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# **The Discrete Charm of Managed Competition in Health Policy Reform**

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## The Discrete Charm of Managed Competition in Health Policy Reform

Lawrence D. Brown (Columbia University)

### Abstract

*The prospect that health care markets, famously resistant to the iron laws of economics, might be "normalized" after all has attracted much attention over the last three decades. Managed competition, a strategy that spearheads this project, proposes to instill new efficiencies in health care systems, without damage to equity and solidarity, with a model that sets market forces within a framework of sophisticated rules designed to avert market failure. This paper seeks to explain why managed competition has found different degrees of favor in different health care systems by reference to cross-national distinctions in policy culture, organizational structures, and professional politics.*

### Résumé

*La perspective d'une "normalisation" des marchés des soins de santé, réputés pour leur résistance aux lois de l'économie, a suscité beaucoup d'intérêt au cours des trois dernières décennies. La concurrence dirigée, stratégie qui constitue le fer de lance de ce projet, propose d'insuffler de nouvelles efficacités aux systèmes de soins de santé, sans nuire à l'équité et à la solidarité, grâce à un modèle qui inscrit les forces du marché dans un cadre de règles sophistiquées destinées à éviter les défaillances du marché. Cet article cherche à expliquer pourquoi la concurrence dirigée a trouvé différents degrés de faveur dans différents systèmes de soins de santé en se référant à des distinctions transnationales dans la culture politique, les structures organisationnelles et les politiques professionnelles.*

**Keywords:** market forces, managed competition, sickness funds, selective contracting, risk adjustment.

## Introduction

Not so long ago health care was widely viewed not as a commodity but as a right—a right that could not be subjected to normal market forces even if one wanted to do so because the basic features of health care markets are congenitally abnormal. (Arrow 1963). Over the last three decades, however, a kind of intellectual revolution has declared both that health care markets can indeed be normalized and that societies that do so correctly can expect to attain (or retain) equitable access and high quality medical care at costs that rise less rapidly than they have in the past. “Managed competition,” whatever its theoretical appeal, has found different receptions in different health care systems: some have embraced it warmly, others have dabbled in it, and still others have been disinclined to adopt it. This paper—essentially a first draft of an exploration in progress-- sketches a brief political history of the discrete charm of managed competition in the hope of shedding light on the practical scope and limits of market forces in health care policy more broadly.

The story began a half century ago when in 1970 policymakers in the United States discovered “health maintenance organizations” (HMOs), an institutional encapsulation of what came to be called “managed care.” Medicare and Medicaid, created in 1965, were proving to be unexpectedly expensive, and the Nixon administration sought politically acceptable strategies for bringing their costs under control. Focusing on Medicare, executive branch officials, having discarded strategies such as cuts in benefits and payments to providers in the program, a grand bipartisan policy bargain that coupled broader coverage with firm cost containment, and “public utility” regulation, were at a loss how to proceed.

Then a policy analyst, Dr. Paul Ellwood, offered officials in the Department of Health, Education and Welfare a blunt diagnosis of the roots of the system’s problems: the conjunction of fee for service medical practice with third party payment for care yields faulty and perverse incentives. Because neither consumers nor providers have a palpable interest in holding down costs, the more care patients demand, and the more care providers supply, the more the latter are paid. Ellwood coupled his diagnosis with a prescription: prepaid group practices, the most notable of which was the multi-million member Kaiser-Permanente health care system in California, combined in one integrated organizational structure both payment for and delivery of care, which generated “correct” incentives that disciplined both the demand and supply sides of medical care and held the line on costs. (Ellwood et. al 1971).

If consumers in (and beyond) Medicare faced a choice among competing prepaid plans with correct incentives the system could be reformed without direct federal assaults on benefits and/or payments, system wide designs for cost containment, or “heavy handed bureaucratic” regulation. The Nixon team discovered in market forces, built on three little words—incentives, choice, and competition—an answer that seemed to be both politic and plausible. The administration proposed, and in 1973 Congress enacted, legislation authorizing modest financial support to would-be creators of HMOs across the land. (Brown 1983).

Not a few American students of health care policy viewed this marketist turn as a step in the wrong direction. William Glaser, among others who had closely studied cross national health policies, argued that the United States ought to adopt the tried and true structures for collective bargaining and negotiation between payers and providers on display in comparable

Western nations such as France and Germany (Glaser 1978). From this perspective the theoretical fables that touted the healing virtues of market forces in the US system merely served to obscure and avoid the real issues the nation faced. Imagine, then, the surprise and dismay in left of center circles when in the late 70s and early 80s delegations of European health policy officials and analysts began showing up on American shores to learn the ins and outs of managed care.

In context, however, the rising interest in managed care in nations that had achieved and sustained affordable universal coverage was not unreasonable. As the “trente glorieuses” years that commenced in 1945 gave way to the mid 1970s these systems were under increasing stress on three fronts. First, economic growth had slowed while health care costs continued their steady upward march, giving rise to lamentations about the future sustainability of health care spending—“We can no longer afford the systems that we have.”

Second, the accumulation and dissemination of health services research called into question the familiar approach that focused cost containment on the regulation of prices, not volume. In and beyond the United States researchers found evidence suggesting that routine medical practices contained considerable unnecessary use of care. These findings seemed to argue that health care systems should indeed seek to control the volume of services by learning how to “manage care.”

Third, generational change amplified voices skeptical of regulation by public bureaucracies and eager to promote consumer choice, deregulation, privatization, new public management, “third way” public-private partnerships, and other strategies to empower markets at the expense of (or in combination with) the public sector.

Theory aside, the visitors to US shores mainly saw in the emerging HMO “movement” an unmanaged and unregulated competition among new entrants who showed little concern for equity, solidarity, and other social virtues fundamental to affordable universal coverage. These anxieties were shared by Alain Enthoven, an economist who in the late 70s took up the challenges of normalizing health care markets and worried that unmanaged competition among HMOs could open doors to market failures such as misrepresentation, underservice, and preferred risk selection, all of which might, alas, appeal to competitors who focused solely on efficiency, revenues, or profits. Enthoven proceeded to develop a system of *managed competition* in which competition among MCOs would be disciplined by a set of firm governmental rules (“pro-competitive regulations”) that would forestall the abuses that might transpire in the absence of such public constraints.

Managed competition, argued Enthoven (1980,1993) would well and truly normalize the health care marketplace. Cooperative organizations of *purchasers* would hold the power to contract on behalf of large consumer blocs with health *insurers* that could bid successfully for these books of business only if they contrived to control the practice patterns and costs of *providers*. The new system would achieve impressive efficiencies without jeopardizing equity and solidarity, protected as were these values by such requirements as community rated premiums and open enrollment by plans.

Even its critics admired the intellectual elegance of the scheme, and its proponents hoped that it would become the centerpiece of health reform projects in the United States. It did in fact achieve that lofty status when President Bill Clinton enshrined managed

competition as the framework for the health system overhaul he proposed in 1993. But it soon became clear that, whatever its theoretical merits, managed competition pleased neither the left of the political spectrum (too much market) nor the right (too much government), and by the summer of 1994 the Clinton plan was dead. (On its demise see Glied, 1997, Skocpol 1997, Hacker 1997).

Other Western nations contemplating managed competition had a head start on the United States because they already enjoyed the universal coverage and system wide rules of the health policy game that managed competition presupposed. The unmanaged competition on display in the United States was too risky a road to the capacity to manage care, but might the incorporation of managed competition in such systems perhaps slow the growth of health care costs without sacrificing the core values at the purposive heart of national health insurance?

Confronting this intriguing proposition, Western systems divided into three camps. Some (Switzerland, Israel, and the Netherlands) developed systems of managed competition that honored many of its textbook precepts. Others (England, Germany, Sweden) dabbled in managed competition, picking and choosing incrementally among its features over time. Still others (France and Canada) showed little inclination to pursue such a reform. Why did nations respond dissimilarly to this common stimulus?

The argument developed here seeks to explain these varying reactions by reference to three factors. The first may be called *policy culture*. As policy tools, markets and their “forces” have different meanings and degrees of resonance in different societies. Contrast, for example, Lionel Jospin’s verdict—“Yes to market economy; no to market society”—with the assertion by former Republican congressman Richard Armey that “Markets are smart; government is dumb.” Proposals to expand the roles of markets in policy summon up diverse images of how policies ought to work, images that in turn shape the perceived utility and legitimacy of the arguments of market advocates, mainly economists and businesspeople, in policy debates.

The second consideration is *organizational structure*. Because managed competition depends heavily for its benefits on competition among health insurance plans (aka sickness funds), its appeal tends to grow when sickness funds become, for one reason or another, problematic in a national health care system.

Factor number three is *professional politics*. To advance, managed competition must come to terms with medical providers, especially physicians. This is of course ironic given that market forces aim, among other things, to strike a blow at the alleged professional sovereignty and provider dominance of physicians. Although nowadays doctors can rarely wield the plain power of a veto group, their acquiescence in market reforms seems to be crucial to their adoption and progress. In sum, managed competition is an exercise not simply in *economic* policy but rather in *political economy*. Market forces have a chance to “work” if—and only if—they are successfully embodied and embedded within hospitable cultural, organizational, and professional environments.

## I. Adapters

And so to a sampling of cases, beginning with the Netherlands and Israel, which have embraced a fairly literal version of managed competition. The policy culture in both nations was receptive to market forces. Amid years of frustration with regulatory approaches to containing health costs, the Dutch in 1982 put in office a center-right coalition government led by Ruud Lubbers, a neoliberal admirer of Margaret Thatcher, who aimed to install a “business government.” Reelected in 1986 Lubber and colleagues quickly appointed a commission under the direction of Wisse Dekker, a former CEO of Philips Electronics, who was well-known for his “‘orthodox’ and ‘uncompromising’ market orientation.” (Harrison 2004: 136; Tuohy 2018: 332-335). Advanced by a plan formulated in 1991 by the state Health Secretary, Hans Simons, but then put on hold (Helderman et al. 2005: 198-199), the case for managed competition was further articulated by a group of economists at Erasmus University in Rotterdam, who patiently refined myriad details, including a reliable risk-adjusted formula and other “technical and institutional preconditions” (Helderman et. al. 2005: 189) that would reconcile the efficiencies of competition with the durable Dutch commitment to equity and solidarity (Van de Ven et. al. 2004).

Meanwhile in the 1980s and early 1990s Israel’s national government, facing massive expenditures on defense, felt strong budgetary pressure, the assuaging of which depended importantly on finding new efficiencies in the health care system. As the Ministry of Health sought to satisfy political leaders and officials in the powerful Ministry of Finance, who were trained in “rational economics,” and “believed in competition” (Gross 2003:680, 682), policy planners were increasingly drawn to privatization, corporatization, neoliberalization, Americanization (Fisc 2009: 45-48) and thence to managed competition as a health care reform.

In both nations, moreover, the sickness fund system was not only problematic but also seemingly integral to any major reform agenda. In the Netherlands, “the fragile house of cards that was so carefully constructed during the post-war decades had all but collapsed” (Bertens and Vonk 2020: 6). The Dutch system had retained dual levels of coverage—roughly 2/3 of the population participated in statutory social insurance arrangements and 1/3 were free to choose among private insurers—an anachronism that was increasingly viewed as both inefficient and a source of “inequity instead of solidarity.” (Bertens and Vonk 2020: 8). Managed competition promised to solve these deficiencies in one policy package: the government would set rules of the game for a new uniform system of coverage in which sickness funds competed to enroll citizens who would be mandated to choose among them. After nearly two decades of debate and fine tuning the new system became law in 2006. (Tuohy 2018: 362-66).

Israel had four main sickness funds, one of which stood out for its combination of high risk subscribers, weak financial management, and close ties to Israel’s Labor Party. In 1995, scandals and crises within that party emboldened policymakers to end the favored status of the dominant fund, put all four funds on a level playing field, create a basic benefit package, add other accoutrements of managed competition, and let the funds compete for subscribers. (Chinitz 1995). As in Holland, the Israeli reform embodied both efficiency-enhancing promises of market forces for the Right and equity objectives for the Left. (“By acknowledging health care as a right, stressing equality of access and stating government

responsibility, the law was a step toward a more public and equal health care service.” [File 2009: 57])

As for professional politics, managed competition in the Netherlands seemed to offer respite from bitter fights (including strikes and law suits) waged by the medical profession against heavy-handed government attempts to cap and squeeze fees in the early 1980s (Glaser 1994: 710-711). In the course of 20 years of the back and forth among governing coalitions and strategic accommodations typical of the consensus-seeking Dutch “polder” model, the nation’s “unions of medical professionals” had been brought on board along with “trade unions...health insurers, consumers’ organizations, employers’ associations, and patients’ groups.” (Dejong and Mosca,2006: 3-4). As Okma and de Roo (2009: 120,126-27) remark, the elimination from that model of the “direct interest group representation” that had derailed the pro-competitive plan in the early 1980s eased its enactment 25 years later amid “remarkably little debate or opposition to the proposals.” Moreover, remnants of the Polder Model “mentality” sustained a willingness of association of health providers to “sit down with the government and ...discuss social policy...”

Nor, in the Netherlands, was selective contracting of physicians by sickness funds as sharply controversial an issue as might have been expected. Such contracting had already been permitted by law for general practitioners since 1996; ten years later the reform expanded its reach to specialists and hospitals. The provider groups, aware that insurers “had yet to develop an aggressive and sophisticated purchasing capability in contracting” that would offset their power, focused mainly on “parallel changes in their payment mechanisms...” ( Tuohy 2018: 361-62).

In Israel, the sickness funds “have been always managed-care organizations, selectively contracting with providers.” (Shmueli 2015: 871). Selective contracting was therefore not per se a barrier to reforms that might alleviate labor unrest and work slowdowns and had long been demanded (in some form or fashion) by the Israel Medical Association. (Wilf-Miron et.al. 1999: 138, 144; Horev and Babad, 2005: 8; Filc 2009: 55-56). Salaried for the most part, the physicians had little to fear from the economic fallout of managed competition but could have lost their jobs had they acted against their employers’ interests. (Horev and Babad, 2005: 14).

## **II. Incrementalists**

Germany, a Bismarckian system like the Netherlands and Israel, illustrates the political correlates of partial, indeed ambivalent, adoption of managed competition. As the prime post-war articulator of the “social market” state, the nation gave doctrines such as “Ordo-economics” wide play in public policy (Foucault 2008:101-105), and since 1963 an expert panel of “five wise men” has played “a highly influential role in shaping German economic policy.” (Chazan 2021). In this policy culture curiosity about the curative virtues of well-designed market forces in the health care system built slowly but steadily. German employers, who shoulder half the costs of the social-insurance funded health care system, had long been calling on government to enact reforms that would help to bring labor costs under control (Giamo 2001: 352; Pfaff 2009: 95), and German policymakers began in the late 1980s to monitor the move toward managed competition in the Netherlands. (Leiber et al. 2010: 561;



for a penetrating comparison of the Dutch and German approaches to managed competition, see Tuohy [2018]: 563-574.) What they learned confirmed (in the words of one protagonist) the “mainstream within economics. If they can exchange ideas around the world all economists will come to similar conclusions within a certain framework.” (Leiber 2010: 557). The “conclusion” in this case—the Health Care Structure Act of 1993—gave Germany “the most important paradigm shift in the history of [its] statutory health insurance...” (Busse 2017: 15; Hassenteufel 1997: 337).

The commitment of policymakers was fueled by dissatisfaction with the existing system of sickness funds. In the early 1990s Germany supplied coverage by means of roughly 1200 sickness funds, to which most of the population was, and had long been, assigned according to occupation. Because mandatory enrollment “allowed the funds to be largely unresponsive to a captive clientele,” (Jordan, 2008: 176), allowing consumers to choose among newly competing funds seemed to be (as noted above) an advance for equity on the Left, a step toward efficiency on the Right, and, in a consumerist age in which “freedom to choose” was touted as a goal across ever more of the economic landscape, a victory for liberation all around.

German physicians, though on the defensive for having failed to implement features of an earlier cost containment act of 1988 (Giamo 2001: 353), launched “massive criticism” (Riemer-Hommel 2002: 6) against proposals to make contracting plans more flexible and selective, and the law adopting managed competition in 1993 denied plans that option. Absent selective contracting and limited to small price differences as inducements to join or switch plans, the funds faced a vexing question—competition on and for what? Germany, in essence, marched resolutely to the edge of “real” managed competition and then hesitated (Brown and Amelung 1999). Since 2000 the system has cautiously opened its door to selective contracting in Disease Management Programs, Integrated Care Contracts, and Gatekeeping Contracts (Kifmann 2017: 122-123) but political leaders continued to hesitate over the merits of competition as a “driving force” in the system and, inclined to give a merely marginal role to selective contracting, left the nation’s health policy “ambiguous” on the issue. (Shmueli et. al 2015: 870,871). In 2010 Lisac et.al. (49-50) remarked on the “window of opportunity” that had opened for selective contracting, but such contracts accounted in 2015 for only 1.5 percent of the nation’s health spending. (Busse 2017: 16).

The cases reviewed so far encompass Bismarckian health care systems, which is unsurprising given that dissatisfaction with systems of sickness funds is (as argued here) one prime motive to ponder the policy road to managed competition. What then of Beveridgian (single payer) systems, of which England, Sweden, and Denmark are instructive cases in point?

Like their Western peers, these three nations struggled to address rising health care costs in the 1980s and, like Israel and the Netherlands, their policy cultures, newly imbued with libertarian and neoliberal distaste for bureaucratic and professional “monopolies” and with faith in business practices and empowered consumers, were drawn to the promised merits of market forces in the health arena. In England, conservative Prime Minister Margaret Thatcher, finding no issue “more consistently vexing” than health policy in the 1980s (Pierson 1994:134), responded by vainly exploring routes to privatization of coverage and austere budgeting. The potential political costs of the former and the immediate political costs of the

latter proved to be too high, but “internal markets” and purchaser-provider splits, announced in a White Paper in 1989, promised to make “money follow patients.” (Giamo 2001: 345-46).

In Denmark the ascendance of a conservative regime in the 1980s launched designs for the incorporation of market forces and private actors into the governance of the Danish welfare state on the premise that such innovations would simultaneously advance efficiency and free choice. (Larsen and Stone 2015). In Sweden fascination with markets as tools for better, fairer public governance coincided with a steady devolution of authority in the Swedish health system (Saltman in Powell and Wessen eds, 1999: 247) and betokened a long term redefinition of the “publicness” of public policy (Linnarson and Hallenberg 2020).

A commitment to market forces was but a first, tentative step toward managed competition, however, and absent sickness funds as crucial institutional mediators between purchasers and providers, the mechanisms and levers of competition were not obvious. Faute de mieux, these three Beveridgian systems identified unacceptably long waiting lists for services (mainly hospital care in Denmark, both specialist and hospital care in England and Sweden) as the most pressing health policy challenge they faced and proceeded to expand for citizens unable to get timely care at “their” (assigned or regional) provider sites the range of alternative providers—both public and private-- to which they might resort (with public coverage intact), thus (presumably) pressuring their customary sources of care to become at once more responsive and more efficient.

This infusion of market forces markedly reshaped the semantics and sensibilities of health care policymakers in the three nations; how far and how well they reshaped institutional practices and performance is another matter. Relying as they did on (in essence) a kind of “deselective” contracting (of providers by consumers) these reforms fell well short of the full-dress version of managed competition implemented in the Netherlands and Israel. If, as Donald Light (1999: 339) averred “Nowhere in the world has the American paradigm of managed competition been so fully implemented for an entire health care system as in the United Kingdom,” where the NHS meets “the basic criteria” for the reform, implementors apparently missed their cues. The Thatcher measures were questionable specimens of internal markets that failed to put in place the “conditions and incentives required for success” (Klein 1999: 1383) and in fact permitted “very limited competition.” (Giamo 2001: 347). Alain Enthoven, whose subtle adjustments of managed competition for purposes of the British NHS had influenced the new purchasing patterns, lamented that in 1998 he could find “some evidence of improved economic performance, but not much, and not very strong.” Moreover, “Important measures of outcomes, service and satisfaction were lacking.” (Enthoven 2002). The internal market, Enthoven concluded, was “the work of politicians in a hurry.” (Klein 2010: 174). The “formal shape” of the NHS had been transformed, notes Tuohy (2018:161), but “actual change in the decision-making process” fell short of what the formal changes might lead one to expect. For these and other reasons Harrison (2004: 65) concluded that the market reforms had diminished the capacity of the NHS to pursue “its most fundamental mandate of improving the health of the population.”

Market competition morphed steadily into privatization, as policy rhetoric emphasized “market ‘contestability’” on the assumption that private supply “will stimulate improvements in the NHS that the internal market did not.” (Friedman 2009: 163). Meanwhile, the British

physicians, initially despised as professional monopolists, who had vainly fought Thatcher's proposals (and had been largely excluded from their formulation), were by 2010 successfully "clawing back lost ground during the process of policy implementation" and even appeared to be "central," indeed "the solution" to the challenges then facing the NHS. (Klein 2010: 292,293).

Since 2010 market rhetoric (internal and other) has continued to circulate in the corridors of British health care policy, but in practice market forces serve less to denote a systematic template than to connote a set of amorphous and opportunistic conceptual concoctions to attach, garbage-can style (Cohen et.al 1972), to whatever segments of the NHS look ripe for "reform." Tuohy's (2018: 325) verdict on the "tilt towards the market" by the Coalition government's policies of 2010-2012 captures well the prevailing pattern then and since: "The multiple concessions and adjustments made over the course of the legislative passage ... had so fettered those [market] instruments... that a definitive slant was hard to discern. Indeed the resulting structure of multiple checks and balances was organizationally incoherent."

In Denmark, free(er) patient choice of hospitals settled into policy with little objection from providers, but the promise that government could wield market forces as leverage for efficiency was not kept. The free choice reform "opened the gates for large amounts of public revenue to flow into private hospitals, but without significant pressure on them to be efficient," and costs "soared." (Larsen and Stone 2015: 966,955).

Over the course of the 1990s, support for market reforms gave way to "concern and skepticism" as their cost and their threats to "important political values and interests" grew clear. County councils turned attention to regional planning and budgeting and to mergers among hospitals—strategies that shrunk the prospects for market competition. (Harrison 2004: 108). Market forces may indeed have made deep inroads into how Swedish policy culture envisions public governance, but their impact on health policy practices in the early 21<sup>st</sup> century remained intermittent and erratic. To be sure, in 1999, Von Otter (1999: 275) observed that patient empowerment through choice had contributed to a "new responsiveness on the part of providers." And, surveying 30 years of Swedish health policy in 2015, Saltman (2015:206) found that choice had become "an increasingly integral part of the patient options within the public system." But the four major reforms that aimed to instill more (private sector) "diversity" into the hospital sector—a purchaser-provider split, county contracting for elective procedures with two private not-for-profit hospitals, the creation of small private clinics in large cities, and contracting of the management of a public hospital to a for profit management company—had left only "vestigial remains rather than vibrant alternative and/or competing models to the public sector." This outcome left first- contact primary care as "the only clinical medical area where Sweden currently has a more diverse, broadly competitive public-private environment for the delivery of health care services." (Saltman 2015: 202, 204.)

### III. Skeptics

The third category of national responses to managed competition contains France and Canada, neither of which showed much enthusiasm for it. Both nations house an abundance of distinguished economists, but in neither have policymakers been much infatuated with market forces as distinctively superior vehicles of health care reform. In France, the powerful social democratic ethos that shaped social policy in the 20<sup>th</sup> century continues to pervade health care policy in the 21<sup>st</sup>. The famous words (quoted above) of former socialist prime minister Lionel Jospin—“yes to a market economy, no to a market society”—are widely taken to convey that the economy serves society, not vice versa. This in turn implies that while “efficiency, transparency, accountability, responsibility, and even evaluation are acceptable,” competition, entrepreneurship, and profit seeking must be kept within their proper (economic) sphere (Suleiman 2003: 173).

French policies are made by elites trained in “hautes ecoles” in a wide range of intellectual frameworks and perspectives; markets are but one tool among many and are not thought to exercise any particular magic in social policy. Confronted by the challenge of cost containment and the “tournant neoliberal” in and after the 1980s, the defenders of the social security regime (which includes, but is not limited to, national health insurance) responded by “internalizing” the need for fiscal constraints, deepening their expertise in health care policy, rejecting the “‘quasi-market’ experiments underway in the United Kingdom” at the time (Genieys and Smyrl 2008: quotations at 84,85) and promoting managerial and structural reforms designed to preserve both equity and the primacy of the state, thus affirming “the role of public administration as opposed to that of private insurance entities.” (Genieys and Hassenteufel 2015:286-287).

The conviction that economic theory supplies the answer to reconciling competitive efficiencies with equity, which appealed in varying degree to other societies (for example, the Netherlands, Israel, Germany, and Sweden) that also have deep social democratic roots, tends to fall on skeptical ears in France. The French system has, to be sure come to rely more heavily on “managerial methods and economic inducements,” which can be interpreted *prima facie* as a “surreptitious form of liberalisation or privatisation”, but in fact, argue Nay et al (2016: 2240), these strategies serve mainly to reinforce a “hierarchical administration deeply rooted in French bureaucratic culture.”

In Canada the ten provinces have broad (though not unlimited) discretion to shape their health care systems and in some—Alberta, for instance—the appeals of internal markets and kindred approaches are stronger than in others (Quebec, for example). (An excellent review of health policy developments in the provinces is Lazar et al, eds.2013). Provincial health systems underwent considerable policy ferment early in the 21<sup>st</sup> century, but the outcome was a reaffirmation of “the essential institutional mix and structural balance of the system,” which “revolved around a central accommodation between the medical profession and the state.” (Tuohy 2009: 77-78, 66). “In general...business spokesmen have been at best silent on health care policy” (Evans 1999 in Drache and Sullivan, eds.:27), and the nation is home to some highly prominent and assertive economist critics – Robert Evans and Morris Barer, among others—of arguments for the introduction and expansion of market forces in health care policy. (For instance, Evans 1997). Devoutly market minded think tanks and institutes are, at

least in the domain of health policy, conspicuous by their absence. (The libertarian Fraser Institute is the exception that proves the rule.) In short, enjoying an “overall stability” that is “striking,” the Canadian health care system has pursued “nothing like the revolution wrought south of the border by Health Maintenance Organisations (HMOs) and for-profit hospital chains, or by experiments with internal markets in the UK.” (Banting in Obinger et.al., eds. 2005: 125).

Nor do France and Canada face malingering sickness fund systems that managed competition might purport to cure. In France one fund, the Caisse National d'Assurance Maladie (CNAM) covers roughly 85 percent of the population. To honor objectives such as the above-mentioned efficiency, transparency, accountability, responsibility, and evaluation, the French shrunk the power of “social partners” in governing the CNAM, strengthened the authority of its director, pushed the fund to analyze and translate its massive data into guidelines and other forms of advice to physicians, and brought the fund and its smaller counterparts under the umbrella of a new Union Nationale des Caisses d'Assurance Maladie (UNCAM). Managed competition, however, is not in the picture. Merely to sketch a hypothetical path to it—perhaps by breaking up the dominant fund into (say) four competing organizations so as to offer French citizens a choice not only among providers (as now) but also among plans or by admitting onto the scene new private for profit insurers to compete with the CNAM—is to show its fatuity.

In 1966, following a report by a royal commission, Canada decided to replace sickness funds with public plans as suppliers of basic health care coverage (Tuohy 2018:135-37) and limited insurers to marketing supplementary insurance, which now covers about 30 percent of the nation's health care spending. Conversations about the wisdom of (re)introducing competing insurers into basic coverage tend to wind down quickly with references to the health care system of the nation's immediate neighbor to the south.

In France, relations between physicians—“fiercely independent and individualistic” and represented by syndicats (unions) determined to demonstrate their militancy (Glaser 1994: 711,712) and the CNAM are often tense, sometimes volatile. (See also Wilsford 1991 and Hassenteufel 1997). National policy that would try to reconfigure the incentives and behavior of physicians by subjecting them to pressures for efficiency from several competing funds obliged to squeeze payments would not, it is safe to say, go down well with the physicians' unions. Although some signs of interest in managed care have been sighted in France (Rodwin and Le Pen 2004), the predominant reform pattern seems to feature loosely-structured bargaining between physicians and the state to craft acceptable rules and incentives in the design of integrated delivery systems such as Maisons de Sante Pluriprofessionnelles. (Moyal 2021).

Canada's system, the site of many conflicts between government(s) and organized physicians over the years, has, as noted above, sought and generally found peace in a “core bargain” (Lazar et. al, eds 2013: 213-14,278-79) that continues to sustain the accommodation between payers and providers. The medical profession, “drawn into a bilateral monopoly with the state at the provincial level,” accepted the state as its sole payer and in return “secured broad autonomy over the exercise of clinical judgment and the organization of medical practice.” (Tuohy 2018: 149, 417). Reluctance, both provincial and federal, to rock the boat

has nurtured a stability that leads friendly critics of the system to bemoan its lack of innovation, competitive and other.

#### **IV. Exception**

Because the United States claims to be the conceptual home of managed competition, one might expect it to be its institutional home as well. Certainly the nation checks the first two boxes emphasized here: since the late 1960s federal policymakers have searched tirelessly for efficiency-enhancing innovations in the costly US system, and economists have both answered their calls and dominated reform debates. Moreover, the US health insurance system is reasonably competitive, especially in its private sector, but also increasingly in Medicare and Medicaid. Nevertheless, as the demise of the Clinton plan made clear in 1993-94, the nation's physicians and other major stakeholders declined to acquiesce in managed competition and instead fought it bitterly and successfully. To date the farthest reaches of managed competition in the US are “mini” versions of the strategy—Parts C and D in Medicare, Medicaid managed care, and the health exchanges in the Affordable Care Act—a piece of legislation whose proponents tellingly (and prudently) resolved not to pursue or indeed much mention managed care and managed competition in their attempts to sell it to the public.

#### **Conclusions**

Is managed competition, then, the “answer,” the “only practical solution to the soaring cost of medical care”? (Enthoven 1980). The evidence on the *perceived political* merits of managed competition suggests a decidedly mixed verdict—perhaps it is, except when it is not. Summarizing an uncommonly deep inquiry into “what *actually happened*” when England, the Netherlands, and Sweden moved toward market reforms in the 1980s and 1990s, Harrison (2004: 198, italics in original; 200) found scant room for optimism: “[M]arket reforms are very hard to implement in countries with strong social-democratic traditions. Moreover, competition in quasi-market reforms provides little or no help to countries seeking to contain total health costs. Nor do quasi-markets yield many of the other benefits envisioned by their champions.”

Whether two additional decades of trials, errors, and refinements yield different or more equivocal conclusions about outcomes is a question beyond the scope of this paper. But is worth noting that even in that (relatively) faithful adapter, the Netherlands, the marketist answer continues to raise several salient questions about the goodness of fit between theory and practice and between process and outcome. The Dutch experience so far suggests that: the growth of health care costs has not much declined; policymakers have been slow to dismantle budgetary controls and trust to market forces; mergers among insurers and hospitals may be narrowing the span of competition and consumer choices; many citizens do not trust insurers to put quality above cost considerations when contracting selectively among providers; the reliability of the quality data on which consumers may rely in exercising choice is not all it should be; and the vaunted risk selection mechanism may be unable to prevent subtle forms of risk selection. (Maarse et.al. 2016). More than three decades after it took center

stage among Dutch health policy reform options, this highly refined iteration of managed competition remains a work in progress.

On the day after the announcement of the award of the Nobel Prize in Economics to Esther Duflo, she co-authored an article titled “Economic Incentives Don’t Always Do What We Want” in the New York Times on October 26, 2019. As a vehicle of health care reform, market forces may (at some times and in some places) be *necessary* but they are seldom if ever *sufficient*. In the United States, market forces have for 50 years served mainly as an excuse to avoid the systemwide rules of the health policy game on which other Western nations have learned to rely for effectiveness, equity, and efficiency (Oberlander 2011, Gusmano 2011). In its Western peers the theoretical appeal of market forces has been mediated, distinctively in different systems, by political forces—cultural, organizational, and professional—that shape demand for the policy goods market forces claim to supply. Time and again, the parsimonious package of incentives, choice, and competition descends as a kind of *deus ex machina* to rationalize the accreted institutional confusions of traditional health care systems, only to find itself embedded in—and obliged to conjure with—the ever-frustrating forces of *political* economy.

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