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Editorial

Competitive healthcare and the elderly: Handle with care

An unprecedented wave of major, market-based reforms is sweeping through health systems across high-income economies. In Greece and Portugal, the reforms which feature cost-cutting and cost-shifting measures as well as structural changes, are knock-on effects of austerity measures put in place resulting from the global financial crisis of 2007–2008, and the subsequent 2008–2012 global recession. In comparison, similar health reforms in the United States and England were already an agenda prior to the economic slump and were finalized and reinforced in the midst of the global recession. While the impetus for the reforms and their features are different, the end is the same: introducing more competition in healthcare markets and opening the doors of traditional public health systems to the private sector. As an immediate consequence, providers, purchasers (i.e. local commissioners and insurance companies) and consumers of healthcare have been subject to new competitive pressures as well as new conditions that support competitive behaviors. Competitive healthcare, it is hoped – and promised by policy makers, will lead toward achieving affordability, acceptability and availability in healthcare, after all competition has worked wonders elsewhere.

Increased competition in air travel, with the proliferation of low-cost carriers, for example, has dramatically reduced the cost of flying, accelerated the automation of services and changed travel staple or airline standard (such as the availability of complimentary in-flight treats and checked baggage, unfortunately). The evidence on competitive healthcare, covering competition on the supply-side both in terms of delivery of care and insurance as well as demand side, however, is mixed [1]. Whereas the findings indicate that competition leads to a reduction in prices, as economic theory suggests, the change in quality in terms of clinical outcomes is less clear. At the same time, analysis of the efforts aimed at individuals to act more sovereign in their utilization of healthcare (i.e. choice care provider or health plan) have delivered ambiguous conclusions. Given the evidence on competitive healthcare – indeed, the nature of the markets for healthcare, as second best (whereby interventions aimed at addressing market failures actually lead to a decrease rather than an increase in economic efficiency as intended), a cautious approach to increased competition is warranted.

Just as the side-effects of medication should be paid attention, the unintended consequences of competitive healthcare should be considered especially as they affect the lot of the vulnerable, both in terms of material wealth and health status, such as the elderly. Unlike air travel, the purchase of health insurance or utilization of medical treatment is riddled with (combinations of) market failures including asymmetric information, missing or delayed cost signals and (presence of and extent of) uncertainty. Health insurers and providers alike have the incentives to cream-skim (i.e. select good risks) while providers have the incentives to dump (i.e. refuse low-margin, complex cases) and skimp (i.e. under-provide services to patients) [2].

While competition in healthcare markets can deliver on efficiency and cost containment across providers of care, this might also reduce the rent available to providers to cross-subsidize more expensive patients with profits made from other patients. In doing so, equity goals in providing care might be harmed. A study examining the differences in the cost of providing elective care to vulnerable socio-economic groups in England finds that patients aged 65 and above are far more expensive to treat than other patients with length of stay (LOS) for a hip replacement exceeding 50% of the average patient [3]. Considering that age is an important determinant of LOS, the elderly might, therefore, be a potential target of dumping and skimping policies. In the absence of safety nets for the vulnerable and appropriate regulation and monitoring, competition might increase the incentives in undertaking such practices.

The introduction of a small dose of competition in the market of public hospitals in England (in 2006), fortunately, had no negative consequence on the access to elective care of the elderly as well as socio-economically vulnerable [3]. One of the reasons is the increased resources and funding availability for healthcare that accompanied the implementation of the reforms [4]. The new scenario of healthcare cuts generated by the financial crisis might overturn these initial gains, since providers and purchasers of care might be forced to make hard choices with tight budgets. Policies promoting competitive behaviors in an environment where resources are more and more limited might not guarantee the welfare of the more vulnerable groups in society.

Healthy competition – one that maximizes health gain with regard for the distribution of health gains, may well be an approach that reaches the intended consequences while keeping in check the unintended consequences of competition. Healthy competition as an approach to competitive healthcare can be seen as version of the positive-sum competition in healthcare which targets US healthcare [5]. It is positive-sum competition attuned to the European values of solidarity and cohesion and (the social) market model of European economies. It is one where markets for healthcare are prudently regulated by the state as well as non-state actors, that

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upholds values of members of society and recognizes healthcare for the vulnerable as a merit good, recognizes population health as the sine qua non of health systems and emphasizes value with regards to the allocation of resources favoring [6]. Healthy competition in healthcare implies that the state acknowledges the limitations of competition in a free market and that it is co-responsible for the health of its peoples. Moreover, it entails intergenerational justice in the provision of healthcare whereby no individual is priced out of the market for effective care and that the consumption of care today is not at the expense of consumption tomorrow.

In rescuing the financial market at the height of the financial crisis, the argument was banks are "too big to fail". In our search for price and non-price gains by means of competitive healthcare, we should regard health and healthcare should be seen as "too important to fail" and that the vulnerable, including the elderly are valuable too to be left to their own devices.

Q2 Contributors

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