

The Market vs. Regulation: The Case for Regulation

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THE CURRENT HOSTILITY TOWARD REGULATION (and the converse promotion of competition) owes little to dispassionate intellectual analysis. Rather, it arises from a conjunction of short- and long-term political forces with the tendency of health policy makers to adopt new fads every two or three years. The case for regulation is not often made, for political reasons; but, as an unrepentant regulator, I would like to argue the case by listing, with brief discussion, ten characteristics of the health care system and the regulatory process which seem to me to make health care regulation desirable.

The focus is on the regulation of health care, including health care facilities, health care providers, and health insurance mechanisms—my remarks are not meant to apply to regulation more generally, although some of them do. One of the major shortcomings of the current debate over regulation and deregulation is the often willful failure to identify the extent to which regulation in one area may differ from regulation in another. There is no plausible defense for the Interstate Commerce Commission's protection of truckers or railroads at the expense of shippers and consumers, but few of us would be prepared to dispense entirely with the police. There has been

considerable discussion of “public utility model” regulation of health facilities (McClure, 1976:22–68; Vladeck, 1977:107–150); but, as an economic entity, the typical labor-intensive, publicly supported, nonprofit hospital is profoundly unlike Con Ed or Pacific Gas and Electric.

The Nature of Medical Care Consumption

The most important consideration in a discussion of regulation and competition in health care is that, no matter how much devotees of the market might wish it were otherwise, medical care consumption decisions are simply atypical: most citizens in their consumption of medical care services do not behave like the theoretical construct of a rational consumer on which most of Western economics is based. Indeed, if one stops to think about it, where health care matters are concerned, it may not even be desirable to encourage people to behave more like rational “economic man.” The science of medicine still relies on the patient’s nonrational acceptance of the physician’s role as healer.

The current argument for greater competition in the health care sector is based on the initial assumption that health care markets are distorted because of the wide prevalence of insurance, specifically including first-dollar insurance, which induces consumers to over-consume. When insurance—especially insurance purchased through employment relationships in which the individual consumer is never directly involved in the decision-making on benefit packages—makes the out-of-pocket, immediate cost of health services zero, consumers at the margin will be more likely to incur health care expenses than they would be if they experienced an out-of-pocket liability. Remove the moral hazard created by insurance practices, goes the argument, and the greater price sensitivity of consumers will begin to create market discipline on providers.

This argument is perfectly sound so far as it goes, and there is no question that in many instances the phenomenon of moral hazard works just as it is supposed to in the economics textbooks. But the advocates of increased competition seldom go the further step: to inquire just why it is that there is so much health insurance around, particularly insurance that is so comprehensive in its coverage of

relatively small discretionary expenditures. One can agree that low-probability, high-risk events, such as hospitalizations for severe illnesses, are precisely the sorts of things against which rational consumers will insure, accepting some degree of copayment as a rational pricing mechanism; but no one is arguing that the problem of medical care costs has been created by insurance for such episodes. It is first-dollar coverage for relatively more discretionary services or marginal elective surgery and things of that sort that has everyone so excited—even though, in the actuarial sense, insurance for something like routine physician visits is not really insurance at all, since there is relatively little risk in the pure sense and the incurring of a loss is entirely at the discretion of the insured.

While advocates of competition, substituting static elementary economics for any knowledge of history, attribute current health insurance practices to relatively insubstantial tax subsidies (Congressional Budget Office, 1980:1–45), the basic fact is that medical care expenses are the most insured-against hazard in this society. The proportion of people with health insurance is substantially greater than the proportion of automobile owners with liability insurance, even in those states with compulsory automobile insurance laws. Something is going on here; consumers are trying to tell us something that professional social scientists have sought to ignore. People have walked picket lines and taken bitter strikes not only to get health insurance *per se* but also to protect first-dollar coverage. As one goes up the socio-economic ladder, one finds ever-richer benefit packages with diminishing copayment. People want health insurance, and they want it without deductibles or coinsurance.

Consumers have sought the kinds of health insurance they have, not because they wish to act irrationally in the aggregate economic sense, but precisely because they don't wish to be forced to make rational trade-offs when they are confronted with medical care consumption decisions. No matter how we draw our curves or shape our abstract arguments, the elemental fact is that medical care is about living and dying, something considered by many to be of a rather different character from the purchase of tomatoes. The primary characteristic of most consumers of medical care most of the time is that they are scared. They are scared of dying, or disfigurement, or permanent disability; and these are serious matters. It is hardly fair to expect any of us to make rational decisions about matters of such

import. As a society, we may be prepared to pay a substantial economic premium to insulate people from having to make such decisions.

This argument is flawed, the proponents of a greater role for markets will say, because most encounters between individual consumers and health care providers do not involve life and death situations; indeed, most physician visits and even most hospitalizations involve conditions that will go away on their own in the absence of medical intervention. That is probably true, but it is also probably irrelevant. The real question is not, as Schelling (1968:127–162) would have it, what we are prepared to spend to reduce in the fourth decimal place the extremely low probability of a very highly disvalued event. Rather, it is a question of how much we are prepared to spend to be able to seek reassurance—of a variety of kinds in a variety of circumstances—when we are scared, or anxious, or lonely, when we are not dying. It is one thing for social scientists to tell us that freeing people from marginal trade-offs between out-of-pocket expenditures and the intangible benefits of health care is very expensive. It is quite another thing for them to then tell us that doing so is illegitimate and must be abolished by legislative fiat—talk about government interference in private decision-making!

Equity

Whether or not the content of medical care is effective from the perspective of narrowly drawn cost-benefit analyses, it is something we value highly. Indeed, it is something we value so highly that as a society we are committed to providing it to all, even if some can't afford to pay for it from their own pockets. As a matter of social policy, we certainly do treat health care very differently from housing, or clothing, or any other set of commodities other than food. We have taken the basic position that all citizens are entitled to receive it. Those who can't afford to pay for it themselves should receive it at public expense. To be sure, we may penalize them in many ways for their impecuniousness. Not least are what Uwe Reinhardt terms "hassle factors." But this probably has more to do with a disapproval of poor people than with a disavowal of the basic responsibility for providing care.

Everyone learns in the first week of Economics I that the one thing

markets don't do very well is insure equity. Equity considerations are thus always the major arguments for public intervention in a market economy. What is often ignored, however, is that the very same equity concerns often require some degree of regulation in the form of government intervention. It is not enough, as market advocates would contend, simply to redistribute income. To begin with, as a society we are prepared to distribute access to services, not to redistribute cash income. More to the point, narrow economic incentives will not satisfactorily distribute even services.

One of the most important characteristics of poor people, but one economists tend to ignore when they so blindly consign questions of equity to the outer fringes of nonmarket areas, is that almost by definition poor people fare less well in markets of any kind, even when they are given purchasing power (Caplovitz, 1963). Most people receiving direct government subsidies for medical care have limited access to that care not merely because of low incomes per se but rather because of low income arising from certain kinds of social or ethnic status. Even when incomes are relatively more equal, these socioethnic disparities make access to health care difficult. The poor in the United States are characteristically old, or black, or hispanic, or young members of families with a single parent. At all income levels, people in these categories have special problems with health care services. The elderly and the poor young are bad risks from the insurance point of view. Blacks, hispanics, and members of other minority groups frequently encounter barriers to the receipt of health care services totally unrelated to price or income. Simply giving income support, or even cash equivalents such as vouchers, to people in these categories will not assure their having equal access to services when they need them.

People are poor for a reason; and the same things that make them poor frequently make it less attractive to sellers to provide them with services, as well as making it more difficult for the poor to rationally consume services. If you are the head of a supermarket chain, or indeed of a chain of for-profit hospitals, the last place you are going to locate your next expansion is in the midst of a poor community, even in this day of food stamps and Medicaid. You want to go where the economic growth and the young, affluent markets are; and, by long historical practice in this and most other countries, that is generally where poor people aren't. For hospital services, after all,

Medicaid is a kind of voucher; but inner-city hospitals continue to close; and, even if physicians could earn the same incomes in Harlem, they'd probably prefer to practice in Scarsdale.

It is not so long ago that the widespread extension of community-rated health insurance was seen as a great social advance, precisely because it provided for greater equity in access to health services through insurance than a free market would permit. In this context, it is surely noteworthy that the most sophisticated health maintenance organizations (HMOs)—the only identifiable beneficiaries to date of procompetitive health legislation—increasingly resist community rating. Competition among insurance plans, unless it were constrained by an enormous and pervasive regulatory system, could not help but encourage “creaming” of the lowest-risk population groups. Conversely, it might be suggested that standardized health insurance at a universal community rate with progressive subsidies to help the poor purchase such insurance would be conceptually indistinguishable, in many ways, from what used to be called national health insurance.

As committed as I am to the necessity for regulation in the health care sector, I am confident that the healthier, more affluent three-quarters of the population would do just as well in their receipt of health care services in the absence of any major regulatory activity at all. It is that other one-quarter that I worry about, and that provides the major justification for what it is we in government do.

Public Purse

Given our predispositions in this country away from public ownership (or direct public provision) of services and toward market solutions whenever they are thought to be available, the primary way in which Americans have sought to ensure access to health services for old and poor people is through subsidies in the form of Medicare and Medicaid. But that approach creates the most important political rationale for extensive regulation of the health care sector. Put most simply, the dollars we are talking about controlling are tax dollars; and the public tends to be rather protective of how its tax dollars are spent.

At the most elemental level, any industry that receives more than 40 percent of its revenue from government should simply accept at the outset that it is going to have to undergo a substantial loss of

autonomy. Put more positively, we have an obligation to be at least as careful in our expenditure of tax dollars for health care as we are in our expenditure of tax dollars for highways, welfare, or sanitation. Whatever their cause, excessive hospital costs waste tax dollars as efficiently as more obviously unnecessary projects. We outlaw excess profits for defense contractors, but not for Medicare providers.

The historical record seems very clear to me. Extensive regulation of health care providers is the price we pay for not having national health insurance. Given a political stalemate in society which precludes development of a health insurance system like that in every other modern society, we have chosen to subsidize particular groups while consciously refusing to make major structural changes in the health care industry. Fee-for-service health care and reasonable cost, however, lead to inordinate public expense—unless there is substantial and effective regulation of fees and services. Equal access for the poor and elderly will feed cost inflation unless costs are directly controlled.

A somewhat more subtle, but equally critical, point links these concepts of equity and protection of the public purse. Government is always the provider or insurer of last resort. To the extent that our society is unwilling to deny life-saving or disability-preventing medical care to those without other resources, there is a role for government in arranging for their care. The more competitive the private insurance market, the more such people there will be—because insurers avoid bad risks and have a marketing strategy of selling low-cost, low-benefit programs to those with the lowest income (but the greatest probability of needing services)—and thus the greater the burden on public funds. There is, for example, essentially no private market for nursing home insurance; so, government pays for more than two-thirds of nursing home days.

Slaying Dragons

In evaluating the competing claims for regulation and competition in health care, there is also the small matter of empirical evidence. The standard to which regulation is generally compared, that of the “efficient” performance of perfect theoretical markets, is almost purely a theoretical construct. Apart from a few markets for agricultural commodities, there are almost no true markets left in modern society;

and one can even raise historical questions about how many ever really existed. It was Adam Smith, after all, who warned of the inevitable tendencies to monopoly, mercantilism, and other exercises of economic power. As a regulator, I'm growing tired of being beaten over the head by defunct economists.

Dispute rages over the fine points, but there is no question that state-operated hospital cost-containment programs work (Biles, Schramm, and Atkinson, 1980; Comptroller General, 1980:28–42); and, while my counterparts in New York may have overdone it, there is no verifiable evidence of seriously dysfunctional outcomes in any state with strong regulation, even New York. Well-managed HMOs do reduce costs, but it's hard to develop them, and harder still to get lots of people to voluntarily enroll in them (Brown, 1981). At the other pole of the debate, I think close examination of most of the currently trumpeted procompetitive plans would reveal how much regulatory content of their own they would require. In these plans, the focus of regulation is shifted from providers to insurers, but a powerful, external guiding hand remains. In order to make reality look more like the textbook theories, we would need lots of regulation anyway.

Destructive Competition

One of the curious facts about the argument for increased competition in the health care sector is that there has been so much competition for so long, although of a kind that is less than perfectly desirable. Specifically, note the classic patterns of competition among hospitals, which are widely thought to have resulted in substantial excess capacity and enormous overinvestment in dubiously useful technology. In a market structure in which consumers do not make basic consumption decisions about hospital services themselves, in which they are forced to rely on the preferences and decisions of physicians, competition among institutions for physicians' favor is bound to be inordinately expensive and destructive. One could argue that the sorts of destructive competition we have seen among hospitals result from the nature of health insurance coverage. But that argument ignores the way in which people and physicians actually perceive and care about the hospitals with which they do business (Vladeck, 1976:76–101). The

so-called technological imperative in medical practice may not be a technological or professional/scientific phenomenon at all, but rather a competitive one (Joskow, 1980:421–447).

Competition among health insurers is, in fact, a major source of the expansion of comprehensive first-dollar health insurance. Moreover, as Diana Chapman Walsh (1980:71–85) has recently illuminated so superbly, the structure of the real health insurance market strongly discourages cost containment. Forcing insurers to sell packages that would make consumers more price sensitive would require extensive new regulation.

Under conditions in which ideal markets do not prevail, various forms of monopolistic competition often occur, with all sorts of unhappy consequences. We get product differentiation on the basis of nonprice, rather than price, characteristics, which permits individual providers to behave as quasi monopolists with consequent restrictions in output and increases in prices. I think that is a fair description of much of the health industry, and I do not know how more pro-competitive strategies unsupported by substantial regulation could change that very much.

Idle Profits

Closely related to this kind of competitive behavior is the fact that the most expensive and most pervasive institutions in health care, those where the greatest expenses are incurred, are overwhelmingly run on a not-for-profit basis. Even in the absence of a fully satisfactory theory of the nonprofit firm, it is clear that the behavior of nonprofit firms varies in significant and critical ways from the classic theory of the for-profit firm. Prospects of profit maximization, for example, have very limited incentive effect in most of the hospital industry. Most hospital boards do not make policy choices on the basis of profit or loss; their choices are influenced more by other considerations. To give a simple and concrete illustration: most nonprofit hospitals do an astonishingly poor job of collecting money owed them by individuals and even some third parties. Aggressive collection policies are thought to be poor public relations; and, besides, they are too “businesslike” for the self-images of many hospital administrators. That is laudable in many ways, but it does imply that one has to think

long and hard about the kinds of incentives one is seeking to employ to induce certain kinds of behavior.

As another example, a generation ago through the provision of Hill-Burton subsidies public policy makers attempted to induce not-for-profit hospitals to expand their provision of long-term care services for the disabled elderly. So unresponsive were hospitals to these very substantial financial incentives that policy makers soon had to reach outside the health care sector altogether, to the class of real estate speculators, in order to achieve a sufficient increase in the supply of nursing home services. I think it fair to say that that latter experience was not altogether a happy one (Vladeck, 1980:122–127).

It is hard to have much of a market when the major suppliers refuse to act like firms in the classical economic sense. Market incentives may produce surprising, unexpected, and even counterproductive results. Indeed, if one takes narrow economic models of hospital behavior to heart, what is most surprising is that the industry has not grown—in terms of assets and debt—much faster than it has. Perhaps we should be grateful that hospitals are not conventional firms. But because they are not—and because their patients refuse to behave like conventional consumers—some degree of regulation comes to be inevitable.

The Golden Mean

Traditionally, the possible social arrangements for the control of certain kinds of essential services have been defined as markets on the one hand and public ownership or direct public provision on the other. The sorts of regulatory phenomena we see in health care, or utilities, or other segments of American life are uniquely American, a sort of compromise between the two historical ideological poles. Moderation of this kind, suggested Aristotle, is a principal characteristic of effective democracy.

I do not imply that regulation is a “golden” mean between markets and public ownership, but I would suggest that there may be something of value inherent in the regulatory process itself that has been sought and then preserved by those who have made public policy. When it works correctly—and it doesn’t always—regulation of the kind we practice in this country tends to involve the oversight of an

industry by informed, sometimes judicious, and certainly meddling experts. As a general rule, regulators have some professional training and background in the industry they are regulating; and, as a result, they may be more prone to protect the industry's interests than those of the anonymous consumer. (However, when the service involved is thought to be essential, there is something to be said for the industry's interest as well; the public convenience and necessity may be served by the continued existence of even a very inefficient airline, railroad, or hospital.) In contrast to the functioning of an ideal market, regulation is extraordinarily cumbersome, time consuming, and inefficient; but it has the virtues of its weaknesses. The most important of these virtues are due process, stability, and accountability.

Due Process

Whatever else one may or may not say about the regulatory process as it is practiced in most jurisdictions, it is certainly characterized by a high degree of formal due process. Given the interests involved, that may very well be a desirable attribute. In a pure market, individual physicians or individual nursing homes, for example, might well be badly battered by the forces of market competition in a way that was unfair from the perspective of anything but economic efficiency. Formal fairness is a value of some significance in and of itself, and I do think the regulatory process compares quite favorably to most competitive processes in its ability to provide for it. Anyone who has ever sat through a heated hearing on a contested certificate-of-need (CON) application or read the transcript of a hearing of a state hospital rate-setting commission should recognize that public notices, public meetings, adversary procedures, formal records, and the constraints of appeals processes sometimes lead to better decisions and at least sometimes produce decisions favoring the economically or politically weaker parties.

Stability

Another thing which regulatory processes are good at providing, and which they are frequently criticized for, is a high degree of stability.

Again, the health sector may be a bit different from the kinds of sectors in which one is more comfortable talking about markets. We have all heard that some substantial proportion of private firms fail in any given year; for a healthy market economy, a high degree of attrition among unsuccessful competitors is not only necessary but also desirable. Imagine, on the other hand, a world in which a quarter of the nursing homes, a quarter of the hospitals, or a quarter of the health insurers or HMOs went bankrupt in any given year.

In the sense of being “affected by public convenience and necessity” and of there being no quite comparable substitutes, hospitals (generically—not *all* hospitals) are public utilities. When one is talking about something like the assurance of access to health care services for thousands of people, a degree of stability over and above that characteristic of competitive markets is probably highly desirable. Nor does it make sense from the viewpoint of public policy or narrow economic efficiency to let the market play out until Chrysler-style bailouts become necessary to insure the stability of firms. (I will ignore the charges about regulation-induced bankruptcy, since in the health sector those charges have some degree of validity only in the State of New York, where the closing of facilities has been closely tied to the very near avoidance of a fiscal calamity, or as a conscious strategy for ridding the nursing home industry of some of its less desirable operators when other sanctions were not available.)

Accountability

Whatever the failures in the process, governmental regulators do retain a substantial degree of political accountability to the general public. That accountability may be imperfect and highly attenuated; yet it is often strong and direct. Indeed, many of the things for which regulators are most severely criticized (for example, the political nature of some CON decisions) suggest a high degree of accountability. Anyone who professes a faith in democratic self-government would be hard pressed to argue against a policy mechanism that legitimately claims the advantage of increased responsiveness to the expressed interest of voters.

One of the things that has been wrong with the discussion of regulation versus competition in the health sector has been the failure

to address this very basic characteristic of regulation: that it is an essentially political process. Market strategies are, of course, essentially political processes as well. They just tend to promote the political interests of different groups from those whose interests are served by regulation.

It may be a bit unfair, but not historically inaccurate, to suggest that market advocates have identified with the interests of the haves while regulatory advocates have sympathized, at least rhetorically, with some of the have-nots. It is no accident that regulators tend to be Democrats, and deregulators, academics and Republicans. Airline deregulation has benefited (in the short run) middle-class residents of major markets and New Yorkers wintering in Florida, but residents of many smaller cities must now fly substantially less safe and reliable commuter airlines.

Regulation, in its most basic terms, constitutes the imposition of influence and power by those with a political majority on those who have customarily exercised power in a given sector of economic activity. Of course, the critics of regulation are immediately going to respond that most regulatory processes have more effectively served the interests of those already in power, particularly the providers of service, than of consumers. That is probably accurate. Upon obtaining any short-term profits at all, any rational, self-interested, utility-maximizing capitalist will immediately invest those profits in political influence. This, as Lindblom (1977:170 ff.) has noted, is the major short-coming and major tension of representative democracy in a market society: market power too often is translated into political power. But, when there is no consumer sovereignty to begin with, surely consumers stand a better chance of getting their interests served in a competitive political environment than in an historically uncompetitive and anticompetitive market for health services.

Conclusions

All these virtues notwithstanding, regulation is hardly the answer to all of the problems of health care policy. It deals poorly with qualitative issues, for example (although the record of markets is hardly encouraging either), and tends to penalize the very best or most efficient institutions while focusing on the worst. More to the point,

regulation is a rubric that encompasses, even within the health care sector, a wide diversity of activities of widely varying degrees of success. Indeed, beyond a certain point, it probably makes little sense to talk generically about regulation at all.

For ideological reasons, the debate between competition and regulation has heretofore been rather lopsided. It has also, more fundamentally, been profoundly misplaced. Both regulation and competition are, or should be, tools—means to an end. Neither is really worth very much as an end in itself. The real questions are what kind of health care system should we have and what kind of health care system, in the short run, given the constraints, can we have. How one answers those questions largely determines how much regulation one thinks is necessary.

Advocates of greater reliance on market forces in health care tend to talk a great deal about efficiency, economy, and consumer choice. Regulators tend to focus on access, equity, and governmental budgets. Basic value choices are at issue, down beneath several layers of rhetoric. It is an old quarrel, and one with no immediate end in sight. It may be useful, though, to remember what the fight is all about.

If health care—or at least access to a defined minimum set of health services—is a right, or at least something we have agreed that everyone in society should have, then it might be suggested that the protection of rights is something we are generally loath to leave to the marketplace. Indeed, there are economists who define rights as those activities determined to require insulation from market forces. A poll tax is unconstitutional; so is slavery. Although we health care regulators sometimes tend to forget it, some things are too important to be defined solely in terms of cost.

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Acknowledgments: This paper was originally prepared for presentation at a Symposium on Health Care Regulation and Competition: Are They Compatible?, 22-25 May 1980, sponsored by The Project HOPE Institute for Health Policy Study, Millwood, Virginia. It has been substantially revised in response to comments at the Millwood conference.

The views expressed herein are solely those of the author and cannot be attributed to the New Jersey State Department of Health or any other organization or institution.

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