Just a little bit of healthy competition: An assessment of the neoliberal policymaking paradigm as it relates to the United States healthcare system

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Abstract

Instead of creating perfect market conditions where Pareto optimality has been realised, the US healthcare system exists in a state of market failure. The US spends more on healthcare per capita than any other country in the world and yet it lags far behind all other industrialised nations in standards of public healthcare provision and health outcomes. I argue that three main elements endemic to the US healthcare market have created conditions in which it has necessarily failed. Firstly, consumers' willingness to pay for healthcare is often disproportionate to their capacity to do so. The result of this behaviour is inelasticity of demand for health-related goods and services. Secondly, there exist a number of barriers to competition that would not occur in a 'perfect' free market system. Market monopolies conferred by intellectual property protections and regulatory processes mean that prices of healthcare and its related services can be raised to levels disproportionate to the actual value of the goods and services provided. Lastly, the US healthcare market is not an arena in which all parties to a transaction have access to perfect information. This informational asymmetry, compounded by the 'agency relationship' means that it is impossible for consumers to rationally compare competing options in the provision of health services.

Introduction

Milton Friedman, author of the definitive *Capitalism and Freedom* is perhaps most famous for stating that a free market 'gives people what they want instead of what a particular group thinks they ought to want'.[1] In a single sentence, Freidman encapsulates the ultimate sentiment of neoliberal policymaking: liberty. But in the context of the post-war world, has this economic doctrine actually come to bear the fruit of prosperity and choice, or instead lead to a society described by Karl Polanyi as one in which humans exist only as 'an accessory of the economic system'?[2]

Neoliberalism is a term that defies straightforward definition because of the sociocultural baggage it has come to shoulder since the early 1970s and the decline of the Keynesian paradigm. Nevertheless, for the purposes of this essay, I will consider neoliberalism to pertain specifically to those liberal economic policies such as deregulation, privatisation, 'small government' and the like that have come to characterise the 21st century's dominant and 'conservative' approaches to economics.[3] In this context, an assessment of the United States (US) healthcare market as it relates to the question of neoliberal economic success would seem to support Polanyi in its conclusions. Instead of creating perfect market conditions where Pareto optimality[4] has been realised, the US healthcare system exists in a state of market failure. The US spends more on healthcare per capita than any other country in the world and yet it lags far behind all other industrialised nations in standards of public healthcare provision and health outcomes.[5] Not only has this prevented this North American economy from developing at a faster rate, but has also devastatingly harmed the lives and livelihoods of millions of its citizens.[6]

Three main elements endemic to the US healthcare market have created conditions in which it has necessarily failed. Firstly, consumers' willingness to pay for healthcare is often disproportionate to their capacity to do so.[7] The result of this behaviour is inelasticity of demand for health-related goods and services.[8] As the desire for

1 Milton Friedman, *Capitalism and Freedom: Fortieth Anniversary Edition* (University of Chicago Press: Chicago, 2002), 15.
2 Karl Polanyi, *The Great Transformation: The Political and Economic Origins of Our Time* (Beacon Press: Boston, 2001), 75.
3 Andrew Vincent, *Modern Political Ideologies,* (Blackwell Publishing Ltd: Malden, 2010), 67.
4 This term refers to a market state in which the allocation of resources has become zero-sum; i.e. one individual must lose in order for another to gain.
5 The World Bank, 'Health expenditure per capita (current US$)', 2014, data.worldbank.org/indicator/SH.XPD.PCAP, accessed 1 October 2014; Steffie Woolhandler, 'The Sad Experience of Corporate Healthcare in the USA' in *Restructuring Health Services: Changing Contexts and Comparative Perspectives* ed. Kasturi Sen. (Zed Books: London, 2003), 180.
6 Ruth Lopert, 'Pharmacoeconimics as a Response to Market Failure: An International Perspective' in *Handbook of Pharmaceutical Public Policy,* 2nd edition, eds T.R. Fulda and A.I. Wertheimer (The Haworth Press: Philadelphia, forthcoming).
7 Ibid.
8 Ibid.

healthcare is rarely discretionary, the balance of inputs and outputs in the US health economy cannot exist in a state of equilibrium, and as such creates conditions whereby healthcare providers can exploit their monopoly position of market power. Secondly, there exist a number of barriers to competition that would not occur in a 'perfect' free market system.[9] Market monopolies conferred by intellectual property protections and regulatory processes mean that prices of healthcare and its related services can be raised to levels disproportionate to the actual value of the goods and services provided.[10] Lastly, the US healthcare market is not an arena in which all parties to a transaction have access to perfect information. This informational asymmetry, compounded by the 'agency relationship', means that it is impossible for consumers to rationally compare competing options in the provision of health services.[11] Resultantly, producers and providers are able to manipulate prices and distribution in favour of profit.

Ultimately, it is clear that the neoliberal paradigm that has dominated policymaking in the US healthcare system has acted against improving the lives of millions of people, and exists only in a state of perpetual market failure.

'Put it on lay-by'—willingness to pay and the problem of elasticity

In a perfect market, the price of any transaction will be set at a compromise between the prospective buyer's willingness to pay and the prospective seller's willingness to accept.[12] Prices thus come to reflect the true and actual value of the goods and services that are being sold, as any derisory pricing by the vendor will result in a loss of capital as consumers take their business elsewhere.

This model for price determination, however, cannot adapt itself to the US healthcare market, primarily because within any economic arena concerned with health services, demand and desire is necessarily inelastic.[13] This means that even when the prices of goods change, the demand does not—behaviour that would never be seen in a perfect market.[14] Such inelasticity of demand is not limited to but

9 Ruth Lopert and Sara Rosenbaum, 'What is Fair? Choice, Fairness, and Transparency in Access to Prescription Medicines in the United States and Australia', *Global Health Law, Ethics, and Policy* vol. 35, no. 4, (2007), 647.

10 Lopert. op. cit.; John Logan, David G. Green, and Alan Woodfield, *Healthy Competition* (The Centre for Independent Studies and The New Zealand Centre for Independent Studies: Sydney, 1989), 145.

11 As discussed later, the 'agency relationship' refers to a transaction wherein an agent acts for the principal buyer as if they were themselves the principal.

12 Per-Olov Johanson, *An Introduction to Modern Welfare Economics* (Cambridge University Press: Cambridge, 1991), 73.

13 Lopert, op. cit.

14 Stephen Brown, 'Harold Hotelling and the principle of minimum differentiation' *Progress in Human Geography* vol. 13, no. 1, (1989), 472.

is much more intense within healthcare markets.[15] This is because, as consumers, people necessarily value the utility of some goods and services over others. When demand for purchases such as whitegoods and appliances must be delayed for financial reasons, an average consumer might consider this only inconvenient. However, in the instance that a person is forced to put off life-saving treatment by virtue of similar budgetary constraints, the results are necessarily disastrous.[16]

The US healthcare market is also home to a comparatively isolated trend in inelasticity of demand—namely, the role of insurance. Insurance companies, acting as third-party players in concert with vendors and consumers, have great capacity to further distort elasticity of demand in the economic arena.[17] In the most reductive form of a market where there exists only a buyer and seller, demand to participate in the transaction will exist in relation to the adequacy of the price vendors assign to their goods. Thus, if the buyer deems a purchase overly expensive in relation to its utility, no purchase will take place. However, if a third-party player (and payer in this case) becomes involved such predictable behaviour disappears. This is because, as a rational agent that seeks to maximise personal utility, a buyer will theoretically consent to innumerable transactions—or health treatments—if it is their insurance agency and not themselves who take on the burden of expenditure.[18] It is important to note that this conduct is not endemic to every American consumer of healthcare, but in the upper echelons of wealthy society, this pattern is more pronounced.[19] And although the moral hazard of such behaviour is perhaps exaggerated at times to serve certain agendas, it is still clear that insurance agencies have the capacity to upset the equilibrium of inputs and outputs within a market.

The immediate and measurable result of such imbalances in demand and provision is that producers and providers of healthcare and health-related services in the US are able to exploit their market power and monopolies to artificially raise and maintain high prices. As the demand for healthcare is not discretionary, the desperation of people to consume it is preyed upon in the knowledge that the inflation of prices will not alter their willingness to pay.[20] Maddeningly, it is also clear that even as consumers continue to pay higher prices for treatment, healthcare standards have in fact declined. The rate of morbidity has risen by

15 Lopert op. cit.
16 Ibid.
17 OECD, 'The Reform of Health Care Systems; A Review of Seventeen OECD Countries' *Health Policy Studies No.5* (Organisation for Economic Co-operation and Development: Paris, 1994), 329.
18 Patricia M. Danzon , 'Making Sense of Drug Prices' *Regulation,* vol. 23, no. 1, 2000, 60.
19 Lopert, op. cit.
20 Ibid.

more than a percentage point in the last 15 years, while the US trails behind all other OECD nations, even as health expenditure per capita has topped more than US$8,800.[21]

Evidently, the inelasticity of demand endemic to the US healthcare market means inputs and outputs can never be in a state of equilibrium. This not only precludes the economic arena ever functioning with Pareto optimality, but also engenders market failure, and as such measurably harms the lives and prospects of millions of consumers.

Hurdle jumping—barriers to competition

In order for a perfect market to function in a state of equilibrium, there can exist no barriers to entry and exit of the economic arena.[22] Perfect competition is predicated on the ability of all willing actors to maximise their utility; or act opportunistically to maximise profit whenever the circumstances are sound. Barriers to entry—or any hurdle a provider must clear to enter a given market—pose especially great problems for the functioning of a perfect market model. This is because when obstacles inhibit the participation of new competitors, existing vendors have the capacity to take advantage of their own market dominance and favourable economies of scale. Resultantly, prices not only become artificially heightened, but the market experiences failure as barriers create a vicious cycle of declining competition and higher pricing. The US healthcare market is no stranger to such trends; in fact, barriers to entry constitute one of the main reasons for its perpetual state of failure.[23] In particular, two obstacles prevent market entry in the US healthcare system.

Firstly, regulatory processes in the form of legislation, imposed by the US Government, impose high barriers to market entry for emerging healthcare firms and providers.[24] These regulations are managed by the Federal Food and Drug Administration (FDA), a division of the US Department of Health and Human Services that regulates medicines and food products for the protection of public health.[25] New medicines, for example, are regulated under a New Drug Application before they are approved for commercialisation.[26] This process involves vigorous and time-consuming testing, often in concert with longitudinal studies to ensure the

21 OECD, 'Health Status' (Organisation for Economic Co-operation and Development, 2014), stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#, accessed 29 September 2014; The World Bank, op. cit.

22 Wim Dubbink, *Assisting the Invisible Hand: Contested Relations Between Market, State and Civil Society* (Kluwer Academic Publishers: Dordrecht, 2003), 57.

23 Lopert and Rosenbaum, op. cit., 647.

24 Ibid 650.

25 US Food and Drug Administration, 'About: What We Do', 2014, www.fda.gov/AboutFDA/WhatWeDo/default.htm, accessed 29 September 2014.

26 US Food and Drug Administration, 'New Drug Application (NDA)', 2014, www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/default.htm, accessed 29 September 2014.

medicine is safe, effective and advertised appropriately.[27] The shortest time period set by the FDA for the 'priority review' of new drugs is six months—an ambitious goal that is rarely if ever met.[28] Waiting periods such as the above (in addition to the development, application, and production periods of new goods and services) present great barriers to entry in the US healthcare market.[29] This is especially true of health-related products, as the utility derived from safe treatment is considered much higher than that derived from whitegoods, or other household appliances, and resultantly engenders a much more intense regulatory process.[30]

Secondly, within the US healthcare market there exists a state of monopoly that bestows undue advantage upon some established firms. This particular monopoly is conferred by intellectual property restrictions that take the form of patents, and 'trade secrets' (particularly in the case of medicines) that prevent competitors seeking to provide health-related goods and services from developing, advertising, and selling their own rival products.[31] Additionally, by making small 'changes' in drug formulas or treatments providers are able to repeatedly extend their time-limited monopoly over certain goods and services.[32] Such practices also entrench the market dominance of strong players, and limit the competitiveness that would—in a perfect system—ensure that the prices of health products changed only in relation to their innate utility, and not the profit inclination of corporations.

Ultimately, the high barriers to competition that exist in the US healthcare market do not only ensure that it exists in a state of failure, but that the artificial inflation of prices in the healthcare sector measurably damage the livelihoods and health of the millions of citizens who are incapable of affording treatment for economic reasons.

'Where might I find the answer?'—the fallacy of perfect information

In addition to elastic demand and freedom of entry to the economic arena, a perfect market system presupposes that all agents have access to perfect information.[33] Such an expectation ensures that in cases where both the vendor and buyer have

27 Ibid.
28 US Food and Drug Administration, 'Frequently Asked Questions about the FDA Drug Aroval Process', 2014, www.fda.gov/drugs/resourcesforyou/specialfeatures/ucm279676.htm, accessed 29 September 2014; Lopert, op. cit.
29 Danzon, op. cit. 56.
30 Lopert and Rosenbaum, op. cit. 648.
31 Srikumaran Melethil, 'Landscape and Considerations of Intellectual Property for Development Biosimilars' in *Biological Drug Products: Development and Strategies,* eds Wei Wang and Manmohan Singh (John Wiley 7 Sons Inc.: Hoboken, 2014), 122; Lopert and Rosenbaum, op. cit. 650.
32 Melethil, op. cit. 122.
33 Dubbink, op. cit. 44.

access to all available knowledge, transactions are made only when both parties would optimise their utility in participating. Or, in other words, prices are set only in accordance with what both vendors and sellers consider appropriate for the goods and services that they exchange with one another.

This ability to rationally compare competing options, however, is not representative of the authentic ways buyers and sellers interact in the economic arena—and the US healthcare market in particular.[34] Instead, a high degree of informational asymmetry exists between consumers and providers, the latter being those who generally possess more or better information.[35] Such informational asymmetry occurs in many forms, but generally can be identified between discrepancies in understanding that buyers and providers possess about the purpose, proper use, and effectiveness of medicines, along with production, development costs, profit margins, and procedural considerations of healthcare.[36] If, for example, a rational agent wished to shop for a selective serotonin reuptake inhibitor (SSRI) or other antidepressant, they would be faced with a choice between dozens of different brands and formulations, about which there is little available information regarding their comparative effectiveness or long-term side effects.[37] Even with a medical degree, it is impossible to expect actors in the economic sphere to be able to make fully informed or 'perfect' decisions about their purchases in the health market.[38]

The existence of the 'agency relationship' also acts to compound the informational asymmetry that is ingrained within the US healthcare system. This term describes the connection between a medical patient and their doctor—the agent—whereby that agent is given the legal responsibility to act on behalf of the patient to secure their best interests—in this case, adequate and effective healthcare.[39] With regard to informational asymmetry, the existence of an actor separate from the primary client further distorts their ability to make informed decisions about their purchases in the healthcare market. This is because it is not the purchaser who personally makes decisions about their treatment; it is their doctor.[40] Moreover, this third-party dependence can also be influenced by contractual or employment-related agreements that are often made between doctors and particular healthcare

34 Lopert and Rosenbaum, op. cit. 648.
35 Phillip Jacobs and John Rapoport, *The Economics of Health and Medical Care* (Jones and Bartlett Publishers: Mississauga, 2004), 333.
36 A.K. Bagchi, 'Governing the Market in Healthcare' in *The Economics of Health Equity,* eds Di McIntyre and Gavin Mooney (Cambridge University Press: Cambridge, 2007), 44–45.
37 Melissa Martinez, Lauren B. Marangell, and James M. Martinez, 'Psychopharmacology (Table 26.2 Antidepressant medications; dosing and half-life)' in *The American Psychiatric Publishing Textbook of Psychiatry,* eds Robert E. Hales, Stuart C. Yudofsky, and Glen O. Gabbard, (American Psychiatric Publishing Inc: Arlington, 5th ed, 2008), 1059.
38 Lopert and Rosenbaum, op. cit. 648.
39 Lopert, op. cit.
40 Ibid.

providers in the US.[41] Such agreements can compel them to preference certain medicines, treatment centres, and healthcare providers over others in return for some monetary or material incentive.[42] This creates 'captured markets', whereby patients are directed towards particular providers simply because their doctors (who they may be forced to see as a result of their health insurance in the first instance) are obligated to favour them, rather than because they are more efficient ways of attaining ultimate utility.[43]

The development of such trends means that the distribution of health services and medicines is not decided by virtue of utility maximisation—the way in which it should in a perfect market—but rather the asymmetrical information funnels consumers toward a monopolising minority of healthcare providers. Not only does this take control or rational decision-making away from the primary agent responsible for expenditure on goods and services, but supports the maintenance of inefficient treatments, centres, and processes that a truly competitive market would render obsolete. Evidently, the informational asymmetry that exists within the US healthcare market not only generates inefficiency, but also creates conditions for market failure, and measurably harms those consumers who depend upon adequate healthcare for their lives and livelihoods.

Conclusion

Although it is clear that the US healthcare market has failed as a result of headstrong adherence to free market principles, it is important to note that it constitutes an especially remarkable example of the societal idolisation of laissez faire capitalism. This is at least partially explained by Polanyi's assertion that all economies are necessarily immersed in the social relations that support their function.[44] It follows, therefore, that this lack of economic autonomy from the proud culture of freedom long embedded in the US psyche can go some way to explaining why neoliberal policymaking has been more pronounced (even in the face of great challenges) in that country than any other modern industrialised nation.[45]

Regardless of its origination, however, the failure of the neoliberal policymaking paradigm as it relates to the US healthcare market has acted to measurably harm the prospects and lives of millions of citizens. Three main elements endemic to

41 Maynard A. Keynes, 'The libertarian wolf in egalitarian sheep's clothing' in *The Economics of Health Equity,* eds Di McIntyre and Gavin Mooney, (Cambridge University Press: Cambridge, 2007), 91.
42 Lopert, op. cit.
43 Evelyne Hong, 'The Primary Healthcare Movement Meets the Free Market' in *Sickness and Wealth: The Corporate Assault on Global Health,* eds Meredith Fort, Mary Anne Mercer and Oscar Gish (South End Press: Cambridge, 2004) 34.
44 Polanyi, op. cit. 57.
45 George M. Marsden, *Fundamentalism and American Culture* (Oxford University Press: New York, 2006), 251; Neil Gilbert and Tang Kwong Leung, 'The United States' in *Private Markets in Health and Welfare,* ed. Norman Johnson (Berg Publishers Limited: Oxford, 1995), 204, 207.

he US healthcare system have been primarily responsible for creating conditions in which the market necessarily failed. Firstly, citizens' willingness to pay for healthcare is almost always disproportionate to their capacity to do so, specifically because demand for healthcare is not discretionary. The resulting inelasticity of demand for healthcare has precluded equilibrium in the market and increased the ability of providers to exploit market monopolies to advance their own interests.[46] Secondly, the US healthcare market is home to significant barriers to entry; namely protracted regulatory processes and market monopolies conferred by intellectual property protections.[47] Not only do these act to supress competition and market efficiency, they also allow healthcare providers to artificially raise prices of goods and services disproportionate to their therapeutic value.[48] Finally, the US healthcare market is not an environment in which all parties to a transaction will have access to the kind of 'perfect information' expected of a perfect market system. This informational asymmetry, in concert with the 'agency relationship' prevents consumers from being able to rationally compare different health-related goods and services to increase their personal utility. Resultantly, healthcare providers are able to distort prices in favour of higher profits and enhanced shareholder value.[49]

Ultimately, the US example provides a clear demonstration that the neoliberal policymaking paradigm has in fact acted against improving the lives of millions of people, and constitutes a worrying economic trend for the 21st century.

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46 Lopert, op. cit.
47 Lopert and Rosenbaum, op. cit. 647.
48 Ibid.
49 Ibid.

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