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Competition in Health Services:Overview, Issues and Answers

Clark C. Havighurst

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I. INTRODUCTION

Competition must now be taken seriously as a strategy for reintroducing cost-consciousness into the health care system and for guiding the system's growth and development in the 1980s. Throughout most of the 1970s, the prevalent assumption was that regulation would necessarily be the dominant mechanism of social control. In 1979, however, the Ninety-Sixth Congress definitively reopened the debate over whether competition or regulation can better serve the public. Among other signs of renewed congressional interest in this question, the Health Planning and Resources Development Amendments of 1979 put Congress expressly on record as favoring competition "wherever competition and consumer choice can constructively serve . . . to advance the purposes of quality assurance, cost effectiveness, and access."[1] While this stated preference for competition intentionally begs the ultimate question of its efficacy in particular circumstances, it indicates that competition is now to be given some chance to show what it can do. The amendments are just one sign of an emerging national policy to rely, wherever it is responsible to do so, on the demand side of the market for health services, rather than on regulation, to discipline the market's supply side.

This Article is intended to put in context the many issues raised by this new interest in competition as a disciplinary force in the health services industry. After presenting a statement of the

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** Professor of Law, Duke University. A.B., 1955, Princeton University; J.D., 1958, Northwestern University.

1. Pub. L. No. 96-79, § 103(a), 93 Stat. 594 (amending § 1502(a) of the Public Health Service Act).

general theory supporting increased reliance on market forces, the Article turns to the key arguments advanced against that theory. The issues are many and complex, and the Article makes no attempt to treat them exhaustively. Rather, the aim is to highlight the weak as well as the strong points for and against competition in a manner that focuses the controversy and clarifies the issues.

Until very recently, market advocates could responsibly discuss competition only in a general way, emphasizing its many substantial strengths in comparison to regulation's weaknesses. Now that the goal of reopening the policy debate has been achieved, however, market advocates have an increased responsibility to address the hard questions, which have previously been treated in footnotes or in theoretical pieces that escaped widespread attention. By the same token, the advocates of regulation now need to admit its problems and to approach the market in a more constructive way, seeking both a better understanding of how the market can function and solutions that do not too readily sacrifice the market's strengths. This Article, then, is concerned principally with establishing how competition can be used to obtain better performance from the health services industry. That is, at the moment, the key issue in health policy.

II. Common Themes of Market Advocates

Informed advocates of a market-oriented strategy do not all view issues in precisely the same way. Significant differences exist, for example, regarding the need for regulation to structure and limit the range of consumer choice in order to improve the intelligibility of choices and to prevent improvident ones. There are also some disagreements over how the transition to a more competitive market should be made, particularly whether a single comprehensive legislative enactment is necessary. Despite these differences of tactics and emphasis, however, many common themes run through the thinking of market advocates that can be usefully reviewed to discover the essentials of the market approach.

Market advocates have often argued their case by painting a rosy picture of what a competitive health care system would look like. Their visions of competing delivery systems, each priced according to its costs and chosen by consumers on the basis of quality, cost, and other factors, are beguiling and have attracted policymakers' interest. Though highly speculative, such scenarios have been a natural response to the claims of regulation advocates, who, because they recommend direct command-and-control interven-

tion, can promise specific and concrete results. Advocacy-by-scenario has also been helpful in communicating the competition idea to audiences that have only an imperfect grasp of the underlying theory. Nevertheless, this "rosy picture" way of presenting the market strategy has the disadvantage of inviting challenges over whether the advocates' predictions—for growth of health maintenance organizations (HMOs), for example—would really come true and whether people would really be better off if they did. Market advocates have adopted this style of advocacy largely because the health care world is unfamiliar with competition and perceives it as either a radical or a reactionary idea. The resulting need to portray competition in attractive and nonconceptual terms helps to explain both why most discussions of competition quickly focus on the prospects and merits of HMOs and why the market strategy sometimes sounds simplistic and utopian.

Although my own advocacy of greater reliance on competition has also included some speculation about how the market might deal with the cost problem if given a chance, I have tried to emphasize the need for competitively inspired experimentation with new techniques and to disavow predictions or prescriptions.[2] To my mind, it has seemed vital to stress, not the probable *outcome* of competition, but the *process* by which a particular allocation of resources is arrived at. The competitive process, if it does in fact allow people to reveal the strength of their varying preferences, goes far toward legitimizing market outcomes—even if they are not to some experts' or policymakers' liking. Although other market advocates[3] would probably agree with the ethical judgment implicit in my preference for consumer (rather than political) choice as the best guide to the public interest in this complex field, they are usually not as explicit about such matters. Nevertheless, they too focus first on the cost problem as a candidate for public or private attention and then on the relative efficacy and attractive-

2. Havighurst, *Private Cost Containment—Medical Practice Under Competition,* in SOCIOECONOMIC ISSUES OF HEALTH, 1979 at 41 (G. Misek ed.); Havighurst, *Professional Restraints on Innovation in Health Care Financing,* 1978 DUKE L.J. 303, 321-34; Havighurst & Hackbarth, *Private Cost Containment,* 300 NEW ENG. J. MED. 1298 (1979).

3. Of course, a complete list of market advocates cannot be presented here, but any list must include Professor Alain Enthoven of Stanford University School of Business and Paul Ellwood, M.D., and Walter McClure, Ph.D., of InterStudy, a Minneapolis health policy research group. Also meriting special mention is David Stockman, formerly a congressman from Michigan and now Director of the Office of Management and Budget in the Reagan Administration. Mr. Stockman was instrumental in introducing the market strategy into the health policy debate in Washington.

ness of the various political and market processes for registering individual preferences with respect to health care spending.

A. *Major Problems in Health Policy*

1. Complex Benefit/Cost Tradeoffs

The central fact bedevilling health policy is the existence of extraordinarily complex quality/cost tradeoffs, and the central policy issue is how these tradeoffs are to be addressed.[4] Each encounter between a patient and the health care system presents a unique set of problems. The risks and probability of medical benefits vary widely from case to case, as do the circumstances and preferences of the individuals involved. At each stage of diagnosis and treatment, as well as in the design of myriad system inputs, a multiplicity of choices are presented, many of them extraordinarily complex when viewed in benefit/cost terms. Not only are large dollar costs involved, but, on the benefit side, great uncertainties exist concerning everything from diagnoses and the efficacy of some major therapies to the value of the specific health benefit sought. At the margin, decisions about whether to provide a little more, or a little better, service constantly encounter the law of diminishing returns.

The cumulative effect of the multitude of provider and patient choices—both the big choices, such as whether to make a major capital investment or to initiate a costly therapy, and the little ones, such as whether to provide added increments of quality or service—is of immense social significance. Health policy analysts have come to believe, on the basis of impressions, theory, and both anecdotal and statistical evidence, that removing cost from the calculus of providers and patients has caused systematic neglect of important tradeoffs and a severe misallocation of resources. Although we have no clear idea how much money is excessively spent on health services or even whether an ideal system would in fact spend less, we do know that the system that has yielded the present allocation of resources is not one that reliably translates individual or societal preferences into provider and patient behavior. Health policy is concerned with discovering and instituting a sys-

4. Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 9-20 (1975). Other analysts also recognize that the problem is not simply the elimination of fat or waste—that is, purely unproductive expenditures. *See* L. RUSSELL, TECHNOLOGY IN HOSPITALS 1-6 (1979); Schwartz & Joskow, *Medical Efficacy Versus Economic Efficiency: A Conflict in Values*, 299 NEW ENG. J. MED. 1462 (1978).

tem that succeeds in capturing all the relevant factors and in translating them into performance. Market advocates believe that restoring crucial links between consumption and spending will allow private incentives to discipline the system and thereby legitimize the system's performance and its claims on resources. They believe that competition is the best way to transmit roughly correct signals to the participants in crucial spending decisions and to communicate consumer preferences concerning complex tradeoffs to the prescribers and providers of services.

2. Ineffective Regulation

Market advocates doubt that the highly personal, highly individualized business of prescribing, providing, and consuming health services is amenable to effective regulatory control. Their instincts are confirmed by the fact that attempts to impose artificial constraints on the market have generally failed to achieve appreciable cost containment. The disappointing results of efforts to limit the supply of capital facilities (through certificate-of-need laws)[5] and the flow of funds to hospitals (through hospital rate or revenue controls)[6] seem to have been politically inevitable, a reflection of the public's misunderstanding of any effort to ration health care. I have propounded the theory that regulation cannot afford to be sensitive to claims of "need" or "quality of care" precisely because regulators operate in a political environment.[7] That environment, while supplying few cost-containment incentives, threatens to penalize any apparent weakness in adherence to symbolic health goals. Lacking a solid methodology for making benefit/cost tradeoffs, regulators cannot consistently say "no" to facilities and services that would be nice to have or to spending that is directly linked to "quality" or a desirable service.

If it is to be effective in containing costs, regulation must be arbitrarily unconcerned in any specific way with needs, quality, and tradeoffs. This view was confirmed by the use of arbitrary

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5. *See, e.g.*, D. SALKEVER & T. BICE, HOSPITAL CERTIFICATE-OF-NEED CONTROLS 51 (1979); Sloan & Steinwald, *Effects of Regulation on Hospital Costs and Use*, 23 J.L. & ECON. 81, 83-85 (1980).

6. *See, e.g.*, Ginsburg, *Impact of the Economic Stabilization Program on Hospitals*, in HOSPITAL COST CONTAINMENT 293 (M. Zubkoff, I. Raskin & R. Hanft eds. 1978); Sloan & Steinwald, *supra* note 5. *But see* Biles, Schramm & Atkinson, *Hospital Cost Inflation under State Rate-Setting Programs*, 303 NEW ENG. J. MED. 664 (1980); F. Sloan, Regulation and the Rising Cost of Hospital Care (1980) (unpublished paper on file with the author).

7. *See* Havighurst, *Health Care Cost-Containment Regulation: Prospects and an Alternative*, 3 AM. J.L. & MED. 309, 313-15 (1977).

mathematical formulas in the Carter Administration's hospital cost-containment proposal[8] and the national health planning guidelines.[9] More recently, arbitrary budget cutting, justified by references to a hemorrhaging federal budget, has shown the cost-saving potential of insensitivity in many fields. Despite its potential effectiveness, however, arbitrary regulation is basically unattractive in a pluralistic society and thus politically untenable. The ultimate arbitrary cost control is, of course, the fixed-budget approach to health care financing, which has been proposed both for capital expenditures and for the entire health care system under variations of the British model.

To the market advocate's mind, complex tradeoffs of the sort encountered in medical care cannot be addressed well in a politicized system in which even unproved benefits have high symbolic value, costs are hidden, and interest groups possess the balance of power on specific choices. Imperfect as it may always be, the competitive market represents, potentially at least, a situation in which consumers can see the benefits of economizing in tangible terms and in which each economizing choice benefits the individual involved rather than a governmental or some other deep pocket. Indeed, only when most of the benefits and costs of economizing behavior accrue to or are borne by the same party can one reasonably hope that the symbolism that pervades the health care enterprise will not unduly dominate decisionmaking. It is the sense that private decisionmaking can better cope with difficult tradeoffs—"tragic choices" that would be demoralizing to the body politic[10]—that leads market advocates to believe that they have found a better way.

3. Artificial Obstacles to Market Efficiency

Market advocates have focused primarily on the private sector and its failings rather than public sector health programs. The market strategy proceeds from a belief that consumers did not

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8. *See* S. 570, 96th Cong., 1st Sess., 125 CONG. REC. 2187 (1979); H.R. 2626, 96th Cong., 1st Sess., 125 CONG. REC. 1106 (1979); S. 1391, 95th Cong., 1st Sess., 123 CONG. REC. 12179 (1977); H.R. 6575, 95th Cong., 1st Sess., 123 CONG. REC. 12082 (1977). The arbitrariness of the Carter cost-containment proposal was the primary reason Congress received it unenthusiastically. Ultimately, the House of Representatives voted down even an amended version of the proposal riddled with exceptions and qualifications. 125 CONG. REC. H10809 (daily ed. Nov. 15, 1979).

9. 42 C.F.R. §§ 121.1-.211 (1980).

10. G. CALABRESI & P. BOBBITT, TRAGIC CHOICES (1978).

willingly surrender their spending discretion to providers but instead were prevented by artificial constraints from revealing their true wishes. With this perception, the market advocate looks for important changes to occur following the removal of some or all of the obstacles that have prevented the market from working well in the past. As developed below, the most substantial of these obstacles include: unwise tax subsidies for the purchase of private health insurance; restraints of trade imposed by providers on each other and on innovative prepayment plans; the purchase of insurance by employers and unions fearful of appearing to economize at workers' expense; government financing programs and reimbursement policies; and regulation itself. Each of these specific demand-distorting or supply-inhibiting factors is deemed by market advocates to be substantially remediable by relatively straightforward actions that government might take. For this reason, market advocates are not put off by the charge that the market has already failed; instead, they see great potential for private sector change resulting from policies that alter incentives and restore bargaining opportunities and power to consumers.

Market advocates do not accept the argument that the health services industry is in some technical respect unsuited for discipline by market forces. Rather, they see numerous opportunities for consumers to have their interests effectively represented by agents who assist them in purchasing wisely, in curbing exploitation of the insurance funds, and in forcing providers to compete in the sale of their services. Providers long ago perceived grave dangers to themselves from the introduction of private health insurance. They feared that health insurers, if permitted to act as consumers' purchasing agents, would introduce powerful competitive forces into providers' markets,[11] and they took steps that effectively prevented insurers from assuming an active role.[12] Market advocates are surprised that so many nonprovider observers are so thoroughly conditioned by decades of experiencing only provider-approved forms of insurance and of accepting provider versions of the issues that they fail to see this same competitive potential.

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11. *See, e.g.*, COMMITTEE ON THE COSTS OF MEDICAL CARE, MEDICAL CARE FOR THE AMERICAN PEOPLE 163-68 (1932) (referenced pages are part of a minority report filed by representatives of organized medicine).

12. For an extensive discussion of this thesis, see Havighurst, *Professional Restraints on Innovation in Health Care Financing*, *supra* note 2.

4. Public Financing as a Subsidiary, but Not an Unimportant, Issue

Market advocates have only secondarily addressed public programs—Medicare and Medicaid—largely because they perceive them as having been modeled after those same private insurance plans that have failed adequately to address the cost problem. While advocates of increased regulation have long anticipated a future dominated by expanded public financing programs and a gradual reduction of the private health plans' role, recent developments in the national health insurance debate have borne out competition advocates' view that private financing mechanisms continue to be important. Not only do recent proposals, particularly Senator Kennedy's,[13] preserve a substantial role for private insurance and competition, but the shortage of federal resources to launch new spending initiatives has also caused health policy increasingly to focus on the private sector's actual and potential performance.

The apparent disinterest of market advocates in public programs is sometimes interpreted as lack of concern for the beneficiaries of those programs and for the large number of other citizens whose health needs are not well met. Moreover, because the market's reliance on willingness to pay would necessarily give rise to consumption differences reflecting ability to pay, the market advocate is again vulnerable to the charge of neglecting social justice. The initial defense offered is that a market-oriented system does not preclude equity. It may be necessary, however, in a market system for government subsidies to be supplied not through direct financing and reimbursement programs but by assisting public beneficiaries to purchase private financial protection. Market advocates view a voucher-type system, embodying approaches similar to those in the most recent Kennedy proposal, the Enthoven Consumer-Choice Health Plan,[14] and the pending HMO option for Medicare beneficiaries,[15] as a promising idea capable of meeting social goals by strengthening rather than undercutting competition. Now that the voucher system is potentially available, market advocates can claim that restoration of vigorous price competition

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13. *See* S. 1720, 96th Cong., 1st Sess., 125 CONG. REC. 12048 (daily ed. Sept. 5, 1979).

14. Enthoven, *Consumer-Choice Health Plan* (pts. 1-2), 298 NEW ENG. J. MED. 650, 709 (1978). *See also* A. ENTHOVEN, HEALTH PLAN (1980).

15. *E.g.*, H.R. 2508, 97th Cong., 1st Sess., 127 CONG. REC. 941 (daily ed. March 12, 1981). The HMO option for Medicare is discussed in text accompanying notes 16-18 *infra*.

in the private sector would actually facilitate new government actions to meet promises long unfulfilled.

In answer to the claim that basing health care on ability to pay creates inequalities, it can be observed that public subsidies can shift substantially the margin at which lower income people will confront a serious cost constraint. Moreover, some regulation of the choices made available to public beneficiaries would be appropriate to prevent severe or frequent hardships. On these grounds, it can be asserted that a market system would not be incompatible with at least some commonly held views of social justice. Those who would object to the residual inequalities would seem to have the burden of overcoming competing ethical views concerning the value of individual choice and responsibility, the evidence that equality may not be achievable in fact, and the argument that efficiency counts too.

B. Market-Inspired Approaches to the Cost Problem

1. Health Maintenance Organizations

From the beginning, the market strategy for dealing with health care costs has been closely identified with the HMO movement. This equation of HMOs and competition has occurred naturally for two reasons: first, HMOs are the most tangible and substantial competitive development thus far, and second, competition advocates have found it helpful to refer to HMOs to illustrate their theories. Treating HMOs as synonymous with competition, rather than as merely one example of it, has, however, also served the interests of some important groups opposed to the market-oriented approach. For example, government officials and those who look primarily to government for valid reforms have been comfortable with HMOs because they have been federally sponsored since 1973[16] and might be claimed as a success of government rather than of the market. More ominously, as long as group-practice HMOs are the only recognized vehicle for importing competition into health services, the competitive threat to the medical profession is effectively isolated and can be more readily combatted by local providers.

While federal support for HMOs may have legitimized and encouraged one type of innovation, it may have discouraged others,

16. Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e to 300e-17 (1976 & Supp. III 1979).

and therefore prevented vigorous competition from occurring. Indeed, traditional but inefficient financing mechanisms may actually have gained legitimacy from the presence of a federally approved alternative whose stated merits seemed to confirm that third-party insurers' payment methods could not be expected to change. Thus, the HMO movement may have given health insurers a convenient excuse for not competing in ways that would alter their basic product. Further, HMOs themselves, while they appear to be instruments of change, have been quite satisfied to face potential competition only from other HMOs. It is thus possible that, in subtle ways, the HMO movement has served to confine and limit competition as much as to foster it and that HMO development has been primarily an innocuous exercise in pluralism, emphasizing the availability of a nice alternative rather than real, hard competition. Certainly the dual-choice provisions of the Federal HMO Act[17] carry a strong implication that a single independent HMO is all that a community requires. Acceptance of HMOs sponsored by organized medicine also suggests that the government has been more interested in organizational reform and the expansion of choice than in competition.

Market advocates have recently sought to expand the discussion to give competitive innovations other than HMOs equal credence in order that HMOs will be viewed as simply one species of the innovations that might occur in a competitive market. The debate over competition in the health care sector has now reached the point at which it is most important to recognize that the cost-containment problem confronts, and can and should be addressed by, health care plans of all types. The key insight is that the cost problem is attributable to the monopolistic freedom enjoyed by providers in their pricing and output decisions. Providers' discretionary power can probably be addressed fully and effectively only if there is active bargaining—that is, competition—at the crucial interface between individual health plans on the one hand and individual providers on the other. In order to appreciate the potential of this market, however, one must begin by conceptualizing the cost-containment problem as a whole rather than by settling upon some particular solution, such as the HMO model. Competition is, after all, a dynamic process, not a thing, and its most prominent feature, which is also a reflection of its greatest strength, is that its achievements cannot be predicted reliably in advance. While one

17. 42 U.S.C. § 300e-9 (1976 & Supp. III 1979).

can make guesses about the directions in which competition-induced change would take us, it is dangerous to try to sell competition on any basis other than the argument that promising opportunities for innovation exist and that consumers should have the chance to buy in a market that encourages efforts to serve them better.[18]

2. Explicit Exclusions from Coverage in Private Insurance

Cost containment in an insurance or other risk-sharing and cost-hiding plan is essentially an administrative problem. In a competitive market, cost-containment measures would have to be acceptable to both patients and providers, each deciding for himself whether to participate in a particular plan. As a conceptual matter, an insurance plan is not in the business of providing services and can deal with costs only by varying its coverage—that is, its contractual commitment to pay particular expenses. It can limit coverage on dollar lines by imposing copayments, deductibles, and policy limits on what it will pay in the aggregate or in particular circumstances. Alternatively or additionally, a plan can limit its obligation to pay for particular services, some of which might be totally or partially excluded from coverage because they are so highly discretionary in particular cases (and thus so prone to the effects of moral hazard[19]) that to insure fully against the need for them would be too costly. Yet another way to curb patient-provider discretion in spending the insurer's funds would be to agree to pay for a service only under specified conditions. For example, the insurer might require that it be given an opportunity to determine in advance the extent of its responsibility to pay for recommended hospitalization or treatment.

These cost-containment strategies available to insurers would present various administrative difficulties, and the costs of overcoming these would, in a competitive climate, be relevant to the decision whether to adopt particular measures. Nevertheless, when such techniques could be introduced at reasonable cost, consumers might find the lower premium to be advantageous despite the greater exposure to certain risks. In a competitive market, one would expect to find a great deal of experimentation with such

18. For further development of this thesis, see Havighurst & Hackbarth, *supra* note 2.

19. "Moral hazard" is the term economists assign to the propensity of patients and physicians to consume more resources and services when they know an insurer or other third-party payer will pay the resulting bill.

cost-containment techniques.

Because explicit exclusions from insurance coverage would be difficult to administer without provider cooperation, one could expect that insurers would enter into contractual understandings with providers. Under such participation agreements, providers would become obligated to disclose potential costs to the patient and to submit certain cases for prior authorization or predetermination of benefits. In a competitive world, some providers would accept such agreements, while others would not; all providers, however, would have a competitive incentive to agree to such limitations because they would thereby become more attractive to the plan's beneficiaries. An insurer might exclude services provided by nonparticipating physicians and hospitals from coverage altogether, or it might simply pay for their services on a less advantageous basis, reflecting the higher costs that their uncooperativeness creates for the plan as a whole.

3. Closed-Panel or Preferred-Provider Coverage

Rather than exclude certain services from coverage, an insurer might exclude providers, limiting its coverage to services obtained from a closed set of physicians or hospitals, such as a prepaid group practice, an IPA,[20] or a "health care alliance."[21] By extending eligibility to render covered services only to efficient providers who are perceived to render and prescribe only services that are worth their costs, the plan could effectively limit its coverage of questionable items without explicitly excluding specific services. These plans closely resemble HMOs and would qualify as HMOs under some definitions, but their more important characteristic is

20. An "individual practice association" (IPA) is a group of physicians who practice independently of one another but who through the association contract with a health plan to provide medical services to the plan's enrollees. The contract specifies the terms of payment (usually fee-for-service) and utilization controls; under the contract, the physicians may also agree to bear some of the financial risk from an unexpectedly high utilization of services.

21. A "health care alliance" is a set of physicians and perhaps a hospital selected by an insurer to provide health care to the insurer's enrollees. The premium paid to the insurer by the enrollees reflects only the costs generated by that set of participating providers, not those of the provider community at large as in the case of a conventional open-panel health plan. A provider participating in a health care alliance retains the same patients as he had before joining the alliance; he also practices in the same location and receives payment in the same way. The only difference is that the underwriter evaluates the cost of the participating providers separately and assigns coverage for their services to a separate premium. Thus, services of the participating providers are marketed independently from those of other providers.

that they divide the provider community into competing groups. A similar effect can be obtained if the plan identifies "preferred providers" and, instead of requiring that all covered services be obtained from them, simply gives subscribers an economic incentive to patronize the efficient group.[22] The plan could provide such an incentive, as in prescription drug prepayment plans,[23] by paying for services obtained from other providers on a less advantageous basis—requiring a larger copayment from subscribers, for example.

Many consumers would, of course, prefer never to confront the hard choice of whether to spend their own money on services that were not fully covered by insurance and about which the physician was uncertain or to forgo the service. Indeed, one seldom noted advantage of the HMO model is that it presents the consumer with few such choices, leaving medical determinations to the providers themselves. One would suppose, however, that consumers would have varying reactions to giving up their freedom of choice about how much to spend on a specific health need. A competitive market would allow a consumer to elect whether to put himself entirely in the provider's hands, as in an HMO, or to purchase a plan that preserves his discretion to choose what he wants with professional advice and the costs in view.

The closed-panel or preferred-provider model, like explicit exclusions from coverage, would be greatly facilitated by the use of provider participation agreements. Indeed, such agreements may be very nearly essential both to cost-conscious health plans and to a competitive system in which organized plans, competing among themselves to keep factor prices low, force providers into unwanted competition. It is possible, however, that an insurer, having identified a group of providers—a multispecialty group practice, for example—whose charges, efficiency, and style of practice assure lower costs, might offer individual insureds a lower premium or broader benefits if they agree to confine their patronage to such providers. In this way, providers might be put at risk and forced into competition even without their consent. Perhaps other creative techniques might also be developed. In general, it will be observed that potential innovations in financing and delivery lie at numerous points along the inadequately explored spectrum between traditional insurance and service-benefit plans on the one hand and group-practice HMOs on the other.

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22. A plan using this technique may be called a "preferred provider organization."
23. *See, e.g.*, Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

C. Summary

This brief discussion suggests that the redesign of private health care financing is both possible and promising as a way to reduce the heavy burden of moral hazard that is carried by medical insurance. The market strategy is based on the belief that if cost-conscious consumers can purchase health plans in a competitive market, they will transmit to insurers, who will in turn transmit to providers, their concern about health care costs. An insurer's objective in such a market would be to contain costs while preserving essential coverage and providing the patient with access to providers of acceptable quality.

Providers, too, would be able to operate free of external constraints in such a market, except that they would be accountable to consumers for the costs and other conditions of care. Thus, efficiency would be rewarded. Moreover, the continuing opportunity for both lay and provider entrepreneurs to organize new alternatives should assure both consumers and providers that their various needs and preferences will continue to be served. At the same time, a competitive market requires its participants to adapt to changing needs and preferences and to experiment with new ways of balancing constantly changing competing factors. These features of competition, which make it a workable and sensitive means of addressing the central problem of tradeoffs, give it a strong claim to play a central role in allocating resources in this unruly industry.

This review of the conceptual foundations of the market strategy leaves many questions unanswered. The remainder of this Article indentifies the issues and arguments that have been or might be raised in opposition to a procompetitive policy, and sketches the market advocates' response to those challenges. Since the aim is to touch generally on a comprehensive range of problems, identified issues are treated in a highly abbreviated fashion. Some of the responses will be less satisfying than others because, although some of the issues are largely false ones, others are real, and some important uncertainties do exist. My belief is, however, that once the market advocates' positions are clarified, the range of misunderstanding and disagreement will be reduced.

III. Claimed Problems with the Market Approach

A. Objections to Market Theory

Many authorities believe there are numerous technical

problems inherent in the marketplace that make it unlikely that it could function well in allocating resources to and within the health services industry. The following discussion presents and rejects the most common criticisms of the market approach.

1. The health services industry does not fit the textbook model of a competitive market.

Certainly the health services market is unusual in many respects. Third parties pay the bills for many highly discretionary services, and consumers find it difficult to know in advance what they are buying. The fact that the health care industry deviates from the textbook model of competition is unimportant, however; the textbook model of regulation is also unfulfilled—as earlier discussion of regulatory politics has shown.[24] Thus, rather than reject the market because the industry is not perfectly suited to it, the proper inquiry is to compare imperfect competition with imperfect regulation. The fact is that many less than perfect markets function rather well over the long term, featuring a dynamism and adaptability that are quite impressive compared to those qualities in regulated markets.[25] None of the health care market's imperfections amounts to a true market *failure* of the sort that textbooks recognize as a justification for regulatory intervention.

2. Consumers are ill-informed about medical services.

Consumers are strongly motivated to, and often do, finds ways of coping with their ignorance of medical services. Their best strategy is to select knowledgeable agents to help them make decisions about technical matters, and clearly the physician serves the patient in this professional capacity. In a competitive environment, consumers will have new needs for information, particularly about costs, and the market strategy contemplates that market forces will stimulate the production of needed information both in the form of advertising and in the form of more cost-sensitive professional advice. Because "free rider" problems do reduce the quanti-

24. For more general discussion of how real world regulation differs from the model of regulation, see Schuck, *Regulation: Asking the Right Questions*, 11 NAT'L J. 711 (1979); Wolf, *Theory of Nonmarket Failure: Framework for Implementation Analysis*, 22 J. & ECON. 107, 132-38 (1979).

25. An overview of the economic theory of market concentration and some of the pertinent empirical literature can be found in R. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF 178-97 (1978).

ty of information generated in a free market,[26] however, government has a legitimate role in generating additional information.

Under competition, physicians will ultimately organize, or be organized into, competing groups, with the result that consumers' choices will be simplified. Each group, in attempting to earn a reputation for giving good quality care at a low cost, would act, in effect, as the consumer's agent in selecting providers. Paradoxically, although the consumer in such a market would have fewer options, competition would be more intense because comparative information would be available on the competing groups and choices would thus be more informed. It is possible to understand the medical profession's historical opposition to group practice only if one appreciates consumers' difficulty in buying intelligently in markets that are so fragmented that their individual experiences are unlikely to overlap, making useful comparative evaluations difficult to obtain.

3. Shifting the cost burden to consumers is unlikely to reduce health care costs, since it is physicians who make health care decisions.

Just as nonprice competition has encouraged doctors not to economize, competition that occurs with costs in view can alter behavior in the other direction. As things have stood, physicians who appeared to economize in spending third parties' money lost patients, and physicians naturally developed a sense that economizing that did not benefit the patient was unethical. Physicians, however, did, do, and will behave differently when costs matter to the patient, and indeed they have already proved to be quite creative in economizing when they perceive it to be part of their professional service. Of course, fraud is always possible, but there are innumerable influences that should curb its incidence. Moreover, if patients perceive fraud by fee-for-service doctors to be a problem, they can resort to more organized plans, such as HMOs. Building on the traditional doctor-patient relationship is the best strategy to reduce costs, for physicians are likely to change their style of

26. Economists apply the term "free rider" to those individuals who benefit from the productive efforts of others without having contributed themselves. Because they can benefit without paying, free riders do not compensate the productive firm for its efforts, and therefore deny the firm its just reward. If there are many free riders, the productive firm may not be able to earn enough to justify its efforts. Free riding is particularly common when the firm's product is information, since it is difficult for a firm to control the dissemination of information and thus to limit its use to paying customers.

practice substantially only when they perceive that it is in their patients' interest—and thus in their own competitive interest—to do so.

4. Consumers are ill-informed about insurance.

Most consumers are now grouped in ways that allow them to obtain expert assistance in choosing insurance packages, and this feature of the market should be preserved. Under the multiple-choice approach for example, employers and unions would screen the choices presented to individuals. While there is a great deal of sentiment for prescribing minimum benefit packages as a protection against consumer mistakes, it would be a serious policy error to substitute regulation for group choices. Such regulation would deprive insurers of the opportunity to vary coverage as a method of cost containment, a strategy that seems to me to have great promise. Although some regulation of the scope of individual, as opposed to group, coverage would probably be appropriate, one would hope that the market for group coverage rather than regulators' own preferences would provide the main reference point for determining which exclusions from coverage are tolerable.

5. The third-party payment system impedes market functioning.

The problem is not third-party payment as such but the way in which it is designed and administered. Currently, Americans have too much of the wrong kinds of insurance. As noted above, in a truly competitive market, health insurance plans would look significantly different. Indeed, they might not be insurance in the technical sense at all. Decisions about spending the insurer's money would be subject to substantial conditions imposed in the interest of the insurance fund and those who contribute to it.

6. The prevalence of nonprofit firms impedes market functioning.

Even nonprofit firms have to break even, and they like to earn enough profits to finance desired growth. On the other hand, although they do respond to basic market signals, they are slower to enter and to leave the market than for-profit firms, which respond more quickly to profit potential and seek to conserve their owners' capital when the enterprise is failing. More serious than the somewhat unusual incentives of the nonprofit firm, however, are the

special advantages conferred on them by government, mostly in the form of tax benefits. Because nonprofit firms enjoy these competitive advantages, innovative for-profit firms may be reluctant to enter a market in which nonprofit firms are present. Finally, the nonprofit firm lends itself to domination by those whose interests lie not in advancing the firm's own welfare but elsewhere—perhaps in preserving the noncompetitive status quo in provider markets. The antitrust laws are being invoked to deal with some egregious manifestations of this problem.[27]

It seems unlikely that the market would be disabled by the presence of nonprofit firms if they did not enjoy special government-conferred advantages. The nonprofit form of organization can best be understood in health care settings as a legal device allowing a firm to give its customers some assurance that their welfare will not be sacrificed to the profit motive.[28] Once adoption of the nonprofit form is understood as simply a marketing strategy, no good reason exists why government should subsidize the firms that adopt it.

7. Even if the market works in urban areas, it will fail in rural areas where providers are few in number.

To begin with, rural areas present few cost problems at the moment. Moreover, they should benefit from competition in urban areas because physicians whose market opportunities in the cities are increasingly constricted will spill over into less populous areas.[29] Many new rural practitioners will be agents of organized health plans, and their close ties to efficient systems promise improved quality and lower cost. In addition, residents of rural areas already face monopoly in many forms, and it should not be crucial that providers' monopoly power might be somewhat greater in rural areas. Most rural hospitals are nonprofit institutions, and excess profit normally will be plowed back into services. More impor-

27. Settlement Agreement, Ohio v. Ohio Medical Indem., Inc., No. C-2-75-473 (S.D. Ohio, settled March 22, 1979) (on file with the author). *See also* FEDERAL TRADE COMMISSION, STAFF REPORT ON PHYSICIAN CONTROL OF BLUE SHIELD PLANS (1979) (proposing that physician organizations he harred from controlling nonprofit health plans such as Blue Shield because those plans can be used to attenuate price competition in the market for physician services).

28. *See* Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1417, 1447 (1980); Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 844 & n.34 (1980).

29. *See also* Schwartz, Newhouse, Bennett & Williams, *The Changing Geographic Distribution of Board-Certified Physicians*, 303 NEW ENG. J. MED. 1032 (1980).

tantly, the relevant market within which to assess monopoly power varies greatly with the service in question. For those services that are extremely expensive and present the greatest cost problems, the market area in which rural residents would shop is much larger than a single community. In such a case, it is of little consequence that the local health services market is monopolistic.

8. The market has failed already.

Perhaps the greatest fallacy of all is that consumers have already indicated the kind of health insurance they want—namely, comprehensive coverage without appreciable cost controls. The market evidence on this score is misleading because consumers have never been offered a full range of options under conditions calculated to reveal their true preferences. The factors that account for the market's failure to offer a full range of choices also suggest the solutions that should be adopted. As discussed more fully below, the market's poor performance can be persuasively attributed to the tax laws, private restraints of trade, the fact that unions and employers rather than individuals purchase health insurance, the design of government financing programs, and regulation itself. The striking thing about this list is that every problem it identifies—and any other problems are de minimis—can be remedied by legislation, regulatory reform, or antitrust enforcement. Later discussion elaborates the remedies required. Until such remedies are imposed, it cannot be claimed that the market has had its chance.

B. Doubts About the Anticipated Increase in Competition Among Health Plans

1. Health insurers already compete actively among themselves; thus, one should not expect much benefit from increased competition.

Although the health insurance industry is quite competitive in some respects, insurers still do not compete very actively in the purchase of their product's most important inputs—namely, providers' services. Insurers do compete over benefit packages, service, and administration, as well as in risk selection. They do not, however, bargain with providers over price and utilization controls—except by occasionally negotiating with a medical society. Placidity rather than competition prevails at the interface between plans and providers primarily because providers have in the past

collectively and effectively prevented insurers from acting as consumers' agents in procuring providers' services.[30] It is likely that antitrust enforcement aimed at provider-imposed restraints and provider collective bargaining will permit cost-conscious insurers to compete in enlisting providers' services on favorable terms and will thus trigger competition among the providers themselves. Pressure on insurers from newly cost-conscious employers is already beginning to force cost-containment moves.

2. Since only a few health plans may compete in any given market, competition cannot be vigorous.

In industrial settings, a scarcity of competitors impairs the intensity of competition only when products are homogeneous and opportunities for secret price-cutting and service competition are few. Competing health plans will find it very difficult to collude effectively because their services are heterogeneous and competition can take so many different forms. Government-sponsored collusion and regulatory suppression of certain types of competition may, however, impede vigorous competition. Thus, health planning agencies, which have troublesome cartel features, could allocate geographic and service markets and prevent the introduction of new services. Also, profession-sponsored Professional Standards Review Organizations (PSROs), acting in the name of quality, could undermine plans that introduce cost-saving innovations; indeed, giving providers any self-regulatory role raises the possibility that those powers will be used selectively to discipline those who compete too aggressively.[31] Finally, government regulation of benefit packages and pricing practices, particularly insistence on community rating,[32] could easily reduce health plans' competitive flexibility to a point at which explicit or tacit collusion on price would be a real danger.

Beyond these considerations, one must consider how entry conditions might affect oligopolistic behavior. Although entry into the HMO market has been costly and time-consuming, it should become easier in the future. Also, once competition becomes more

30. For a detailed discussion of this thesis, see Havighurst, *Professional Restraints on Innovation in Health Care Financing*, *supra* note 2.

31. *See* Havighurst & Bovbjerg, *Professional Standards Review Organizations and Health Maintenance Organizations: Are They Compatible?* 1975 UTAH L. REV. 381, 401-11.

32. A health plan "community rates" its coverage when it charges all enrollees the same premium for the same benefits, regardless of the individual enrollee's actual health status or actuarial category.

familiar and physicians fall more naturally into competing groups, a commercial insurer with an innovative program to offer needs only a salesman and some local organizers to enter a new market or seek a new account. With capital requirements low and the antitrust laws enforced, potential competitors, threatening to enter the market, should expose incumbents to the discipline of competition.

3. Commercial insurers do not possess sufficient "clout" to challenge providers.

Insurers, assuming that they must deal with the medical profession as a whole, claim that they do not have sufficient market power, acting independently, to challenge physicians. To remedy this perceived deficiency, the commercial insurance industry has sought an antitrust exemption to allow them to bargain collectively with physician organizations. The insurers' diagnosis and suggested remedy reflect not only their past experience with organized medicine but also their own preference for not competing among themselves in the procurement of inputs. With the antitrust laws acting as a new deterrent to concerted action by the profession, however, insurers are now much freer to impose special requirements. Instead of giving insurers the right to bargain collectively, antitrust enforcement should drive home the fact that collective bargaining by providers as well as insurers violates the law. Then countervailing power on the buyers' side of the market will not be necessary.

Certainly insurers would prefer not to challenge the medical profession, and their frequent statements that they are doing all they can about health care costs may be simply an exchange of assurances that they will not embark on a competitive course disruptive to the industry as a whole. Nevertheless, competition forces competitors to do what they would prefer not to do, and it is likely that the health care market will become more competitive as the threat of provider restraints is diminished. It is possible to view the situation in the past as one in which the medical cartel disciplined an acquiescent insurer cartel to the mutual advantage of each.

4. Competitive innovations are too risky for insurers.

Innovation *is* risky for insurers in the current climate. Organized medicine will resist efforts to alter the bargaining relationship between insurers and providers, and antitrust law is not a complete protection against the wrath of the medical profession. Innovation

is financially risky as well. It will be costly for insurers to embark on new programs that require them to negotiate new arrangements with hostile providers, sell innovative plans to employment groups, and introduce new administrative procedures. Moreover, an insurer's successes might have to be shared with its competitors. For example, measures that effectively change the way in which physicians practice may have automatic spillover effects on community standards, thereby reducing other insurers' costs. In addition, competitors can easily imitate the innovator's successful techniques, with the result that, while the innovative firm bears the costs of innovation and of unsuccessful ventures, it cannot hope to gain a major competitive advantage from a successful one.[33] Finally, oligopolistic interdependence might sometimes discourage an insurer from undertaking competitive measures that could disrupt the entire industry.[34] While it is far from clear that the foregoing factors would inhibit all competitive moves, the possibility of sluggishness in innovation must be recognized. Goverment might therefore usefully make demonstration grants to encourage the design and implementation of innovative financing schemes. Perhaps health planners could smooth the way for innovations in local markets by helping to educate employers and employee groups—in effect, bearing some of an innovating insurer's planning and selling costs. It is noteworthy in this connection that health systems agencies (HSAs) have recently been given the new function of "preserving and improving . . . competition in the health service area."[35]

C. *Provider Objections to the Market Approach*

Many providers of health services question the desirability of the market approach and argne that it will have unfair and disadvantageous effects on them and their ability to function effectively. The following discussion examines the concerns of providers and demonstrates that their objections are unfounded.

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33. Professor Mark Pauly was among the first to call attention to the possibility of such spillover effects and imitation and their adverse effect on insurer innovation. M. PAULY, THE ROLE OF THE PRIVATE SECTOR IN NATIONAL HEALTH INSURANCE 30, 37-38 (Health Insurance Association of America pub. 1979).

34. The possibility of such oligopolistic interdependence is discussed in Havighurst, *Professional Restraints on Innovation in Health Care Financing*, *supra* note 2, at 336-42.

35. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, § 103(c), 93 Stat. 595 (amending § 1513(a) of the Public Health Service Act). HSAs are areawide planning bodies created by Congress to help facilitate health planning.

1. Promarket schemes allow insurers to discriminate unfairly against qualified providers.

In a private market, buyers and sellers decide with whom they will deal, and the law does not characterize a private party's decision to deal with one seller rather than another as discrimination. Indeed, such selectivity is the essence of competition, and it would be wrongheaded to deny consumers the right to have their agent select providers for them or to deny efficient providers the opportunity to benefit from their greater attractiveness to consumers. In medical services, the question is not simply a provider's qualifications, as the argument implies, but his willingness to meet the terms offered. In a number of pending antitrust suits, providers are claiming that insurance plans discriminate against them by refusing to pay their higher fees, which they claim are justified by higher quality or better service.[36] While these providers would like to be included in a particular insurance plan's coverage, their proper remedy is in the marketplace, where they are free to organize alternative plans and to compete with those plans that they claim are not providing consumers with the coverage and services they desire.

2. Insurers will exploit providers.

Because many insurers are large, providers fear that the insurers would dominate any open health care market and would use their preponderant bargaining power to exploit providers.[37] Although a monopsonist can sometimes exploit producers, potential exploitation is an unlikely problem in these local markets since providers are highly mobile and have the option of organizing competing plans and marketing them to employers. Providers have invoked the monopsony fear to justify their own collective actions, but it seems more likely that their joint efforts are designed to protect them from competition, not monopsony. In any event, the law now provides remedies for monopsony where it exists[38] and does not permit market power across the bargaining table to justify cartelization.

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36. *See, e.g.*, Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979); Manasen v. California Dental Serv., No. C-75-0329 (N.D. Cal. May 16, 1980).

37. This argument is, of course, a contradiction of the insurers argument, mentioned earlier, that insurers are impotent when dealing with providers.

38. *See* Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

3. Quality of care will suffer.

Many ways exist to reduce costs without impairing quality,[39] and one would expect a competitive system to exploit those opportunities. Furthermore, many aspects of "quality" are unproved, and competition should encourage closer attention to the benefits and costs of many practices and procedures. It must also be acknowledged that quality may be too high in some circumstances—in the sense that consumers would be better off spending their money on other things. In a competitive world, some increments of quality might well be sacrificed on the ground that they are so marginal as not to be worth their cost. On the other hand, a competitive market might do a great deal to improve quality by better organizing the delivery of services and by giving each competing provider group a strong incentive to outperform others. Of course, even while making these positive contributions, competition might also open some doors to poor quality that are currently shut. This problem would undoubtedly be a matter for continuing regulatory and professional attention.

4. Competition will undermine medical education and research.

To a significant though unknown degree, university and some other medical centers depend on monopoly profits to finance educational and research endeavors. In a competitive world these resources would undoubtedly be jeopardized. Nevertheless, the fact that competition will deprive the industry of discretionary funds with which it does things that it regards as desirable is not a sufficient reason to forgo the benefits of competition. Rather, new subsidies must be found to replace at least some of those that might be eliminated by competition. Resorting to other sources of funding would bring heretofore hidden subsidies into the open and would require new social judgments about the appropriateness of each. Society may be unwilling to continue subsidies at the rate they have been involuntarily provided in the past, and some worthy activities may in fact go unfunded. Moreover, significant transitional problems would occur because one set of funds might dry up at a rate that is not offset by the provision of new money. In the final analysis, while the market strategy should not be rejected simply because of the problems it will create, market advocates

39. *See, e.g.*, Enthoven, *Shattuck Lecture—Cutting Cost Without Cutting Quality of Care*, 298 NEW ENG. J. MED. 1229 (1978).

have some obligation to support efforts to replace the desirable cross-subsidies that competition eliminates.

5. Federal subsidies to HMOs are not justifiable in a free market.

Physicians are particularly critical of federal subsidies to HMOs, which they regard as a cornerstone of the promarket strategy. In fact, market advocates have not actively favored such subsidies. Nevertheless, a strong case can be made that, given the substantial barriers to entry that the medical profession artificially created and long maintained against HMOs, a federal effort to overcome those barriers was justified. It is arguable now, however, that HMO subsidies are no longer needed but that other forms of needed innovation should receive similar encouragement, particularly in view of the impediments to insurer innovation noted earlier.

6. Antitrust enforcement undermines the medical profession's efforts to control costs.

The antitrust laws are based on the premise that competition will solve market problems in due course. Even if this assumption is incorrect in a particular situation, Congress must create any exceptions to the law's requirements, and so far it has not seen fit to do so in the health care industry. It is no reflection on the sincerity of those professionals who have attempted to upgrade the profession's overall performance to observe that they are operating in violation of fundamental antitrust principles.[40] Despite what may well be worthy purposes, these providers, in thinking of the profession as an entity, have been proceeding on a monopolistic premise rather than a competitive one, and the nation seems no longer willing to rely on a benigu monopoly to define and supply its health care needs. Instead, we are embarking on an experiment with competition. There is no denying the depth of the challenge that this change of rules presents to traditional professional prerogatives, but the idea of making physicians more accountable, not through

40. IPA-type HMOs controlled by local medical societies are widely credited with lowering health care costs, but they nevertheless raise important antitrust issues. *See* Havighurst & Hackbarth, *Enforcing the Rules of Free Enterprise in an Imperfect Market: The Case of Individual Practice Associations*, in HEALTH CARE—PROFESSIONAL ETHICS, GOVERNMENT REGULATION OR MARKETS? (M. Olson ed.) (forthcoming).

the political process but through the marketplace, requires no apology.

D. Equitable Concerns with Market Theory

Some observers, even though they have nothing to lose directly from the introduction of competition, are nevertheless troubled by the necessity for reintroducing ability to pay as a factor in consumption decisions. Because the potential impact on low-income consumers is significant, the following discussion attempts to put these issues in their proper context.

1. The market discriminates against the poor.

The nation is not yet committed to a system in which total equality prevails in this or any other area. On the other hand, there seems to be some commitment to providing a minimum level of health services for everyone, a goal that could be achieved within the context of a competitive system by subsidizing the purchase of private coverage and by providing special protection for uninsurables.[41] As noted previously, reasons exist for thinking that the reintroduction of competition, by generating new cost-containment mechanisms and greater efficiency in the system, would make it somewhat easier for society to extend public subsidies to a larger population. As the market makes it more difficult for providers to earn an adequate income by serving the middle class, the supply of services available to low-income persons should increase. In order to preserve the benefits of the competitive model, however, even low-income persons must eventually face some costs in some form at some margin. If public subsidies were adequate, significant hardships would be rare. Hardship would be further minimized by the system's residual charitable capacity and by the availability of public hospitals and publicly subsidized health centers as backstops for the public subsidy system. While some inequalities would necessarily remain in such a system and be deplored by some, probably the greater source of hardship would be governmental unwillingness to provide the necessary subsidies.

2. Hospitals will not be able to provide charitable care.

Cross-subsidies within hospitals are currently financing a great

41. *See, e.g.*, Enthoven, *supra* note 14, at 651-52.

deal of indigent care, and competition surely threatens the continuation of these subsidies. Thus, the fear that hospitals will be unable to provide charitable care in an uncontrolled, competitive market is not an unreasonable one. In the short run, denials of certificates of need to new providers might be justified in extreme cases by the need to protect internal subsidies supporting indigent care, but one has to hope that, in the long run, hidden financing will become unacceptable and will be replaced by new public subsidies.

3. It is not certain that government will replace revenue sources eroded by competition.

No one can guarantee that Congress will do what is just and right, but at some point continuing back-door financing at high cost may be regarded as less legitimate than putting the question to Congress for a definitive reexamination of the public's obligations. Clearly, market advocates have some obligation to prevent the market strategy from becoming a device for eroding the quality and availability of care to low-income populations. It is not unreasonable to expect that, once competition has taken hold, the Medicare and Medicaid programs will need to be redesigned to reallocate their already committed funds in such a way as to provide very nearly the same quality and availability of care to a much larger population. Regrettably, however, government may continue to rely on providers' charitable instincts as a basic source of financing to attain public objectives rather than merely counting on charity as an ultimate protection against severe hardships that may sometimes result from government and private cost-containment efforts.

E. Difficulties with the Explicit Exclusion and Closed-Panel Strategies

As discussed earlier, insurers could use strategic exclusions from coverage and selectivity among providers as cost-containment strategies.[42] Some commentators, however, object to these approaches because they see them as departures from the ideal of comprehensive benefits, uniform and universally high standards of practice, and free choice of physician.

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42. For a discussion of exclusions and closed provider panels, see text accompanying notes 19-23 *supra*.

1. Insurers should not engage in the corporate practice of medicine or interfere in the doctor-patient relationship.

Exclusion of a service from coverage or limits on the amount to be paid do not amount to the practice of medicine or dictation to providers and patients. On the contrary, the doctor and the patient remain free to order the service if they deem it desirable in light of all the factors, including the constraint introduced by the patient's obligation to pay. If the insurance plan is well designed —and competitive pressures should lead to well-designed insurance—spending decisions would be faced under conditions in which any hardship is not intolerable and is justified by the high cost of avoiding it. Because selective coverage contemplates patients' decisionmaking with professional advice, it builds on, rather than undercuts, the doctor-patient relationship.

2. Strategic exclusions from insurance coverage will create hardships.

While many factors would contribute to keeping hardship at a minimum, it probably could not and should not be avoided altogether. In those rare instances where the patient was unable to pay for a service that he and the physician thought was necessary, there would be nothing wrong with expecting providers to give free care, as they do now in a wide variety of circumstances. Indeed, the system's ability to provide some charitable treatment, even though substantially reduced by competition, should serve as an important buffer against harmful side effects from cost-containment measures. The system has long accepted responsibilities of this kind, and, while it would be unconscionable for government to take advantage of private philanthropy and providers' charitable instincts, no reason exists why this backstop should not be acknowledged as a significant feature of a cost-conscious system.

3. Employers and unions will not tolerate the hardships resulting from economizing choices.

Employers and unions have often pressured insurers to be liberal in their payment decisions and reversed attempts to enforce contractual limitations on coverage. In a multiple-choice situation, however, it would be clear that the employee had benefitted from his original economizing decision, and it should be easier to make him bear the consequences. Even if occasional exceptions were made out of charity, they would not vitiate the overall cost-con-

tainment benefits anticipated.

4. Patients will be restricted in their choice of physicians.

Free choice is certainly desirable, but its cost is quite high. Allowing every physician to serve the insured group on the same terms means that the insurer has little opportunity to bargain and providers have less reason to be efficient. While price competition can operate as long as fees are not fully covered by the insurer, utilization is hard to control—that is, exclusions from coverage are hard to enforce—without explicit agreements with the providers; this is true because many exclusions from coverage would be difficult to enforce retrospectively, making it highly desirable for providers to be obligated to seek prior authorization or predetermination of benefits.

In a competitive world, one would expect that free-choice plans would be available but that their cost would be substantially higher than plans that took aggressive action on costs. Free choice is simply one of the many competing values that consumers must weigh in deciding how they can get the best value for their money in purchasing health services and financial protection. Preferred-provider plans have the possibly attractive feature of allowing free choice, subject to an incentive to accept the insurer's choice.

5. Fear of malpractice liability will discourage physicians from suggesting less costly treatment alternatives to their patients.

There is no question that the malpractice courts are enforcing a standard of care that, because it is drawn from existing practice, embodies many of the system's distortions and its lack of cost consciousness. One of the law's effects is to make any economizing move suspect—hence, the problem of "defensive medicine." Nevertheless, health services research is beginning to legitimize certain economizing efforts—the use of intensive care units, for example[43]—and courts should be willing to view such research findings as evidence of due care. Moreover, courts should be more tolerant of economizing when, as would occur in a competitive world, some

43. On efficiency in the use of intensive care units, see Mulley, Thibault, Hughes, Barnett, Reder & Sherman, *The Course of Patients with Suspected Myocardial Infarction: The Identification of Low-Risk Patients for Early Transfer from Intensive Care*, 302 NEW ENG. J. MED. 943 (1980); Relman, *Intensive Care Units: Who Needs Them?*, 302 NEW ENG. J. MED. 965 (1980); Thibault, Mulley, Barnett, Goldstein, Reder, Sherman & Skinner, *Medical Intensive Care: Indications, Interventions, and Outcomes*, 302 NEW ENG. J. MED. 938 (1980).

of the cost saving accrues to the patient. Additionally, although one should be wary of turning every economizing move into an "informed consent" issue, the physician who had disclosed the available options to the patient would run fewer risks of malpractice liability.

The malpractice problem may be greatest for HMOs, since their prepayment feature makes them appear to economize at the patient's expense rather than for his benefit.[44] With respect to all types of closed-panel plans, interesting possibilities exist for altering the legal regime by contract. Thus, an insurance policy or health plan contract might provide for consultation with subscribers on the standard of care—about whether to use fetal monitoring, for example—for arbitration of malpractice claims, or even for a no-fault compensation scheme as the exclusive remedy for specific mishaps.[45] Such innovative contract terms are another example of the important dividends that can result from a competitive environment.

IV. Remedying the Current Market Failure and Moving Toward Free Competition

A. *Correcting Existing Market Defects*

As discussed earlier, the true causes of the market's past failures are remediable. Proposals now pending suggest changing the tax laws, stepping up antitrust enforcement, and expanding the range of choice in the employment setting—all in an effort to remove artificial constraints on the market. The following discussion sets forth several of the proposed measures and indicates their relation to an effectively functioning market system.

1. Reduce the tax subsidy for employer-purchased health benefits.

Many believe that reducing the tax subsidy[46] would make no

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44. *See* Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 Duke L.J. 1375.

45. On the use of a no-fault malpractice scheme by competitive health plans, see ABA Commission on Medical Professional Liability, Designated Compensable Event System: A Feasibility Study 57-61 (1979). *See also* Havighurst, *"Medical Adversity Insurance"—Has Its Time Come?*, 1975 Duke L.J. 1233, 1273-79.

46. Under current law, employer contributions toward employee health benefits are not included in the employee's taxable income. I.R.C. § 106. Although the exact extent of the subsidy varies for individuals according to their tax bracket and whether incremental wages are subject to FICA taxes, Martin Feldstein and Bernard Friedman have estimated

difference because consumers have shown their preference for comprehensive coverage at whatever cost. One cannot predict with any precision how much difference a tax change would make, but demand for health insurance is surely not perfectly inelastic. Experience to date is an unreliable guide to consumer behavior because consumers have not had a full range of choice. For example, participants in the Federal Employees Health Benefits Program,[47] who get no tax subsidy for additional coverage, have often had to buy first-dollar coverage in order to get the adequate catastrophic protection that is available only in "high-option" plans. (Moreover, before relying too heavily on FEHBP experience, one should ask whether federal employees as a class are typical of the population at large or are apt to be atypically risk-averse).

In any event, the question of how consumers will behave in the absence of the tax subsidy is not particularly relevant to the policy question. People should be allowed to buy what they are willing to pay for, and we should not second-guess their spending decisions unless they are spending our money or unless their decisions have material spillover effects—as a decision to forgo catastrophic coverage may have. In a competitive market with redesigned tax subsidies, people should have the opportunity to economize, but whether they do so or not is up to them. Those who purchase wisely may be better off than those who do not, but that is simply their reward for making the effort to inform themselves and to search out alternatives. Even though the usual argument is that the tax subsidy causes an inefficient allocation of resources,

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that the tax law provides a discount (before administrative expenses) of roughly 35% for all health services purchased through an insurance plan. Feldstein & Friedman, *Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis*, 7 J. PUB. ECON. 155, 156 (1977). Moreover, since effective marginal tax rates have been increasing as inflation pushes taxpayers into higher income tax brackets and Congress legislates increases in the FICA tax rate and wage base, the value of the tax exclusion for employer-paid premiums has been increasing. The Congressional Budget Office estimates that the exclusion will reduce federal revenues by $21.4 billion in fiscal year 1982 and by $41.4 billion in fiscal year 1986. CONGRESSIONAL BUDGET OFFICE, REDUCING THE FEDERAL BUDGET: STRATEGIES AND EXAMPLES, FISCAL YEARS 1982-1986 130-31 (1981).

The tax subsidy for employer-paid health benefits distorts demand for insurance and medical care in two ways. First, it induces the purchase of more comprehensive insurance than would otherwise be purchased, which in turn extends third-party payment's distorting effect on the demand for medical care. Second, it causes consumers to undervalue insurer cost-containment efforts, since any saving in premium that results from such efforts and is paid out as increased wages becomes taxable income. That means a dollar saved is not necessarily a dollar earned, and as result a consumer is less likely to accept the added monetary or nonmonetary costs of, say, strict insurer fee limits or more restricted choice of providers.

47. 5 U.S.C. §§ 8901-8913 (1976 & Supp. III 1979).

perhaps a better argument for a tax change, particularly given second-best qualifications, is simply that it would provide a strong new incentive for innovation by insurers, providers, and others.

If Congress sees fit to continue the current tax subsidy, it can still be argued that competition is the best allocative mechanism. While clearly the equilibrium point the market seeks is substantially influenced by the tax subsidy, it would be unwise to try to offset the subsidy by regulation. If the subsidy is to be accepted despite its defects, the market could still function if attention were paid to the other obstacles that have inhibited competition in the past.

2. Increase antitrust enforcement efforts.

The courts have now begun to grapple with the problems of applying antitrust principles to the professions and to a market in which insurance is a major factor. The courts have so far been uncomfortable with the fact that the health care market does not closely resemble the competitive model of two-party commercial transactions on which the basic principles of antitrust law were founded.[48] Nevertheless, progress is being made, and in due course the usual rules applicable to concerted action by competitors will be applied to deter at least the most destructive types of explicit restraints.[49] Often, however, anticompetitive parallel conduct will not require explicit communication between providers, with the result that antitrust enforcers may sometimes find it difficult to prove a conspiracy when one in fact exists.[50] Nevertheless, many of the changes that are occurring—elimination of provider control of financing plans like Blue Shield, for example[51]—will force providers to conspire in more overt and thus more detectable ways if

48. *See, e.g.*, Arizona v. Maricopa County Medical Soc'y, 1980-1 Trade Cas. ¶ 63,239 (9th Cir. 1980), *cert. granted*, 49 U.S.L.W. 3663 (Mar. 10, 1981).

49. *See, e.g.*, Pollard, *Fostering Competition in Health Care*, in REGULATING HEALTH CARE: THE STRUGGLE FOR CONTROL 158 (A. Levin ed. 1980).

50. Through the use of code words and signals, physician organizations can invite an outpouring of sentiment calculated to discipline an innovator. For example, a professional group might pass a resolution that "there ought to be a law" against an insurer's making the plan's prior authorization a prerequisite for payment for elective surgery. Such a resolution could in turn induce individual physicians to refuse to deal with the insurer based on the expectation that others will do likewise. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, *supra* note 2, at 345-49.

51. *See, e.g.*, Settlement Agreement, Ohio v. Ohio Medical Indem., Inc., No. C-2-75-473 (S.D. Ohio, settled March 22, 1979) (on file with the author). The Federal Trade Commission may initiate a proceeding to consider a rule prohibiting physician control of financing plans. *See* FEDERAL TRADE COMMISSION, *supra* note 27.

they are to continue to avoid competition.

Although antitrust law has sometimes been used to destroy competition in other industries and can be disastrously regulatory, its dominant objective is to maintain independent pricing and to enable private entrepreneurs to take independent actions that contribute to consumer welfare. Fortunately, antitrust enforcers operating in the health care industry are invoking only those laws that govern collaboration among competitors. These rules inhibit only collective action and thus do not restrain the individual firm. They are an essential feature of any market in which competition rather than regulation is relied upon to control the behavior of individual firms and practitioners.

3. Require "multiple choice" of health plans in the employment setting.

Several of the market reform bills pending in Congress would require substantial employers to offer a choice of several health plans to their employees and to make the same contribution irrespective of which plan is chosen.[52] The idea, which is to foster consumer choice by taking the final decision away from the employer or union, seems to be a good one. Employers and unions are to some extent trapped by their own past rhetoric, which has inflated their health plans' symbolic value. Because health plans are a focal point of their political relationship with the rank-and-file, a situation exists in which any economizing move seems a betrayal of an obligation already assumed. Multiple-choice, however, might help, since, as long as the high-cost plan is available as a fulfillment of the acknowledged obligation, employers and unions should not be reluctant to offer lower-cost alternatives that would benefit the employee. Indeed, employees should regard the new opportunity to economize as an added benefit; the increase in take-home pay resulting from an economizing choice would be a palpable benefit in precisely the way that a distribution of savings from a general cutback in health benefits would not be. Of course, paternalistic considerations might continue to dominate the choice of plans in some instances and might cause some unions to reject certain options, particularly those that seem too commercial or that provide less than comprehensive coverage. While such attitudes could be overcome by dictating that at least one noncomprehensive option be

52. *E.g.*, S. 433, 97th Cong., 1st Sess., 127 CONG. REC. 1096 (daily ed. Feb. 5, 1981); S. 139, 97th Cong., 1st Sess., 127 CONG. REC. 179 (daily ed. Jan. 12, 1981).

offered, I am not persuaded that this is necessary or desirable. Indeed, I am inclined to think that it is not necessary to mandate multiple choice at all because it is ultimately in an employer's interest to adopt it voluntarily.

Some would argue that multiple-choice proposals ignore the reality that insurers compete primarily by selecting and avoiding risks and that rational consumer purchasing may result in adverse selection.[53] These problems, however, can be readily overcome. The problem is essentially the employer's since he will be under pressure to increase his contribution for everyone if, through adverse selection, one high-risk group is left inadequately covered. Unless some badly drawn regulatory requirement for equal contributions interferes, an employer could present the choices to his employees in such a way that the price tags do not reflect cost differences based on actual enrollments. Thus, insurers could quote rates for a cross-section of employees and the pool of premiums could then be allocated to the various plans on the basis of actuarial adjustments reflecting the actual populations covered. Employers could also regulate gaming by letting high-option plans impose waiting periods for some benefits. Ultimately, an employer would probably find it desirable to cash out the incremental benefits by increasing each employee's pay by the actuarially determined value of that coverage and then letting him decide whether to buy it.

4. Develop voucher systems to facilitate consumer choice in public programs.

If beneficiaries of public programs could be given the opportunity to enroll in private health plans at public expense, a vast new population would suddenly become the object of competition. Proposals currently being considered[54] would allow Medicare beneficiaries to enroll in HMOs. Although these proposals would be a step in the right direction, they are probably too narrowly conceived since they unduly limit the beneficiaries' options. There is no good reason why beneficiaries should not be free to join health

53. "Adverse selection" occurs when individual consumers base their choice of health plan on their anticipated medical expenses so that a disproportionate share of the high risk consumers enroll in plans offering comprehensive coverage and a disproportionate share of the low risk consumers enroll in plans with less complete coverage. The effect of such adverse selection is to reduce the extent to which plans spread risk and thus to increase the disparity in cost between the comprehensive plans and the less comprehensive plans.

54. *E.g.*, H.R. 2508, 97th Cong., 1st Sess., 127 CONG. REC. 941 (daily ed. March 12, 1981).

plans other than HMOs as long as a reasonable benefit package is offered. Because coverage would be offered to individuals rather than groups, some regulation of benefit packages would probably be necessary to prevent serious gaps, but one would hope that government would tolerate substantial experimentation in the design of coverage.

Under a voucher-type system, competition for the patronage of federal beneficiaries would focus on the scope of benefits offered to individuals in return for the federal contribution. Plans could, for example, offer the basic Medicare benefit package with reduced cost sharing or with additional benefits for which a supplemental premium might or might not be charged; state Medicaid programs could be administered in comparable ways but without substantial supplemental premiums, at least for the lowest income groups. The resulting interplan competition would reinforce concerns about cost-effectiveness and would encourage providers to develop or participate in competitive plans and to accept their cost controls. In due course, Medicare and Medicaid might be converted from open-ended entitlement programs to a more controllable commitment of a fixed number of dollars per beneficiary.

As attractive as voucher systems would seem to be, substantial implementation problems are presented. Although some regulatory oversight is clearly needed,[55] government administrators, fearful of charges that they were steering public beneficiaries toward substandard care, might be inclined to overregulate the participating plans. The effect would be to narrow the range of choice and reduce the chances for cost containment. A further problem lies in calculating the appropriate public contribution—particularly for Medicare beneficiaries, whose health status is apt to vary widely without strict regard to age or other objective factors. Whatever premium was paid, a substantial uninsurable population would exist and remain dependent on federal financing. Adverse selection would also exist between plans because enrollment would be on an individual basis and health status could not be readily captured in

55. In the early 1970s, California began encouraging enrollment of Medicaid beneficiaries in prepaid health plans. The effort was marred by the participation of plans that provided inadequate medical services to their Medicaid enrollees. Despite indications that the program was poorly managed by the state, critics of a voucher system often cite California's experience as evidence of fundamental flaws in the voucher concept. The experience of Project Health in Multnomah County, Oregon, suggests, however, that a voucher system can work if the enrollment process is more effectively policed. *See* D. Lawrence, Project Health: A Case Study in Government-Sponsored Competition (May 13, 1980) (unpublished paper on file with author).

actuarial adjustments. Despite these obstacles, the attractiveness of this approach would warrant its adoption even if the fine points could not be perfectly worked out. No other satisfactory method of introducing meaningful cost-containment incentives and the benefits of competition into public programs has been identified.

B. Implementation

The transition from a market in which monopoly and regulation have the upper hand to one in which competition operates as the primary mechanism of social control will not be easy. A number of obstacles must be overcome before the market approach can be fully and effectively implemented. This part of the Article examines some strategic elements of market implementation.

1. Rethink the role of planners and regulators.

The 1979 health planning amendments[56] require regulators to withhold regulation wherever the market appears to operate reasonably well. This new mandate, assuming that it is accepted in the right spirit, will allow regulation to adapt to changing market circumstances at the right pace. The new law also encourages health planners to strengthen competition, focusing particularly on competition-oriented changes in the financing system. This legislation seems to require the health care system's planners and regulators to reconceive their role. Instead of prescribing how the system will function, they are now seen as presiding over a shift to greater reliance on competitive forces. While this changed perception is more easily articulated than implemented, this conceptualization of the regulators' role does leave the market open to possibilities for experimentation and change. Above all, the regulators must cease to act on the unexamined premise that the market cannot function and that cost containment is a public and not a private responsibility. On the contrary, planners must become actively concerned with how to make the market function better and with promoting meaningful private sector change in their communities.

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56. Pub. L. No. 96-79, § 103, 93 Stat. 594 (1979) (amending scattered sections of Title XV of the Public Health Service Act). The procompetitive provisions of § 103 are discussed in detail in Havighurst, *Health Planning for Deregulation: Implementing the 1979 Amendments*, 44 LAW & CONTEMP. PROB. 33 (1981). *See also* Havighurst & Hackbarth, *Competition and Health Care: Planning for Deregulation*, REGULATION, May/June 1980, at 39.

2. Minimize cooperation among providers.

Public policy must begin to look skeptically at industry-wide efforts to contain costs. Professionally sponsored reforms must be subjected to close scrutiny under the antitrust laws even if they seem to promise real cost reductions. It is not always correct that a bird in hand is preferable to those in the bush. Accepting competitor cooperation as a primary vehicle of reform threatens to perpetuate all of the anticompetitive assumptions of the past and to lock providers into combinations that will necessarily inhibit competitive developments. The antitrust laws do not permit anticompetitive collective action to be justified on the basis that competition would be undesirable or would not work well. Instead, the law embodies the conclusive presumption that competition is always preferable unless Congress has declared otherwise. Even though this presumption may sometimes be invalid, case-by-case analysis of the justifications for anticompetitive collaboration would be costly and the effort would be ultimately self-defeating. In addition, the necessary judgment is essentially legislative, and Congress so far has not seen fit to create an exemption.

While stating that the law is clear does not establish the wisdom of rejecting anticompetitive collaboration, antitrust authorities need not apologize for enforcing the law and for insisting that the long-run benefits of competition be weighted more heavily than short-run expediency. Besides perpetuating the assumption that cooperation is preferable to competition, successful collective action would reduce the incentives for individual initiatives. Indeed, they are probably so intended. Thus, the medical profession frequently has formed IPAs and other collectively controlled plans to head off independent developments, particularly closed-panel HMOs.[57] Moreover, many of the profession's peer-review and cost-

57. For example, the San Joaquin County Foundation for Medical Care was organized by the local medical society to head off inroads into that market by the Kaiser HMO. Egdahl, *Foundations for Medical Care*, 288 NEW ENG. J. MED. 491 (1973). In effect, such a foundation provides peer review of fees and utilization for independent insurers as a way of coordinating the competitive response of fee-for-service physicians. Although such an effort involving only a relatively small percentage of the market's physicians would be legal, larger foundations sponsored by the local medical society and encompassing nearly all of the market's physicians pose an anticompetitive threat. Independent health plans, such as Kaiser-model HMOs, may be harmed by a profession-sponsored foundation (or IPA-type HMO) because the profession-sponsored "reform" may reinforce the profession's sense of solidarity in resisting change and thereby lead individual physicians to refuse to participate in the new competitive plan, to grant its doctors hospital privileges, or to accept referrals from the new plan. The profession-sponsored organization may also engage in limit-entry pricing to deter

control efforts are designed to preempt insurer initiatives.[58] Profession-controlled financing plans and peer-review efforts should be regarded as violations of the antitrust laws in order to stimulate the private sector to approach these problems competitively. This conclusion seems fully warranted as a matter of both antitrust law and sound policy.

3. Give up the notion that a minimum benefit package should be prescribed by federal law.

A common assumption is that government has an obligation to guarantee some minimum level of financial protection against health care costs and that this obligation can be met only by prescribing a minimum benefit package for private insurance. For example, competition advocate Alain Enthoven has consistently stressed comprehensive coverage as a fundamental requirement of his innovative Consumer-Choice Health Plan.[59] His plan would not allow for coverage exclusions that could facilitate cost containment. While such exclusions are somewhat problematical, I see no good reason to prescribe a minimum benefit package for all consumers, thus impairing insurers' cost-containment capabilities by restricting them to HMO-type strategies and traditional cost-sharing techniques.[60] Because Enthoven contemplates that insurance would no longer be purchased through employment groups, he feels the need to insure that there are no unconscionable gaps in coverage. The employment setting, however, provides a valuable screening mechanism that will prevent inappropriate coverage gaps. Thus, keeping insurance in the workplace makes it possible to leave a full range of strategies available. As noted earlier,[61] plans that enroll public beneficiaries may require benefit-package regula-

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threatened entry, or in predatory pricing to eliminate or discipline any entrant that might appear. For a more detailed discussion of why profession-sponsored "reforms" such as IPAs and foundations for medical care pose an anticompetitive threat, see Havighurst & Hackbarth, *supra* noto 40. *But see* Arizona v. Maricopa County Medical Soc'y, 1980-1 Trade Cas. ¶ 63,239 (9th Cir. 1980), *cert. granted*, 49 U.S.L.W. 3663 (March 10, 1981) (holding that maximum-fee setting by a foundation for medical care representing 80% of a market's physicians is not a per se violation of the antitrust laws).

58. For more on this thesis, see Havighurst & Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, 4 J. HEALTH POL., POL'Y & L. 48, 58-61 (1979).

59. *See* Enthoven, *supra* note 14.

60. Consider, for example, the desirability of the following types of exclusion: an expensive and highly debatable new surgical procedure; hospital days beyond "x" days after a particular surgical procedure; hospitalization connected with procedures that could be done on an outpatient basis.

61. *See* text accompanying notes 54-55 *supra*.

tion, since public beneficiaries will purchase as individuals and not in groups.

4. Avoid community-rating requirements.

Another significant difference existing between Enthoven and myself has to do with his proposal that all plans engage in community rating. I would regard such a regulatory requirement as a prohibition of normal cost-based pricing—and of price competition—and as an invitation to collusion. Moreover, no need exists for it if group purchasing continues and if adverse selection problems raised by multiple-choice offerings can be solved within employment groups. Although Enthoven's plan contemplates a good deal of regulation and would curtail and channel competition more than I think necessary, he has actively supported both a tax change and the multiple-choice concept and would, I think, be quite comfortable with the competition that those proposals would bring about.[62]

5. Suppress the urge to pursue a comprehensive legislative program.

Aside from tightly limiting the tax subsidy and mandating multiple choice for public and possibly for private health plan beneficiaries, little immediate need exists for legislative change. In my view—which is more laissez-faire and less legislation-oriented than that of some market advocates—the greatest contribution that government could make at the present time would be to declare that, except in the government's own programs, cost containment is a private, not a public, responsibility—to be carried out in a competitive environment with neither assistance nor interference from government. One reason that the private sector has developed so few cost-containment tools is that it has anticipated that the government would take some kind of definitive action to control costs. Although this action was never taken, the prospect of it kept the private sector virtually transfixed for a decade, since it appeared that any private effort, other than HMO development, might quickly be rendered obsolete. With government looming as so large and unpredictable a factor, the industry's best minds were absorbed in trying to understand its behavior, in adjusting to its latest actions, in anticipating and influencing its next moves, and

62. *See* Enthoven, *The Competition Strategy: Status & Prospects*, 304 NEW ENG. J. MED. 109 (1981).

in generally trying to satisfy public officials rather than consumers. It would be most unfortunate if competition and private cost containment continue to be perceived as activities that require a legislative signal to begin. While the Enthoven proposal[63] and the Gephardt-Stockman bill[64] are interesting and important, competition focusing on cost containment requires little new legislation, and it would be a constructive step for government so to declare.

6. Undertake a thorough policy review of the myriad regulatory and other policies that inhibit competition in this industry with a view to making them consistent with a market-oriented regime.

It has been argued that there are too many regulatory programs in place, too many barriers to the creation of the open market, and too many contrary assumptions already built into public policy to permit the kinds of changes necessary to implement the market strategy. Several considerations, however, persuade me that a thoroughgoing policy overhaul is possible. First, the antitrust laws are already in place and are being applied to the industry with some skill and insight. Second, the Reagan Administration and Congress seem prepared to reexamine the premises on which public policy has been based in the past.[65] Third, the nation as a whole is willing to reexamine questions concerning the role of government in general, and we may be on the brink of a period in which it will be possible to reduce government involvement in areas in which it is not clearly needed. Last, market forces are beginning to take over even without government's explicit permission.[66]

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63. *See* Enthoven, *supra* note 14.

64. H.R. 850, 97th Cong., 1st Sess., 127 CONG. REC. 116 (daily ed. Jan. 16, 1981).

65. Sponsors of procompetitive health bills occupy key positions in the Reagan Administration and the 97th Congress: the Secretary of Health and Human Services, former Senator Richard Schweiker, was the sponsor of S. 1590 in the 96th Congress, S. 1590, 96th Cong., 1st Sess., 125 CONG. REC. 10664 (daily ed. July 26, 1979); before he was confirmed as Director of the Office of Management and Budget, former Congressman David Stockman was a cosponsor of H.R. 850, 97th Congress, H.R. 850, 97th Cong., 1st Sess., 127 CONG. REC. 116 (daily ed. Jan. 16, 1981); Representative James Jones (sponsor of H.R. 7528, 96th Congress, H.R. 7528, 96th Cong., 1st Sess., 126 CONG. REC. 4686 (daily ed. June 9, 1980)) is Chairman of the House Budget Committee; Senator Orrin Hatch (sponsor of S. 139, 97th Congress, S. 139, 97th Cong., 1st Sess., 127 CONG. REC. 136 (Jan. 15, 1981)) is Chairman of the Senate Committee on Labor and Human Resources; and Senator David Durenberger (sponsor of S. 433, 97th Congress, S. 433, 97th Cong., 1st Sess., 127 CONG. REC. 1096 (daily ed. Feb. 5, 1981)) is Chairman of the Health Subcommittee of the Senate Finance Committee.

66. The most often cited example of a workably competitive market is the Minneapolis-St. Paul area. Christianson & McClure, *Competition in the Delivery of Medical Care*,

It is possible that we will eventually be faced with a virtual *fait accompli* demonstration that government has only to stand aside to allow the market to finish the job. Given these forces, predictions are unreliable. Even though programs and assumptions may have been immune to criticism in the recent past, I see reasons to think that all the old bets are off and that the basic foundations of policy can indeed be reexamined and changed. While a major reeducation and reform effort is needed, I believe the time has come to scrutinize and revise established precepts and programs in such areas as health manpower, insurance regulation, professional self-regulation, malpractice law, and quality assurance.

V. CONCLUSION

Arguments against the market reform strategy frequently begin with charges that it represents a naive application of the models of Economics 101 to a uniquely complex industry. Market opponents then usually proceed to cite the textbook conditions for perfect competition—*e.g.*, the need for perfect information—to show how the market cannot work. What such arguments reveal, however, is that it is the market opponent himself who is basing arguments on simplistic economics. Moreover, such critics of the market strategy usually fail to employ the same skepticism in invoking the textbook model of their preferred strategy, whether it be government regulation on the one hand or industry or professional self-regulation on the other. In fact, the competitive strategy, in addition to being supported by a powerful theory that is not undercut by the existence of any insurmountable market failure, comes out very well in any realistic comparison with alternative mechanisms for controlling the health care industry's economic performance.

The empirical evidence supporting the competitive strategy, while still highly anecdotal, is increasingly compelling. Although we have yet to see a truly untrammeled market or any long-term results, the industry has demonstrated a potential for competitively stimulated innovation. Moreover, persuasive and well-docu-

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301 NEW ENG. J. MED. 812 (1979). The Hawaii and Portland, Oregon, markets are also reasonably competitive. A. ENTHOVEN, HEALTH PLAN 82-89 (1980). Still other markets hold considerable competitive promise. Aquilina & McClure, *The Potential for a Competitive Health Care System in Boston, Massachusetts* (InterStudy, 1980); Christianson, *The Potential for a Competitive Health Care System in Denver, Colorado* (InterStudy, 1979); Enthoven, *supra* note 62 (dealing with the potential for a competitive market in northern California).

mented explanations exist for the industry's past failure to solve the cost problem. In sum, it is extremely difficult to dispute that, if care is taken about the details, the market reform strategy of removing demand distortions and restraints on innovation would do just what it sets out to do—that is, facilitate the efficient allocation of private resources in the provision of health services.

If market efficacy were the only consideration, controversy over the desirability of competition would hardly exist. The only problem would be political resistance from those who stand to lose power, perquisites, and profits in a competitive world. Unfortunately, however, national health policy must be concerned with more than how consumers can get value for their money in purchasing health services. If we are not careful, the victims of competition may include not only those who lose monopoly power but also some innocent citizens whose losses, and some activities whose loss, we are not prepared to tolerate. If competition's erosion of hidden internal subsidies is coupled with an unwillingness or inability of government to supply new explicit ones, competition could do real, though inadvertent, harm both to the cause of social justice and to medical education and research. While social policy probably should not tolerate a huge sacrifice of efficiency to forestall such problems, I believe that the policy agenda should give equal priority to compensating for these potential losses by assuring the equitable distribution of the dividends of competition. Political leaders and market advocates now have a duty to address the danger that competition-induced stringencies may widen the cracks into which some citizens and some useful activities can fall.