of market based reforms

- Market reforms aim to bring medicine into the realm of commerce, where commodities (homogeneous goods or services) are bought and sold for profit
- The first stage of this process is to divide the medical enterprise into discreet, saleable units (commodities), creating buyers and sellers—for example, separating responsibility for financing and providing care or moving from global hospital budgets to fixed payment for a specific procedure
- Once medical commodities are defined, the sellers (medical providers) are forced to compete, giving rise to financial winners and losers
- Because most medical commodities are heterogeneous (patients differ) providers can gain advantage by market segmentation—for example, caring for a relatively healthy subgroup of patients with a particular diagnosis
- Profitable providers attract investors and amass the financial (and political) power to expand their opportunities, while unprofitable ones are driven from the market

Such reforms offer a covert means to redistribute wealth and income in favour of the affluent and powerful. Privatisation trades the relatively flat pay scales in government for the much steeper ones in private industry; the 15-fold pay gradient between the highest and lowest paid workers in the US government gives way to the 2000:1 gradient at Aetna.

But even more important, privatisation of publicly funded health systems uses the public treasury to create profit opportunities for firms needing new markets. US private insurers used to focus on selling coverage to employer sponsored groups and shunned elderly people as uninsurable. Now, with employers cutting health benefits, insurers have turned to public treasuries for new revenues. And why stop at selling insurance? Why not tap into the trillions spent annually on care in hospitals and doctors' offices?

Lessons for other countries

Market fundamentalists conjure visions of efficient medical markets partnered with government oversight and funding to assure fairness and universality. But regulation is overmatched. Incentives for optimal performance align imperfectly, at best, with the real goals of care. Matrices intended to link payment to results instead reward entrepreneurs skilled in clever circumvention. Their financial and political clout grows; those who guilelessly pursue the arduous work of good patient care lose in the medical marketplace.

Health systems in every nation need innovation and improvement. But remedies imported from commerce consistently yield inferior care at inflated prices. Instead we prescribe adequate dosing of public funds; budgeting on a community-wide scale to align investment with health priorities and stimulate cooperation among public health, primary, and hospital care; encouragement of local innovation; explicit empowerment of patients and their families; intensive audit for improvement, not reward or blame; a system based on trust and common purpose; and leadership not by corporations but by "imaginative, inspired, capable and . . . joyous people, invited to use their minds and their wills to cooperate in reinventing the system, itself . . . because of the meaning it adds to the lives and the peace it offers in their souls."[34]

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Contributors and sources: SW and DUH work as primary care doctors at an urban public hospital. Stimulated by their patients' difficulties in obtaining care, they began research into the inadequacies of US health care. In 1986 they cofounded Physicians for a National Health Program (**www.PNHP.org**), which advocates non-profit national health insurance in the US. Both authors participated equally in all aspects of this work, which draws on their research, experience as clinicians in the US healthcare system, and extensive literature review. Both serve as guarantors.

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SUMMARY POINTS

The US has long combined public funding with private healthcare management and delivery

Extensive research shows that its for-profit health institutions provide inferior care at inflated prices

US experience shows that market mechanisms undermine medical institutions unable or unwilling to tailor care to profitability

Commercialisation drives up costs by diverting money to profits and fuelling growth in management and financial bureaucracy

The poor performance of US health care is directly attributable to reliance on market mechanisms and for-profit firms and should warn other nations from this path

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