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*A New Look at Health-Care  
Reform*

Murray Weidenbaum

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## A New Look at Health-Care Reform

Murray Weidenbaum

The time is ripe for taking a new look at health-care reform. Clearly, conventional approaches have bogged down in the legislative process. A fresh start is necessary. To begin, truly reforming the health-care delivery system of the United States requires developing a sensible and sensitive mechanism to balance the demand for health care with its supply. That is the only effective way of dealing simultaneously with the powerful demand for medical services, the limited resources available, and the pressures of rising costs and prices.

Managed competition may help, but it will not suffice. Instituting global budget caps or otherwise attempting to restrain medical care prices is not workable for any extended length of time. As with all forms of price controls, such a bureaucratic approach merely postpones the difficult decisions to another time. It still leaves unanswered the vital question of how the now unrestrained level of health-care demand is to be met and paid for.

I put aside the question of lack of universal health-insurance coverage — and for good reason. My justification for doing so is that most public discussions equate lack of insurance with lack of medical care. That is just erroneous. A large array of health-care providers does give medical services — at low or no cost — to those without insurance. To be sure, often the result is inefficient, such as the excessive use of emergency rooms. But, to clear the air, we must note that is just a special case of a problem that I will be dealing with — people demanding expensive health care without paying the full cost.

One complication is curable. At present, employees — or their employers acting in their behalf — cannot buy a modest health-care plan. State insurance commissions dictate the

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composition of these plans and they are very amenable to lobbying by special interests. Thus, in many states, the plans must include hair transplants, acupuncture, and other inherently optional items. In effect, the purchaser of health insurance cannot buy a Ford. It must be a Lincoln — or nothing. As Voltaire said it, “the best is the enemy of the good.” Of course, this is not a federal case. Each state insurance commission should shift its focus from serving the special interests among health-care providers to meeting the needs of the patients.

### **The Two Basic Alternatives**

Let us begin with the fundamentals. There is a spectrum of possible responses to the health-care dilemma, each with its own set of advantages and disadvantages.

#### **The Free-Market Approach**

At the free-market end of the policy spectrum is an approach based on each family (or unattached individual) making their own choices on what type of medical outlays they will request — and pay for. This means a general elimination of third-party payments and a restoration of the traditional producer-consumer relationship which is found in most, but not all, other product and service markets.

Indeed, the primary reliance on third-party payments is a relatively recent phenomenon — which reminds us that the present pattern can be changed. Third-party payments have become increasingly important only in the last several decades. Back in 1960, people paid 49 percent of their health-care costs, while government agencies paid 24 percent and insurance companies paid 22 percent. A complete reversal has occurred in the intervening years. By 1993, people paid less than 18 percent of their medical costs. The lion’s share was borne by government (44 percent) and insurance (34 percent). For hospital service, as an example, the patient now pays only 3 percent. For doctor bills, the average patient payment is 15 percent of the total.

The implication of the shift to “third-party” financing of health care cannot be overestimated. Important evidence comes from an experiment by the non-profit Rand Corporation. For a few years, thousands of families in the experiment were given one of four health insurance plans. The difference between the plans was the co-payment rate, that is, the portion of health expenses paid by the family. The co-payment rate varied from 0 to 95 percent. Under all the plans, if a family’s out-of-pocket expenses reached \$1,000, the insurance paid for all additional expenses.

The experiment’s main finding was that the higher a family’s co-payment rate, the less often members of that family went to a doctor and the less often they incurred medical expenses generally. In the words of my colleague David R. Henderson, “people do consume more health care when they are spending other people’s money.” Interestingly, the Rand experiment found no substantial improvement in health outcomes for the higher spending by the families with low co-payment rates.

Relying on the marketplace is the self-policing way to control medical costs. When patients pay the bills directly, they become cost conscious — and so do the people and organizations serving them. The market approach differs fundamentally from the typical “third-party” payments so widely used in the United States. Under this latter method, patients usually do not know the prices and costs of their medical care before hand, if ever.

In the United States, third parties that pay the bills have effectively removed the patient from the traditional consumer role of watchdog. Rarely are prices of physician and hospital services or goods such as prescription drugs advertised to consumers. Economist Rita Ricardo-Campbell and her associates state the matter quite bluntly:

When patients become concerned about prices (because they pay the bills directly), physicians will become concerned about costs. . . . The only way to lower the cost of medical care in this country, and simultaneously maintain a high level of quality, is to give medical-care consumers the incentive to worry about prices.

Of course, there always were important exceptions to the operation of the free market in health care. Modern society has never been willing to accept the full consequences of

allocating medical care solely on the desire and ability to pay. To economists, this signified that health care was a “merit want,” meaning that society wanted a bit more supplied than resulted simply from the operation of market forces. However, in this approach, market forces are supplemented, not supplanted. Destitute — or just poor people — receive free or low-cost medical treatment, although sometimes of a lower quality than the rest of the society and usually at greater inconvenience.

Primary reliance on the market means that the price system effectively rations the amount of health care produced and consumed. As a practical matter, that amount is likely to be considerably less than the results of current policy. A sensible step toward the free-market approach would be to reduce the various governmental subsidies which increase people’s demand for the “best” health-care service. A good place to begin is to eliminate the tax advantage now given to health care over other consumer expenditures. Specifically, employer-financed health insurance should be included in taxable employee compensation along with direct payments of wages and salaries. Few people recall that the popularization of employer-financed insurance plans and other fringe benefits occurred during World War II as a loophole to get around wage controls. The special tax treatment is not justified by any canon of efficiency or fairness and should be eliminated.

Furthermore, much of the formal effort to “economize” on health-care costs by departing from marketplace competition is illusory. A major example is the cost shifting under Medicaid (and to a lesser extent, Medicare). That does little to reduce the nation’s total medical outlays. That procedure mainly forces other patients to pay for a portion of health care for the elderly. The effects of the large “purchasing pools” are often quite similar and especially devastating to the smaller enterprises which are excluded. However, sometimes the activities of the purchasing pools do force some serious economies of operation.

To some significant extent, private health plans — goaded by employers who are unhappy at the steady stream of premium increases — can try to weed out high-cost providers, to limit the use of expensive specialists, to monitor closely the performance of health-care

providers, and to emphasize preventative care. As we will see, such pressures are becoming increasingly effective. They can be reinforced, however, by giving employees a similar stake in controlling health-insurance premiums.

### **The Governmental Approach**

At the other end of the policy spectrum is the notion that the society should finance whatever level of health care is required by each citizen. This general notion is embodied in the "single payer" plan, whereby — at least in theory — government simply pays everyone's health bills. That may be the basis on which this plan can be sold, but practical problems abound. When health care becomes a free good, the individual response quickly becomes "Nothing's too good for me if I don't have to pay for it."

Because human wants are insatiable, the notion that each of us is entitled to all the medical care that we ask for exhausts the ability of even the most generous source of financing. Therefore, in practice, each single player plan adopts or reluctantly backs into some form of rationing. One of the most widely used means of limiting care is oblique or indirect. It is the bureaucratic technique of delay and inconvenience. I refer to the queue — forcing people to wait longer than they now do before they receive medical services, including having to go through a variety of reviews or "gatekeeper" approvals. For example, it has been said of some high-risk surgical procedures under the Canadian system that the patient is more likely to die while waiting his or her turn than on the operating table. On average, it takes nine months for a hip replacement.

Rationing by delay appeals to the bureaucratic instinct. It does not require making many difficult decisions. It is easy to administer. The queue even sounds fair: first come, first served. But, rationing by delay distributes the benefits of limited care in a very arbitrary manner. At the policy level, relying on the queue does require making some difficult choices in terms of determining the supply of the various treatments that are available. Just as the free-

market approach in practice is supplemented by free or low-cost care, the "health as a free good" approach is usually supplemented by a limited free market.

A safety valve often accompanies the queue approach. However, it favors upper income individuals or at least people who value health care highly enough to pay for it. Wealthy Canadians, for example, come to the United States for serious surgery when they are not content with the quality or the time availability of the health care provided in Canada. Under the Clinton plan, even such a safety valve would have been restricted or prohibited.

One of the claimed benefits of the single-payer approach could be achieved without resorting to a massive expansion of the government's role. A standard medical card for each person with the vital personal and insurance information would avoid the repetitious collection of the same data by each health-care provider. The transcription errors which occur so frequently would be avoided, as well as the delays bedeviling patients and medical offices alike.

Surely, in this electronic age, the paperwork burden could be reduced substantially. Voluntary cooperation on the part of key private associations — the American Medical Association, the American Hospital Association, the American Pharmaceutical Association, etc. — should be able to accomplish this useful change.

Along these lines, the Quincy Foundation for Medical Research has proposed the establishment of a network of computer terminals located at care delivery sites. Each participant in the program would receive a code card containing his or her social security number and basic personal data. Other information could be included, such as medical status. We can endorse this portion of the Quincy Foundation proposal without embracing the notion of using the medical card to administer eligibility for a variety of governmentally imposed benefits. More recently, Congress's Office of Technology Assessment has urged the standardization of insurance claim forms and electronic submission and payment of insurance claims as other ways of using information technology to curb health-care costs. The French have pioneered card technology in health care and claim to be saving substantially on administrative costs.



All in all, it seems unlikely that — at least in the near future — public policy will adopt either of the two extremes that I have just presented. Yet, it is useful to view the various individual proposals in terms of whether they move the health-care system toward the governmental pole or toward the individual choice pole.

### **An Upbeat Outlook**

There is a natural tendency to look to government to correct the various shortcomings in our society. Health care, of course, is no exception to the search for reducing so-called market failures. However, over the years we have discovered the substantial presence of what can be called government failures — the disadvantages that often result when the public sector attempts to improve on the imperfect performance of the private sector. This line of reasoning does not support the arbitrary elimination of government activity. Rather, it injects a useful note of skepticism in the recurring debates over expanding the role of government in the economy.

Along these lines, it is pertinent to note a separate and noteworthy development. While the Congress and the Clinton Administration have been debating inconclusively the various ways for the federal government to provide better health care, the institutions that actually provide medical care have been undergoing an unprecedented but voluntary restructuring. The health-care delivery system is being reformed. To a substantial degree, the marketplace is transforming itself and is delivering health care at reduced costs. Technically, the rate of price increases is slowing down more frequently than actual prices are turning down — but that is still an improvement over the previous trend. In Southern California, the Hospital Council reports that the incomes of medical specialists are “dropping like stones.”

The voluntary changes being made in health care are taking many forms. By the end of 1994, a majority of privately-insured Americans were enrolled in managed-care plans that limit choice of doctors and treatments. In California, three-fourths of all privately-insured

patients are now in Health Maintenance Organizations (HMOs). At least three-fourths of all physicians had signed contracts, covering at least some of their patients, to reduce their fees and to accept oversight of their medical decisions. About nine out of every ten doctors who work in group practices have agreed to such managed-care arrangements.

Large insurance companies are setting up "community care" networks. They are acquiring hospitals and clinics, so that they can offer a full spectrum of treatment for a fixed price. In suburban Atlanta, Aetna has opened six primary care centers. In the same area, another large insurance company, Cigna, has acquired medical practices and is recruiting doctors for its own clinics. Ultimately, these conglomerates may include, in addition to insurance companies and hospitals, some of the following — outpatient clinics, doctors' offices, nursing homes, hospices, home health-care services, pharmacies, drug treatment centers, and medical equipment suppliers.

The Michigan health-care network is a good example of the voluntary changes taking place. The network is vertically integrating the Henry Ford Health System, Mercy Health Services, and Michigan Blue Cross/Blue Shield. The network of 13 hospitals offers health care to groups of 100 employees or more. It requires a fixed monthly payment averaging \$200 for an individual and \$466 for a family. The Michigan network promises that premiums will not rise more than 5 percent in 1994 or 1995. Similarly, New York Hospital has established a regional alliance with seven other non-profit hospitals, two nursing homes, and four walk-in clinics. The latter send their most complicated cases to New York Hospital.

Three large hospital alliances, created in the last two years, now care for about three-fourths of the hospital patients in the St. Louis area. Each alliance is actively buying up the practices of primary-care physicians (those who refer patients to hospitals and other specialized services).

In many communities, hospitals have been hiring or buying out the practices of primary-care doctors — family practitioners, general internists, and pediatricians — to assure a stream of patient referrals and to increase their bargaining power with insurance companies.

The South Carolina Medical Association has been developing an alternative approach. It is forming a statewide network of doctors to negotiate contracts with employers and take responsibility for controlling their health costs. Health-care networks already dominate Southern California. Hospitals, physicians, and insurance companies all have established health-care networks. Mullikin Medical Enterprises, which is owned by 200 physicians in Southern California, is acquiring the practices of other medical groups around the state. Solo practitioners are becoming rare.

On a national scale, an unprecedented wave of mergers and acquisitions is occurring among major health-care providers. Columbia/HCA Healthcare, the country's largest for-profit hospital chain (with more than 190 hospitals), has bought out Medical Care America, the largest chain of surgery centers and now accounts for about one-half of the for-profit hospital capacity in the United States. In contrast, Surgical Care Affiliates, which operates a chain of outpatient surgery centers, is luring patients away from hospitals. These centers provide a lower-cost setting for many of the less critical operations, such as removal of cataracts, tonsillectomies, and laparoscopic gallbladder removals.

The large pharmaceutical companies — squeezed by national policy and regional health-care providers — have been actively diversifying within the health-care sector. Merck acquired Medco Containment, the managed-care drug distributor, for an impressive \$6.6 billion. SmithKline Beecham merged with Diversified Pharmaceutical, another managed-care drug marketer, in a \$2.3 billion transaction. Eli Lilly paid \$4 billion to buy PCS Health Systems, the largest company that processes payments for prescription drugs. In that instance, the Federal Trade Commission made its antitrust "clearance" contingent on assurances that patients using the drug benefit company would not be limited to Lilly products. In an unusual foray into providing health-care services, Zeneca Group, a manufacturer of cancer drugs, acquired 50 percent of Salick Healthcare, an operator of cancer care centers. In this segment of health care, a pattern of mergers and acquisitions is also evident. Thrifty Drug Stores

bought the Payless drugstores of Kmart. Revco acquired Hook-Supe Rx and Rite Aid purchased Perry Drug Stores.

Meanwhile, many individually-owned pharmacies are finding that they lack the resources to compete for managed-care business and are becoming members of chains, franchises, and other group efforts. In the future, perhaps insurance companies and hospitals will get together. Between them, they have the large organizational skills and recordkeeping that are necessary. Hospitals have the patients and insurance companies have the market — the willingness of employers to pay for the health care of the employees.

Stepping back from the concern with health care, important as it is, we have to raise several serious questions from the viewpoint of the structure of the American economy; Is the day of the small “business” in services over? Will the opportunities for cost reduction be translated into lower prices for the patient? So far, competition in the various parts of the health-care sector has been on the rise, thus advancing the cause of restraining health-care costs. Nevertheless, the future viability of new and small providers and the ultimate impact of the consumer remain open questions.

### **Conclusions and Recommendations**

The operation of market forces often proceeds more rapidly and more effectively in responding to serious problems than do the more ponderous decisionmaking mechanisms of the public sector. Indeed, often the reduction of governmental impediments to competition represents the most efficient and least costly solution. Medical care is no exception to that basic proposition.

The most effective driving force to slow the rapid rise in health-care costs is now the business firms who find that this special expense reduces their competitiveness in an increasingly global marketplace. The pressure they exert on their health-insurance carriers, in turn, is transmitted to health-care providers. As we have seen, hospitals, physicians, and

pharmaceutical firms have been engaged in an unprecedented effort to restructure, streamline, diversify, and otherwise reduce their costs — while they maintain or expand their share of a rapidly and radically changing marketplace for health care.

There is an important role for public policy in this important adjustment process, but it is not the role envisioned by most participants in the political process. To continue the movement to greater efficiency while meeting the needs of the consumer (i.e., the patient), it is necessary to further reduce the impediments to the fuller operation of competitive market forces.

Surely, the most fundamental change needed is to reduce the dependence on third-party reimbursements. To the extent that patients view medical care as a “free” (or low-cost) good to them, the ability to contain costs will be greatly limited. It is basically unfair to maintain a situation where party A demands the “best” medical services and party B must find a way to pay for that largesse.

For the typical middle class patient/consumer, it makes no sense to go through an insurance/reimbursement system for routine office and out-patient hospital visits and procedures. What is required is to stop looking at health insurance as a benefit or, worse yet, as an entitlement. Rather, each of us must consider health insurance as a form of insurance protecting us from chance but potentially devastating circumstances. The implication of that seemingly simplistic change is profound.

Take automobile insurance as a basis for comparison. Each vehicle owner chooses a form of deductible. This means that many fender benders or paint scratches (the equivalent of the routine office visit) are not covered by insurance. There is no massive outcry that this approach is “unfair” to poor people. Motorists generally understand that a deductible is necessary to avoid swamping the insurance system with the paperwork that would push up premiums very sharply. As a result, of course, many paint scratches and dented fenders go unfixed — but that is the considered choice of the owners who would rather spend their money on something else.

Indeed, Dominion Resources, Inc., a Virginia utility holding company, has moved in this direction. The company treats its health program like true insurance, reimbursing for insurable events rather than for routine medical expenditures. The plan is structured so that employees are reimbursed for a small number of large claims rather than a large number of small claims. Savings that result from shifting away from traditional health-care coverage are shared equally between the employer and the employees.

The Dominion Resources approach seems in accord with the recent reminder by Martin Feldstein and Jonathan Gruber that the purpose of insurance is to protect individuals against unexpected expenses. An optimal insurance policy, in their view, involves balancing the gains from financial protection against the losses that result from the distortion of behavior toward excessive care induced by reducing the cost of treatment to the patient.

Under the present array of public policies, primary reliance on third-party reimbursement strikes most taxpayers as highly desirable. First of all, not many of our fellow citizens are sophisticated enough to understand that such fringe benefits as employer-paid health insurance are a substitute for wages in the employee's compensation package. But even among the growing minority that comprehend the process, the status quo is still considered to be a good deal because wages and salaries are taxable income, while fringe benefits are not.

The answer, of course, is to make the entire compensation package taxable, including employer-paid health-insurance premiums. That will not eliminate the demand for such fringes, even among the most sophisticated, for a variety of reasons. Some of these are eminently sensible, such as the desire to obtain the economies of scale that result in lower group rates for a given coverage than the rates charged to the individual or family who tries to deal directly with an insurance carrier. A level playing field in the taxation of compensation would not constitute a panacea but it surely will help.

Many other changes in public policy would be helpful, especially to increase the knowledge available to consumers to enable them to make more informed choices. In one specific area — the purchase of pharmaceutical products — government policy now restricts or

prevents the ability of the patient even to acquire the basic information concerning the prices to be charged by different providers for the same or similar products. At the present time, many states prohibit advertising the price of prescription drugs. Such restrictions make it difficult for consumers to shop for the best price. Every state legislature which has enacted such anti-consumer legislation should promptly repeal it. Even pharmaceutical industry critic Senator David Pryor (D-Ark.) has urged that the market for medicine be made more price sensitive. He specifically states, "Any reform effort should make sure that both doctors and patients are more aware of prices."

At the federal level, the Food and Drug Administration should reduce the barriers it has set up that inhibit advertising prescription medicines. Because consumers must obtain a prescription from a physician in order to acquire prescription drugs, there is less reason to fear deception in advertising in this market than in any other. On the positive side, experience shows that direct advertising can reduce the prices that consumers pay. Such evidence was cited by the Supreme Court in the decision overturning state bans on advertising eyeglasses.

The current FDA rules on advertising appear to be needlessly bureaucratic. Specifically, the agency should reconsider the requirement for the misnamed "brief summary" which must accompany any ad that both mentions a health condition and indicates the name of a drug which can be used for the condition. The notorious "brief summary" is actually a lengthy statement in small print listing side effects and contraindications associated with a prescription drug. Of course, such information is essential for physicians, for whom the brief summaries were originally designed. But, for the average patient, the technical language borders on the incomprehensible.

The FDA regulations also discourage prescription drug ads from being shown on television, a major source of information for many consumers. The high cost of ads in the print media — resulting from the FDA requirements — also reduces their use. Like so much government regulation, the result is just the opposite of what the FDA says it wants. Due to the restraint on advertising, consumers may not be aware that a treatment exists for a certain

condition and so they will not consult a physician. In other circumstances, consumers may suffer some symptoms (e.g., thirst) without realizing that these are symptoms of a treatable disease (e.g., diabetes). Alternatively, a new remedy with reduced side effects may become available, but patients are not aware of it and do not visit their physicians to obtain a prescription.

If there is any single conclusion that emerges from this presentation, it is that no single solution — no silver bullet — is available to cure all the ailments besetting the American health-care system. What will help — and in a fundamental way — is to acknowledge that difficult choices have to be made among imperfect alternatives. I trust that the package of alternatives I propose — based primarily on the free market — is less imperfect than the others.



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