2006

The Role of Competition in Health Care: A Western European Perspective

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Abstract The Federal Trade Commission and Department of Justice 2004 report *Improving Health Care: A Dose of Competition* expresses a clear allegiance to competition as the organizing principle for health care. In Europe, by contrast, the key organizing principle of health care systems is solidarity. *Solidarity* means that all have access to health care based on medical needs, regardless of ability to pay. This is not to say that competition is not important in Europe, but competition must take place within the context of solidarity. This article critiques the report from a European perspective, describes the role of competition in Europe (focusing in particular on European Union law), and suggests that the United States could learn from the European perspective.

Improving Health Care: A Dose of Competition (Federal Trade Commission/Department of Justice [FTC/DOJ] 2004) has a clear vision of the health care policy universe in which competition is at the center. If health care professionals, providers, suppliers, manufacturers, and insurers would only be allowed to compete with one another, all of the desiderata of health policy — access, quality, and cost control — would fall into place. Competition would lower health care prices, which in turn would improve access to health care for those who currently cannot afford it. Competition focused on quality would make health care safe and effective. All that is necessary is that barriers to competition, public and private, be cleared away, and all will be well.

The report on its face appears to be based on an impressive body of empirical evidence. The authors of the report conducted an extensive literature search and heard from numerous witnesses at several hearings.[2] But in the end, the report's conclusions seem to be driven by an ideology, which the evidence is marshaled to support. The fundamental article of faith of this ideology is that a society functions best when the members of that society, identified as consumers, are unimpeded in their ability to satisfy their preferences by purchasing goods and

[1] Published in the *Journal of Healt, Politics, Policy and Law*, Vol. 31, No. 3, June 2006.

[2] With rare exceptions, the literature and comments on which the report relies were describing and analyzing the health care system of the United States. Fewer than two pages of the lengthy report are devoted to international sources, and these comments appear in chapter 8, "Miscellaneous Subjects."

services from producers, who are in turn unimpeded in their ability to compete with one another for the allegiance of consumers. “A well-functioning market maximizes consumer welfare when consumers make their own consumption decisions based on good information, clear preferences, and appropriate incentives” (FTC/DOJ 2004: Executive Summary [ES], 4).

The health care systems of Western Europe are based on a quite different ideology: solidarity. *Solidarity* means in principle that all members of society must have access to health care, regardless of their ability to pay. Solidarity is not a woolly notion about the common good. It has a specific meaning: that a health care system is organized and managed on the basis of universal access, without risk selection, based on income-related premiums or tax finance, and with no significant differences in the benefit package. It is a concept enshrined in the basic laws and traditions of Western European countries and recognized by the decisions of the European Court of Justice (ECJ), as described below.

Western European countries are also, of course, interested in controlling health care costs and in improving health care quality, just as Americans are, but they are committed to doing so within the framework of solidarity. In each country, competition plays a role in organizing the health care system, but it is valued only as a means to the end of maintaining a solidarity-based health care system, and not as an end in itself. It is also not viewed as a panacea for the problems that plague all health care systems.

Insofar as European health law and policy are concerned with competition, they have focused primarily on eliminating barriers to competition, which is necessary to form a single market in Europe. Single-market legislation has focused on realizing the four freedoms — freedom of movement of goods, services, labor, and capital — within the European Union. Its objective has been to remove impediments to competition that individual countries have erected or may try to erect to protect their own national health care markets. The cases of the ECJ, however, have not treated economic efficiency itself as a relevant goal of or justification for competition, but have focused on whether restriction of the market freedoms is necessary to protect the financial viability of solidarity.

This article offers a Western European comparative perspective of *Improving Health Care*. It first briefly explicates the role of competition in the report and critiques the report’s vision of that role. Next it outlines an alternative vision of the role of competition in health care from a European perspective. In particular, it considers how European Community (EC) legislation and the decisions of the ECJ directed at removing barriers to free trade and competition within the European Union market are affecting health care systems. Finally, it reflects briefly on the lessons the European experience has for the United States.

The Role of Competition in *Improving Health Care*

Improving Health Care offers a particular vision of a peculiar health care system. In most developed nations, virtually all residents are covered by public or private health insurance. In the United States, 45 million people, almost 16 percent of the population, are uninsured (DeNavas-Walt, Proctor, and Mills 2004), yet the United States spends far more on health care than any

other country, whether measured by health expenditures per capita or percent of gross domestic product spent on health care (Reinhardt, Hussey, and Anderson 2004). Finally, though it is true that, as the report states, "At its best, American health care is the best in the world" (FTC/DOJ 2004: ES 1, chap. 1, 12), the same thing could be said about the health care systems of other developed countries. A recent five-nation study looking at outcomes and processes of care concluded that the United States performed best in some measures, worst in others, and somewhere in between in most, just like the other four countries in the study (Commonwealth Fund 2004). In sum, the American health care system is ailing.

The report suggests that the cure for the U.S. health care system is "a dose of competition." Its explanation as to how competition might be able to address the problem of health care costs is relatively straightforward, though the barriers of information deficiencies and agency failures that would have to be surmounted for it to do so are perhaps even more daunting than the report acknowledges. The mechanisms through which competition might improve quality are more speculative, and the report acknowledges that, 690 Journal of Health Politics, Policy and Law to date, competition has focused on cost and largely ignored quality. How competition can solve the massive access problem in the United States, however, is a mystery. The report itself acknowledges that better-functioning markets are useless to those who lack the resources to participate within them. It suggests hopefully that, if costs were controlled effectively, access might marginally expand. It also offers a glowing evaluation of consumer-driven health plans as a means to expanding coverage, ignoring the growing body of scholarship supporting the conclusion that consumer-driven health plans will worsen, not improve, risk segmentation and access to health care for those in ill health (Jacobi 2005).

Competition Is Not the Only Game in Town

Within Europe, individual national health care systems can appear to be very different. They vary in the mix of public, not-for-profit, and for-profit providers as well as in the form of finance. What essentially distinguishes them from the U.S. system is the requirement that instruments used to promote efficiency — cost control, cost-effectiveness, and quality — must be consistent with universal access. European countries often use other policies to secure the outcomes that some attribute to market competition in the United States Competition is not the only game in town.

Cost Containment. Most European countries have a fixed global budget that contains total expenditure. The effectiveness of this system varies. In England, a fixed national budget allocated among local purchasers via a risk-adjusted capitation formula has, some would argue, been overly successful in containing costs. In France, the global budget is often exceeded. Despite this variable experience, overall these systems have been more effective in controlling costs than has that of the United States with its reliance on competition. Controlling costs in aggregate, however, does not place effective pressure on the least efficient hospitals. Some European countries are adopting elements of prospective reimbursement, such as fixed diagnosis-related group (DRG) prices, to exert downward pressure on the costs of relatively high-unit-cost providers (Langenbrunner et al. 2005). Contrary to the message of *Improving Health Care*, history may record that the most useful lesson from the U.S. health care system for

the rest of the world is the potential role for administered prices in promoting efficiency rather than reliance on market competition.[3]

Reducing Excess Demand. Whereas the United States depends on local competition between payers to reduce excess demand, European countries tend to achieve this through measures adopted at the national level. Many countries have legal frameworks in which gatekeeping restricts direct access to specialists. A patient must first consult a general practitioner, who decides whether referral to a specialist is indicated. Other countries are moving in this direction (Rodwin and Le Pen 2004).

The financial incentives for pharmaceutical companies and equipment manufacturers to develop high-price new products are overwhelming, but many of these products are of questionable cost-effectiveness. Often neither patients nor doctors have the information needed to discriminate between new products. Within Europe, there is a two-pronged approach to dealing with this problem. First, governments (or arm's-length institutions) negotiate prices with pharmaceutical and medical equipment companies. The effect this can have on the cost of products has recently been highlighted by the debate over the contrast between U.S. and Canadian prices for pharmaceuticals. Second, some European countries have created institutions to review research evidence on the clinical effectiveness and cost-effectiveness of pharmaceuticals and medical procedures and to recommend which should (or should not) be made available to insured patients. The National Institute for Health and Clinical Excellence (NICE) in England is perhaps the best-known European example, but the approach is used in other countries, including the Netherlands, Germany, and Switzerland (Jost 2005).

Health Outcomes and the Quality of Care. As in the United States, efforts to improve the quality of health care delivered by different providers have lagged behind measures to control costs. England has developed a system of quality assessment similar to the Health Plan Employer Data and Information Set (HEDIS) "quality scorecard" in the United States. Hospitals are ranked with respect to a variety of outcomes, including waiting times, mortality rates, and patient satisfaction. Where hospitals appear to be delivering poor quality, action is taken at the national level to improve or ultimately close the relevant units. Payers and patients can also use this information to select providers, but, as in the United States, market response to information on quality has been weak, so the focus has been on more direct methods to intervene where evidence of poor quality emerges. Data in Sweden are collected by specialty on clinical health outcomes in hospitals (national quality registers). This information is publicly available to patients and clinicians. Other European countries (including Denmark and the Netherlands) have developed systems of performance indicators that make information on provider performance available to payers and patients. In this area, there is little difference between the United States and Europe. The agenda is to develop more sensitive and discriminating measures of the quality of health care and to present the information in ways that are relevant to regulators, payers, and patients.

[3] See Mossialos and LeGrand (1999) for a review of fifteen European countries.

What Is Distinctive about the European Approach?

The outcomes that the United States seeks to secure from competition between local payers and providers, European countries seek to secure through instruments that may deliver these gains to the entire population — not just to patients in lucrative competitive markets. The European approach has weaknesses. Political pressure from local populations to protect local hospitals mutes the effectiveness of national cost-containment and quality initiatives. Merger and reconfiguration of services are often seen as more acceptable responses than is closure of local facilities, especially in semirural areas. In practice, this may be little different from the subsidies paid under U.S. Medicare to rural hospitals.

Regulation of new entry and investment in new capacity is much tighter in Europe than in the United States. This has enabled most countries to avoid much of the waste that the United States has experienced from the development of excess capacity. As in most things, the impact of regulating investment has been varied. In England, capacity constraints have been so severe as to contribute to the emergence of some of the longest waiting times for elective care in Europe. In France and Germany, on the other hand, regulation of new investment has been sufficiently generous that waiting times are negligible. One consequence of regulating investment in new capacity, however, is that less excess capacity means any competition among providers will be relatively weak.

An interesting difference between the United States and Europe is the emerging role of patient choice. Evidence suggests that the economic gains from competition in the United States are strongly related to reduction in patient choice through managed care (Dranove and Satterthwaite 2000). Within Europe, increasing patient choice has become an important policy issue. Denmark for a decade and Norway and Sweden more recently have offered patients a choice of any hospital in the country. Beginning in 2008, English patients will be able to choose any English hospital offering the relevant treatment. French and German patients have always had the right to choose a provider. Moreover, some of the most important health care cases decided by the ECJ have addressed the issue of the extent to which countries may legally restrict patient choice of providers located in EU countries other than the country where the patient is insured. By adopting regulatory mechanisms other than competition between plans, many European health care systems are attempting to secure cost and quality efficiency gains by policies that do not rely on restricting patient choice of provider.

A European Role for Competition

Although Europe is distinct from the United States in its overriding concern for universal access and risk pooling, the role of competition within this framework varies among European health care systems, depending on historic inheritance of different national institutions and willingness to embrace new policy initiatives.

Competition among Plans

One of the best documented characteristics of competition among third-party insurers is risk selection, which can be direct where health plans concentrate on low-risk/low-cost populations. It can also be indirect where payers compete for contracts with employers. A plan offered to all employees of a university or software company will cover a lower-cost population than will a contract with a coal-mining corporation. The chronically sick and unemployed are always losers. This type of competition is unacceptable in Europe. The majority of Western European countries have elected not to have competing payers. In the countries where competition exists (Germany, the Netherlands, and Belgium) the problem has been to ensure that insurance plans do not compete by risk selection. This has often resulted in complex national systems to equalize costs and risks among competing plans (sickness funds). As a consequence, the scope for competition is severely limited.

This is not to say that there is no competition among plans. Dutch sickness funds offer supplemental packages of amenity/luxury care. Under the new Dutch social health insurance scheme, there will be as of 2006 a broader element of price competition among plans, though it will be constrained by open enrollment, a prohibition on risk selection, and a risk equalization scheme. Similar arrangements are under discussion in 694 Journal of Health Politics, Policy and Law Germany with the so-called *Burgerversicherung* (citizen insurance) and in Switzerland with the *Krankenversicherung* (sickness insurance).

Competition among Providers

A number of European countries have also seen competition among providers (hospitals and professionals) as potentially useful. There are three main approaches to accomplishing this. First, prospective reimbursement based on DRG prices creates a form of “yardstick” competition (Shleifer 1985). Hospitals with unit costs above the set price must reduce costs to remain solvent. Hospitals with costs below the set prices may increase the number of patients they treat. The objective is to increase cost efficiency, particularly in markets where population density and scale economies make direct competition among hospitals unlikely and inefficient.

Second, historically integrated public sector health care systems have introduced “purchaser-provider splits” (Sweden and England). Publicly funded purchasers can shop around and, on the basis of price and quality, negotiate contracts with hospitals. There are few published studies on the effects of this direct competition. Propper, Burgess, and Green (2004) found that, in England, quality, measured by mortality rates, fell in the most competitive markets, indicating that competition might not be good for one’s health. Another study (Propper, Croxson, and Shearer 2002) found that a different aspect of quality — waiting time — improved where purchasers used their budgets to seek out alternative providers.

The third approach to encouraging competition among providers is to promote patient choice of physician and hospital. While this has been the norm in France and Germany, patient choice has also been introduced in traditional public sector health care systems, such as those in Sweden, Denmark, and England, to create incentives for hospitals to compete by offering shorter

waiting times. There are few studies on the impact of these competition policies on performance of hospitals. In Denmark, the effects appear limited (Vrangbaek and Bech 2004). In England, pilot studies of choice have revealed a high willingness of patients to switch provider, but found it difficult to identify the impact of patient choice per se on the competitive behavior of hospitals (Dawson et al. 2004).

Although the role of competition among providers is of less importance in Europe than in the United States, European competition law does in fact apply to the behavior of hospitals and purchasers. Whether these health care organizations are in the public or private sector is irrelevant. Even the secretary of state for health in England, the senior politician in charge of the National Health Service (NHS), was held to have contravened European competition law when, by executive action, he tried to ban the prescription of Viagra on the NHS (*Regina v. Secretary of Statefor Health ex parte Pfizer Ltd*, Case No: C/4934/98, May 26, 1999). The key issue for most European countries is how competition law, developed with reference to industries very different from health, is to be applied to the highly regulated health care industry.

European Community Competition Law and Health Care

Within the European Union, competition policy is principally related to the functioning of the common market as established by the free-movement provisions in the EC Treaty. Community competition rules pursue the promotion of competition among undertakings (enterprises) and aim to remove distortions of such competition. Two crucial provisions on competition in the EC Treaty are articles 81 and 82, which prohibit agreements that distort intracommunity trade and the abuse of a dominant position.[4] These provisions also affect the health sector and are most problematic in their application to the health insurance market when insurance is provided as a public service.

Balancing the Solidarity and Freedom of Contract Principles

Traditionally, social health insurance has been classified as a public service, performing a social instead of an economic function, and therefore is exempted from EC competition law. However, the introduction of market elements into social health insurance challenges the assumption that competition rules should not apply. It may change social insurance into a more market-based activity. The main question is when does this happen? The fundamental issue is whether the social activity's underlying principle is the solidarity principle or the principle of freedom of contracting that grounds the liberal market idea of the "invisible hand."

True solidarity is solidarity with the unknown, or "Solidarität zwischen Fremden" (Habermas 1993). In health care, it means that there is no relationship between the premium paid

[4] These provisions forbid "all agreements between undertakings, decisions by associations of undertakings and concerted practices which may affect trade between member States and which have as their object or effect the prevention, restriction or distortion of competition within the common market" (art. 81) and stipulate that "any abuse . . . of a dominant position within the common market or in a substantial part of it shall be prohibited as incompatible with the common market insofar as it may affect trade between Member States" (art. 82).

and access to the insurance entitlement (no equivalence). Unlike the ancient and Christian *caritas* concept, solidarity among strangers is institutionalized by means of social security legislation and therefore has been accomplished by (legitimized) force. This concept of compulsory solidarity leads to political choices, such as the redistribution of resources in order to guarantee equal access to health care. Its redistributive effect shows that solidarity is based on the notion of social justice.

In contrast, the leading principle of economic activities is freedom of contract within a market of demand and supply. Freedom of contracting has two dimensions: the freedom to select one's own contract partners and the freedom to define the content of the agreement. A typical example is private (health) insurance, generally considered as an economic activity, in which both the insurer and the insured are free to conclude an insurance policy and its conditions within a competitive insurance market. Competition can be a useful tool to improve the market's efficiency, but it is certainly not the fundamental principle of economic activity.

The introduction of market principles into social health insurance reflects the struggle between the competing principles of solidarity and freedom of contract. Confronted with antitrust cases in health care, the ECJ balances both principles, although the arguments it uses are rather ambiguous. An important conclusion that can be drawn from the Court's more recent case law is that the introduction of market principles into social health insurance — such as freedom of choice of plans or provider — does not necessarily change the scheme's social character. Thus, competitive social health insurance schemes may still be exempted from EC competition law, as long as the solidarity principle dominates.

The Court's existing cases operationalize the solidarity principle in the field of social security. First, the Court requires a social objective. It further requires that insurance benefits be identical for all who receive them; that financial contributions be proportional to the income; that sick and the healthy persons share the cost of sickness; and that contributions for insurance be compulsory to the extent necessary for application of the solidarity principle.[5] As a rule, social security schemes fulfilling these conditions are not considered to perform an economic activity within the meaning of competition law and, therefore, fall outside the scope of articles 81 and 82 of the EC Treaty. In principle, all conditions should be met, but because the weight or importance of the conditions may differ, it is difficult to predict when a social security activity will fall outside the coverage of European competition rules.

What has become clear so far is that the social purpose of an organization is not in itself sufficient to preclude its activities from being classified as involving an economic activity for the purposes of the competition rules. For example, in a case in which a social security organization

[5] Other characteristics that should be considered include the facts that the social security entities act as agents of the state and do not autonomously determine the amount of the contributions they require or scope of benefits they offer; they perform their activity under supervision of the state; and they operate on a nonprofit basis (Poucet and Pistre ECR [1993] I-637, par. 10-15).

offered an *optional* old-age scheme that operated on a capitalization basis[6] with limited elements of solidarity, the Court held that the organization was engaged in an economic activity and therefore fell under the competition rules (Fédération Française des Société d'Assurance [FFSA] Case C-244/94 ECR [1995] I-4013, par. 17 – 19). The principles established in the FFSA case were confirmed in three parallel judgments in which a pension fund providing supplementary old-age pensions to medical specialists was classified as an undertaking.[7] The Court emphasized that the funds themselves determined the amount of contributions and benefits and were operated in accordance with the capitalization principle, under which the amount of the benefits depended on the financial results of the investments made. The social purpose, the body's nonprofit status, and restrictive rules under which it operated made the scheme less exposed to competition rules, but did not prevent such organizations from being classified as undertakings in terms of the treaty. Thus, when elements of the capitalization principle, ergo, the freedom-of-contract principle, are added to solidarity-based health insurance schemes and premiums are fixed in relation to the degree of risk, the legal status of the scheme becomes increasingly blurred, and the scheme can even take on the features of private insurance: "Too sharp an increase in, for example, the non-income-related part of the premium (the nominal premium) could cause social health insurance to lose its original character" (Hermans and Tiems 1997).

Unlike the capitalization or equivalence principle that governs private insurance, the solidarity principle requires equalization of costs and risks. For example, the Court has held that sickness funds are not in competition with one another or with private institutions with respect to providing statutory pharmaceutical benefits where they provide equalization of benefits. Even the latitude the sickness funds have for setting their contribution rates and their freedom to compete with one another to some extent in order to attract members does not call into question the noneconomic nature of their activity (C-263/01, AOK Bundesverband, ECJ, March 16, 2004). Indeed, the Court approved some competition with regard to contributions to be in accordance with the principles of sound management (efficiency) and in the interest of the proper functioning of the social security scheme. As long as a sickness fund is pursuing a specific interest inseparable from or integrally connected with its exclusive social objectives, the fund does not act as an undertaking and therefore competition rules are not applicable to it.

Even in a case in which the Court might conclude that sickness funds are performing an economic activity as that concept is understood under the competition rules, a separate exception under article 86(2) EC might apply.[8] This provision provides for special immunity from the general competition rules for certain undertakings that perform a task of "general economic interest." It is clear that sickness funds have been entrusted with performing such a service of

[6] Also known as the equivalence principle. In this case, entitlements depended solely on the amount of contributions paid by the recipient and the financial results of the investments made by the managing organization. Payments were not made on a redistributive basis, and contributions were not solely dependent on income and limited by a ceiling.

[7] Joined cases C-115/97 to C-117/97 Albany, Drijvende Bokken and Brentjens ECR [1999] I-6025 and in the subsequent judgment in Pavlov, joined cases C-180/98 to C-184/98 ECR [2000] I-6451.

[8] Article 86 section 2 EC reads, "Undertakings entrusted with the operation of services of general economic interest . . . shall be subject to the rules contained in this Treaty, in particular to the rules on competition, insofar as the application of such rules does not obstruct the performance . . . of the particular tasks assigned to them." In May 2003, the European Commission issued a green paper, COM (2003) 270, on services of general interest in order to clarify this concept and the Community legal regime relevant to it.

general economic interest; namely, the provision of a solidarity-based health insurance system. The Court did not rely on this line of reasoning in the AOK case since the sickness funds were already exempted from article 81 EC because they were not engaged in economic activity.

Antitrust immunity was, however, accepted in a case involving private ambulance services. The Court held that government authorities may refuse authorization to new private ambulance-service operators when granting such authorization could have an adverse effect on the functioning and profitability of the public ambulance service. Such an effect is likely because profit-oriented ambulance operators prefer to operate mainly in the market of nonemergency transport, where qualified personnel and equipment are less expensive. In the Glöckner case, the ECJ ruled that, although existing ambulance services (providing both emergency and nonemergency transportation) may have a quasi monopoly on the transport of patients, the general economic interest task of transporting patients that was entrusted to these organizations by law could justify a restriction or exclusion of competition if necessary to make the activity economically feasible (Case C-475/99 Ambulanz Glöckner ECR [2001] I-5751, par. 65).

The Glöckner case has made it clear that "general economic interest" antitrust immunity, originally meant for broadcasting, postal, and public transport services, can also be applied to the health sector, both to health insurance funds as well as to health care providers. This provision gives member states some ability to remove social policy fields such as health care from the competition rules.

Conclusions Regarding European Competition Law

Although Community law explicitly excludes national health care policy from Community intervention, competition law increasingly affects member states' health care schemes. Indeed, in principle, many forms of conduct necessary for the sustainability of social security schemes are prohibited by the antitrust laws. Nonetheless, on a number of occasions, the ECJ has ruled that anticompetitive elements in social security schemes can be justified to make it possible to perform the particular tasks assigned to these schemes, either by denying the economic nature of the social activity or by using the escape clause of "general economic interest." This openness to restrictions on competition to permit the fulfillment social purposes may change when the solidarity elements become blurred or subordinated due to the introduction of competitive elements into health care.

Lessons for the United States

In the United States, solidarity is not universally embraced as a foundational principle of the health care system as it is in Europe. The fact that the report largely ignores solidarity as a value certainly demonstrates this. There is an identifiable impulse within the United States to provide some minimal level of health care to the poor. Cross-subsidization within health care providers to finance uncompensated care, generally condemned by the report, is one manifestation of this. Health care programs for the poor such as Medicaid and the State Children's Health Insurance Program 700 Journal of Health Politics, Policy and Law (SCHIP), only briefly mentioned in the report, are another. But the provision of health care services to

indigents is not what solidarity is about. Solidarity is rather the principle that all citizens have an equal right of access to health care, regardless of their economic status, by virtue of their being citizens.

The best representation of the principle of solidarity in the United States is the Medicare program, which was designed as a social insurance program along the lines of European models. Like some European social insurance programs, it is financed through wage-based premiums. It is not means tested and offers more or less equal benefits to all beneficiaries. Medicare has been a remarkable success. It has extended coverage for basic health care to 41 million elderly and disabled persons — the most expensive population for any nation to insure — while holding cost growth below levels experienced by private insurers (Boccuti and Moon 2003). The FTC/DOJ report is almost uniformly critical of Medicare, disparaging it because it (like most of the world's successful public insurance programs) largely relies on an administered price system for paying providers.[9] Yet the success, and the popularity, of the program cannot be gainsaid.

Medicare, like several European solidarity-based systems, has attempted to use competition as a means of achieving more efficient provision of services. Congress has repeatedly tried to support the existence of a Medicare managed care program based on competition among private managed care organizations. Yet Medicare managed care has succeeded neither in saving money for Medicare nor in demonstrably improving quality of care, while proving to be remarkably unstable, with plans and providers frequently entering and exiting. The current Medicare Advantage program has been able to attract plans only by paying rates substantially in excess of what it costs to cover beneficiaries in traditional Medicare (Berenson 2004). Attempts by traditional Medicare to purchase services competitively have repeatedly foundered as they have run up against opposition from members of Congress who vigorously support competition in principle but not in practice if it means that their constituents might end up losing out (Cooper and Vladeck 2000).

Similarly, European attempts to incorporate market-based elements into solidarity-based systems have not always gone smoothly. In general, however, European health care systems have remained focused on goal of solidarity, seeing competition as a possible means to achieving this end rather than as an end in itself. As we have seen, even the ECJ, despite its focus on the goal of creating a Europe-wide market for goods and services, has acknowledged solidarity as supervening value in health care insofar as the ECJ has shielded solidarity-based institutions from the full brunt of competition law. It is quite possible that the Medicare program could benefit from the experiences that European nations have had in experimenting with market-based elements in their solidarity-based systems, just as those systems have learned from the experience of Medicare with DRG-based administered prices. The main lesson that we can take away from the European experience, however, is that, in health care, competition is a means, not an end, and that one of the ends of a just health care system is solidarity.

[9] The report's critique of Medicare is based largely on the testimony of three witnesses, two of whom are affiliated with right-wing pressure groups.

Conclusion

Improving Health Care promotes competition as the primary organizing principle of the American health care system. The authors describe the key objectives for the U.S. health care system as access, cost control, and quality. These objectives would appear little different from those of the European "solidarity"-based system. Why then do we observe such significant differences between the United States and Western European countries in the role competition plays in delivering these system objectives? First, and of prime importance, the evidence is clear that decentralized competitive markets do not deliver universal access to health care. This is implicitly recognized in the United States by the key role of Medicare and Medicaid in delivering health care to a significant proportion of the population. Health care, like education, must be universally available in any society that espouses equality of opportunity. If market competition obstructs achievement of this goal, other instruments must be used.

The role of competition in delivering the other two objectives — cost control and quality — should also be judged by the evidence. There is much more competition among payers and among providers in the United States than in Western Europe. The evidence indicates that European instruments for controlling costs have been more effective than the U.S. reliance on competition. All health care systems are experimenting with instruments to promote the quality of health care while reducing inappropriate treatment. The evidence to date does not suggest that countries relying on market competition are delivering better quality than those using other instruments to influence the quality of health care.

Competition is one of many instruments that can be used to achieve health care policy goals. Several European countries are experimenting with a greater role for competition in securing improvement in efficiency and quality. When the evidence becomes available, regulation and competition may be rebalanced. In the meantime, politicians and policy makers often forget that health care, a significant sector of the economy, is subject to competition law. If the role of competition is increased, judicial exemptions, based on solidarity, may be undermined. At present, however, even the goal of achieving a common European market with free movement of goods and services among member nations and free competition among economic undertakings within the Community must yield when the goal of maintaining solidarity in the face of disease and disability conflicts with it. In this respect, Europe has its priorities straight, and the United States could learn profitably from it.

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