**e-Rounds 16**

*Competition in a publicly funded healthcare system*

**Background:** Although we typically think of the United States healthcare system as “private”, we are reminded that the US government’s true share of total healthcare spending (2005) was 60%, or 9.7% of its’ GDP (6.9% in Canada). This month’s e-Rounds reviews an essay examining tax funded healthcare and market-orientated delivery, as exemplified by Medicare’s social insurance for the elderly in the United States.

**Methods and Limitations:** This is an essay by two influential and well-informed health policy academics from Harvard Medical School. It is an interpretation of the evidence subject to any and all biases arising from such a source. While debate remains intensely polarized in the US, the analysis offered by Woolhandler and Himmelstein represents a view held by many, including Canadian Doctors for Medicare.

**Analysis:** The U.S. Congress enacted Medicare in 1965, opening a vast new market for, and the launch of, private, investor-owned, for profit healthcare delivery. The number of private hospitals sky-rocketed. With health care costs escalating through the 70s, managed care and health maintenance organizations (HMOs) were introduced, mostly owned by private investors keen to maximize profit. In the name of cost control, HMOs aggressively intervened in clinical decision-making. In the 1980s, Medicare encouraged the elderly to enroll in private HMOs and set HMO payment rates at 95% of the average monthly costs of care in “traditional”, non-HMO, Medicare. The expectation was a 5% savings, through improved efficiency. By the 90s, private health plans were selectively enrolling the healthy and rejecting the sick, with these “expensive” patients fleeing back to the safety net of traditional Medicare. HMOs that were not profitable simply closed, thereby disrupting care for countless seniors. Even with such risk selection, private Medicare HMOs could not compete with the traditional plan, largely because of the 15% administrative cost in investor-owned Medicare HMOs, compared to 3% in traditional Medicare. In an attempt to stay afloat, private Medicare HMOs have been given progressively greater subsidies from the government; today the cost of caring for the 8 million Medicare patients enrolled in HMOs is 12% greater than it would be caring for them in traditional Medicare.

The promise of greater efficiency through private, investor-owned, Medicare HMOs is a myth. Moreover, this politically powerful healthcare industry still retains its large-scale, public subsidy, despite the failed experiment of market competition in health care. By contrast, and at the same time in the United States, the government-owned, operated, and publicly-funded Veterans Health Administration system stands as a shining example of what is possible; it offers “more equitable care, of higher quality, at comparable or lower cost than private sector alternatives.”

The authors comment on the “cost” of market forces. These include administration being “transmogrified” from the servant of medicine to its master; and the transformation from dedicated staff focused on patient care to a “vast army preoccupied with profitability.” Using the additional knowledge from international examples, Woolhandler and Himmelstein argue there
are two factors at work: Multiple payers, rather than a single payer, add complexity and redundancy, and money better spent on patient care is diverted to the higher administrative costs inherent in any commercial enterprise, including private healthcare. In short, unleashing market forces directs dollars from healthcare to paperwork.

Why have costs not gone down under market-based reforms? The authors suggest that, by and large, healthcare firms such as HMOs are not cost-minimizers, but rather profit-maximizers. Profit maximization strategies do not necessarily or naturally improve efficiency. In fact, attention to maximizing revenues allows firms to devote less attention to quality and efficiency. As the authors note, “it is fashionable to view patients as consumers. 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.’”

The larger question is why do politicians in the U.S. persist on this path? The authors opine that such reforms “offer a covert means to redistribute wealth and income in favour of the affluent and powerful” and that with private employers cutting health care benefits, “privatization of publicly-funded health systems uses the public treasury to create profit opportunities for firms needing new markets”.

**Lessons for Other Countries:** Good patient care loses in the “medical marketplace.” The authors assert that remedies imported from commerce yield inferior care at inflated prices. They prescribe “adequate dosing of public funds;” budgeting on a community-wide scale to align investment with health priorities; stimulating cooperation among public health, primary, and hospital care; and, amongst other attributes, “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.”

As Canada and European countries contemplate or engage in publicly funded, yet market-driven delivery, we would be wise to heed the lessons in this essay on competition.