

Issues in Health Sector Regulation
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Looking at health sector regulation the other way around
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The relative ignorance of health service consumers, compared with providers, is generally thought to give rise to 'principal-agency' problems and to be a major cause of inefficiencies in health markets. However, consumers may not be as short-sighted or as ignorant as many suppose. Rather they may be powerless unless they are part of a health consumer 'community'. Although consumer action may be threatening to health service providers, society has a whole might benefit if well-informed communities exerted greater influence over the patterns and quality of health services and the prices at which they were offered.

Health service communities

'Communities' are groups of individuals with common aims that act together in ways that further their interests. In a world where people are connected electronically they no longer need to live together in order to act together. There are many kinds of health service communities: health service providers, third-party payers, activists, lobby groups, government bureaucrats and politicians with an agenda that includes health protection or promotion. An analysis of the transactions between health service communities provides one way of understanding why health services are so poorly regulated.

One of the central causes of inefficiency in health markets is the asymmetrical nature of the transactions that occur between health providers and patients. Not only is the provider's knowledge perceived to be superior, but the patient's inferior position of ignorance may be exacerbated by anxiety and a sense of powerlessness during an encounter with a health adviser. This asymmetry gives providers relatively greater influence over treatments, costs and service quality.

However, health service providers are deeply aware of their fallibility and of the costs of error. They have strong incentives to seek protection from these risks by being secretive about the extent of their knowledge, by minimising contacts with patients, by insuring themselves against error and by forming professional associations to spread their risks and to act on their behalf in the case of misadventure.

Moreover, politicians and government bureaucrats may find it easier to engage with established provider bodies and so may be persuaded that professional self-regulation is cheaper and more effective than public intervention. Groups of providers may argue that they have incentives to maintain high quality standards and are best placed to impose sanctions on their members who fall short of the mark or who behave unethically. These professional synergies augment the relative superiority of provider over consumer interests.

On the other hand, the incentives to form health service consumer associations are weak. Most people use health services intermittently unless they are chronically ill. They are unable to assess how often they will need to use the services of providers. They have little knowledge of the quality of care they can expect or of its costs. Health service consumers have a weak basis for assessing the benefits of association in relation to the costs of establishing and contributing to a community of health service consumers. As a result, health service consumers remain a 'virtual' community, without connections, the means of association or a voice.

Health service consumer communities

Until recently, the desirability of health service consumer communities was rarely considered. The idea challenges the dominance of provider communities and threatens their monopolistic power. Yet health service communities offer advantages. If well informed, they are likely to make health markets more competitive by redressing power imbalances between professionals who associate and consumers who do not. Consumer communities can access information more efficiently than individuals by assigning responsibility to a member with particular skills to act on behalf of the community, or even by recruiting an information agent. These advantages have been demonstrated by consumer communities with chronic diseases such as diabetes and hypertension.

Their activities may also reduce the social costs of consumer complaints. The absence of a vent for consumer fear, anger and ignorance may lead to a rising sense of frustration and unnecessary litigation. The experience of the Oxford Mediation Project suggests that pent-up anger from the absence of a low-cost channel for complaint was a more common source of litigation, aided by willing advocates, than either firm evidence of provider incompetence or a justifiable need for compensation. Well, informed and trusted health service consumer communities could provide that channel.

Health sector regulation 'the other way around'

This notion leads on to the view of health sector regulation 'the other way around' by giving consumers a collective voice and empowering them to make informed choices between providers and the services they offer. In short, consumer communities might offer an instrument for health market regulation more effectively and cheaply than either professional self-regulation or public intervention.

However, there are a number of theoretical and practical problems with this idea. First, while knowledge is empowering, all knowledge is not good. Informational asymmetries can only be reduced if providers and consumers have access to and use sources of reliable and reputable sources of knowledge. Where there is doubt about which interventions are most effective at least cost, consumers may need a 'validating agent' to filter what is good from what is less good information. It is not clear, in general, who should be this validating agent.

Second, consumer communities often designate a spokes-person to negotiate on their behalf, frequently a community leader or activist. This may result in apparent participation in decisions about health care services that is no more than token

participation because the community's agent is expressing personal rather than collective preferences. Important agency problems may arise if the community's agent negotiates with external agents who bring resources as well as new technology and have vested interests in marketing their products or services successfully, whether or not they are effective.

Third, health service consumer communities may hold entrenched beliefs about health interventions that are unsupported by evidence of effectiveness. It is tempting for a third-party to advocate alternatives. It may be better to allow consumer communities to learn from their mistakes. But this may impose serious social costs, for example, if communities believe that HIV infection is caused other than by sexual transmission and act, or fail to act, as a result.

Finally, the slow development of health service communities suggests that some changes in the incentives governing provider-consumer transactions is required. On the face of it, the revolution in information technology should make the acquisition of information less costly. However, it is not yet clear whether the internet will be a source of social cohesion, allowing virtual consumer associations to form and become active, or whether it will be a source of differentiation, marginalising the poor and disadvantaged and allowing those better endowed to negotiate with their health care providers from a relative position of strength.

Conclusions

While the evidence is still fragmentary, there are theoretical reasons to suggest, and some empirical evidence to support them, that more and better-informed collective consumer demands would be a more powerful regulator of volume, price and quality in health markets than either professional self-regulation or public intervention. The information revolution offers opportunities to place knowledge in the hands of consumers that were unimaginable hitherto. However, this will only yield social benefits if that knowledge is 'good' and if agency problems can be managed. It will only yield equitable results if that knowledge is made available widely.

The public regulatory role in the future may be more to do with filtering consumer information and reducing its acquisition costs, so that health service consumers make better informed choices and express their preferences more powerfully, than with attempting to regulate volume, quality and price on the supply side.

Meantime simple things could be done to improve health service consumer knowledge. Providers could be required to publish prices, quality standards and the results of their treatments. Pharmaceutical prices could be displayed and patients could be offered choices amongst alternative, costed remedies. At the very last, patients should have the same access as providers to information about treatment outcomes. Some steps are already being taken in this direction but more could be done.

Looking at health sector regulation 'the other way around' raises many unanswered questions. But they are intriguing enough and important enough to merit further enquiry.