Procompetition in Health Care: Policy or Fantasy?

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FOR THE BETTER PART OF THREE QUARTERS OF A century social reformers sought to persuade the American people that national health insurance (NHI) was the only practical answer to providing universal access to health care. Around the time of World War I, even the American Medical Association favored the enactment of NHI, but within a few years it retreated and assumed leadership of the opposition.

After a long journey in the wilderness, the reformers scored their first success in 1965 with the passage of Medicare and looked forward to final victory in a two-stage advance: the proximate passage of insurance for mothers and children to be followed by coverage for other adults.

Even in the absence of coverage for mothers and children, the chairman of the Ways and Means Committee of the House of Representatives, Representative Al Ullman, prophesied in the spring of 1976 that the long-delayed victory was at hand: Congress would pass NHI and President Ford would be reluctant to veto it in the face of the approaching election.

Ullman proved to be a poor prophet. Congress never came close to passing NHI. What is more, six years later, public opinion polls

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now find that only 1 out of every 10 respondents places NHI high on his or her list of priorities. This encapsulated account of the natural history of NHI should serve as a reminder that the current excitement about imminent Congressional action to legislate competition into health care may yet turn out to be of passing, not permanent, interest.

Irrespective of the eventual outcome (the Administration, as of June, 1982, has still to forward its recommendations to the Congress), the arguments advanced by the proponents of competition warrant close scrutiny. The trend toward ever higher health care expenditures, considerably in excess of the rate of inflation, appears to many to make the competition proposal the only game in town.

The Competitive Strategy

The principal building blocks in the competitive solution are:

- Increased choice to consumers at the point when they purchase health insurance or select a prepaid health delivery plan. Such a broadening of options can be assured by legislative mandate that 1) requires each employer to offer his employees a choice of at least three plans, 2) establishes a monetary incentive for the consumer to select a less costly plan, and 3) takes the employer out of the insurance transaction completely other than to provide a "health care contribution" for each employee with which to shop the market (The National Health Reform Act of 1981, H.R. 850, introduced by Representative Gephardt).
- A ceiling on the maximum amount of tax-free health benefits that the employer could cover. If the employer agrees to a plan with a higher premium, both his outlays and benefits received by employees above the maximum allowable figure would be subject to tax.
- Higher deductibles and more copayments, usually with a tradeoff in the form of coverage for catastrophic expenditures after a family has incurred large out-of-pocket expenses (in the range of $2,500 to $3,500) during the course of the year.
- A Medicare voucher, set at 95 percent of average adjusted per capita cost and indexed for inflation, to broaden the choice of the elderly. It would be offered initially on a voluntary basis.

- Reduction and elimination of many regulatory approaches to health care cost containment, extending even to preemption by the federal government of state regulation of insurers.
- New forms of prepaid health care delivery that will help to control costs, encouraged by the foregoing reforms.

Kenneth Arrow Revisited

Before looking more closely at the heart of the competitive proposals—enhanced consumer choice (Enthoven, 1980), prudent purchasing of insurance (Health Insurance Institute, 1981), limitation on tax benefits (Enthoven, 1980), increased copayment (Feldstein, 1981), Medicare vouchers (Blue Cross and Blue Shield Associations, 1981), less regulation (McClure, 1981), and more prepaid provider plans (Brown, 1982)—one should review what the Nobel laureate economist, Kenneth Arrow (1963), wrote about competition in health care in his essay, "Uncertainty and the Welfare Economics of Medical Care." Admittedly the passage of nineteen years has seen a great many changes in the health care system of the United States, not the least of which has been the growth of Medicare and Medicaid. But our concern is less with institutional change and more with the theory of the health care marketplace which Arrow elaborated. Arrow's twelve principal arguments against the indiscriminate application of competitive criteria to assess the efficiency of the health care market may be summarized as follows:

- Insurance, the market's answer to risk, will always be less than perfect because health insurance will be unable to distinguish adequately among risks, especially between avoidable and unavoidable risks, and thus incentives to avoid losses will be diluted.
- In the face of uncertainty, information becomes a commodity but differs considerably from the usual marketability of commodities.
- Demand for health care is both irregular and unpredictable and medical services provide satisfaction only in the event of illness.
- The advice that the physician provides ought to be completely divorced from self-interest. Since the nature of the physician-

patient relationship affects the quality of the medical care product, a pure cash nexus would be inadequate.

- In the face of product uncertainty, no patient ever experiences a sufficient number of trials to eliminate residual uncertainty.
- Price competition is frowned upon and physicians do not see themselves as maximizing profit. Nevertheless, the patient retains a freedom of choice that effects changes in the market, albeit slowly.
- Making tuition cover the full cost of medical education, as some free marketeers have suggested, will result in too few entrants.
- The availability of insurance increases the demand for medical care but the professional relationship between physician and patient limits the moral hazard.
- Large economies of scale in administrative costs point to the advantages of comprehensive plans, including a compulsory system.
- The preferred approach is for the maximum possible differentiation of risks, but there is a tendency to equalize rather than differentiate premiums which would not be the case if the market were genuinely competitive.
- Under ideal conditions, the patient could seek insurance protection against a failure to benefit from medical care. The social obligation for the best in current practice is intrinsic to the commodity that the physician sells. Rigid entry requirements are designed to reduce uncertainty in the mind of the consumer as to the quality of the product.
- The failure of the market to insure against uncertainties has created many social institutions in which the usual assumptions about the market are to some extent contradicted.

Arrow's analysis warns against any simplistic projection of the competitive model onto health care because of many "imperfections" including, but not limited to, the following: the nature of the risk and the inability to fully insure against it; the imbalance between the information available to the buyers and the sellers of health care services; the desirability in the physician-patient relationship of minimizing the cash nexus; and the substantial economies of scale realized from large-scale insurance coverage.

Competitive Theory: Two Readings

What can be learned from juxtaposing the schema advanced by the competition advocates and Arrow's critique of the limits of competition in health care? Once one recognizes the inherent limitations in sophistication of laymen with respect to medical care, the high costs of their acquiring information, and the inability to draw valid conclusions from their own experiences and exposures, the benefits of increased consumer choice become problematic. There may be little gain and conceivably considerable loss in encouraging consumers to shop for the least costly plan if one postulates that they are incapable of drawing valid conclusions about the efficacy of different types of medical care.

Similarly, the recommendation of the competition advocates to modify the tax laws and thereby discourage the trend toward more comprehensive health insurance conflicts with Arrow's analysis that calls attention to the substantial economies of scale resulting from large enrollments in comprehensive schemes and the desirability of removing, insofar as it is possible, the cash nexus from the physician-patient relationship.

No one opposes the reduction and removal of regulations that have come to weigh heavily on the providers of health care, especially when they have largely failed to stem the rise in costs. But modern societies, according to Arrow, resort to political interventions in the health care market not because of their preference for collective action but rather because of their unwillingness to accept the shortcomings of competition. They are determined to find ways of providing access for all to basic health care services.

Arrow also questions the presumed benefits that will accrue from the attempt to force more physicians into prepayment schemes—a major objective of the competition proposals. He presents a twofold caution: the undesirability of confounding the physician's economic interests with his professional role as diagnostician and therapist, and the belief that physicians will take strong evasive actions in their practice arrangements to avoid being placed directly at economic risk.

This juxtaposition of Arrow's 1963 analysis of the limitations of the competitive model and the claims of the 1982 procompetition forces should alert those who are looking for the answer to the pressing problem of steeply rising health care costs not to exaggerate the gains

likely to result from seeking to make the market more competitive. Competition cannot provide the answer.

Stimulation of Demand vs. Market Failure

"The procompetition group" is a misnomer. It consists of a number of academics with little sensitivity to politics loosely aligned with a number of legislators possessed of an unwarranted respect for economics who are convinced that Congress must act to constrain the increases in health care costs, and see competition as the only hope. The common thread that justifies talking of them as a group is that they trace the steep rise in health care costs to "market failure" and that they believe that until the market is permitted to function freely there will be no way to bring runaway costs under control. Each of the reforms that they advocate is directed to overcoming one or another type of market failure.

Their critique of the extant system is founded on the observation that the consumer who purchases health insurance or joins a prepayment plan has little or no incentive to be concerned with its cost. The consumer will choose the richest benefit plan that the employer offers and because of the hidden tax subsidy will, with his union representative, press for ever more comprehensive benefits. The procompetition critics have a point, in fact two points: the tax subsidy provisions encourage the recipients to select the "richest" coverage; and pressure is exerted on current plans to expand coverage to include mental illness, eyeglasses, dental services, and still other "extras."

But this is not the whole story. Tax benefits were introduced to encourage the growth of private insurance. Consumers have repeatedly expressed a strong preference for first dollar coverage in the case of hospitalization, a concept which is admittedly at variance with the logic of insurance but surely legitimate in an economy that honors consumer sovereignty. Furthermore, workers and their leaders who negotiate for them are not oblivious to the tradeoffs between more and better health care benefits and attractive alternative rewards in the form of higher wages, more vacations, increased pensions. One major reason for the steep rise in health care costs has been the continuing preference of employees for more and better health benefits with first dollar hospital coverage.

The pressures on the demand side were greatly increased in 1965 with the public's decision to broaden access to quality health care for the elderly and the poor. Forecasts of the future costs of Medicare and Medicaid proved to be gross underestimates, but that is typical for most public programs—from new weapons systems to the construction of public buildings. The American people made a deliberate decision to spend more on health care through government.

In fact, the entire post-World War II era speaks to the sustained efforts of Americans to broaden and deepen the health care system through large-scale expenditures for hospital construction (Hill-Burton, P.L. 79–725), biomedical research (National Institutes of Health), the expansion of educational opportunities for health professionals (state and federal governments), private health insurance, and public grants, loans, and tax guarantees to encourage accelerated investments in the health care industry.

The American people began a love affair with therapeutic medicine and for several decades asked no questions about the cost of the relationship. Their sole concern was to speed expansion—more hospitals, more research funds, more equipment, more physicians, more support personnel, more financing—more everything.

Leaders in the present administration such as Messrs. Stockman and Schweiker claim that the preexistent competitive market was destroyed during this period. But it is more consistent with the facts to recognize that health care never conformed to the competitive market. At the end of World War II, the dominant health care institution was the nonprofit acute-care hospital with community leaders serving as trustees. Most physicians treated a large number of "no-pay" or "part-pay" patients, and those seeking admitting privileges at teaching hospitals often devoted several half-days a week caring without pay for patients on the wards and in the clinics. Federal and state governments provided a considerable volume of health care without charge to special groups—to those suffering from chronic mental and other long-term illnesses, to veterans and members of the Armed Services and their dependents.

True, physicians and dentists functioned primarily in a fee-for-service environment and the pharmaceutical and medical supply companies were "for-profit" enterprises, but by no stretch of the imagination could it be said that the United States health care system of 1950 conformed to the model of the competitive market. In the

succeeding decades the gap between the model and reality widened as indicated by the substantial decline in the proportion of health care expenditures paid out-of-pocket by consumers—from around three-quarters to one-third.

The marked departures from the competitive model were deliberate and reflected the expressed preferences of the American people both in the private and public domains. The public wanted first dollar insurance coverage for its hospital expenses; it wanted the elderly and the poor to have access to the system; it believed that large-scale governmental support for research would more quickly find the answers to many dread diseases; it saw merit in providing access to a modern hospital for people living in small as well as large communities; and it made large investments in broadening and deepening educational and training opportunities to assure an adequate supply of competent health professionals.

In this expansive mood, the public's preoccupation was with increasing the quantity and quality of health care services and with assuring access of the entire population to a sophisticated health care system. For a long time it paid little or no attention to the costs. It agreed to reimburse hospitals on the basis of their costs or charges; and it paid physicians on the basis of their usual, customary, and reasonable fees, methods of reimbursement that unquestionably contributed to accelerating the rise in costs. Most of this rise, however, was attributable to the deliberate stimulation of demand. If the competitive market never existed, and it never did, it is misleading to talk of market failure.

Competition and Cost Containment

To what extent are the current procompetition proposals likely to contribute to cost containment for the system as a whole, as distinct from cost shifting among payers or forcing a reduction in the total quantity and quality of services available to the American people?

If employees are encouraged to purchase coverage below the maximum amount that their employer will provide through the monetary incentive of pocketing the difference, what is to stop the younger, healthier group from buying the less costly policies, thereby raising the costs for those who are poorer risks? If this occurs, the total

outlays for health care are likely to increase because of the rebates to the healthier group.

Placing a ceiling on tax-free health care benefits will presumably lead to less comprehensive coverage and this in turn will lead to a lower level of demand for care because less of it will be prepaid. This may happen, but several other outcomes cannot be ruled out. Employees may press for comprehensive plans even if they and their employers have to pay taxes on coverage above the ceiling. Or they may follow the pattern set by the elderly and buy supplemental coverage, paying more and getting less for such coverage than if it had been part of the original package.

If the Gephardt bill (H.R. 850) were enacted and all employees were given purchase vouchers by their employers with which to shop the market, marketing costs would far exceed those currently involved in selling group policies. Moreover, many persons in the lower income brackets might be inclined to buy the least costly policy, assuming that somebody else—the hospital or government—would pick up the tab if their hospital expenses exceeded their coverage.

Many proponents of competition are convinced that higher copayments will moderate the demand for health care services and most of the literature, including the recent Rand report (Newhouse et al., 1982), suggests that this would in fact be the case. However, such cost containment need not reflect more efficient production and distribution of the current level, but rather a reduction in level of health care services. Such a reduction might or might not be viewed as desirable depending on the answers to the following two questions. Are the American people currently consuming too many, and too expensive, health care services? And would a decline in utilization induced by copayments result in the elimination of marginal services to the overusers or of basic services to justified users? If the latter were the case, it would be difficult to interpret the outcome as cost containment.

The Medicare voucher proposal that has been advanced is also difficult to prejudge. The American Association of Retired Persons sees the proposal as a way to place a ceiling on federal expenditures with indexing for inflation set below the projected rise in health care costs. If the voucher led to a shift in the nature of health care provided the elderly, from high-cost acute hospital care to more home care and community-based services, some cost containment might be achieved.

The procompetition group expects important gains from a reduction and removal of regulations, including certificate of need (CON), which has erected barriers to the rapid construction, expansion, and modernization of hospitals. They argue that CON has been ineffective in controlling capacity at the same time that it has increased costs by prolonging the period from initial planning to final construction. The recent report by the U.S. Congressional Budget Office (1982) confirms that the initial assessments of the efficacy of CON were unduly pessimistic. If the experts are correct in their belief that the country is overbedded, it is difficult to see how freeing hospital construction from all prior assessments of public need would contribute to cost containment. Such a policy would have just the opposite effect of adding to excess capacity, jeopardizing the financial stability of many existing institutions, and resulting in further cost expansion.

The advocates of competition anticipate that the growth of prepaid delivery systems would be stimulated by the foregoing efforts to expand competition, which in turn would lead to cost containment. They may be right, but there are reasons for caution. First, the record sheds little or no light on how prepayment plans would serve the elderly and the poor, who together account for around 40 percent of all health care expenditures. Next, the experience of Health Maintenance Organizations (HMOs) in California, Minneapolis–St. Paul, Washington, D.C., and New York City provide, at best, equivocal evidence of their ability to contain costs. Furthermore, one cannot assume that once a large proportion of a community's physicians are organized within prepayment plans, their professional and economic behavior will parallel that of the small number of their colleagues who initially were drawn to prepaid practice plans. But the most telling argument against exaggerated expectations is the probable modest rate of growth of prepayment plans even if the procompetition proposals were enacted into law, a growth likely to be constrained by the preferences of both consumers and physicians for the status quo.

The Market Is Changing

The supporters of competition may be grossly overemphasizing the beneficial results that would follow upon congressional action to en-

large the role of competition in health care. But the years ahead will see many significant changes in the health care market even in the absence of legislation affecting competition:

- Federal and state governments will accelerate their efforts to limit their outlays for health care. Governments will probably succeed in reducing the number of poor persons entitled to health care services as well as in cutting back on the services currently provided them.
- As the growth in total health care dollars in the system decelerates partly in response to efforts of governments to contain their outlays, many hospitals will find themselves in increasingly strained circumstances resulting in closures, mergers, affiliations, and conversions. Faced with a leveling off in admissions and utilization, many more strongly positioned hospitals will seek to increase their revenues through diversification: entering into arrangements with satellite institutions, organizing HMOs, and establishing new programs such as "Home Care" and "Hospice Care." By the end of this decade or shortly thereafter, the number of unaffiliated hospitals may have been reduced by one-third, possibly more.
- The rapid increase in the number of physicians per 100,000 population, about 30 percent per capita between 1978 and 1990, represents another area of rapid change. When one recalls that physicians receive about 1 out of every 5 dollars spent on health care, and hospitals about 2 out of every 5, it becomes obvious that the only way physicians can slow reductions in their earnings in a period of constrained total dollars and increased numbers will be to deflect some of the dollars that otherwise would flow into the coffers of hospitals. Third-party payers will press for more patient treatment in an ambulatory setting. The large increase in the physician supply will facilitate the expansion of new forms of delivery systems which in the past have been hobbled by the disinclination of most physicians to elect an alternative to fee-for-service practice.
- There are few success stories of local health planning aimed at the more efficient use of scarce health resources. In the decade ahead, however, the principal purchasers of health care services,

business and labor, are likely to work more closely with the principal payers, insurance and government, to stretch the total health dollar. The large number of business coalitions which are now being established suggests that the decade ahead will be the first real test of area health planning. Although enthusiasm should not be confused with achievement, it would be unduly pessimistic to write this effort off prematurely.

A decade characterized by constrained dollars, hospitals under pressure, a large expansion in the physician supply, and local health planning is likely to bring about many changes in the manner in which health care is financed, produced, delivered, and consumed. The procompetition forces may be left at the starting gate, but the health care market will nonetheless be significantly transformed. Ours has always been an economy and society more receptive to the forces of reality than the allure of ideas. And we are probably the better because of it.

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