H or V

H

H

H

62

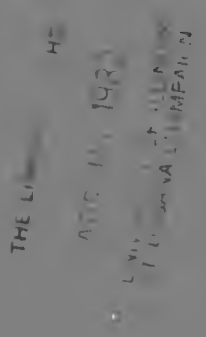
1079136

BEBR

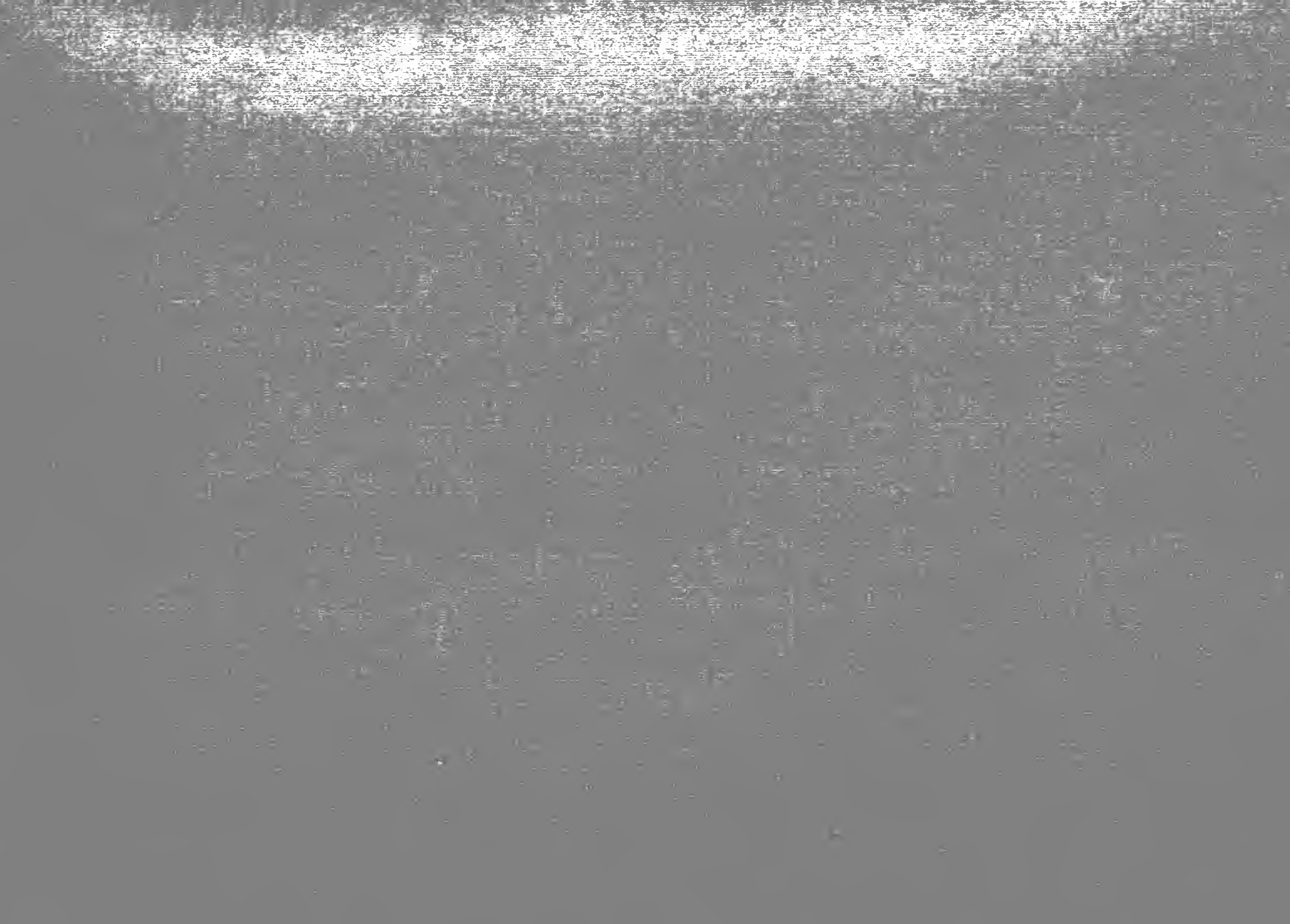
FACULTY WORKING
PAPER NO. 854

The New Competitive and Incentive Approaches to Health Care Cost Containment

Walter W. McMahon
Ronald R. Aldrich



College of Commerce and Business Administration
Bureau of Economic and Business Research
University of Illinois, Urbana-Champaign



BEBR

FACULTY WORKING PAPER NO. 854

College of Commerce and Business Administration

University of Illinois at Urbana-Champaign

March 1982

The New Competitive and Incentive Approaches to Health Care Cost Containment

Walter W. McMahon, Professor
Department of Economics
School of Clinical Medicine

Ronald R. Aldrich
Mercy Hospital, Urbana, Illinois
Clinical Faculty Member, University of Missouri,
St. Louis University and University of Illinois
at Urbana-Champaign

Abstract

The new competitive and incentive approaches to health care delivery now being proposed have several new and interesting implications that are explored in this paper. The dramatic changes, some of which are already underway, include the deregulation of hospitals with increasing new entry, the extension of the multiple choice of health care plans provided by employers with rebates to employees when less costly plans are chosen, and restructured cost-sharing for medicare and medicaid. All suggest that there will be entry of more hospitals in many communities, development of new combinations of health care plans, more subcontracting for health care delivery, and perhaps more use of anti-trust laws to preserve the competition. These all suggest the need for advance planning by hospitals, health care plans, physicians, and consumer groups to avoid the problems and to minimize the costs of cataclysmic change.

The impetus for change, including the rising costs to the taxpayers, falling cost-effectiveness of health care, and problems of regulation are considered first in order to define the nature of some of the problems the "New Competition" seeks to address. But since competition also provides no complete panacea, the paper offers a prognosis of a mix of regulatory and competitive approaches.

The New Competitive and Incentive Approaches to Health Care Cost Containment

The new competitive and incentive approaches to health care delivery that are being proposed by Secretary Schweiker and the Reagan Administration will have some relatively predictable kinds of effects on the economic environment for hospitals and physicians. These offer some new insights, even though all of the effects may not be fully predictable, on the kinds of adaptation needed for a more planned and orderly readjustment by hospitals, health care plans, and physicians to the newly competitive environment.

The "New Competition" involves five major new thrusts, with a few of the changes already underway and other changes to be supported by the Administration:

(1) Deregulation of Hospitals - a lot of hospital regulation is currently being dismantled, and accompanied by freer entry as Certificate of Need regulations are weakened.

(2) Employers are Required to Provide a Multiple Choice of Three Plans - the usual plan, a low cost option, and an HMO plan if available - with the likely provision of the Gelbhart-Stockman bill that the employer provide an equal payment toward each with a rebate to the employee if the lower cost plans are chosen.

(3) Taxation of Employer-Provided Health Insurance - a major thrust of the new policy--to remove the tax exempt status of benefit plans that provides an incentive for over-insuring workers.

(4) Restructured Cost-Sharing for Medicare and Medicaid - along the lines that Reagan implemented in California, to provide a competitive incentive to consumers to help police the system.

(5) Voucher-Like Tax Credits - for the working poor, which may or may not be supported by President Reagan, would provide financial supplements if the employer's plan is stingy by means of a tax credit operated through the income tax system.

Taken together, these have a number of new implications for health care delivery which will be explored below. First, however, the impetus for change and the nature of the problems to be addressed needs to be considered. These range from the rising costs to the taxpayers and falling cost effectiveness of health care delivery to the counter-productive effects of retrospective reimbursement and of many of the attendant regulations currently imposed on the hospitals. Although the "New Competition" offers many new opportunities, it also presents many problems and is not a total panacea. We conclude with a prognosis of a mix of regulatory and competitive approaches toward which health care delivery appears to be headed.

I. Why Be Concerned About Rising Health Care Costs?

A Source of Inflation

One major reason for concern is the inflation in per unit costs of health care, with rates of increase that are higher than those of the consumer price index. These unit costs include, for example, 1981 increases in the price of physicians' services at a rate of 17 percent, the inflation of hospital room costs during the same period at 18 percent, and the rising price of other hospital and lab services at 17.8 percent, all during a period within which the consumer price index rose at a 9 percent annual rate. This pattern extends to the increase in the cost per treatment, or per episode. In a study by

Scitovsky and McCall (1975), several treatments are examined. In the period from 1964 through 1971, for example, a period during which the consumer price index rose 30.5 percent, the cost of an appendectomy (simple, nonperforated) rose by 76 percent, the cost of typical maternity care rose at 70 percent, and the cost of breast cancer treatment rose at 76 percent.

Falling Cost-Effectiveness

It is the falling cost-effectiveness of medical care, and not a greater rate of human capital formation, that is the more basic problem. It is true that expenditures on medical care as a percent of Gross National Product began to climb dramatically in the mid-1950's, well before Medicare or Medicaid was enacted, from 4.1% in 1950 to 5.6% in 1967 to about 9% in 1982. If only this had been accompanied by equally dramatic improvements in mortality and morbidity, of the type that had occurred before 1950, it could be argued that improving health status by these means pays for itself in the form of increased productivity. Luft (1975) for example, has found large annual aggregate losses of earnings of $22.8 billion due to poor health, Bartel and Taubman (1979) have found large 20-30% reductions in earnings around age 50 that persist for many years as the result of certain physician-diagnosed diseases, and Grossman (1976, p. 204) has found adverse effects of poor health on schooling, market productivity, and average wage rates.

In view of these large costs of poor health, the rising costs to the taxpayer, if treatments were adequately cost-effective in improving the health status of those who have poor health, some of whom are poor, could be defended as a productive investment. But overall measures of health status of the population (that were rising sharply before the dramatic increase in medical expenditures came ir 1957) leveled off, except for a modest increase after the enactment of Medicaid. This pattern suggests that the growth of third-party cost-plus reimbursement and the weakening of incentives for cost-effectiveness

that it implies may be significantly responsible for a significant fraction of the climbing medical care costs, and not just the extension of access to the elderly and the poor which came later. It is in this sense that insufficient cost effectiveness, rather than the effort to improve health status, is a major source of concern about rising health care costs providing an impetus to try the new competitive approaches.

Limited Taxpayer Support

On other grounds in addition to these, a continuing government concern is assured. This is because of the large percent of taxpayer support that is involved. For example, 24 percent of the cost of all physician's services are paid for by the government, 55 percent of all hospital care is paid for by the government, and 51 percent of all lab and other services are paid for by the government, according to Gibson and Fisher as cited by Paul Feldstein (1979, p. 32). The percent paid for by all third-party payers including Blue Cross/Blue Shield, as well as Medicare and Medicaid, was 34 percent in 1957, and now has risen to over 69.7 percent (ibid). This suggests that third-party cost-plus-reimbursement, which includes not only Blue Cross/Blue Shield and most private insurance which pay full charges when these are deemed reasonable, but also Medicare/Medicaid which also uses retrospective reimbursement methods, is a significant part of the source of the lack of incentives for maximum efficiency and rising costs.

Taxpayer's support is not unlimited. The equity question raised by Fuchs (1974), "Who Shall Live?," dramatizes the resource limits that restrict further access to health care that are inherently involved. Recent Medicaid cuts for example may limit some inefficiencies, but they also further limit needed access. If there is waste, access is then denied to others who are unable to pay, simply because the taxpayer's resources and taxpayer support is not unlimited.

There are many stories of the numbers that are turned away at Cook County Hospital in Chicago, for example, and of the big problem of treating Medicaid patients at the University of Illinois hospital in Chicago. So, patients do get turned away, and will continue to, as budgets are cut. Yet, the third-party reimbursement under Blue Cross often requires that patients be put in the hospital to be covered, inducing over-hospitalization when there is not true need, and causing beds to be denied to others just in order to tap the reimbursement mechanism. Another example is to be found in unnecessary duplication of high-cost facilities. This presents a very serious ethical and moral dilema, with inequity as one result of the currently inefficient cost-plus approach.

Contrasting Regulatory and Competitive Approaches

We have heard lots about the regulatory approach in recent years. The Certificates of Need granted after HSA review is a franchise that acts as a grant of monopoly power similar to those in the public utility sector--the telephone system, the water companies, and electric utilities, for example. Such grants are justified where there are high fixed costs because there is a large amount of equipment necessary. You don't want to duplicate that equipment and have many different competitive firms that cannot realize economies of scale and full utilization. For instance, if we would have five water companies servicing each city, you would have water pipes interlacing under the ground to the point of ridiculous extremes and it's very costly. So, one company is given a degree of monopoly to supply the water; another is given a franchise to supply the electricity; and another to supply all the telephone service. Then it is necessary to have a regulatory commission regulate the rates that they charge, once entry is limited, so that their new leverage is not used merely to run up the price and reduce service to the less affluent.

In the case of hospitals there are not major economies of scale except in some kinds of high-cost services, such as maternity care, open-heart surgery facilities, trauma units, and cat-scanners. So regulatory approaches have attempted to limit duplication, often without commensurate regulation of rates or rationing of over-utilization.

The competitive approach now proposes that companies give cash rebates to employees who choose less expensive health care plans (e.g., an HMO, instead of Blue Cross in its present form). There would be tax penalities imposed on those who chose the more expensive plans, and vouchers for older people not current employed. Such competition is feasible in larger metropolitan areas or health care regions where there are a larger number of health plans and hospitals to choose from. If there is just one or two health care plans available in any given locality, then there would still be local monopolies (or conscious parallelism among the two or three plans) and competition will not do the job. Regionalization will increase the choices, as will sub-contracting by several plans with one hospital. But there must be relatively free entry, which requires anti-trust protection, more and simpler information required for health care users, and easier entry of new physicians and new hospitals for price competition to really work in containing costs.

II. Life Under Regulatory Approaches

From a public policy standpoint, we are at a clear directional point where we are either going to move more toward greater regulation, more serious types of regulation, and regulatory impacts on hospitals to contain costs, or toward dramatic modification of the regulatory environment as proposed by the new competitive approaches. By and large, hospitals and businesses in general support the deregulation proposed by the Reagan Administration. But they are also very apprehensive about new waves of competition. It's curious that we are finding that many of the same types of proposals that were brought forth

by President Carter and his Administration are now being brought forth by an administration that is more effective in terms of getting things through Congress. Some hospital administrators wish at times that Carter were back there bumping along as he did through his efforts to get relatively limited regulation.

Origins of Regulation

If you look at the history of regulation, the major thrust, other than fundamental things like licensure and certifications, started with the passage of Medicare and Medicaid and the accompanying involvement of large numbers of taxpayer dollars. There was the Hill-Burton program that came earlier, but the real major thrust started with Medicare and Medicaid. In looking back, the main sales pitch that the Federal Government made was that Medicare/Medicaid was only a financing mechanism, accompanied by many assurances and comforting statements to the effect that there was no intent to change the structure of medicine. At that time the government had considerable concern that a fair number of hospitals would not participate in Medicare and Medicaid; in fact in the mid-sixties it geared up military hospitals at the time that Medicare was coming in to provide alternate coverage for elderly people.

But what has happened since then, for good and bad reasons, has been an ever increasing dialogue, confrontation, and regulatory structure involving hospitals, individuals, and between the Federal Government and state governments. We have evolved a very, very complex regulatory process involving hospitals, and it has been increasing at an increasing rate. Whether you think that is desirable or undesirable depends somewhat on your perspective. From the standpoint of the patients and the regulators, many believe that these kinds of processes were needed to attempt to put some controls on the medical-industrial establishment that they saw raising the costs. From the standpoint of the regulated, many believe that all of the regulations have not been useful.

Certificate-of-Need Franchises

Planning and regulatory processes have a cornerstone in the Certificate of Need administered by health systems agencies. We think there are varying reports in the literature that give indications about the mixed success of these programs. By and large, health systems agencies have been phasing out gradually. They get an occasional reprieve. But it seems to be an idea whose time has come and gone, especially now that the Reagan Administration is proposing deregulation and the competitive approach on a number of fronts.

However, it is not yet clear what is going to happen to Certificates of Need. Many states have passed Certificates of Need legislation and may well keep certificates of need regardless of whether health systems agencies are there. Essentially, the Certificates of Need process was aimed at controlling the initiation of new services and new capital expenditures that were over a certain dollar cost; it was a hundred thousand dollars initially, but more recently that's been raised by the Federal Government to six-hundred thousand for certain things, and to four-hundred thousand for others.

These limits are predicated on the assumption that if you control the rate of capital expansion, you will have some impact on the overall cost. But as you look at the cost of operation of facilities versus the cost of capital construction, clearly the capital costs are inconsequential compared to the total life cycle of operating costs. A paticular hospital may have an annual budget that is equal to its total assets, so its operating budgets may be much larger. Hence the utimate impact of franchises may be to limit the competition on room charges and raise operating costs. But, the theory was to limit capital costs. What has evolved with Certificates of Need is a very lengthy process of review; a very expensive, costly process. It has developed a whole group of consultants and accountants and other types of people whose only business it is to help hospitals creatively get through the Certificate

of Need process. There have been some benefits, in that it has brought about greater consumer input in health care planning. But on balance, it may well have added to operating costs and room charges.

Professional Standard Review Organizations (PSRO's)

The government put in PSRO's primarily to help reduce the length of stay. At the time however the length of stay had been dropping dramatically for some time for reasons other than PSRO involvement. Recent studies of PSRO's have raised questions as to whether they make any significant contributions in terms of reduction of length of stay, or whether they've had any other major impact. Effectiveness studies done by the government have contributed to the decision to decrease funding and ultimately to eliminate PSRO's.

Problems with Third Party Reimbursement

The regulations surrounding reimbursement for Medicare/Medicaid, in contrast to more limited regulations in the Blue Cross health plan, have grown to ten's of thousands of pages. It is a full employment act for accountants and lawyers, because what happens is that each time a new regulation comes out, people develop very sophisticated systems on how to beat the regulations or how to do things in a different way.

The major failure of prospective reimbursement is that it does not deal with the fundamental incentives. The basic problem is that initially it seemed reasonable to pay the costs of care. Particularly for those who did not have an economics or accounting background, cost seemed like it would be something relatively easy to determine. What has evolved is a whole set of regulations defining what constitutes cost, what constitutes reasonable cost, provisions for negotiations, arbitrations, and legal actions appealed back and forth as to whether a particular cost is reasonable or unreasonable or whether the full costs of operation is being covered.

Rate Regulation

Recently, there has been a greater interest in terms of saying, "OK, we recognize that we cannot effectively control cost using a cost-reimbursement approach. Let's look at something that we may be able to control more effectively, and that's rates." So there is the development in many states of public utility type models, of which the developments in Illinois offer a relatively typical example. There the Illinois' Hospital Association, helped sponsor such legislation several years ago in part because they thought that if they could help write the law they'd have more input. The resulting law then had been in the process of slow administrative implementation for the last several years when Governor Thompson personally intervened. Suddenly the Joint Commission of Administrative Rules passed all the rules, and now there is a real possibility that rate review will be implemented. Obviously, hospitals are taking a number of political and other types of actions to influence that process. Probably, that's one of the more dramatic changes that has come about.

On balance, the regulatory processes have not worked as well as one would have hoped they would. Like many other areas where regulated industry has learned ways to gain substantial impact and control over the regulators, this has been a problem in health care as well.

A Basic Problem Leading to Regulation: Retrospective Reimbursement of Costs

The concept of retrospective reimbursement of cost regardless of what level those costs are fundamentally unsound from the very beginning. So what we have continued to do through this process of negotiations, suits, appeals, and all the other things that have gone on back and forth, is to make more complex the use of a basic principle that still is fundamentally unsound, and thereby make things worse. There has got to be some change, whether it is change in a regulatory direction or a change into a competitive mode. But there has got to be some change in terms of that fundamental principle of retrospective

cost reimbursement that does not exist in any other area of economic activity. It is not rational.

This is not to say that the world would be a better place if suddenly all regulation dealing with health care were eliminated and we went to no regulation at all. There are some fundamental regulations that have to occur to reasonably control the quality of care, and base level regulations that are going to be needed under any system of payment and incentives.

III. The New Competitive Approaches

It should be clear that regulation as the only approach is no panacea. It is possible that as we turn to the competitive approach that you'll feel that the competitive approach is not a panacea either. There probably are no panaceas in this field, but at least the competitive approaches do have the merit of dealing with the basic problem of trying to restructure the incentives within the system so that there are stronger incentives to be efficient, less wasteful, or more cost-effective.

Consumer Choice Health Plans

Briefly the main thrust of the Reagan Administration's plan, consistent with Enthoven's earlier proposal, is that employers will provide a certain basic fixed amount to the health care user, with the government providing vouchers for the elderly. Each individual will be free to choose (there would be an open enrollment period once each year) between several different competing health care delivery plans, and if a more efficient or less costly plan is chosen the individual could keep the rebate. For instance there would be in any given locality an HMO operated by each local hospital and doctor-clinic groups to choose from. Blue Cross/Blue Shield the way it is now structured would not be a qualifying plan, but it could offer a new prospective reimbursement plan and contract with local providers, and thereby qualify. In any event there potentially would be an annual choice by the consumer among the qualified plans,

and then the consumer could keep the difference. If he chose a very expensive cost-inefficient plan, he would not be permitted to deduct the excess cost from his income tax. The consumer would have an incentive to choose carefully, and to pay attention to the kind and quality of care that he was getting. The provider who then must cover all health care costs would have an incentive to be efficient.

The qualified plans will have to publish clearly stated annual limits on individual out-of-pocket outlays for the benefits that are covered. These out-of-pocket outlays include deductibles, copayments, and any differences between indemnity payments and the actual cost of covered services beyond the limit. Plans must furthermore provide a low-option package of basic benefits as defined in the national health insurance law. Qualified plans must set community rates according to a market area, so that competitive cross-subsidies, as between regions for example, would be ruled out. In other words the qualified plan would have to internalize the costs of meeting all of the health care needs within the covered area of the region and could not either receive a subsidy or absorb costs from other areas. The health plan then, and the doctors, have an incentive to be efficient since they cannot pass the costs to other regions, and if they are not efficient, it comes out of their pockets. So there are direct incentives that are consistent with the supply siders' emphasis on incentives which is a theme of this Administration. The consumer also has an incentive to pay attention to the different plans and what they offer.

A qualified plan would be required to accept all commers within its catchment area. This would be actuarily calculated so that the rate for an elderly person would be greater than that for a child. Also for a very low income person there would be a Federal subsidy or state subsidy to that. In other words there would be a needs-based means test just as there is with

Medicaid, for instance, so that the government would pick up the cost for a low income person.

Finally, a program to provide meaningful and useful information on the features and merits of alternative health plans is an essential part of the consumer choice health plan, and a major departure from present practice. To aid consumer choice each plan would be required to publish total per capita costs including premiums and out-of-pocket costs. An administrative agency will have the authority to review and approve for accuracy and balance these materials.

Physician and Hospital Reactions to Deregulation, and Prospective Reimbursement

One of the interesting dicotomies that exists in the industry is that hospitals and physicians are generally in favor of removal of regulation, but generally also have considerable anxiety about the meaning of what a competitive approach will mean. This contridiction is clearly perceived by most of the industry, which is still waiting to perceive what the effects of the new competition might be. By and large the American Medical Association is in favor of the competitive idea, so long as the system is pluralistic. They do not want to see a requirement that these competing health plans be developed everywhere; they want to keep a fee for service arrangement as a primary mode of practice; and they are concerned that they may be forced into organizational relationships in medicine that may not be common in some localities. One of the AMA's main themes is that in Palo Alto or Seattle or New York or in Champaign-Urbana, where you have fairly large multi-specialty group practices, that it is fairly easy to overlay a HMO or health plan organization on those group practices and have it develop, without jeopardizing other fee-for-service practice. But in Toledo, for example, the largest group practice is a single specialty group of five people, and the traditional modes of practice there are solo practice, partnerships, or very small single specialty groups with

virtually no relationships among them. The referral pattern goes all over the community. It has an older group of physicians who, by and large, still question Social Security, and who still are suspicious that the medical society might be Communistic. Given that structure how does one come in and say, "OK, doctors, we are going to organize you into competing health care plans?" How are you going to make that happen without violating some of their constitutional rights to practice, or to earn their income in the mode structure that they deem appropriate? But perhaps this is overcomplicating the issue. If the alternative was no income versus a change of structure, these alternatives probably would modify behavior rapidly. You would see these individual groups somehow linking together in Independent Practice Associations, or whatever kind of model you want.

The representatives of the American Hospital Association as the primary spokesperson for the not-for-profit hospitals are particularly cautious. They don't like a lot of the things about regulation but they also have deep concerns about the competitive model. The Federation of American Hospitals (which is the for-profit investor group) seemed to be the most pro-competition from the standpoint of the investor-owned chain.

IV. A Critique of Competitive Approaches

One of the concerns that the American Hospital Association has is that typically the way that the for-profit investor-owned hospitals survive is by coming in and skimming the market. They often offer a limited range of service, and avoid high-cost services like obstetrics, pediatrics, emergency rooms, and open-heart surgery. They attempt to apply economic incentives for physicians to utilize their facilities, but to utilize them with private paying patients like younger people, people who have rather healthy lives, and people who are unlikely to demand enormous amounts of service. They tend not to be prone to providing care for the poor or the underserved.

Access to Capital

There are a lot of concerns among the not-for-profit hospitals that if entry is opened up completely, and the franchising effect of Certificates of Need is completely removed, then the investor-owned for-profit corporations will grow dramatically. The Hospital Corporation of America only started in 1968 a local operation in Nashville, Tennessee. It is already a multi-international organization and has just acquired a whole new company of hospital affiliates. They are not only active throughout the United States, but they also operate and build hospitals in various places in Europe and in Asia and just all over. So, one of the big concerns is that as we look at what's happening right now, that the not-for-profit sector is going to be subject to more severe competition that will limit its access to capital markets. In the long run the impact would be to drive out the not-for-profits.

If you take the price-earnings ratio of the four or five big for-profit firms that are in the hospital industry, for example, they are extremely inflated, and their cost of capital currently is significantly lower than General Motors, IBM, or any number of blue chip companies that one could name. It is generally believed by many analysts that they are overstated in value But they still have that potential profitability and hence access to capital. So, whereas a local not-for-profit hospital, for example, may issue $40 million worth of bonds, facing an interest rate on the tax-exempt market of 12 to 13 percent, they will be competing against the Hospital Corporation of America that may have an average cost of capital of about 6 or 7 percent. That differential under a competitive model would clearly drive the not-for-profit sector, ultimately, out of existence, or else force it not to provide services to the poor, or preventative health care services to the community that are less profitable.

Finally, what happens to the high-technology, highly-sophisticated kinds of services that generally are avoided by the investor-owned hospitals? In this respect it must be recognized that the Certificate of Need has some good effects too. It does have some impact in reducing, if not eliminating, the amount of unnecessary duplication, and permitting realization of economies of scale as do franchises in other public utilities. With free entry, a one hundred-bed hospital duplicating these high technology high cost services could be built right across the street from each existing hospital, and provide economic opportunities for the doctors to use it. This would leave the Medicaid, leave the Medicare, leave the programs that don't pay, leave the people who have the most serious illness, and leave the poor to the not-for-profit hospitals, as well as leaving them with underutilized high technology units, and that is a concern. It is not as much a concern to the Federation of American Hospitals, however. They think that all is fair in love and war, and if they have access to that capital market it's because they are, in the eyes of society, somehow doing better so that they ought to be able to grow.

So those are two major concerns that exist in looking at the competitive model: its implications for the differential cost of capital, and the different attitudes that exist between the for-profits and not-for-profits toward community service.

V. The Benefits of Competition, and a Prognosis

The benefits hospitals and physicians see and the major benefit, we think, is the reduction or elimination, of the massive system of controls, regulations, and rules that do not provide appropriate economic incentives to delivering health care in the most efficient way. The retrospective reimbursement of costs in hopelessly wasteful. On one side we are saying hospitals would like to see those incentives change. We'd like to see that system of regulation modified. We would like to see a more competitive kind of health care plan with

prospective reimbursement. On the other hand, hospitals have legitimate concerns that if we go so far in the competitive direction we may substantially modify the ability of the system to respond to the needy, the aged, and the most difficult cases. However, presumably the investor-owned hospitals would have to qualify as part of the system and would have to offer certain unprofitable services, so the new for-profit competition is not likely to see the end to all regulation.

New Competitive Forms of Organization

The specialized for-profit hospitals could operate health facilites that contract with health plans that are operated by others for certain types of services, and still provide an investment incentive for the physician to utilize their facility for certain types of patients. So thus far it is not at all clear how multi-hospital systems will develop versus how health plans which may or may not be hospital based, will develop. Some plans will be physician based, or even may be done by insurance companies such as Mutual of Omaha. If you look right now many of the HMO's originally assisted by the Federal Government are being bought up by various insurance companies who are moving into that business and saying, "OK, we are going to get involved." The insurance companies don't have to own the facilities. A health plan can qualify and meet all the requirements while contracting for every single service.

Anti-Trust Action to Preserve Competition

Another aspect that has very recently been thrown into the whole matter of entry of hospitals, physicians, and health plans is the probable increased use of the anti-trust laws. The Supreme Court ruled unanimously recently in favor of a hospital in Kansas City that wanted to expand and was denied a Certificate of Need. The U.S. Supreme Court essentially said that hospitals and the health care industry is not exempt from antitrust laws. So hospitals cannot prevent others from starting up, which is what some of the hospitals

would like to do using the Certificate of Need. It throws the whole question of continued use of Certificate of Need legislation somewhat into a quandary. There appears to be nothing to stop for-profit hospitals from building in any city and just offering the kind of services that make money.

Another anti-trust aspect is the sometimes contradictory communication in terms of public policy that on one side multi-institutional planning, cooperation, and development assistance are encouraged as a more appropriate, more efficient way of organizing health care delivery. On the other side of the coin lies the concern that if you allow mergers of hospitals, or in other ways limit entry, one system may come to control the whole region, and there would be an unregulated monopoly operating without any control. Finally, there is the problem of preventing price collision among quasi-independent physician or hospital groups. So the antitrust issue is very much a question at this time.

Are the Not-For-Profits at a Competitive Disadvantage?

There may be ways to adjust the prospective reimbursement schedules for serving the poor, the aged, and the especially difficult cases so that the not-for-profits are not at a disadvantage. They don't have to pay profits out to stockholders for one thing. Furthermore, if a problem exists in that the not-for-profits are largely independent units, whereas the profits are part of a large chain, there will be an incentive for the not-for-profits to organize into larger groups, like, say, the IGA stores, to gain the economic advantages of mass purchasing.

It may even be that the not-for-profits are sometimes more profitable in their own way than the for-profit hospitals. The differences are in what happens to the excess of revenue over expenses. In the not-for-profit they are not distributed to the stockholders, but instead cover excess costs and provide for expansion, whereas in the investor-owned hospital, by definition, they supply the retained earnings and augment the return on the original capital. Both

should be earning at approximately the same rate in terms of meeting their opportunity costs of capital. A reasonable prognosis is that the current trend will continue, the not-for-profits will gradually become more like the for-profits, and the for-profits will gradually become more like the not-for-profits. There is a very rapid and significant movement within the not-for-profit sector toward multi-institutional systems tied in through a variety of arrangements where the economies of scale can be gained in terms of group purchasing, insurance, equipment, and staff specialists in a variety of areas. A main ultimate driver of this search for economies will continue to be in the cost of capital. A good example is St. Elizabeth's Hospital in Danville, Illinois. If on its own it had to go to the bond market, it probably would not have been given anything other than maybe a BBB rating by Standard and Poor's, or Moody's, and in today's market it probably would not have done any financing. But by virtue of being part of a system that has 12 hospitals, with risk that is shared over all of the hospitals and with the assets of the entire group pledged against the indebtedness, St. Elizabeth's is able to get an A+ rating and get a cost of capital that is very competitive.

So to the extent that the not-for-profits were operating inefficiently, and the for-profits forced them to do things which saved money, the result is a society where people are better off. The problem thus far has been that the for-profits have done it by limiting the scope of services. The question remains about how adequately the Reagan administration plan will arrange for the for-profit hospitals to provide those services to older people, poor people, and people who are catastrophically ill.

A Prognosis of More Competition with Different Forms of Regulation

Where are we going? It seems clear that deregulation and more competitive approaches are very difinitely coming down the pike and fast. In other areas we've seen rapid deregulation even while Carter was in office. The trucking

industry and airlines were deregulated, and steps now have been taken to deregulate AT&T and natural gas, all with dramatic effects. This move started before Reagan was elected, and now the incentive approaches are more in tune with the Reagan "supply-siders." So it is coming fast, even though as one deregulates the hospital and health care industry, there then is a certain amount of chaos to be expected. But if this deregulation is to be replaced by competition, there then must be restricted use of the Certificate of Need and freer entry. In fact, competition in economics has no significant meaning unless there's entry; that's critical. If the Certificate of Need which is a franchise is continued, it's a grant of monopoly power, and then to say that there is free competition is ridiculous. You then have to have some kind of regulation. So there will be entry, but only of approved plans, and there could be more hospitals, as well as different kinds of homes for care of the elderly, and different kinds of specialized care units.

As a part of the prognosis, to get employers to agree to turn this decision over to employees however may be a major challenge for this Administration. A lot of health care is paid for by benefit plans that have been negotiated by labor unions, and these have been written into the labor union contracts. The labor union wants to say to its workers, "We've got complete coverage, and there's no coinsurance rate, or in other words, 100 percent of your costs will be covered." That, of course, reduces incentives to seek efficiency, and makes everything cost-plus, so that the person then using the health care doesn't care what the bill is. This all involves the union negotiating process, so it's more complicated than it looks on the surface to switch over quickly. It also involves relations between unions and employers.

As we look at where we're going, it is clear that the cost containment issue will continue to be of serious concern regardless of whether the administration is Democratic or Republican, and regardless of whether the theme

is regulation or deregulation. The total amount of Gross National Product being devoted for health care is such that it is already larger than most of the economies of the nations of the world, with the exception of a few large developed countries.

The move toward the competitive model is most likely to occur gradually. Third-party reimbursement regulation at the state level is likely to be strengthened as the Federal Government withdraws, although the serious cutbacks on Medicaid by the Federal Government do little per se to reform an inefficient reimbursement system. The continued deregulation at the Federal level is likely to be gradual because the stakes and risks are so high, both in terms of health and also in terms of the size and complexity of the industry that is involved. Another aspect of freer competition is the freer entry of students into medical training if they wish to bear the costs. But the number of physicians is highly regulated and franchised by medical schools. Deregulation will inevitably also call this regulation over entry exercised by medical school admission committees into more serious question. Competition in health care logically involves freer entry not just for hospitals but also for the training of new self-financed physicians and paramedics.

In conclusion, there is the risk of "Throwing the baby out with the bath water." It is obvious that the "baby" is a bit nervous about what is going to happen. If one would go completely to deregulation and have free entry of large numbers of additional hospitals and physicians, just to carry it to the ridiculous extreme, entry of so many additional providers could lead to the kind of wasteful competitive duplication that we had with gas stations,--one on every corner. Such an extreme might be dubbed "Shell-Care." It is unlikely that the new competitive approaches will go that far. But hospitals, physicians, and employers need to make some plans for adaptation to the coming changes in incentives, without which there can only be continuing problems with growing costs to the taxpayers, retrospective reimbursement, and regulations.

REFERENCES

Bortel, Ann, and Paul Taubman (1979). "Health and Labor Market Success: The Role of Various Diseases." Review of Economics and Statistics, LXI No. 1 (February), pp. 1-8.

Feldstein, Paul J. (1979). Health Care Economics. New York: John Wiley and Sons.

Fuchs, Victor (1974). Who Shall Live? New York: Basic Books.

Grossman, Michael (1976). "The Correlation Between Health and Schooling," in Nextor Terlecki, ed., Household Production and Consumption, NBER, New York: Columbia University Press, pp. 147-223.

Luft, Harold S. (1975). "The Impact of Poor Health on Earnings." The Review of Economics and Statistics, LVII, No. 1 (February), pp. 43-57.

Scitovsky, Anne, and Nelda McCall (1975). "Changes in the Costs of Treatment of Selected Illnesses, 1951-1964-1971," Health Policy Program Discussion Paper, University of California School of Medicine, San Francisco (September), pp. 10, 17.

FOOTNOTES

*Walter W. McMahon is Professor of Economics and Ronald Aldrich is President of Mercy Hospital. Both have joint appointments in the School of Clinical Medicine at Urbana-Champaign. The authors are indebted to the members of the faculty in the Medicine and Society Seminar whose comments and reactions have contributed significantly to the final product.