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Abstract

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The emergence of competition as the result of deregulation coupled with a dramatic shift away from cost-based reimbursement has profound implications for the future of the health care system. This "new competition" represents a trend propelled by powerful economic forces rooted in the escalation of health care costs and in a wider trend toward deregulation, so it is very unlikely to be reversed.

This paper characterizes the nature and source of the restructuring underway and develops the rationale of how the new competition is supposed to work to increase health effectiveness while bringing down costs. It considers the needs for health vouchers as the working poor are squeezed out by increasing competition and the major implications for hospitals, and health professionals as they seek to plan ahead.

THE "NEW COMPETITION" IN HEALTH CARE: IMPLICATIONS FOR THE FUTURE

Walter W. McMahon

Powerful economic forces are transforming health care delivery, a transformation that is becoming the second major revolution affecting health care in modern times. It is a reaction to the first, an extraordinarily rapid diffusion since 1945 of health insurance and third-party reimbursement, unfortunately accompanied by escalating health care costs. The rapid expansion of private health insurance was followed in 1965 by public health insurance, through Medicare and Medicaid, which piggy-backed on the private Blue Cross Blue Shield cost-based reimbursement methods. This first health care revolution and its reimbursement methods encouraged high usage and even permitted padding to creep into health care costs and billing.

It is the escalation of health care costs that has fueled the second revolution, a radical change in the way in which hospitals and physicians are reimbursed, coupled with deregulation of the health sector and the emergence of competition. This "new competition" is the result of efforts by the major buyers of health care which are the large employers, the Federal Government, and the state governments, to contain health care costs. These buyers are the ones that must bear most of the health care bills. They now negotiate in advance to contract for the price of a package of health care services under conditions of increasing competition among providers. The use of these more competitive contracts is extremely likely to continue so long as health care costs continue to rise. It is a new kind of competition

that has profound implications for the way in which health care services will be provided and for the structure of the health care system of the future.

This chapter explores the implications for the future of the health care system of the emergence of the "new competition" which combines deregulation with negotiation in advance for "bundles" of health care services. It is to the advantage of providers to consider the nature of the change and the implications as they plan ahead. The development of health policies at the state level and by employer benefit plans also will proceed better if influenced by an awareness of the economic forces at work and of the economic implications of current trends. To enhance this awareness, the chapter first characterizes the escalation in health care costs that has motivated the continuing interest by government and business in attaining greater efficiency. It explains how cost-based retrospective reimbursement by insurers contributes to the escalation of health care costs, including those resulting from expensive novelties in medical technology and from higher hospital utilization rates. It then describes the forms of the new competition emerging in health care and considers the rationale how competition is supposed to work to bring down costs. As the implications for the structure of the industry are developed, the chapter suggests some of the forms that a sound competitive health care policy should take to meet the needs of marginal groups, such as the working poor or the elderly, and to keep them from falling through the gaps in the system. Finally, the discussion turns to some of the implications for the

activities and training of health care professionals as they become more involved with management decisions and grow more concerned with efficient use of resources.

I. UPHEAVAL, CHANGE, AND CHALLENGE

Deregulation, moves toward more competition, and shifts away from retrospective reimbursement are all producing dramatic change. A description of the economic forces causing this change will set the stage for a description of its nature.

Health Care Costs--A Few Facts

To appraise the scope of this force, it is necessary to look briefly at the current level and trend of health care costs. Health care costs had reached 10.8 percent of Gross National Product by 1983 as compared to only 4.4 percent of the nation's output in 1950.[1] In recent years, health expenditures in real terms have been growing at four times the nation's growth rate.[2] In absolute dollars, health care costs come to $6,936 each year for an average family of four, and more than this for those whose family income is above average. Also in absolute dollars, the total health care bill in the United States has increased eleven-fold since 1960.

The Chief Administrator of the Federal Health Care Financing Administration, Carolyne Davis (1983, p. 13), estimates that 58 percent of the increase is due to the rising price per unit of physician and hospital services. The hospital room rate for example, rose 457 percent just from 1967 until 1983, and physicians' fees by 227 percent, but during the same time the overall Consumer Price Index rose 189 percent.[3] Various regulatory approaches, such as the application

of price "guidelines" during the Carter Administration and, more recently, the freeze on physicians' Medicare reimbursement rates, have not succeeded very well, in that the rate of increase has remained overall at about double the nation's inflation rate.

At the individual level, Senator Metzenbaum from Ohio who investigated hospital prices, cites routine hospital charges of $275 a day for a double room; many additional charges can easily bring the average charges to $1,000.00 a day for a short hospital stay. Physician charges are normally in addition to the hospital bill. As more states collect and publicize rates paid by third party payors for each city and each hospital, the public is becoming increasingly aware of local prices. This is not to suggest that "the public" is likely to do much about this since the insurance company, Medicare, or Medicaid normally pay the bill; but it does suggest that the public is likely to be more permissive as governmental units and employer groups begin to act.

The Forces Propelling Change

The moves toward the new competition, consisting of both deregulation and negotiation on the prices of bundles of services beforehand (prospective reimbursement), continue to be motivated by these sharp increases in health care costs. Various political coalitions have emerged to propel continuing change. These include business employers, who are concerned about the large and rising costs that they must bear for their employee health benefit plans; state governments, which are deeply concerned about the rising cost of Medicaid, and the Federal Government (and the retirees it serves through Medicare) who are concerned that Social Security trust fund remain solvent. Though the

moves toward competition began at the Federal level, employers and state governments increasingly recognize their joint interests in containing costs, and state-level restructuring of the health care delivery system is therefore becoming common. So long as the price increases continue, Federal, state, and employer motivations to act are strengthened.

The Basic Problem With Incentives--Leading to More Change

Cost-based reimbursement without prior agreement on the total price for the necessary bundle of treatments provides perverse incentives, inducing providers to run up the costs. Retrospective reimbursement rewards those who pad the costs with more revenue and penalizes those who seek to be efficient and to not waste resources. This disincentive to be efficient is now widely recognized among researchers into the economics of the operation of our health care system as a primary cause of escalating health care costs.[4]

When retrospective reimbursement is coupled with third party payment--95 percent of those who require health care services do not pay their own bill--health care users lack incentive to police the costs. After all, "the insurance company pays," or "Medicare pays," so why bother? Third party payors include the Federal Government, which reimburses for Medicare patients; the state governments which still reimburse for most Medicaid services on the old retrospective basis (and often in costly emergency room and Medicaid-mill settings); and private insurers, such as Blue Cross/Blue Shield. In virtually all other spheres of economic activity, the final buyer agrees on the the price beforehand.

Cost-based retrospective reimbursement furthermore offers incentives to prescribe unnecessary services.[5] Studies have found that getting a second opinion about the need for surgery, for example, results in the medical opinion that the surgery is unnecessary 50 percent of the time, and as a result, many insurers are now requiring a second opinion before they will agree to reimburse.[6] Extra days in the hospital for a Blue Cross/Blue Shield patient helps to keep the beds filled up (at a time when prospective reimbursement has limited this practice for Medicare and Medicaid patients, leaving hospitals with excess capacity). With some unnecessary utilization and cost shifting to privately insured patients, cost of the traditional Blue Cross/Blue Shield cost based reimbursement insurance to employer health-benefit plans continues to rise.[7]

Another important situation where cost-based reimbursement contributes to rising costs is in the acquisition of expensive high-technology equipment. In most industries the producer has an incentive to purchase new equipment that will do the job as well or better and will save on labor and other costs. In health care, however, the full cost of the new equipment can be passed on to the third party payor as part of the patient's bill. The kind of equipment purchased can therefore indifferently be cost-increasing or cost-reducing. Furthermore, the hospital's image with physicians and therefore its ability to fill beds may be enhanced by having the most recent, most expensive machines readily available. The result is purchase of too many of the new machines of the type that increase rather than reduce costs.

A final illustration of how overutilization under third-party restrospective reimbursement provides weak incentives to manage costs is the example of standing orders for lab tests.[8] More lab tests will always reveal more than fewer lab tests, of course; but tests have diminishing returns. At some point there must be a balance between the additional information yielded, and the additional cost, not just to the third party payor, but also in the form of the cost of the patient's time and other risks.

Deregulation

To turn to the changes now taking place, it is important to recognize that health care is an industry in which entry is heavily regulated. There are minimum money capital requirements for health care plans; extensive state licensure requirements for physicians, nurses, and other providers; minimum quality requirements; state laws requiring certificates of need for new hospitals, certificates of need for new high-tech equipment, and so forth.[9]

But things are changing very fast. The current Federal Administration is heavily committed to fostering competition as a means of containing escalating health care costs and encouraging greater efficiency in the use of health resources.[10] Disillusioned with regulation as a means to these ends, like the preceding Administration, the Reagan Administration is rapidly dismantling certificate-of-need requirements and is cutting back on the funding for HSA planning agencies. The courts have joined the trend by holding in a recent Kansas

City case that state certificate of need laws bar entry and foster monopoly in violation of the antitrust laws. Similarly, the Supreme Court in Goldfarb v. the Virginia State Bar has held that self-regulation by the "learned professions" is not exempt from antitrust scrutiny.[11] These moves toward deregulation and competition have a significant effect in shifting the locus of economic power in health care from the self-regulation by the health care industry, especially by the American Medical Association, and by county medical societies, to the demand side and to the discipline of the market.

Other aspects of deregulation and the moves toward more competition include the recent information that the Administration will no longer enforce the regulations that reguire hospitals that have received Hill-Burton funds for expansion to care for their share of the poor.[12] One result is the widely publicized "dumping" of patients whose funds have run out by many not-for-profit hospitals as they face competitive pressures. "Dumping" is the transfer of patients who are often ill, elderly, and in the (very costly) last few days of their life to under-funded public hospitals like Cook County Hospital in Chicago. Also, at the Federal level, the Federal Trade Commission has insisted that the American Medical Association remove the statement from its code of ethics that advertising is unethical and notify its members of this change.[13] Hospitals and health maintenance organizations are already advertising widely.

States are also moving gingerly toward efforts to use competition to contain costs. Iowa and Illinois have established health care Cost Containment Councils, for example, to increase consumer information

on prices, necessary if competition is to be able to work.[14] Similarly, Massachusetts has released data relevant to the quality of care and to fees for comparable procedures. Following California, Illinois and Arizona are also trying new competitive bidding procedures to serve Medicaid recipients.[15]

However, most state licensure and certificate-of-need legislation is still in place. It is possible that with the greater influence of trade associations at the state level, health care will follow the earlier pattern established in the deregulation of trucking, with some states preserving islands of state-sponsored monopoly under the guise of (ineffective) economic regulation. However, there is increasing awareness that excessive requirements for money capital, overly costly standards for facilities, and licensure run up costs, as well as growing reconsideration of the economic impact of certificate-of-need requirements and other barriers to entry. As the Federal Government moves to dismantle the barriers to entry for which it has been responsible, and as states move to expand the information about prices available to consumers and to re-examine the barriers to entry that remain at the state level, genuine competition is likely to grow rather than diminish.

The New Competition

The new competition involves a combination of these two major changes--the shift toward negotiating on the price beforehand, and the reduction of barriers to entry.

Since the Federal Government is a major purchaser of health services, its shift to prospective reimbursement for Medicare patients sets one significant part of the tone. Its steps to declare in advance the price that it will pay by diagnosis for each of 469 Diagnostically Related Groups (DRGs) is by now well-known, but some of the underlying implications are less well understood. A key element is that perspective reimbursement forces hospitals to establish 469 accounting "cost centers"--and then to allocate their costs to these 469 "bundles" of final treatment-regimens that they sell. Because this kind of data was never available before, within the hospital these 469 "product lines" have never had a cost manager. The main task of managing costs previously has been centralized in Blue Cross/Blue Shield data banks for use with the "cost based" reimbursement rates that they establish, as well as in the state and national offices for Medicaid-Medicare. It is these offices that have had the impossible task of monitoring the level and the volume of procedures that they would reimburse for patients they never saw. With "unbundled" separate charges for separate procedures, the physician, who orders almost all of the services on behalf of the patient, has operated unaware of costs. Without the information about the total cost and cost/effectiveness of the treatments prescribed for each diagnosis, and without the capacity to compare those costs to the cost/effectiveness of treatments performed in response to the same diagnosis by others, even if he did have the incentive, he could hardly become an effective cost manager.

The new steps by hospitals to collect data on the basis of the 469 cost centers is perhaps the most fundamental and revolutionary change involved in the newly emerging health care system. It permits the delegation of more power of a different kind to physicians, power to become managers, power that had been centralized (and still is for private and Medicaid patients) in those who enforce the reimbursement regulations in private health insurance companies and in state government offices. This decentralization of managerial decision-making responsibility is a very new and different kind of power that many physicians have not been trained to exercise. On whether or not it is exercised wisely rests the fate of many clinics and hospitals.

The excess capacity in hospital beds now resulting from the advent of DRGs is causing many hospitals to seek to eliminate local competition by arranging for mergers. Except for the advantage in raising funds nationally, there are not major cost advantages, after hospitals reach a medium size.[16] Although mergers may still be economically advantageous to the hospital as local monopolies are created, there is always the problem of violation of the antitrust laws and still higher hospital prices as the result of the elimination of local competition. Although some mergers of extremely small hospitials can be justifed on cost grounds and can be induced by competition, many mergers that result in local near-monopolies probably should be viewed as anti-competitive moves designed to eliminate competition.

Many new forms of health care delivery have emerged in the wave of the new competition. It's a regular alphabet soup--HMOs, IPAs, PPOs,

PCNs, Management Groups, and even some traditional fee-for-service clinics with surgi-center feeder networks.

HMO's--health care maintenance organizations--which agree beforehand to provide comprehensive services for a single annual capitation fee, are now growing in number very rapidly.[17] Research on their behavior by Luft, Liebowitz and others suggests that HMOs lower rates of hospital admission and shorten lengths of stay.[18] The result, according to some hospital administrators, is about 40 percent cost advantage, allowing them to consistently offer lower out-of-pocket payments and larger benefits to those individuals choosing HMOs. Large private insurance companies such as Prudential have become involved in developing HMOs in Dallas, Austin, Nashville, Oklahoma City, Atlanta, Chicago, and elsewhere. There are Maxicare state-wide networks, and most of the larger hospitals and clinics in most cities have become involved in setting up and advertising their own Personal Care, Heartland Care, Carle Care, or Other Care HMOs.

IPAs--Independent Practice Associations--are looser knit groups of physicians from the fee-for-service sector who join together to bid as providers of medical services for employer or state health plans. Many of these do not have the internal management structures to manage costs and therefore are less likely to be able to win bids and to survive in those localities where competition is more severe.

PPOs--Preferred Provider Organizations--are a new form of competitive health plan negotiated with employers that offer financial incentives to employees to go to designated "preferred providers,"

that is, physicians and hospitals that have agreed to combine more cost effective practice styles with lower fees. Employees are free to go to whatever physician they choose, but at no out-of-pocket fee if they choose preferred providers.

PCNs--Primary Care Networks--are a group of primary care physicians, usually general practitioners, who agree to oversee the use of medical services and monitor costs. They contract with hospitals, and after selling their services for a prospective reimbursement rate, set aside a fund called a "risk pool" to cover both specialists and hospitialization.

Management Groups combine employers into groups to purchase health insurance from the more cost effective providers. Because employer benefit plans are very costly, large employers such as IBM, Polaroid, John Deere, General Mills, Honeywell, and Caterpillar, have begun to circumvent Blue Cross/Blue Shield and contract directly with the more cost effective providers. This has caused Blue Cross/Blue Shield to offer alternative options. Another result of this is a boost to those plans that have abandoned fee-for-service in favor of a prepaid capitation rate.

State governments, as mentioned earlier, are also beginning to solicit competitive bids for serving Medicaid recipients on a capitation basis.[19] Following Medi-Cal in California, Arizona, which formerly had no state Medicaid program, has now written Medicaid-HMO contracts in all communities where there were two or more competitive bids. Illinois has funded six large Medicaid-HMO contracts in Chicago.

Experiments with Medicaid-HMOs are underway in several other states, including the demonstration experiments funded by the Federal Health Care Financing Administration in Florida, Missouri, and Minnesota.

A very large fraction of both Medicare and Medicaid costs goes for long term care of the elderly in nursing homes. These services include medical appliances, which can go as high as $195 per month to rent, often for years, or to $2,000 for a padded wheelchair. Even after the recent increases in Social Security taxes, the continuing rise in health care costs for the elderly means that the Social Security trust fund will be bankrupt by 1990 (as shown in Figure 1) even after the effect of the 1983 increase in Social Security taxes is taken into account.

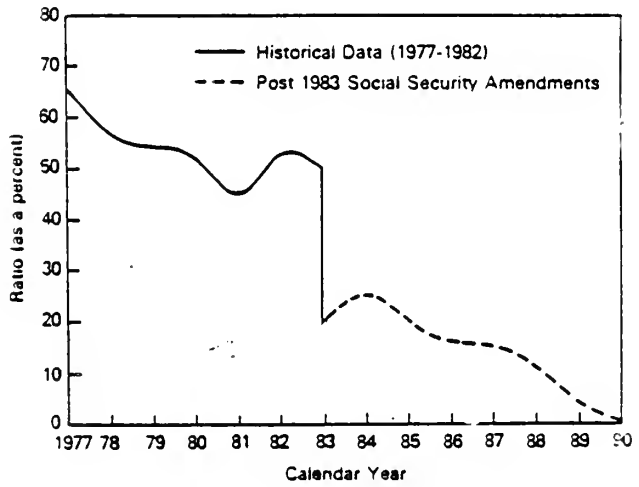

Figure 1. Social Security Trust Fund Ratios

Source: Annual Trustees Report to Congress, as reported by Carolyne Davis (1983, p. 13), the HCFA Administrator.

Under these conditions it would appear virtually certain that the decision to proceed with DRGs will not be reversed. There are inevitable adjustment strains, and problems with "diagnosis creep"; but DRGs are beginning to reduce hospital utilization rates and hence slow down the escalation of Medicare hospital costs.

HCFA furthermore is now experimenting with the extension of the prepayment approach to Medicare and Medicaid-HMOs for long term nursing-home care, important because long term care accounts for such a large function of public health care costs. Some research problems remain to be solved, especially with respect to how to share the risks and the total fee among those admitted when the health condition of those admitted differs widely.[20] If these problem are solved, the HMO concept is likely to be extended to long term nursing home care for Medicaid recipients shortly.

II. THE RATIONALE: HOW ARE COMPETITION AND PREPAYMENT SUPPOSED TO WORK?

It first needs to be emphasized more strongly that the most important kind of competition, the kind for which accurate information on the price and quality of health care needs to be available, is the competition <u>among health plans</u>. Competition after a person is sick is far less meaningful--at that point he or she is not in a good position to shop around. It is the competition by providers for the contract during an annual enrollment period when employers are reconsidering their health insurance contracts with alternative providers and employees are selecting from a multiple choice among health insurance

plans that competition is the most effective. It is in this situation that the most cost-effective plans, which are likely to be those based on prospective reimbursement, are gradually winning out.

The Rationale

But how is this combined effect of prepayment and competition, together with the retention of some necessary minimum quality regulations, supposed to work?

The combined effect may be illustrated in Figure 2. There the curve CC illustrates the minimum cost of production at each given quality-level of health care. Quality must be measured in terms of an ordinal index with better quality reflecting greater health effectiveness further to the right, and lesser quality to the left (without the cardinal measure of exactly how much further between each quality level). More quality of course incurs more costs, so the cost curve slopes upward to the right. Eventually, however, more dollars do less and less to increase the health effectiveness of the care, and the curve becomes vertical. That is, diminishing returns set in as expenditures for treating a given diagonsis increase. Eventually additional outlays of cost simply do not increase further the true quality of care, and with the complications that arise with medical procedures, additional outlays and procedures could even eventually reduce the health effectiveness of the care.

In principle, health services may be provided at any combination of quality and cost located on or above the curve CC. However in

practice certain combinations must be ruled out. Minimum quality regulations rule out the entire area to the left of the vertical line in Figure 2--inadequate nursing homes, untrained health care professionals, and unsanitary hospital conditions. Regulations of this type will always be needed, and hence a blend between regulation and competition can reasonably be expected to be a permanent feature of

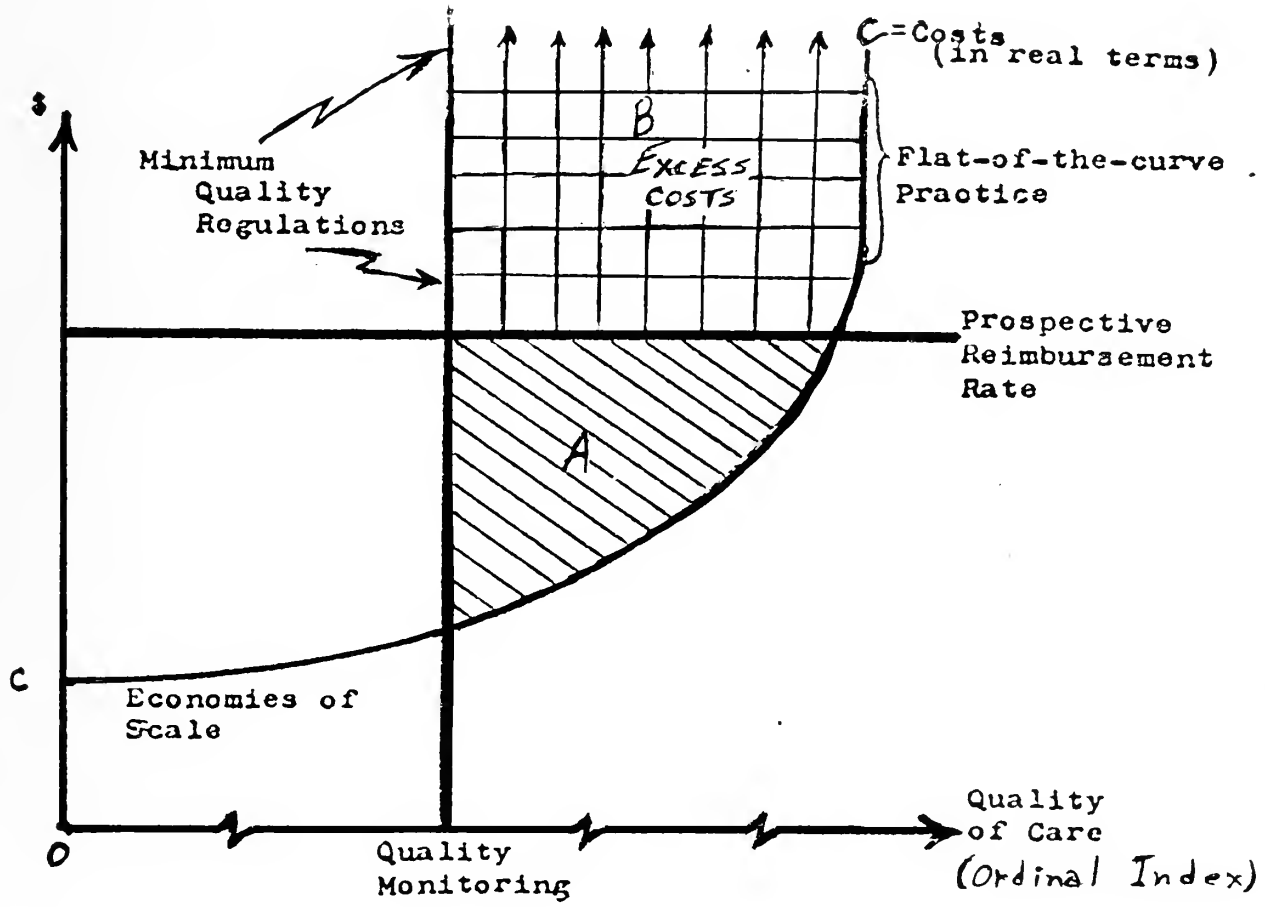

Figure 2. Abandonment of Cost-Based Reimbursement

the new competition. The kind of regulations being eliminated at the Federal level, such as certificates of need, and extraordinary initial requirements for HMO plans, are those that set up excessive barriers

to entry and thereby serve to foster monopoly. At the state level, few regulations of this type have been dismantled, and as mentioned trade-association influence remains very strong. This may permit the perpetuation of anti-competitve economic regulation and of islands of monopoly in some states for many years to come.

The most severe current problems are illustrated in the area to the right of the minimum quality regulations and above the cost curve CC. Here, as discussed above, cost-plus reimbursement, much like the cost-plus contracts in nuclear plant construction, provide incentives to all providers to run up the costs. The area of excess costs, Area B in Figure 2, is without an upper bound for most episodes of medical treatment, since additional costs can be added in and passed on to the insurance company, or the government. Furthermore, the red tape is not only unpleasant to providers, regulators, and to patients, but the large amount of paper work required is also costly and wasteful.

Prospective reimbursement via DRGs is not a form of regulation which involves use of laws and the police power of the state, but instead a use of market power on the demand side by the government to reach a price agreement between buyer and seller before services are rendered. Health maintenance organizations also reimburse prospectively rather than retrospectively. But in the latter case the stipulated price covers preventive care, ambulatory care, and full-service hospital care. As Medicare DRG's are "bundled" to produce a single price for full service coverage they will approach a prospective reimbursement HMO basis. With negotiation beforehand to fix a price for bundles of

services there is a stronger incentive to bring costly technology and other costs under control. The result of combining minimum quality regulations with the abandonment of cost based reimbursement would be to place an upper bound on the feasible region in Figure 2, limiting it to Area A--that is, to good quality care, but at pre-negotiated cost.

However, reasonable prospective reimbursement rates require that there be competitive bidding among health care insurance plans. So as shown in Figure 3, the new competition is designed to limit the feasible region further, providing a curved upper bound symbolizing the discipline of the market. Curve MM' is a total revenue curve based on the final effective demand from both public and private insurance plans (assuming that now all patients, rather than just Medicare patients, are included in the analysis). This new competition--the crux of which is among health care plans offered by HMO's and other health insurance providers is intended to provide disincentives to those providing the lowest quality care at the highest cost (Area F in Figure 3). The largest opportunities to grow, and largest net revenues, are available to those operating at the most cost-effective point, point E. The positive incentives (net revenues) are much smaller for those providing the lower quality care at high cost, below F, although a few may be able to survive, especially in those states that retain protective anti-competitive legislation. The net revenue will also be smaller for those who provide costly increments to health care that do not contribute significantly to health effectiveness up near point M'. Their high costs are not being covered, and survival of these providers will be in jeopardy.

Increasing the intensity of competition beyond that shown in Figure 3 would have the effect of shifting the curve MM (representing the discipline of the market) downward. This would further limit the feasible region and squeeze more of the providers toward the area around the single most cost-effective range near E.

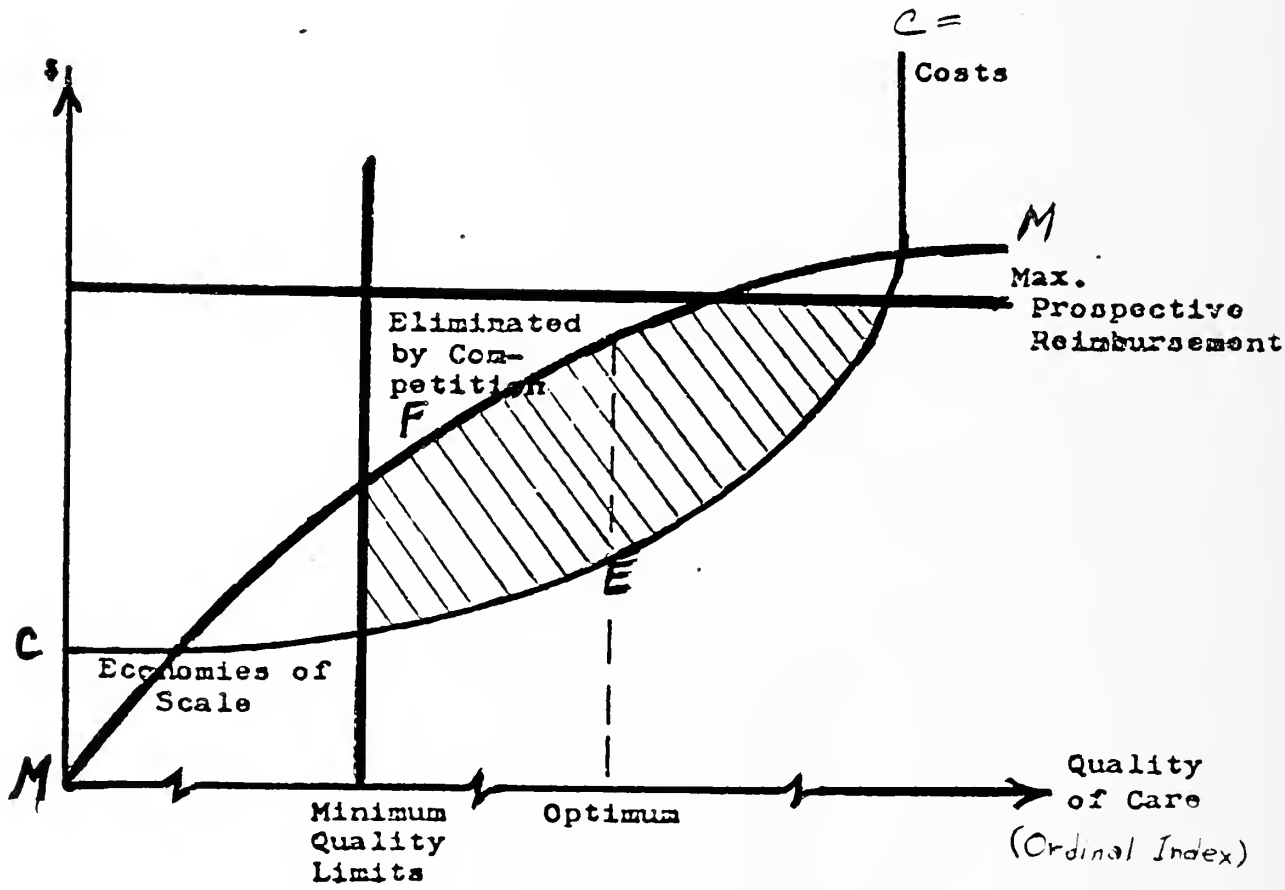

Figure 3. Rationalization of Health Care Delivery

Requirement of Multiple Choice

When employers are required to provide a multiple choice to their employees of several health insurance plans, at least one of which uses prospective reimbursement, the result is to encourage competition

among plans. Multiple choice also encourages the creation of prospective-reimbursement plans in localities now lacking them. It enables employees to compare and to choose the more cost-effective plan, i.e., either the plan that offers the greatest benefits, or the one that has lower out-of-pocket costs, or one that balances these features. Enactment of the requirement that employers go a step further and rebate some fraction of the cost saving to those choosing the more cost-effective health plans would drastically increase the amount of competition because it would alert employees and give them a strong incentive to compare plans. This is a step that the Federal Government has not as yet been willing to take.

To make competition more effective, it is now the state-level economic regulations that bar entry and foster monopoly that next would need to be sharply reduced. State certificate-of-need legislation and state licensing requirements need to be reduced. If state cost-based Medicaid reimbursement also were eliminated, empty hospital beds that now can be used to raise Blue Cross cost-based rates would instead become a strong deterrent to increasing hospital room rates. Instead of raising rates to pass on the costs, the empty beds would be an incentive to hospital managers to lower rates to attract additional business from employers. Underutilized technology also would be avoided in favor of technology that could either reduce costs, be fully utilized, or both, and therefore be more cost effective. Increased admission to medical schools, rather than the decreasing enrollments that are now occurring, would continue to restrict the rise in physicians' incomes, which are already rising more slowly due to the

increased supply, while also continuing to increase the supply of physicians to the underserved rural areas. Reduced barriers to nurse practitioners, who can perform a range of the more standard and simpler medical treatments and refer other cases to specialists, would also help lower costs. In these ways the states could greatly help to reduce cost escalation and, instead of being part of the cost-escalation problem, become part of the solution.

III. INEQUITY: THE BIGGEST CRACK IN THE EMERGING SYSTEM

As competition increases, the discretion available to non-profit institutions to serve those whose insurance is inadequate and who are unable to pay is squeezed. The working poor who are ineligible for Medicaid and yet are underinsured are increasingly denied access or are forced onto the already overcrowded public hospitals.

About 90 percent of all short-term hospital beds are in not-for-profit institutions of the type that dominate the health care industry. As these institutions meet competition, their traditional roles of serving the poor and of providing care in an environment where patients have little information comes under increasing pressure. Largely as a result of this pressure, cracks in the newly emerging system are beginning to appear.

Some of the kinds of government policies that are needed quickly to deal with these cracks cost money. They therefore may not be considered until the new competition succeeds in saving some current resources through increased efficiency. Nevertheless, if the system is to remain humane, grants are needed for the working poor to help them

cover at least a fraction of the annual premium in a prospective-reimbursement health plan.[21] Hospitals currently caring for a disproportionate share of the indigent, mostly in the larger city ghetto areas, are being brought under very serious pressure and are under increasing risk of bankruptcy.

The cost of the health care vouchers needed to relieve this pressure can be reduced by relating the size of the voucher in what could be called a new Healthcare system to the recipient's ability to pay, as measured by his income. This procedure is far less costly since it allows for some resource recovery. It also simultaneously diminishes sharp distinctions between private patients who pay all of their own way and Medicaid patients who pay nothing but must first prove that they are totally destitute. This step would meet the most acute current need without running into the objection of applying ability-to-pay tests to Medicare recipients who have previously paid into the Social Security Trust Fund. There exist very sophisticated methods in wide use for "financial need analysis" for use with college tuition waivers and grants. A one-page form, requiring the recipient to copy a few lines from his last income tax return, could be sent to a central processing center to produce a timely report of the patient's unmet need. This report then could be used directly to determine the size of the grant that is provided and simultaneously the patient's expected contribution to his health care costs.[22]

This simple procedure is far less costly than providing free care to all who are eligible. It makes sense for those above the Medicaid threshold. If Medicare also were to be means-tested in this way,

additional problems are raised but the huge savings then be more than enough to fund at no additional cost to the taxpayers a new Healthcare system for the working poor who are eligible neither for Medicare nor Medicaid. It is this in-between group who are currently being dumped out of the for-profit and not-for-profit hospitals.

IV. SOME IMPLICATIONS FOR HEALTH CARE PROFESSIONALS

Prospective reimbursement that involves a capitation rate covering the entire health of the patient is requiring greater attention to cost management and the cost effectiveness of different alternative treatments (e.g., hospitalization vs. outpatient care) by physicians and nurses. This change in incentives in turn implies the need for greater attention to the cost-effectiveness training of new physicians in the medical schools, and training that increases their awareness of the nature of the new competition. Training in cost-effectiveness is likely to put the health professional who possesses it at a premium. Those physicians who have not learned how to combine medical inputs in cost-effective (and health effective) ways are likely to be under increasing discomfort in the hospitals in which they practice.

Those professionals on hospital boards and clinic boards need to alert their institutions to the need to meet the competition by offering prepaid health plans if they are not already doing so. Physicians are also likely to continue to combine in groups to bid for contracts with employers. Those remaining in solo practice or on a fee-for-service basis are likely to come under increasing economic pressure as they serve a declining share of the market and are not positioned to bid for new business.

V. CONCLUSIONS

The newly emerging health care system shows promise of reducing cost escalation. There is acute need, however, to use part of the savings to help maintain access to health care by the working poor, the unemployed, the underemployed, and the uninsured.

Achieving these combined goals requires a continuing shift away from cost-based reimbursement and toward prospective reimbursement. When combined with the emergence of competition, this new competition is likely to strongly encourage physicians to practice in larger groups, as well as lead to hospital and hospital clinic mergers.

A shift of power is occurring that decentralizes the decisions about the quantity of hospital days and other health care inputs used from state and insurance-company administrators to physicians. This is a more appropriate locus for this power, since the physician has the patients' needs in view. It is necessary, however, that the physician be at risk for wasting resources, as is the case under prospective reimbursement, and that physicians be more adequately trained to make these kind of management decisions.

State-level economic regulations that continue to bar entry and foster monopoly power need to be reexamined and reduced if states wish to join in using the competitive approach to reduce the escalation of costs. Medicaid also needs to shift over to prospective reimbursement as the results of the experiments in process come in.

The result, after an adjustment period, should be a health-care system with incentives to operate both more health effectively and

much more cost effectively. Prepayment also implies stronger incentives to provide preventive care and not just crisis care. Such a system also should be more satisfactory to providers, who will encounter less waste, less red tape, and more independent responsibility. It then has the potential if new legislation is passed to be more equitable and humane in using the savings realized by the new competition to provide health care for those working poor who are increasingly being denied adequate access.

Footnotes

[1]Victor R. Fuchs (1985).

[2]Ibid.

[3]The Medical Care Price Index components in the Consumer Price Index published by the Bureau of Labor Statistics (1985).

[4]See, for example, Feldstein (1983), Fuchs (1985) and Davis (1983).

[5]Feldstein (1983, p. 92) surveys a number of studies which conclude that the rate of surgical procedures is higher when the physician is reimbursed on a fee-for-service basis.

[6]In a study of over 11,000 consultations, it was consistently shown that "33% of those voluntarily seeking a second opinion and roughly 18% of those required to seek a second opinion consultation were not confirmed for surgery by a board-certified panel consultant." The highest rate of nonconfirmation was for hysterectomies, prostatectomies, bunionectomies, and knee surgery. See McCarthy et al (1981).

[7]Medical care prices and insurance rates continue to rise at a 6% annual rate in 1985 as shown by the Medical Care Services Price Index, Monthly Labor Review, Bureau of Labor Statistics (1985), p. 73.

[8]This and the preceding illustration are implications of Feldstein's (1983, p. 130-4) analysis.

[9]See McMahon and Blumberg (1985).

[10]See Carolyne Davis (1983) for example.

[11]See Goldfarb (1975).

[12]The information is based on inquiries made by the physicians in charge of the Admissions department at Cook County Hospital in Chicago who feel under pressure as other Chicago hospitals dump patients onto Cook County Hospital.

[13]Regarding the American Medical Association, 94 FTC 701 (1979) modified and enforced by 638 F.2d 443 (2d Cir. 1980) affirmed by the Court 452 US 960 (1982) (per curiam).

[14]See the "Illinois Health Reform Act" enacted by the State of Illinois in 1984, and patterned to some extent on the Iowa law, that sets up a Cost Containment Council with this charge.

[15]See McMahon and Blumberg (1985) for further description of these developments.

[16]See Ralph Berry (1967).

[17]See Punch and Johnson (1984).

[18]Harold Luft (1980) and Manning, Liebowitz et al. (1985).

[19]See McMahon and Blumberg (1985).

[20]See Thomas et al (1983). Steven Wallach in Boston has been actively working on this problem.

[21]See National Center for Health Services Research (1985).

[22]See, for example, the description of the American College Testing Program's (1985) financial need analysis criteria and methods.

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