C. The U.S. Economy Typically Relies on Market Competition

In the overwhelming majority of markets, the government does not decide the prices and quality at which sellers offer goods and services. Rather, rivals compete to satisfy consumer demand, and consumers make decisions about the price and quality of goods or services they will purchase. A well-functioning market maximizes consumer welfare when consumers make their own consumption decisions based on good information, clear preferences, and appropriate incentives.

Vigorous competition, both price and non-price, can have important benefits in health care as well. Price competition generally results in lower prices and, thus, broader access to health care products and services. Non-price competition can promote higher quality and encourage innovation. More concretely, competition can result in new and improved drugs, cheaper generic alternatives to branded drugs, treatments with less pain and fewer side effects, and treatments offered in a manner and location consumers desire. Vigorous competition can be quite unpleasant for competitors, however. Indeed, competition can be ruthless – a circumstance that can create cognitive dissonance for providers who prefer to focus on the necessity for trust and the importance of compassion in the delivery of health care services. Yet, the fact that competition creates winners and losers can inspire health care providers to do a better job for consumers. Vigorous competition promotes the delivery of high quality, cost-effective health care, and vigorous antitrust enforcement helps protect competition.

At the same time, competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them. The next section identifies some of the features of health care markets that can limit the effectiveness of competition.

II. FEATURES OF HEALTH CARE MARKETS THAT CAN LIMIT COMPETITION

A. The Health Care Marketplace is Extensively Regulated

An extensive regulatory framework, developed over decades, at both the federal and state levels of government affects where and how competition takes place in health care markets. Much of the regulatory framework arose haphazardly, with little consideration of how the pieces fit together, or how the pieces could exacerbate anticompetitive tendencies of the overall structure. Proposals for new regulatory interventions have often focused solely on their claimed benefits, instead of considering their likely costs, where proposals fit into the larger regulatory framework, and whether proposals frustrate competition unnecessarily. Failure to consider such matters can reinforce existing regulatory imperfections and reward incumbent interests. Indeed, in health care, some commentators see competition as a problem to be tamed with top-down prescriptive

regulations, instead of an opportunity to improve quality, efficiency, and enhance consumer welfare.

As a significant purchaser in most health care markets, the government uses regulations to influence the price and quality of the services for which it pays. The government's actions as both purchaser and regulator have profound effects on the rest of the health care financing and delivery markets as well. Price regulation, even if indirect, can distort provider responses to consumer demand and restrict consumer access to health care services. Regulatory rules also can reduce the rewards from innovation and sometimes create perverse incentives, rewarding inefficient conduct and poor results. Restrictions on entry and extensive regulation of other aspects of provider behavior and organizational form can bar new entrants and hinder the development of new forms of competition. The scope and depth of regulation is also not universal; providers offering competing services are routinely subject to widely varying regulatory regimes and payment schedules.

B. Third-Party Payment Can Distort Incentives

Health insurance shifts and pools the risks associated with ill health. By providing greater predictability, health insurance protects the ill and their families from financial catastrophe. Nonetheless, third-party payment of health-related expenses can distort incentives and have unintended consequences.

Consumer Incentives. Insured consumers are insulated from most of the costs of their decisions on health care treatments. The result is that insured consumers have limited incentive to balance costs and benefits and search for lower cost health care with the level of quality that they prefer. A lack of good information also hampers consumers' ability to evaluate the quality of the health care they receive.

Provider Incentives. Panelists and commentators agreed that providers have a strong ethical obligation to deliver high quality care. The health care financing system, however, generally does not directly reward or punish health care providers based on their performance. When this fact is coupled with the consumer incentives outlined above, the result is that providers who deliver higher quality care are generally not directly rewarded for their superior performance; providers who deliver lower quality care are generally not directly punished for their poorer performance and, worse still, may even be rewarded with higher payments than providers who deliver higher quality care.

Payor Incentives. Insurers generally offer coverage terms tied to professionally dictated standards of care, restricting the range of choices and trade-offs that consumers may desire. Insurers aggregate consumer preferences, but there can be incentive mismatches because insurers generally bear the costs but do not capture the full benefits of coverage decisions and because insurance contracts have a defined term (usually annually) that is generally shorter than the period of interest to the consumer.

C. *Information Problems Can Limit the Effectiveness of Competition*

The Lack of Reliable and Accurate Information about Price and Quality. The public has access to better information about the price and quality of automobiles than it does about most health care services. It is difficult to get good information about the price and quality of health care goods and services, although numerous states and private entities are experimenting with a range of "report cards" and other strategies for disseminating information to consumers. Without good information, consumers have more difficulty identifying and obtaining the goods and services they desire.

The Asymmetry of Information between Providers and Consumers. Most consumers have limited information about their illness and their treatment options. Consumers with chronic illnesses have more opportunity and incentive to gather such information, but there is still a fundamental informational asymmetry between providers and patients. There is also considerable uncertainty about the optimal course of treatment for many illnesses, given diverse patient preferences and the state of scientific knowledge.

Consumer Uncertainty about Reliability of Health Care Information. Uncertainty increases transaction costs, fraud, and deception dramatically. Although the Internet can provide access to information about health care, it also enhances the risks of fraud and deception regarding "snake oil" and miracle cures.

Information Technology. Health care does not employ information technology extensively or effectively. Prescriptions and physician orders are frequently hand-written. Records are often maintained in hard copy and scattered among multiple locations. Few providers use e-mail to communicate with consumers. Public and private entities have worked to develop and introduce electronic medical records and computerized physician order entry, but commentators and panelists agreed that much remains to be done.

D. *Cost, Quality, and Access: The Iron Triangle of Trade-offs*

Health policy analysts commonly refer to an "iron triangle" of health care.[2] The three vertices of the triangle are the cost, quality, and accessibility of care. The "iron triangle" means that, in equilibrium, increasing the performance of the health care system along any one of these dimensions can compromise one or both of the other dimensions, regardless of the amount that is spent on health care.

Such tradeoffs are not always required, of course. For example, tying payments to health care providers to the quality of services provided could improve providers' incentives to contain costs and improve quality. Better quality also could be achieved at less cost by reducing unnecessary services and managing consumers with chronic conditions more cost-effectively. Competition has an important role to play in accomplishing these objectives.

---

[2] WILLIAM L. KISSICK, MEDICINE'S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES (1994).

Nonetheless, trade-offs among cost, quality, and access can be necessary. Those trade-offs must be made at multiple levels by multiple parties. Some consumers may prefer a "nothing but the best" package of medical care, but others are willing to trade-off certain attributes of quality for lower cost, or trade-off one attribute of quality for another. For example, some consumers will be more willing than others to travel in exchange for lower prices, while others may be more willing to travel in exchange for higher quality care. Good information about the costs and consequences of each of these choices is important for competition to be effective.

E. Societal Attitudes Regarding Medical Care

For most products, consumers' resources constrain their demand. Consumers and the general public do not generally expect vendors to provide services to those who cannot pay for them. Few would require grocery stores to provide free food to the hungry or landlords to provide free shelter to the homeless. By contrast, many members of the public and many health care providers view health care as a "special" good, not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay. Similarly, many perceive risk-based premiums for health insurance to be inconsistent with obligational norms and fundamental fairness, because those with the highest anticipated medical bills will pay the highest premiums. A range of regulatory interventions reflect these norms.

F. Agency Relationships

A large majority of consumers purchase health care through multiple agents – their employers, the plans or insurers chosen by their employers, and providers who guide patient choice through referrals and selection of treatments. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests.

III. HOW THE HEALTH CARE MARKETPLACE CURRENTLY OPERATES

Competitive pressures for cost containment have spurred the development of new forms of health care financing and delivery. Government payors have adopted new forms of payments for health care providers to slow health care inflation. Private payors have adopted systems, such as managed care and preferred provider organizations, to encourage or require consumers to choose relatively lower-cost health care. Physicians have tried new types of joint ventures and consolidation, and hospitals have consolidated through merger and the creation of multi-hospital networks. These new organizational forms offer the potential for reducing costs and increasing provider bargaining power. More recently, strategies for improving the quality of health care have gained attention. Health care markets remain in flux.