

# The World-Wide Wave of Market Reform in Medical Care

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In the final two decades of the twentieth century we witnessed an attempt at global medical care system market reform, driven more by political ideology than by either problems in the delivery of medical care or economic exigency.<sup>i</sup> This type of reform has taken different shapes in different countries depending on their existing medical care and political systems. Americans have experienced it in the form of insurance company driven managed care, which both patients and health care professionals tend to dislike.

In this paper I will attempt an account of that reform effort. I will first distinguish market reform from professional reform and democratic reform, following which I will review evidence that around 1980 there was a global shift from professional and democratic reforms to market reform. I will end with some thoughts about the consequences of this shift.

## **Types of Medical Care Reforms**

Not all reforms are the same. Some are designed to enhance the capacity of medicine to effectively address patient needs. Some are designed to improve

democratic control over the medical care system to make it, for example, for example, more accessible. Some are designed to make it more profitable to private interests. We can distinguish these along several dimensions based on where core decisions are made, who the dominant actors are, what values are emphasized, what goals the reform has, and how medical care is regulated. [Figure 1]

## **Professional Reform**

Professional organization of medical care was the dominant form in the United States prior to 1994. A class of occupation characterized by extended training, autonomy in the training and discipline of its members, and a commitment to provide skilled service to people in need, was free to organize its work and the system of compensation. Such occupations were professions. A system of service organized and controlled by professions is a professional mode of organization.<sup>ii</sup>

Professions focus on the values of quality and effectiveness. They are rewarded for maintaining skills and by success in meeting the needs of clients. In this regard, physicians built their



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<b>Facet</b>	<b>Democratic</b>	<b>Professional</b>	<b>Market</b>
Definition	Decision making by citizens or representatives accountable to the citizenry.	Decision making by experts with special training and credentials based on abstract knowledge applied to needs of others.	Decision making by consumers under conditions where there are a large number of providers acting independently and perfect knowledge of price and quality.
Dominant Actors	political parties, politicians, civil servants.	professionals.	business interests.
Dominant Value	Equity/Equality.	Effectiveness/Quality.	Efficiency.
Dominant Goals	Preservation and extension of democracy, influence in decision-making.	Enhancement of knowledge, improvement of technique and capacity, application to problems within domain of expertise.	Profit.
Mode of Regulation or Control	Elections, opposition parties.	Socialization, ethical standards, informal sanctions, formal sanctions imposed by colleagues.	Competition.

**Figure 1: Modes of Social Service Organization**

practice on the application of science to health problems. They tried, as a profession, to improve their knowledge and skills so as to cure or control disease in the patients they saw.

The knowledge required to know when a physician was skilled and whether those skills were conscientiously applied required the level of training found only among practitioners. Hence, other people were unqualified to judge medical practice. By necessity, physicians were self-policing. The main mode of regulation was through rigorous training and licensing.

The day-to-day work of medicine, clinical diagnosis and treatment, is almost universally left to the profession. The organization and management of the system, however, vary from one country to another. [Figure 2] Such

things as the allocation of specialists, the number, type, and location of hospitals, and the financing of medical care may be organized by the profession, a democratic process, or the market.

A professional reform in the context of medical care, then, is one that enhances the skills of physicians and provides enhanced professional control over the organizations physicians use for their work (clinics, hospitals, etc.). Professional reforms tend to be associated with high quality in the best settings, ethical norms, the highest levels of professional satisfaction, and high levels of public satisfaction. They also tend toward a misedistribution of resources, overspecialization, overemphasis on tertiary (hospital) care, large numbers of uninsured people, limited charity care, and runaway inflation. [Figure 3]

**Figure 2: Modes of Medical Care Organization by Sphere of Activity in Three Selected Countries**

Type of Activity	US	UK	Sweden
<b>Production of Services</b>			
Diagnostic, Treatment and Referral	Professional/ Market	Professional	Professional
Selection of Students	Professional	Professional	Professional
Curriculum of Medical Schools	Professional	Professional	Professional
Standards for Credentialling/Licensing	Professional	Professional	Professional
Certification of Specialists	Market/ Professional	Professional	Professional
<b>Discipline of Malpractice</b>			
informal	Professional	Professional	Professional
formal	Professional/ Democratic	Professional	Democratic
appeals	Democratic	Democratic	Democratic
<b>Allocation</b>			
Distribution of Physicians	Market	Democratic/ Market	Democratic
Allocation of Specialty Training	Professional/ Market	Democratic	Democratic
Financing of Care for General Public	Market	Democratic	Democratic
Financing of Care for Indigent Patients	Democratic	N/A	N/A
Financing of Care for Special Populations	Market/ Democratic	N/A	N/A
Distribution of Technology	Professional/ Market	Democratic	Democratic
Distribution of Hospital Beds	Market/ Democratic	Democratic	Democratic
Distribution of ambulatory care sites	Market	Democratic	Democratic
<b>Costs</b>			
Of case management	Professional	Professional	Professional
Of Technology	Market	Market	Market
Of Professionals	Professional	Democratic	Democratic

Sector	Clinical	Allocation	Cost
Model			
Professional	<ul style="list-style-type: none"> <li>•High Top Quality</li> <li>•Ethical Norms</li> <li>•Highest levels of professional satisfaction</li> <li>•High levels of public satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>•Maldistribution—overspecialization, overemphasis on tertiary care, large number of uninsured, limited charity services</li> </ul>	<ul style="list-style-type: none"> <li>•Runaway Inflation—fee-for-service system can't regulate</li> </ul>
Democratic	<ul style="list-style-type: none"> <li>•High Average Quality</li> <li>•High levels of professional satisfaction</li> <li>•High levels of public satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>•Universal Coverage</li> <li>•Control of specialization</li> <li>•Control of technology</li> </ul>	<ul style="list-style-type: none"> <li>•Capacity for Cost Control by budgetary and allocation decisions</li> </ul>
Market	<ul style="list-style-type: none"> <li>•Encroachment of fiscal intermediaries on Clinical Decision-making</li> <li>•Restriction of Services</li> </ul>	<ul style="list-style-type: none"> <li>•Maldistribution—large number of uninsured, underutilization of skills, elimination of charity services</li> </ul>	<ul style="list-style-type: none"> <li>•Cost control by denial of service—prior authorizations, service restrictions</li> </ul>

**Figure 3: Tradeoffs Among Models by Sector**

**Democratic Reform**

A democratic system is one in which decision-making is by citizens or their representatives. The dominant actors are political parties, politicians, and civil servants. The main mode of regulation is through elections and opposition parties.

In many countries, there is a strong democratic component to organizing medical care. The production of services (e.g. diagnosis, treatment, referral; the selection of students and curriculum of medical schools; licensing standards, certification of specialists, and discipline of physicians) is usually the prerogative of the profession. The minor exception is that governments often have a secondary or backup role in formal discipline or the appeals process.

In most countries, democratic control of healthcare is limited to the allocation of medical services (e.g. the distribution of physicians, the allocation of

specialty training, the financing of care for the general public or special populations, the distribution of technology and hospital beds, and the distribution of ambulatory care sites) and, most importantly, the financing of medical care.

In this regard, we can call a democratic reform one that enhances the accountability of the system to the general population. A democratic reform will tend to enhance the highest level of average quality, high levels of professional satisfaction, high levels of public satisfaction, universal coverage, control over allocation of technology and specialization, and the capacity for budgetary control over costs. In some countries, it seems to be associated with lower professional satisfaction, especially when the mobility of physicians is limited.

**Market Reform**

Until very recently, the market has

had a secondary role in medical care, largely limited to the production and sale of technology. Even then, it often operated under the rule of professional ethics. Pharmaceutical companies, for example, could not advertise prescription drugs directly to the general public, but had to limit their sales promotions to health professionals. In the past two decades, however, markets have taken a large, often dominant, role in medical care.

The ideal type market consists of decision-making by consumers under conditions where there are a large number of firms that all act independently, make similar products, and are transparent with regard to price and quality that can be judged easily by the consumer. A market system is one in which business interests are dominant and profit is the goal. The regulation of markets is through competition.

When market forces control medical care, business interests tend to encroach on clinical decision-making, constraining professional discretion in the ordering of tests or procedures and in making referrals, and such restricts services available to patients. It is also in market systems where the largest proportion of the population is uninsured and charity services are weakest. These measures are introduced in the name of efficiency. While they do seem to raise profits for corporations in the medical care field, there is no evidence they succeed in reducing prices.

It is the thesis of this paper that there has been a dramatic shift from professional and democratic forms of medical care systems toward the market. This shift has been quite sudden and to some degree seems to have encompassed a large part of the world.

### Comparison of Modes

For now, it is important to note that when professions, as a class of occupation, were first identified and described, they were characterized in specific contrast with the market.

Clients, in the case of medical care patients, were unlike customers since they lacked the knowledge to define their needs or how to meet them, nor could they judge the technical competence of their provider. Furthermore, patients were often compromised by their health problems and had a high level of anxiety, thus making them vulnerable to exploitation, a degree of "helplessness" not typical of business customers.

Professionals (in the case of medical care, physicians)<sup>iii</sup> could not be allowed to operate on the norm of caveat emptor. Rather than being allowed to exploit the patient, the physician was bound to work in his or her interest. In most cases that meant providing care irrespective of ability to pay. To behave like a business was considered unethical. Ethical norms forbid advertising, overt competition with other physicians, or other market-type behavior.

There has been less written on the distinction between democratic and market modes of organization. Here the main issue would seem to be the conflict between the control of the system by representatives of the general population and control by the corporate elite. A major tradeoff would be between a system organized to provide broad access and universal coverage and one organized to generate profits leaving a large portion of the population without service. Democratic systems tend to have lower unit costs than market or professional systems.

In most of the world, democratic and professional modes have been seen as compatible. Professionals have autonomy with reference to clinical activity while politicians control the allocation of services and technology. In the US, by contrast, professional organizations and right-of-center politicians have been resistant to democratic reforms.

### **The Shift Toward the Market**

From the middle of the 19th century until well into the 20th century, with dates varying considerably from one country to another, most reforms of medical care were toward enhancing the profession of medicine. An ideology of quality and effectiveness became dominant. The modern medical school based on science, supervised clinical training, and licensing was established. Physicians gained autonomy not only with respect to clinical decision-making, but also with respect to the organization and financing of the system.

In the early 20th century, accelerating in the 1940s and 1950s, democratic reforms based on an ideology of equity or equality became more common. Most developed countries created systems of national health insurance or national health care systems.<sup>iv</sup> Medical care became available to everyone in those countries either at no cost at the point of delivery (e.g. in the UK) or at nominal cost (e.g. Sweden, Germany). The shape of these systems varied greatly from one country to another, being organized at the national level in some and at the level of smaller political units in others. In some systems, private physicians contracted with the state to provide services, while in others they were employed by governmental units.

Some built their systems around general practice (e.g. UK, Denmark) and others developed more highly specialized services (e.g. Sweden). The former was always more cost effective.<sup>v</sup>

Up to this point, medical care had developed a firmer scientific base, placed the control of clinical decision making into the hands of highly trained and licensed professionals and expanded access to services to a greater part of the populations in most developed countries. Many developing countries also worked to make medical care a right of residence or citizenship.

Beginning in the 1970s, companies with substantial international exposure began to withdraw unilaterally from agreements that supported the welfare state. This was part of a process that came to be seen as a shift from a “Fordist regime” to a “Global Post-Fordist Regime.” This shift was multidimensional and involved all things associated with changes from: a regime based on national economies, domestic mass production, and consumption regulated by welfare states to a regime based on international economic relations, “flexible accumulation” (decentralization of production, “informalization” of labor), global sourcing, and transformation of the nation state.<sup>vi</sup>

Companies began seeking to reduce their cost of production by demanding concessions on the part of labor, seeking to avoid environmental and workplace regulation, and often moving, if they had the capacity, to places that did not demand such high “costs on doing business.”

One consequence of direct relevance to medical care was that internationally exposed corporations exerted great pressure on governments for tax relief.

In the US (which was unique in creating health insurance as an employment benefit), companies pressured labor unions for “give-backs” on employment benefits, which reduced the scope of coverage, increased premiums and deductibles, or, in some cases, dropped health insurance entirely as a form of compensation. Either way, countries found it more difficult to fund the health care system.

This was also a period when the world economy grew more slowly, while medical care inflation continued to outstrip economic growth in almost every country, creating a political climate in which it was easy to propose that the system was “failing” and some more “radical” approach was needed to make medical care more efficient, cost-effective, and cheap. Rightest interests, in the ascendancy in most developed countries, had medical care reform as part of their agenda. The reforms they proposed were those of the market, which they claimed were more “efficient.” By organizing medical care more along market lines, the system would be cheaper, less wasteful, and more “profitable.” Furthermore, by their control over international financial organizations, market forces in the first world could impose similar standards on the developing world.

Of the twenty countries we studied, the number initiating professional and

democratic reforms before and after 1980 stayed relatively constant, while the number initiating market reforms nearly doubled (Table 1). If we look at the number of reforms initiated, professional and democratic reforms dropped by well over half. The number of market reforms increased more than eleven-fold (Tables 1 & 2).

While a large number of reforms were tried, relatively few were attempted by the majority of countries we studied.

- Before 1980, only one country reported an ideal of efficiency compared to 12 countries who reported such after 1980.
- A shift from public to private insurance coverage or service provision was reported by 13 countries, all after 1980.
- A focus on competition, incentives, “productivity,” and “choice” was reported by one country prior to 1980 and by 9 countries after 1980.
- A reduction of benefits to patients and/or “cost shifting” (requiring patients to pick up more of the cost of services) was reported in one country before 1980 and by 12 countries after.
- A focus on cost containment and/or rationing of care was reported by 1 country prior to 1980 and by 9 countries after 1980.
- Nine countries, all after 1980, re-

**Table 1: Countries Engaging in Reforms by Type (N=20)**

Type of Reform	Prior to 1980	1980 or later
Professional	9	10
Democratic	19	14
Market	11	20

**Table 2: Number of Reforms by Type among 20 Countries**

Type of Reform	Prior to 1980	1980 or later
Professional	29	12
Democratic	62	21
Market	20	227

ported decentralization as part of their program.

The United States was in a unique position in these reforms, being the only country in the study without public financing of medical care for the general population. The majority of health insurance came from employer-based plans in the private sector. The percentage of the population with coverage and the scope of that coverage increased between World War II and the 1980s, after which there was a reversal. The numbers of uninsured has increased annually for two decades. The United States has the most expensive medical care system in the world, the highest level of medical indigence, and below average results from the point of view of morbidity, mortality, and life expectancy. It did less in democratic reform than that of any other country prior to 1980 and had, by far, the largest number of market reforms since that time. The cost of care was rising everywhere, but nowhere at the rate seen here.<sup>vii</sup>

Two things were unique in the US experience. First, we had a large, well entrenched system of private insurance companies. In 1994, with the failure of the so-called "Clinton Health Plan," the insurance industry moved in and took over the medical care system, taking the profession and the public by surprise. A system of not-for-profit managed care, which kept clinical decisions in medical hands, was expanded and moved into the for-profit sector. People who financed medical care began exercising control over clinical decision-making. Care was managed not just for cost containment, but profit maximization.

Second, in a series of lawsuits brought by chiropractors against state medical societies challenging the mar-

ginalization of chiropractic under the Sherman Antitrust Act, the courts held that medicine was subject to commercial law. Professional autonomy was undermined and professional activity was legally redefined as a business activity.

### **The Source of Market Reform**

Given the narrow time period within which market reforms were introduced, it is worth speculating whether there was some international coordination of the reform effort. In each of the countries studied, pressure for market reforms developed during the 1970s and came from the internationally exposed corporate sector. Even though the rising cost of medical care was a problem shared in all countries studied, they were very differently situated with respect to that problem. Sweden, for example, had done some reforms that had actually reduced the percentage of gross domestic product spent on medical care. Saudi Arabia had a system without taxes where the royal family provided the whole system.

Yet it was striking that the medical care problem was formulated in virtually identical terms no matter the level of development or the nature of the medical care system. The goals were formulated in similar ways and the projected benefits of market reform were framed almost identically. All of this suggested that some transnational effort was under way.

Indeed, one of the important aspects of globalization was the development of organizations that operated outside the nation state, often with sovereignty ceded by nation states. Organizations like the World Trade Association, the North

American Free Trade Association, and the European Union have been granted legislative, administrative and judicial powers that have removed important aspects of economic policy from the nation state. Older organizations like the World Bank and the International Monetary Fund are the main source of development funds in the third world and exercised their power to enforce a first-world agenda. There are also a large number of organizations that are more ideological and try to set a political agenda for the world. The World Economic Forum, the Trilateral Commission, and the Club of Rome are the best known of these.

To set the agenda for medical care reform, however, a transnational organization must have the following characteristics:

- international scope and representation from virtually all countries on the globe
- membership of people with great political and economic power enabling them to strongly influence economic activity in an important part of the world
- an agenda of promoting a neoliberal (in the US neoconservative) view of public policy
- a program of promoting consensus among economic elites
- having links to operational means for structuring international economic activity

At least one organization meets these criteria, the World Economic Forum (WEF), which was created in 1971 by Swiss economist Karl Schwab, Professor of Business Administration at Geneva University. WEF is a forum of business elites and selected academics and politicians. For membership, one must

be the CEO or CFO of a corporation doing at least one billion Swiss francs (as of 2000) of business each year and pay a “membership fee” of US \$24,000. In addition there is a conference fee of \$6,000 as of 1997. In 2000, the corporations represented at the meeting accounted for 80% of the world industrial output.

Originally set up as a conference of European business leaders to “discuss a coherent strategy for European business to face challenges in the international marketplace,” it soon expanded into a worldwide conference that meets each year toward the end of January in Davos, Switzerland for a week of seminars, lectures, discussion, and networking, all of which were “committed to improving the state of the world” (WEF website).

WEF operates under tight security and secrecy. The village of Davos is cordoned off by Swiss police during the conference. Nobody is allowed in or out of the village except conference participants. It is a rule of the forum that nothing said there may be quoted or attributed to anyone. Excluding speakers at plenary sessions, the names of participants are not released or publicized. Aside from plenary session speeches, there are also no reports on the content of discussions.

Only invited members of the press may attend. Their coverage is limited. Members of the press are certified to attend only certain sessions. They may not report discussions or identify members. Their participation is limited, in the parlance of journalism, to “deep background.” The first news report of a WEF meeting did not appear until 1988.

Each conference is designed to produce a consensus among business elites

on the direction the world economy should take and the policies governments should pursue. That agreement becomes an agenda that can then be carried back to countries across the globe by the most powerful economic leaders in the world.

Given the power of the participants and the nature of the forum, it seems likely that in the mid-1970s the WEF had a meeting focused on medical care in which a plan was developed to promote market reform, complete with arguments on the need for reform, a strategy for critiquing the current medical care system, and proposing specific alternatives.

### **Where are We Headed?**

In countries with strong democratic control of medical care, the efforts at market reform were more contained than in the US. Major reform efforts were either rejected outright or were limited to more incremental changes. Professional control over clinical work was maintained as well as democratic control over the allocation and distribution of services. In the country with the greatest reform effort during the 1980s, the UK under Prime Minister Margaret Thatcher, there has since been substantial decentralization and some growth of the private sector. Even there, the conclusion of one of their experts is that while the reforms kept everyone off balance and upset, very little changed in the long run.

In the US, where the reforms were less planned, not democratic, and driven by the insurance industry, the changes have been substantial. For-profit companies financed care, dictate the allocation of service, and oversee

clinical decision making. Here there is considerable resistance from both the professions and the general public. Physicians are chafing at the oversight by insurance company clerks. Some are unhappy with the assembly line model of medical practice that has been imposed and restrictions on their ability to use their best clinical judgment. Patients, too, find their access to their physicians compromised and the care they receive more expensive as co-pays and deductibles rise. Both see medical care as “colder” and more impersonal.

To the degree that the democratic process can be mobilized to roll back or limit market reforms, politicians may be able to better resist the insurance industry. For the future, look for sharpened battle lines with insurance on one side and patients, physicians, and other professionals on the other. 🗿

### **Notes**

- i. Much of the argument in this paper comes Twaddle, 2002. This was a collaborative project which I coordinated and edited. Collaborators, and the countries they studied were: David Hunter (UK), Christel Woodward and Catherine Charles (Canada), Albert Wessen (USA), Andrew Twaddle (Sweden), Stipe Oreskovic (Croatia, Czech Republic, Hungary, Poland, Slovakia, Slovenia), Vuk Stambolovic (Serbia), Mark Field (Russia), Eugene Gallagher (Saudi Arabia), Revital Gross and Ofra Anson (Israel), Susana Belmartino (Argentina), Luis Duran-Arenas, Malaquias Lopez-Cervantes, Octavio Gomez-Dantes and Sandra Sosa-Rubi (Mexico), Rama Baru (India), Donald Stewart and Ian England (Australia), Ofra Anson (China), and Pathom Sawanpanyalert (Thailand).
- ii. On professions, see Abbott, (1988. On

- medicine as a profession, the standard is still Freidson (1970, 1986).
- iii. There are, of course, other health care providers, chiropractors, naturopaths, social workers, nurses, etc. At the time professions were first discussed, however, chiropractic was illegal in most states and the others were much more subservient to medicine than is now the case. For some of the early work on professions, see Parsons (1968 1975).
  - iv. The distinction here is between a system for financing medical care and one for the delivery of services.
  - v. For a country to control the cost of medical care it must control the allocation of technology and the allocation of personnel. Hollingsworth, Hage, and Hanneman (1990).
  - vi. The best review and summary of this process I have found is in Bonanno and Constance, (1995).
  - vii. The best medical care in the US is the equal of the best in any other country. The average level of care in the US is below that of other developed countries.
7. T. Parsons. "Professions," International Encyclopedia of the Social Sciences, New York: MacMillan, Vol 12, 536. 1968.
  8. T. Parsons. "The Sick Role and the Role of the Physician Reconsidered," Milbank Memorial 1975. Fund Quarterly, 53:3:257-78.

### **References**

1. A. Abbott, *The System of Professions*, University of Chicago Press, Chicago, 1988.
2. A. Bonnano and D. Constance. *Caught in the Net: The Global Tuna Industry, Environmentalism and the State*, University of Kansas Press, Lawrence, 1995.
3. A. C. Twaddle (ed) *Health Care Reform Around the World*, Westport, CT: Auburn House (Greenwood) 2002.
4. E. Freidson. *Profession of Medicine*. New York: Dodd-Mead. 1970.
5. E. Freidson. *Professional Power*. Chicago: University of Chicago Press. 1986.
6. J. Hollingsworth, J. Rogers, Hage, and R. Hanneman. *State Intervention in Medical Care: Consequences for Britain, France, Sweden and the United States 1890-1970*, Ithaca NY: Cornell University Press. 1990.