

Policy Conflicts: Market-Oriented Reform in Health Care

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Abstract: From an institutionalist perspective, we identify five sources of policy conflict. Each may explain why policies intended to obtain particular goals for an institutionalized practice may have unintended consequences. We illustrate by analyzing attempts at introducing market-oriented reform in health care provision.

Keywords: health care, market-oriented reform, policy, policy conflict.

JEL Classification Codes: I28, I38, I11, H40

Despite what is assumed in much of the economic literature, an exception being institutional economics, policies are not fully plastic and cannot be sufficiently tailored such that they regulate a practice in all its manifestations or relevant aspects. Policy conflicts result from this. In this paper we discuss conflicts between instituted policies regulating a practice, rather than conflicts between groups, or classes, of individuals who have an interest in particular policies taking a particular shape. We recognize these are significant, but distinct, dimensions that have received extensive attention in the literature. Rather we wish to identify and investigate further the recognized, but under-emphasized aspect of “practice.” We argue this complements the class and group based conflict analysis, and represents a further dimension of potential conflict.

In this paper we identify five distinctive sources of policy conflict. We discuss two particular sources of policy conflict in particular, emphasizing historical contingency and emergence of institutions in the specific setting of market oriented reform in health care as a means of indicating that the policy conflicts are real and can have substantial influence on activities in this practice. In many countries around the world elements of market orientation are introduced or extended into health care.

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The consequences of the policies may not be as expected as a result of policy conflicts, and may not be uniformly beneficial as a consequence.

The next section of the paper briefly sets our considerations on policy, practice, and conflicts, and is followed by an analysis of market-oriented reform in health care provision. Conclusions follow. Given space constraints our analysis is suggestive rather than conclusive and is intended to stimulate further research in institutional economics.

Practice, Policy and Conflict

For the purposes of framing our argument we draw from John Rawls's classic contribution to the analysis of practice. For Rawls (1955, 3), practice may be defined as: "any form of activity specified by a system of rules [institutions] which defines offices, roles, moves, penalties, defenses, and so on, and which gives activity its structure," and moreover, may be regulated by a number of different rules.¹

Conflict broadly refers to the incompatibility of oppositional entities and/or their clash or dispute. Of course, conflict is multi-dimensional and can relate to the Hegelian opposition of ideas, the Marxian clash of classes, and the Veblenian notion of conflict as emergent in an evolutionary system. Thus, conflict can be manifest as intra and inter personal, group, class, ideological, economic, environmental and so forth. Following this, Máire Dugan (1996) usefully describes conflict as nested. Thus, an inter-personal conflict, for example, may be nested in a deeper systemic conflict. The resolution of the inter-personal may redress a localized crisis, but may not address underlying systemic issues that may be the source of the conflict. Following Dugan, attempts at resolution must recognize conflict's stratified ontology.

Drawing from K. M. Sullivan (1992) and Wilfred Dolfsma (2011), we identify five sources of policy conflict, based on an institutional economic perspective of rules governing a practice.

1. Policies ostensibly conflict;
2. Emergent, previously existing policies cause conflict;
3. Unintended consequences lead to conflict;
4. Path dependent development of policies give rise to conflict; and
5. Policies formulated in an overly broad way that engender conflicts through ambiguities of meaning and interpretation.

In our illustrative case we concentrate on 3 and 4, above, but recognize overlap between these and others. We briefly discuss each in turn.

Referring to the first policy conflict we identify, the more critical a practice is to people's well-being or existence, the more rules from different organizations or sub-units thereof, are likely to apply to it. Different ministries may formulate rules for one and the same practice, for instance, whereas players in a practice can also be confronted with rules formulated at different levels of government. The considerations or values instituted or promoted through rules for such practices may

differ widely; alternatively, similar values may be instituted through very different sets of rules. This can lead to institutional tensions (Dolfsma 2009). Those formulating rules and policies may recognize sources of potential conflict in a suite of policies. Nonetheless, in a complex society policies will almost inevitably conflict in some instances. An example of purposefully developed sets of policies that have been understood to conflict from their inception are anti-trust and intellectual property rights laws. Health care embodies a host of practices across a range of professions centering on the provision of care as treatments framed by the Hippocratic ethos. Yet this does not preclude the first source of policy conflict, noted above. For instance, at some levels access to health care is conceived of as a right, but the pricing of health care suggests otherwise.

A second reason for conflicts to arise even within a single policy domain is (2) that policy rules (institutions) may, suddenly, (re-)emerge as relevant for the practice. The rules may have originally been developed for that domain, but have not been conceived as relevant for a while and have largely been ignored or forgotten. Their relevance for a practice may come to light again later. An alternative is when a rule was not originally perceived as relevant for a practice as it was developed for another practice, but that is later understood to be relevant nonetheless.

Policies may also (3) involve unintended consequences which give rise to a situation where rules or objectives conflict. This source for policy conflict might seem to be similar to the kind of policy conflict that (4) form a (path-dependent) development of rules. The former, however, is a source of conflict that does not involve changes or additions to a current set of rules that regulate a practice. The latter source of policy conflict arises from changes to rules in line with a logic internal to the set of rules or relevant to the rule makers (Dolfsma and Welch 2009).

A possible additional source of policy conflict arises when policy is formulated in overly broad terms (Sullivan 1992), such that only in their application does conflict become inevitable. This is the fifth policy conflict we identify. If rules are formulated too broadly, that is sets of policies lacking in detail of application and/or aims, one consequence may be that they are interpreted and applied in ways suiting the more powerful (Dolfsma 2009). In a complex economy rules broadly formulated will inevitably come into conflict with other rules for the same practice or for similar practices. Broad rules may prevent over-inclusion or under-inclusion of situations in a category of events to which a rule applies and allow for more discretion and flexibility, but are possibly more costly to *apply* as a substantial amount of information needs to be gathered and processed, and hence knowledge acquired, for each case at hand. In particular, when events to be regulated are rather heterogeneous or change rapidly, broader rules may be preferred in terms of affording over-arching guidance principles.

Needless to say, the different sources for policy conflict may be difficult to disentangle. Distinguishing these five different sources for policy conflict does, however, permit an enhanced understanding of them as well as, potentially, a better way of addressing their consequences. We attempt to demonstrate this below.

An Illustrative Case: Market-Oriented Reform in Health Care

The thrust of recent health care reform at a global level has emphasized market-orientation, ranging in the structure of provision, such as in development of competing units and decentralization, and finance, such as the imposition of user fees and a shift to private insurance systems, and the adoption of quantifiable target setting of outcomes. This agenda has been clearly pursued by the World Bank and International Monetary Fund as well as other supranational bodies and national governments (Mooney 2009; Stein 2008). The conventional wisdom of this overarching policy initiative is that institutional change in physician practices engender efficiency-enhancing and empowers the patient by attenuating medical power and paternalism. There is a considerable literature both advocating market-oriented reform and critiquing it (e.g., Harding and Preker 2003; Mooney 2009; Stein 2008), which accompanies a longstanding advocacy of configuring access to health care as a basic human right (United Nations 1948).

Advocacy of market-oriented policy revolves around two aspects that directly impinge on practice and habit: First, restructuring medical (producer) practice will enhance efficiency, addressing concerns over rising health care costs. Second, market orientation will also act as a source of patient empowerment, curtailing information asymmetries and constraining medical paternalism and moral hazard. These are familiar arguments, suggested from a mainstream economic perspective, that need not overly detain us. However, it is worth highlighting health economics' perspectives on conceiving medical practice. For instance, Alan Williams (1988) held up the physician-patient relationship as the "perfect agency" relationship, primarily on the basis of physician motivation based on the Hippocratic Oath. The standard view, however, is perhaps represented by Tom McGuire's (2000) allusion to medical practice as being governed primarily by orthodox selfish utility maximizing motives on the part of the physician. Indeed, Mark Pauly (1988) argues that a significant proportion of clinical-medical procedures are sufficiently routine and standardized to consider them analytically equivalent to other consumer-initiated purchases. Thus, the introduction of a market oriented relationship between physicians and patients is predicted to change physician practices in a number of straightforward efficiency-enhancing ways. With the pricing of physician activities and procedures patients will be able to exercise judgment over the potential value-for-money associated with a particular medical provider. Where such conditions, drawn from mainstream economics, do not hold, consumption of medical procedures resembles that of an experience good where *ex ante* evaluations consumers may make systematic errors. The potential for adverse selection and moral hazard is potent. This consideration has not, however, prevented advocates from downplaying the perceived benefits of markets functioning in health care (Le Grand 2003).

Even by the standard model, market oriented reform may, however, encourage supplier-induced demand, thereby accelerating the cost of health care. From the perspective of policy conflict this is an obvious unintended consequence. The view in health economics of what drives physicians is one where medical ethics conceived as

other-regarding, and in particular as patient- regarding, is traded-off with selfish incentives (McGuire 2000). Supplier-induced demand is thus intrinsic to the model of health care provision.

The nursing, medical, philosophy and sociology literatures also offer critical analyses resonating with some work in health economics. For instance, D. P. Sulmasy (1993) emphasizes the historical embedding of medicine in the Hippocratic ethos, where the virtue of caring and the non-proprietary nature of medical skills are potent in molding practice. Sulmasy further argues medical practice is profoundly relational. By contrast, Jerome Groopman (2007) and Ian Kennedy (1981) describe the dominant practices of doctors as being founded on the Cartesian dichotomy between mind and body, where the body is essentially objectified as a machine (Engel 1977). Illness then is conventionally explained in terms of bio-medical correlates. This leads to reductionist thinking on the part of physicians, as socio-economic factors are either relegated or disregarded, thereby undermining their ability to interrogate a diagnosis. Indeed, physicians' communication with their patients is beset with difficulties leading to cognitive errors and inherent biases (Groopman 2007). With the dominance of Cartesianism and the biomedical paradigm in shaping physician habits and practices there remains the potential for care to be imposed, which leads to the "oppression" of the patient (Carse and Lindemann Nelson 1996), the crowding out of compassion (Aasland 2001) and ultimately to dehumanization via the objectification of the individual. The nursing literature notes the stereotypical delineation between doctors engaged in the "hard science" of curative medicine and nurses offering "feminine" therapeutic care embodying ambiguous, "soft," and therefore "inferior," concern for patients' emotional needs (Adams and Nelson 2009; Watson 1997).

Market orientation could reform the relationship between physician and patient as it possibly empowers patients. Physicians are compelled to recognize a consumer agenda and consumer rights. Indeed, coupled with the ready access of medical information from the internet there is considerable potential for the reconfiguration of physician-patient relations (Batifoulier, Domin and Gadreau forthcoming).

From the perspective of producers, however, consumers only have rights once they are in a position to enter into an exchange. If they lack the resources, no health services may be provided. Market-orientation in policy indicates the potential emergence of, at best, unintended consequences. The latest evidence from the United States indicates that in excess of 45 million people (in the region of 15% of the population) are either under, or un-insured (DeNavas-Walt, Proctor and Smith 2009).² This seems to contradict the notion of universal patient empowerment, highlighting instead the disenfranchisement of a significant section of the U.S. population from access to medical care: patient empowerment is confined to wealthier groups in society.

A growing body evidence, highly critical of the effects of such "neo-liberal" reforms, suggests that health care systems are failing to enhance social justice or engender greater equity. Stein (2008), for instance, provides a compelling institutionalist review of this evidence, emphasizing the adverse impact of user fees on access to medical care and health outcomes, and the fragmentation of health care

systems in developing regions (Mooney 2009; Unger et al. 2008; World Health Organization [WHO] 2008).

Indeed, the 2008 WHO Report noted:

Three particularly worrisome trends can be characterized . . . health systems that focus disproportionately on a narrow offer of specialized curative care; health systems where a command-and-control approach to disease control, focused on short-term results, is fragmenting service delivery; health systems where a hands-off or *laissez-faire* approach to governance has allowed unregulated commercialization of health to flourish (xiii).

The foregoing are suggestive of unintended consequences from the broad application of policy in a market-oriented frame. Increasingly, introducing market orientation into health care has had unintended consequences, unappealing even from the perspective of health economics emphasizing cost-control and efficiency. The U.S. evidence highlights not only obvious concerns over equity and by the UN's reference a possible infringement of human rights, but also of inefficiency in the array of practices making up health care. Far from public health, with its obvious benefits being the focus of resource allocation, market orientation has concentrated resources on a relatively narrow range of health care activities. This is skewing resources in an ineffective fashion and may act to reinforce as opposed to ameliorating the flaws of the biomedical paradigm and confirming the dominance of a Cartesian objectification of the patient. Thus, notions of patient empowerment may be no more than illusory as health care practices are increasingly standardized in a path-dependent fashion, into a narrow suite of codifiable procedures in order to accommodate the measurability demands of policy. For instance, following diagnosis patients are offered particular treatment pathways without sufficient regard to their circumstances and socio-economic background: cognizance of patient heterogeneity is relegated. An unintended consequence thereof is the reinforcement of the objectification of the patient as legitimate protocol is applied from the general to the particular (Davis and McMaster 2007). Arguably, imaginative or innovative practice is rendered illegitimate. Of interest is how the emergence of the consequences of policy implementation has revealed conflict with policy ends. Thus, prominently, sources of policy conflict (3) and (4) above may be nested in a broader range of conflictual sources, but contributing in particular ways to the manifestation of conflict. Specifically, the path dependence of policy implementation imposes a boundary on acceptable practice, which may undermine dynamic sources of efficiency. Moreover, an unintended consequence is the reinforcement of the objectification of the patient; as legitimate protocol is confined to deductive reasoning and measurability.

Conclusions

Institutional analysis may be enriched from the recognition of conflict as ontologically stratified and nested. We have attempted to briefly demonstrate the heuristic value of such an endeavor by applying it to the notion of *policy* conflict in the complex terrain of health care provision and practice. By distinguishing and emphasizing particular sources of policy conflict a deeper comprehension of the forces of emergence may be apprehended. Our references to contested practices in health care and how the implementation of a particular policy may reinforce the underlying institutional bases of specific practices from which conflicts may arise.

Notes

1. We use the terms rules, laws and directives interchangeably.
2. Klerman et al. (2009) dispute DeNavas-Walt, Proctor and Smith's estimate, claiming that this fails to accurately record the proportion of the population on Medicaid. A later survey by Families USA (2009) estimated that over 86 million people (approximately 29% of the population) had been uninsured at some point over the period 2007-2008.

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