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‘Mangled Competition’ And ‘Managed Whatever’

Why would Germany wish to emulate the U.S. style of managed care, with its as yet unproven effect on quality and outcomes?

by Uwe E. Reinhardt

L arry Brown and Volker Amelung’s beautifully styled paper sought to soar far above the fray of German and American health care to search for patterns not visible to the worm’s eye. Unfortunately, they have soared so high that, in the end, they believe to have detected in the haze below clear delineations that often are but preconceived images projected from above, rather than facts beamed up from the ground.

A few hard facts gathered at ground level might have enhanced the authors’ acuity. In terms of purchasing-power equivalents, German health spending in 1997 came to $2,339 per person. The comparable U.S. figure was $4,090, 75 percent more. Expressed as a percentage of gross domestic product (GDP), the German figure was 10.4, versus the American 13.6. The lower German spending is all the more remarkable because the recent merger of East Germany into West Germany added much more health spending to the numerator of the ratio than it added GDP to its denominator. (An American analog would be the absorption of Mexico into the United States.) Furthermore, the percentage of the German population age sixty-five and older has reached a level projected to be reached by the United States only in 2018–2020, in the midst of the baby boomers’ retirement. Finally, no one has ever shown that the U.S. population achieves commensurately superior health status for its higher spending. In a recent edition of this journal Gerard Anderson reported the opposite.1 Thus, whatever the Germans have done with their health care system, they must have “managed” something very well, especially in view of the fact that every German enjoys fully portable, permanent, and comprehensive health insurance.

Against this backdrop, one is puzzled by the authors’ overarching conclusion that the United States is “awash in managed care” but has yet to practice “managed competition,” while Germany has “crafted a handsome framework for the management of competition but has yet to figure out how to manage care.” What precisely do the authors mean by managed care and managed competition?

- Managed care. Managed care ultimately involves exercising control over (1) the volume of goods and services going into medical treatments, (2) the production cost of these treatments, (3) the money transfers made to the providers of these treatments (prices), and (4) these treatments’ impact on their recipients’ quality of life. One might even include (5) the impact that the entire health care system makes on the quality of life of the population, which would include the financial inroads that sickness is allowed to make into household budgets and the sense of security the system bestows on families. A thorough cross-national comparison must focus on all of these variables.

Germany has long managed prices through
a formal process of negotiations among regional associations of private sickness funds and providers. By federal statute, the prices determined through this process are common to and binding on all providers and payers within a state (Land), mainly to avoid the rampant price discrimination by payer class and individuals that might otherwise obtain. In the United States, for example, large health plans may succeed in paying less than full production costs for certain health services, forcing weak payers to cover a disproportionate share of providers' overhead and profits. Among the weak buyers are small employers and, alas, the uninsured with some ability to pay, as well as the roughly eleven million elderly Americans who do not have any insurance coverage for prescription drugs and who usually pay much more per drug than do well-insured younger Americans. Germans would consider such price discrimination grossly unfair (as, of course, do many Americans). It can be doubted that Germans will ever wish to “figure out” how to “manage care” on this model.

Germany has attempted to manage volume through two instruments. First, for decades now the system has relied on detailed practice profiles prepared for the individual physician, an instrument reinvented by many U.S. health plans as well. Large deviations from established norms (so far mainly relevant averages) can trigger uncomfortable audits. Second, in recent years physicians have been subjected to regional budgets, which have forced them into intraprofessional zero-sum games, as is the case under full capitation in the United States. Hospitals’ budgets are negotiated annually with the sickness funds. Spending on drugs is controlled through a system of reference pricing and an annual drug budget per physician, techniques that are now being adopted in U.S. managed care as well.

Germany has not gone far in controlling the most important remaining dimension of care, “quality” or “outcome,” but neither has any other country. If, as the authors claim, “managed care” means actually holding providers accountable for the “quality and cost” of their treatment decisions, then can it really be said that “the United States is the native land of managed care” and “awash” in its practice? If so, how would one explain the two- to threefold variation across U.S. regions in per capita health spending for similar populations? How can the authors’ conclusion be reconciled with Mark Chassin’s claim that overuse, underuse, and misuse of health care are rampant in the United States?

To be sure, by sheer volume and vigor, U.S. research on quality measurement and control now leads the world (although among the cognoscenti Canada [McMaster University] and the United Kingdom are generally viewed as the native lands for “evidence-based medicine”). But to convey to readers of this journal that the United States is “awash in managed care” seems to let myth get the better of fact. After all, a common lament in the United States is that, so far, the managed care industry has managed mainly “costs,” in the form of price discounts, but not “care.” If that be “managed care,” Germany is literally flooded with it.

Competition. The authors assert that throughout “its hundred-plus-year history, the German system has been resolutely non-competitive.” That statement projects onto the German setting the habit of American policy analysts to treat “competition” as a synonym for “competition on the basis of price.” Even American dictionaries define competition simply as a “rivalry,” and rivalries can be acted out on many factors besides price. Health care providers in many other countries, Germany included, cannot compete for patients on the basis of their fee; but they vigorously compete for patients on the basis of factors that map
into patients’ and their referring physicians’ perceptions of “quality.” It is odd to write off that form of competition as “noncompetitive.”

It would be better in cross-national comparisons to distinguish carefully between price and nonprice competition and then to explore more carefully the pros and cons of each form of competition. In plainer English, price competition means “resource allocation on the basis of price” and, in the plainest English, “rationing resources among people by price and ability to pay.” Viewing it in that way, one can understand why a country beholden to the Principle of Solidarity in health care has been so reluctant to become “competitive” in the American sense of that term, especially when that competition leads to forms of price discrimination that many people on both sides of the Atlantic consider morally objectionable.

Managed competition. The term managed competition is a mellow term used to sell Americans on the idea that individuals should pick, from a roster of rival candidates, one health plan that would thereafter have powerful sway over the treatments received by the enrolled person at the time of illness. Even staunchly conservative U.S. legislators have come to realize belatedly that so daunting a contract requires government supervision of the bidding process, of the contents of the insurance contracts, and of the subsequent adherence to these contracts. For that reason, one of the earliest proposals for this form of competition, penned by Herman and Anne Somers in 1972, forthrightly called the idea by its proper name, “regulated competition.”

In the end, to make it work, “managed competition” even in the United States will slouch heavily toward the “manacled competition” the authors ascribe to the German version. In the meantime, it will remain what one may call “sporadically attempted but badly mangled competition.”

At one point the authors accuse the German government of “nullifying price as a competitive consideration” by risk adjustments designed to cope with the problem of adverse risk selection against individual sickness funds. It is an astounding criticism. In the United States, as elsewhere, risk adjustment is considered the sine qua non of any workable form of managed competition. Far from nullifying price competition, it makes that competition meaningful. One is left to wonder what the authors actually mean by “managed competition,” and whether the “manacled” German competition that the authors derive in the text is the same “handsome framework for managed competition” for which they credit Germany in Exhibit I.

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