Beyond neo-classical economics: planned markets and public competition*

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I INTRODUCTION

In times past, parents would admonish their children to pray that they didn't live in »interesting times.» While the meaning of that admonition today is considerably more sobering in Eastern Europe and the Soviet Union, it also applies in a different way to the changes that are being contemplated in Western Europe, specifically in the structure of the welfare state, and of the human services it delivers. Certainly, these are »interesting times» in terms of the future of the welfare state, particularly in Finland where you are poised to replace prior state-controlled services in the health, social, and educational sectors with the new, Hiltunen-based system of municipal responsibility and, perhaps, control.

The core problems which welfare state human services confront are dilemmas which neither a traditional planned command-and-control bureaucracy nor a neo-classical market system can adequately resolve. If one looks specifically at the example of the health care sector, and not just in Finland but across Northern Europe, one reason these are »interesting times» is that neither of these two standard paradigms are capable of solving the service delivery dilemmas that currently exist. In response to the current situation, a new hybrid paradigm is necessary, in which elements of a market approach are extracted out from the neo-classical paradigm and injected into a traditional planning model, in order to preserve the universality and quality of these services for the next generation of citizens. Examples of this new hybrid paradigm, which my writing partner Casten von Otter and I have termed »planned markets» (Saltman and von Otter, 1991 forthcoming) are already taking form in a number of countries.

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II THE LIMITATIONS OF EXISTING PARADIGMS

It may be helpful to review briefly the nature of the current problem, the integral role of the present public sector in creating the problems it faces, and the inability of neoclassical market models to resolve these quandaries. Since these are familiar issues, I will only touch on the key points.

Current problems of welfare state human services can be summarized in three terms: a) *inefficiency* b) *rigidity* and c) *insularity* (von Otter and Saltman, 1991 forthcoming). While these three dilemmas are particularly visible in the health sector, they could equally be applied to social services and primary and secondary education as well. *Inefficiency* refers to the simultaneous combination of rationing essential services by queue, and high fixed expenditure rates. *Rigidity* refers to the often-noted inability of public sector services to accommodate ethical and other preferences of clients concerning service design and delivery. *Insularity* reflects the absence of individual patient participation in and policy validation of these public sector planning processes. Taken together, these political and organizational characteristics make publicly operated health services increasing unattractive to a substantial segment of the citizenry, and put at risk the necessary broad base of political support which public human services require if they are to survive as universal high quality services.

These dilemmas in existing public sector planning systems are matched by a similar set of limitations that affect the neo-classical market paradigm as it applies to public sector human services (von Otter and Saltman, 1991 forthcoming). First, there is the well-known dilemma that neo-classical theory simply presumes that all citizens have the necessary tools

with which to make economically rational decisions — that is, perfect information about prices and quality, sufficient time to balance all options, etc. Beyond this, however, there also is the dilemma that neo-classical theory does not recognize the distinction between basic and residual goods. A basic good is one which is central to an individuals ability to participate in society, or in a market. In turn, basic goods provide the foundation upon which an individual builds his or her pursuit and enjoyment of other, residual goods. Health and education services, for example, are central to an individual's capacity to act rationally in pursuit of his own benefit, and thus ought to be included among the necessary preconditions for a well-functioning market. A third dilemma of neoclassical markets is that they are not interested in preserving universality of access to basic goods, which is of crucial importance to the welfare state both normatively — in terms of social justice — but also politically, in terms of maintaining broad political support for public delivery of basic goods.

Fourth, and somewhat more complexly, neoclassical theory has its own internal technical flaws. The theory's nominal assumptions about Pareto-optimality, which is central to the very notion of a self-equilibrating market, do not hold for the design of adequate welfare state policy for human services. Pareto-optimality presumes that, in a perfect market, with all goods consumed privately and no barriers to entry, no individual can be made better off without making someone else worse off. If Pareto-optimality prevails, all goods will be produced just to the level where someone in society is willing to pay for the marginal cost of production, and all trades will be made that can improve the welfare of any possible trading partners.

In practice, Pareto-optimality does not fit very well to welfare state human services. Beyond capital and human resource limitations on new entrants, there are three key technical flaws:

A) *The »free-rider»* problem. Market outcome cannot be efficient in the allocative sense defined by Pareto if there are significant »externalities» — that is, if some benefits spill over to individuals who are neither purchasers nor providers. Yet one central purpose of human service programs like vaccination or literacy campaigns is to create just that spill-over to all citizens.

B) *Distributional Failures.* A »well-functioning» neo-classical market takes no notice of how adequately goods are distributed across different social groups. Markets don't concern themselves if, as in USA, 40 million people lack health insurance.

C) *Informational asymmetries.* For markets to work effectively, products must be easily defined and easily monitored for quality, such that consumers can make »rational» decisions. Yet the degree to which the physician knows more about the »product» than do patients, or teachers than do students, suggests, as Kenneth Arrow noted, that complex human services don't fit well into these market assumptions. In sum, then, for all these reasons, neoclassical theory is no more capable than traditional planning theory of providing an adequate solution to the current welfare state dilemma.

III THE PROSPECTS FOR PLANNED MARKETS

In response to the inadequacies of both neoclassical economic as well as traditional planning models, policy makers in a member of Northern European health systems have recently begun to develop hybrid models whose content is best captured by the term planned markets. These planned market models involve the intentional combination by public officials of a selection of market and planning mechanisms in order to achieve a specific set of policy objectives (Saltman and von Otter, forthcoming 1991). Planned markets hold an intermediate position between the traditional planning and the neoclassical economic models. If one compares a planned market to a regulated market, the notion of a regulated market involves essentially an ex post facto role for government that involves intervening in an existing market reactively, after that market has been disrupted, in order to deflect undesirable consequences. A planned market, as we use the term involves pro-active behavior, in which government policymakers seek to directly structure a new market — to intentionally design a new market — in order to accomplish a specific agenda of policy objectives.

A similar relationship can be observed coming from the planning side of the continuum, when one compares the notion of a planned market with what we have termed »flexible planning.» »Flexible planning» refers to the process of decentralizing authority within an existing planning structure, within an existing bureaucratic framework of decision-making. In this situation, the same Weberian system of rules and offices exists, but the decisions them-

selves are pushed lower down in the hierarchy. Flexible planning, as we use the term, does not involve the introduction of specific market-style incentives or mechanisms into the planning structures.

This concept of a planned market, of an intentionally designed market, can be developed in a wide variety of directions. How the market is designed, and the policy objectives it is intended to achieve, will vary depending upon the country, the culture, the context, and the political beliefs of those policymakers involved in the design process. In a paper delivered last summer at Nuffield Institute in Leeds (Saltman, Harrison, and von Otter, 1991 forthcoming), we suggested that the following 10 questions apply to the design of all planned markets:

1. In which sector(s) of the health system will competitive incentives be introduced? Hospitals? Primary Care? Social Service?
2. On which specific incentives will competition be constructed? On price? On quality? On market share?
3. For which actors in the health system will market-style incentives be introduced? For physicians? For administration? For patients?
4. What innovative forms of market-oriented behavior could create effective competition within »natural monopolies» in the health sector? Kuopio University Hospital, for example, intends to have clinical departments »buy» services from its laboratory.
5. Where will integration and co-operation be emphasized rather than competition? All public financing has been combined in one spigot in Sweden, however this has not occurred in Finland.
6. How can new information systems be constructed to limit distortion of clinical treatment patterns and priorities?
7. How will »regulatory capture» and other forms of provider domination be forestalled?
8. How will a market-generated explosion of new managerial costs be prevented? Will hospitals create their own strategic planning units? Will they be able to advertise?
9. Where will accountability over capital decisions be located? Within each unit? In private bonds or with stockholders? Or in publicly accountable hands.
10. How will new competition designs be field tested?

Having developed this general notion of what a planned market is, and of some of the key questions involved in designing such a market, it may be helpful to look at the specific planned market models which have thus far been developed or proposed. Professor von Otter and I have suggested that different answers to these broad market-design questions lead to two general types of planned market models. One of these we have labelled mixed markets, the other we term public competition.

A mixed market involves both privately as well as publicly capitalized providers — hence the term »mixed», from the notion of a mixed economy. In the United Kingdom, this has been termed an »internal market,» which it obviously isn't. A public competition model, by comparison, involves only publicly capitalized providers. Thus a public competition model is a true internal market, that is, internal to the existing publicly operated health service, and without private providers.

These two models have rather different characteristics, based upon the quite different answers their designers had to the key questions involved in creating a planned market. Mixed market models have been proposed in the United Kingdom, in the 1989 White Paper, and in Sweden's »Dalamodellen» in Kopparberg County. In a mixed market model, the central actor is the manager or administrator, and the market mechanism he or she adopts is that of the negotiated contract. By empowering managers to negotiate contracts with private as well as public providers, the mixed market approach runs a considerable risk in two areas. First, the type of planned market will likely become based on price competition rather than quality competition. This reflects the simple reality that health care providers, particularly physicians, know much more about the quality of the product than do the administrators they are negotiating with. As a result, administrators will likely focus on the key element in the negotiations that they do understand, namely price. Economists, of course, will argue that this is a good thing, that price competition is exactly what a market ought to generate. However, in a complex human service like medical care, quality of care could become a secondary issue, left behind in the contracting process.

A second dilemma concerns the role the patient in a mixed market model. By shifting more authority to managers, a mixed market ap-

proach would reduce further whatever minimal influence the patient still had in the traditional planning model over the care he or she received. As a result, the patient would be even more the passive object of the delivery system for whom decisions are made by administrators and health professionals. In short, if public sector planned systems traditionally had problems with a) efficiency of production b) effectiveness of outcome, and c) responsiveness to patients, it would appear that a mixed market would make headway only in terms of efficiency, and only if efficiency is defined in narrow economic rather than in broader health quality and outcome terms.

It may be useful also to briefly note a few key points conceming public competition. First, the central market mechanism to be injected into a planned public system, to allocate demand and resources, would be patient choice of health professional and treatment facility. General practitioners, hospital specialists, and hospitals as well would therefore be forced under this new allocation arrangement to compete for patients — to compete for public market share — in order to maintain institutional revenues and personal salaries, both of which would be tied to performance. To protect against financial incentives that encourage providers to cut quality so as to increase volume, two or three tracer measures for quality ought to be tied to the reimbursement system. For example, one might adopt referral rates for general practitioners, or infection rates for a surgical clinic. Ideally, the measure to be adopted should be selected by the physicians they evaluate.

Second, in a public competition model, decisions about capital investment for new services and new facilities would remain in public hands, ideally as in Sweden in the hands of directly elected, hence directly publicly accountable officials. Thus the strategic direction of the overall service, the balance curative and preventive services, and most particularly of the types of care and the number of alternative providers, would remain in publicly responsible, politically responsible hands.

Third, the notion of choice used in a public competition model is rather different than that found in neo-classical economics. In public competition, patients choose among existing providers, among existing institutions, ideally anywhere in the country. But choice only involves selection among the existing stock of publicly operated facilities, as currently distributed, with limited market entry as determined by public control over capital.

Public competition is intended to expand existing consumer options within publicly operated health systems. From only *voice* — or protest — and *exit* — going to the private sector — public competition creates a new intermediate category, what we term *lateral re-entry* within the public system. This approach empowers citizens, giving them broader democratic control over the human services they receive. We have described this as »civil democracy», (Saltman and von Otter, 1989b), which we contend is a necessary supplement to existing forms of political, economic, and social democracy.

Further, from an economic efficiency perspective, and for both urban and rural patients, the source of empowerment in this public competition choice-based model is not based on the assumption that large percentages of patients would shift their custom away from their regular local hospital. Rather, as in all private sector markets, a relatively small shift in market share can have a substantial impact on revenues received. Equally as important, in this patient choice model, improvements in service effectiveness and responsiveness to patients can be expected primarily because providers fear that current patients might utilize their option to go elsewhere and, by doing so, take a piece of the providers' budget with them. Thus it is the role of anticipation of patient decisions to go elsewhere that would have the most powerful effect on provider interest in satisfying patient concerns.

Fourth, in a public competition model, the public market would be structured in terms of fixed prices set by political authorities, such that patient choices to seek service at one or another facility need not involve separate contract, price, or quality negotiations for each service rendered. These prices are not set exclusively by supply and demand; rather, they can be calibrated by political authorities to reflect social as well as economic preferences: ie. to pay general practitioners more for vaccinations than for curative visits, for example. This is an administratively less expensive arrangement, in terms of the transaction costs associated with introducing and maintaining a new planned market.

So, to summarize, public competition consists of patient choice among existing public providers whose budgets would be tied to pub-

lic market share, with large new capital expenditures remaining in the hands of politically accountable officials, and in a market defined by regularly established prices. As we have conceived it, public competition reduces the three central flaws of a command and control planning model, that is, inefficiency, rigidity, and insularity, while still retaining the basic goods orientation that lies at the core of the traditional command-and-control planning model.

IV A CASE STUDY FROM STOCKHOLM COUNTY

How would this work in practice? One experiment which has been underway in Stockholm County in Sweden has been to establish elements of public competition for maternity care. Since January 1988, expectant mothers can chose among maternity ward. Mothers »book» at 18 weeks thru a central office. Clinics receive the price of an uncomplicated delivery: 5,400 SEK in 1989; 5,800 SEK in 1990. As a result, new patients are welcomed by providers, since each patient means additional reimbursement. In the first half of 1990, 17% of expectant mothers chose a different hospital from the one to which they »belonged» (Karolinska hospital, 1990). However, of the hospitals themselves, 5 of 7 had stable volume. Thus, although mothers shifted to where or what they preferred, overall volume in the majority of maternity clinics remained roughly constant. Moreover, no contract or voucher limitations were introduced to limit utilization within this maternity »market». One hospital gained perhaps 15% and, in what is a key point here, one lost 25% (Södertälje). Södertälje's maternity clinic rapidly developed a budget crisis, and political intervention ensued. The first attempt to resolve the damage was to create cooperation on ultrasound diagnosis, in which Södertälje performed these assessments for a more popular hospital. Subsequently, however, it became necessary to close a ward. Because this closure was seen as managerially necessary rather politically motivated, and because the obstetricians could not argue that the patients needed the service (the patients had in fact chosen go elsewhere), the process of closure was straightforward and rapid.

Obviously, pregnancy is an interesting »ideal type». It is not an illness, the mother is not »sick», there is a large literature as well as substantial peer group information about preferences, and there are several clearly defined clinical practice strategies for patients to choose among. In addition, it should be noted that Stockholm County did not adopt a full public competition approach: institutional budgets were affected, but not salaries of personnel. Capital and premises also were not part of the experiments's budget picture. Lastly, clinics dIdn't have a full range of management options regarding efforts to reduce operating or transaction costs — they were not seen as self-defined public firms.

Among the lessons to be drawn from this experiment are that choice can work under the unique conditions found in maternity care. We need to learn from this example to extrapolate key elements, to develop similar conditions in other clinical areas.

V DRAWING CONCLUSIONS

To step back from this example, it would seem fair to conclude that current efforts to develop different planned market models will be the focus of health sector policy making over much of the 1990s. While they won't resolve all the dilemmas that welfare states currently face, and while they undoubtedly will create new problems of their own, these emerging planned markets stand a good chance of preserving the benefits of a universal welfare state for the next generation. To return to the opening theme, however, it will remain an interesting time as this process evolves, and there is considerable uncertainty about how it will turn out.

In Finland, one worries about the type of planned market that is being created indirectly by the combined effects of the new specialist hospital legislation (Sairaanhoitopiiri) as well as the Hiltunen municipal bloc-grant plan. A number of questions occur: I) Will 22 hospital districts or 450 municipalities negotiate contracts? 2) Will private as well as public providers participate? 3) What about the patient? Will Finns accept even less influence over care? Aren't they already going »private» to get control? Given this set of questions, I would simply conclude by stating again that the development of planned markets will determine whether the welfare state survives as a universal set of human services, and note that outsiders will observe the decisions taken in Finland with great interest.

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