During the 1980s, the United States veered away from an entitlement health policy framework toward the unleashing of competitive forces in health insurance and services. In a health system as vast as the American system, disaggregating the multiple impacts of this revolutionary movement is no easy task. But competition has significantly altered the health care landscape in only five years, confronting policymakers with new challenges.

Though many observers believe that Medicare payment reforms were the principal catalyst of market change, the root causes run far deeper. Public and private health care financing reforms stemmed from the collision of hyperinflation in health costs following the 1979 oil shock with the deep recession of 1981–1982. This collision produced a series of weakening aftershocks that lasted well into the decade. The recession resulted in a severe fiscal crisis both for state and federal governments and led not only to Medicare prospective payment but to tightening of Medicaid eligibility and payments as well. However, more significantly, the recession forced a fundamental restructuring of private health coverage, reversing almost three decades of steadily expanding benefits.

Shifting the risk. The central dynamic of the health care revolution was a shifting of economic power away from providers toward payers and a concomitant shifting of economic risk from public and private payers to patients, physicians, and hospitals. Risk-free payment schemes such as cost-based Medicare payment to hospitals gave way to prospectively determined rates, placing hospitals at risk for the cost of Medicare services. Medicaid abandoned cost-based hospital payment as well, in
favor of fixed or brokered rates. Risk-free physician payment under fee-for-service began to give way to capitation, negotiated fee schedules, and gatekeeper arrangements that placed physicians at risk for the cost and volume of services. Employers and the government asked patients to pay a larger share of their hospital and physician bills and a larger portion of their health insurance premiums.

By early 1988, this shifting of risk has been only partially consummated and has varied sharply across the country. In some regions, such as southern California, traditional forms of hospital payment have virtually disappeared, leaving hospitals at the mercy of a chaotic, multilateral negotiating process to assure continued cash flow. Young physicians there stand almost no chance of building practices without multiple health plan contracts. In other areas, such as the Southeast and Middle Atlantic regions, alternative payment schemes have had an insignificant impact on hospital and physician behavior.

The impact of even a partial shifting of economic risk within the industry was stunning and paradoxical. Strangely, for the first three or four years, nearly everyone involved seemed to be “winning.” The Medicare program won its first measurable relief from rising hospital costs in twenty years. Employers got the first sustained relief from double-digit health insurance premium increases in more than a decade. Despite sharply declining census, hospital revenues and profitability increased, as did physician incomes. Health insurers reversed catastrophic losses from 1979–1980 and experienced almost three years of record profits. Health maintenance organization (HMO) enrollment tripled. The patient, though burdened with some new and unfamiliar choices, won new status as a valued consumer both of health insurance and health services. And health costs overall rose at a single-digit level for four successive years.

These apparently salutary impacts of market change, aided materially by declining inflation in the general economy, lulled many actors in the health system into inactivity. Employers reacted to three years of modest health insurance premium increases by reducing their vigilance and search for new cost-containment methods. Further innovation in health care payment reform from state and federal governments also slowed.

The reward for declining vigilance on health costs quickly appeared: a sharp resurgence of health cost inflation during 1987, particularly in the private insurance sector. With the prospect of a severe fiscal crisis at the inevitable end of the “Reagan recovery,” the very forces that produced the seismic event of 1981–1982 are building again. The likelihood of an even more violent tremor in the American health economy toward the end of the decade is excellent. Understanding how the health system reacted to the first wave of economic pressures may help us predict the
Hospital costs and utilization. Because hospital costs were the driving force of increased health costs at the beginning of the decade, hospital utilization was the principal target of the revolution. As a consequence both of payment reforms and technological change, hospital inpatient utilization fell by almost 20 percent, reaching an eighteen-year low during 1986. However, despite these steep reductions, overall hospital costs rose an astonishing 80 percent from 1980 to 1986. Inflation and increased technological intensity certainly played a role, but, in my opinion, a relatively minor one. Changing hospital strategy may have played a more significant role.

The American hospital of 1987 offered a richer and more complex mix of clinical and human services than it did in 1980. Hospitals moved aggressively to capture emerging health care markets and succeeded in carving out major positions in ambulatory surgery, diagnostics, and home health care. Overall hospital outpatient revenues increased from $10.4 billion to $26.9 billion during the same period. Hospitals also attempted, with less success, to diversify into nontraditional services, from ambulance companies to durable medical equipment to health insurance. While no one has been able to quantify the losses accumulated in these efforts yet, my field experiences suggest that they were substantial, and indirectly contributed to rising hospital costs. Hospitals also strove to market their services to patients and physicians, expending almost $1.4 billion on advertising and marketing efforts during 1987. On balance, these efforts do not appear to have shifted market share as hospital managements had hoped. Hospitals also reacted to the threatened loss of access to tax-exempt debt markets by sharply increasing their indebtedness. As a consequence, hospital depreciation and interest costs increased from $4.9 billion in 1980 to $12.3 billion in 1986.

Most significantly, however, hospitals labored under an overhang of more than 350,000 empty hospital beds without meaningful reductions in staff or capacity. Though productivity in the newly diverse hospital is difficult to measure, some signs suggest that hospital productivity fell sharply during the first half of the decade. Full-time-equivalent (FTE) hospital employment per adjusted occupied bed (adjustment to reflect the sharp increase in outpatient activity) increased by more than 0.7 FTE from 1980 to 1987. While many hospitals cut direct patient care staff (whom they now are desperate to rehire given the current nursing shortage) in response to diagnosis-related groups (DRGs), they simultaneously added expensive new administrative staff in complex support areas including finance, information systems, marketing, and quality assurance.
As hospital cash flows narrow and hospital profits begin to erode or disappear altogether, major reductions in hospital capacity and employment seem both inevitable and appropriate. Nor has the potential for further use reductions been exhausted. While some western markets such as San Diego and Albuquerque reached inpatient use levels of between 500 and 600 days per thousand, many eastern communities remain at double or more these levels. Major potential savings in hospital use and cost remain to be wrung out of the system nationwide. As a consequence, the hospital share of total health spending, which shrank from 41 percent in 1980 to an estimated 38.8 percent in 1987, could reach as low as one-third or less by the mid-1990s.

**Investor-owned hospitals.** One of the biggest surprises of competition has been the fate of the investor-owned hospital management firms. Many experts predicted that these corporations, with presumed economies of scale, superior management, and access to capital, would dominate the American health care market. Yet the first major casualties of competition appear to have come from among these very firms. During 1987, eight investor-owned firms declared bankruptcy or suspended debt payments, while the four largest firms pared back unsuccessful ventures and reduced their hospital holdings.

The causes of the decline of these firms are multiple and complex. Virtually all of them were burdened, to varying degrees, by hospital franchises of marginal quality. Onto these franchises were heaped high corporate overheads and increasingly costly debt. As Medicare froze hospital DRG payments, early “profits” turned to widening losses. In highly competitive markets, the firms also were compelled to give steep discounts to health plans and to share their profits through a variety of mechanisms with their medical staffs to retain their loyalty. Investor-owned hospitals also were affected disproportionately by the shift to outpatient services and by the loss of highly profitable privately insured patients’ to aggressive utilization control programs.

While some investor-owned firms have continued to grow in psychiatric and rehabilitation care, they also may own a healthy chunk of the excess acute care capacity in the country. Although the larger firms bought temporary relief by diversifying into subacute care, this sector is likely to be a major target of cost-containment efforts in the next three to five years. Many signs point to an intensification of the problems that damaged the investor-owned hospital sector in the next few years, and only the strongest of these firms seem likely to be major players in the future American hospital system.

**Physicians and competition.** The impact of competition on physicians has been obscured by the extraordinary tumult unleashed in physician
communities. If one attended a lot of medical meetings or read the letters columns of medical journals, one would have concluded that the physician’s economic franchise was a smoking ruin, overrun and captured by the Huns of cost containment. Physician reaction in many communities bore a strange resemblance to Kubler-Ross’s famous grieving process, in the transition from denial to anger to depression and bargaining. Professional collegiality evaporated in highly competitive markets as competition for outpatients disturbed the traditionally disinterested collaboration of primary care physicians and their consultants. Tensions between primary care physicians and specialists over compensation issues boiled over into the health insurance market, as many primary care physicians embraced capitation and gatekeeper arrangements as a vehicle for redistributing income and power.

The contrast, however, between the anguished rhetoric of doom and catastrophe and the economic performance of physicians during the decade could not be sharper. Physician incomes not only rose consistently throughout the decade, but actually outpaced inflation in three of the first six years, despite horrendous malpractice rate increases and cost-containment efforts. Procedure-oriented physicians such as surgeons and radiologists capitalized on the boom in less invasive surgical and imaging technologies, and the payer tilt toward ambulatory medicine, to widen substantially the income gap relative to their primary care colleagues. While the growing supply of physicians and cost-containment pressures eventually will reverse many of these gains, those who predicted the quick demise of the private practice of medicine under competition can only be sobered by physicians’ raw display of economic muscle during the past seven years (Exhibit 1). Rising physician and ambulatory services costs (which helped drive Medicare Part B costs up by close to 20 percent in 1987) may be the most important cost pressure emerging in the new surge of health care cost increases.

Though utilization review programs have proliferated, they have not yet progressed to the stage of being able consistently to deny reimbursement for services the patient’s specialist deems medically necessary. While these programs have succeeded in reducing hospital admissions for many procedures, directly challenging the medical necessity of the procedure itself is a new and daunting prospect.

The role of employers. Employers entered the decade as the sleeping giants of the health financing systems. As government programs tightened payments, the role of employer-paid private health insurance as the system’s residual payer—financier of excess capacity and supplier of operating margins—became clearer. The enormous power in this relationship was displayed by the benefits redesign in the wake of the 1981-
Employers’ receptivity to HMOs was the key to that sector’s explosive growth during the decade. Employers also took bolder action than government in holding employees accountable for their own health costs and hedging the physician’s power through utilization controls. However, the quick successes these measures achieved lulled the sleeping giant back to sleep by mid-decade. The latest surge in health costs has reminded employers that regardless of the progress made in benefits redesign, private health insurance remains the society’s most reliable conduit for health cost inflation.

**A New Wave Of Cost Pressures**

As a consequence of the surge in health insurance premiums during 1987, the stage has been set for a new wave of cost-containment pressure and a further shift of economic risk to providers and patients. Managed care plans, which have marginally better control over their costs than indemnity plans, will be major beneficiaries of this next wave. Preferred provider organizations (PPOs), which languished due to employers’ lack of interest during mid-decade, also will benefit. Managed-care plans seem poised to capture a majority of the health insurance market by the early 1990s, compared to only about 20 percent today. Any downturn in the general economy or in corporate profits will only quicken and sharpen employers’ reaction to new cost pressures.
Employers, insurers, and government policymakers will face a much more difficult cost-containment challenge at the end of the decade than at the beginning, as a consequence of procompetitive changes in incentives and coverage. Hospital costs have been supplanted as the driving force of health cost increases by the very sectors of the health economy that were expected to blunt them—ambulatory services, home health care, and behavioral medicine. These services represented significant additions to America’s health care market basket. The growth of that market basket has played an important role in American health cost growth. At the same time, owing to the absence of mechanisms to force the cost-saving tradeoffs made possible by new services and technologies, the health system has not effectively squeezed out the costs that these new services have rendered unnecessary, nor has it controlled the abuses that usually accompany explosive growth in demand for any service.

The difficulty in controlling the new wave of cost pressures will be compounded not only by the direct role of the physician in generating them, but by the diffusion of technology and services out of the hospital. The hospital is becoming increasingly dispensable as a site for complex medical practice. The diminished centrality of the hospital in the health system may have damaged beyond repair the hospital’s utility as a control point for cost-containment efforts. “Global budgeting” focused on the hospital will not have that much effect on the new cost pressures. Controlling procedure volume, the diagnostic process, and the “softer” subacute services will be vastly more complex than reducing hospital admissions or length-of-stay.

Policy-Making Challenges

Where do these structural changes brought about by competition leave the policymaker, and how relevant are competitive models for addressing the short-term and long-term policy challenges the American health system faces? I contend that competitive models not only are highly relevant, but may be indispensable adjuncts to policy in an era of chronic mismatch between resources and social needs.

**Competitive bidding and selective contracting.** The most serious short-term problems Medicare faces are how to contain the explosion of outpatient and physician services costs and how to preserve cost-containment gains in hospital services without destroying the hospital system. In both cases, the most powerful tool in addressing these problems is likely to be franchising both high-risk and high-volume specialty services through competitive bidding and selective contracting. The recent decision to focus Medicare reimbursement for cardiac transplantation on a
few high-volume centers has set an important precedent for handling payment for other high-risk services. A recent analysis by the Inspector General of the Department of Health and Human Services concluded that the cost of open-heart surgical services under Medicare could be cut more than 15 percent, at a savings of around $200 million, by franchising these services through competitive bidding and concentrating them in a limited number of high-volume centers.\footnote{12} The continued proliferation of open-heart programs has reached absurd proportions in many markets. Concentrating open-heart volume probably could be justified on quality grounds alone, independent of any cost savings.

Though the problem is more complex, and the utilization control problems greater, competitive bidding and selective contracting may be the answer to containing the explosion of ambulatory surgical and diagnostic volume. The highly competitive physician markets in many parts of the country would provide fertile ground for franchising selected groups to perform intraocular lens implants, cardiac catheterizations, and other easily abused diagnostic imaging procedures. In these cases, as well as other big-ticket procedures, the patient’s relationship with his or her primary care physician would be undisturbed, since only specialty referral destination would be limited.

A more venturesome extension of the competitive bidding/selective contracting approach would be regional contracting for routine inpatient services. This alternative to the “Procrustean bed” DRG system could particularly benefit rural institutions, which thereby could exploit their significant cost advantage over suburban and urban hospitals. Selective contracting could reduce the costly migration of patients from rural areas and provide the increased cash flow and volumes rural hospitals need to upgrade their facilities and recruit a new generation of physicians.

Competitive bidding and selective contracting for Medicare Part A services is the ultimate weapon against excess hospital capacity and, unlike the present system, would reward the efficient facility with additional volume. Patients’ freedom of choice could be preserved under selective contracting by permitting them to use noncontracting facilities or practitioners at a higher level of cost sharing.

Capitation, and the conversion of Medicare from an open-ended “service entitlement” program to a “defined contribution” multiple health plan option program, remains the most attractive long-term policy option for the program. However, with only a million elderly enrolled under Medicare risk contracts, and the program mired in a variety of problems, it remains at best a long-term option. Whether capitation ever achieves its major potential for savings and improved coordination of Medicare services will depend on whether the program can regain sufficient credi-
bility with potential contractors to warrant the business risk of working with a federal government in chronic fiscal difficulty.

Solutions to the longer-term structural problems of the American health system are likely to be both more difficult and more painful. In a health system capable of consuming more than one-half trillion dollars annually, the existence of more than 30 million uninsured citizens and a yawning gap in coverage of chronic care services constitute nothing less than an authentic moral crisis. Solutions to these problems are hampered not only by chronic fiscal problems, but by a dearth of creative thinking.

Dealing with the uninsured. The problem of a large uninsured population is, as previous authors in this journal have explored, a complex and multifaceted one. While it is tempting to blame a laissez-faire attitude by employers toward extending health benefits to low-wage workers, I believe that the root of the problem is a declining commitment of public health financing programs to protect the poor, working or otherwise. While many blame the Reagan administration for this problem, the failure to index eligibility for Medicaid services to inflation and absurd variation in state definitions of income eligibility has a long, sad history. Four presidents and a largely Democratic Congress have collaborated to produce the legacy of policy default that has hampered protection of the poor from health costs.

The current panacea for the problem of uninsured citizens is to slough the problem off onto the private sector by mandating health insurance benefits as a condition of employment. While it is politically convenient to “tax” employers by mandate and bury the cost of extending health benefits in the general inflation rate, it is difficult to think of a more dangerous time to be testing the robustness of the private economy. A reemergence of a wage price spiral or a recession would be a disastrous consequence of well-meaning but ill-timed efforts to improve workers’ security by increasing minimum wages and expanding benefits by federal mandate. Given the precarious state of the economic recovery, and the fiscal nightmare an economic downturn would create, it would be irresponsible economic policy to encourage small employers (who have produced virtually all new U.S. jobs in the past fifteen years) to cease creating new jobs by raising the cost of employing existing workers. Mandated benefits represent a selective tax—estimated as high as $27-$40 billion for the first year—on the growth segment of the U.S. economy. Current group insurance premiums for small firms are rising at a rate that would cause the first-year cost of mandatory benefits to double in just three years.

While hospitals in particular would find highly attractive the promise of converting “no-pay” to privately insured patients, adding billions of
dollars in mandated health benefits to the current private health insurance market would have wildly inflationary consequences. Only a minority of health insurance plans yet provide any economic buffer against rising health costs. The logical policy response to the sustained health cost inflation created by mandated benefits would be government controls on both hospital costs and physician fees. Indeed, these two approaches—mandated benefits and strict regulation of provider incomes—are combined in the highly publicized universal health insurance plan proposed and recently enacted in Massachusetts.

Reforming Medicare and Medicaid. Perhaps because the challenge seems so daunting, and the constituency support for it so weak, the alternative of Medicaid and Medicare reform seems to have attracted less policymaker attention. Yet, it may be the only responsible policy alternative. Repairing the tattered safety net for the poor will require reforming the Medicare program, because Medicare’s failure to cover chronic care costs have diverted almost three-quarters of Medicaid’s total resources from covering the nonelderly poor. Only by redesigning Medicare to provide chronic care coverage can resources be freed up to improve health coverage of the poor. Severing Medicaid eligibility from eligibility for welfare (a process begun in 1986) and broadening the program to permit the working poor and their employers to “buy into” the program on a sliding-scale, tax-advantaged basis could increase program participation sufficiently to remove its welfare cast. Given the economic influence a broadened program could exert as a prudent purchaser of health services, and the potential role of capitated programs in controlling costs, Medicaid restructuring and reform is a more promising and economically responsible solution to the problem of the uninsured than mandated benefits.

Refocusing the Medicare program on the problems of chronic illness is the largest and messiest problem on the American health policy agenda. Political pressures are building to support this extension, as more elderly and their advocates realize that so-called catastrophic health insurance under Medicare does little more than plug holes in a program that has not materially changed in structure in more than twenty years. A Part C entitlement approach to chronic care funding under Medicare would be a fiscal disaster, as the painful experiences with renal dialysis and extended home health benefits should have taught us.

Two inseparable ingredients of an effective Medicare long-term care policy in the contemporary fiscal climate must be the use of some fiduciary mechanism not only to match patients’ needs to services but to control service use, cost, and the employment of private capital and patients’ economic responsibility for chronic care financing. The social
HMO appears to provide an elegant model of a fiduciary mechanism that can employ acute care savings to finance a portion of the cost of extending benefits, as well as provide the coordination of services so critically lacking in the existing, fragmented system. At the same time, finding a way to encourage and leverage private capital formation by future patients and their families through tax-sheltered annuities or tax-assisted private long-term care insurance will be essential to augment limited federal dollars in extending insurance.

Enhancing Economic Responsibility

While a growing number of proponents of an entitlement approach to health care financing have surfaced, those who advocate greater government control over the American health system must be sobered not only by the modest results of past regulatory efforts, but also by the limited resources to finance an expanded government role in health care payment. For government to provide only 40 percent of health care financing—the lowest percentage of any major country in the world—and yet to claim a central coordinating role, is increasingly difficult to justify.

In the past twenty years, American medicine has grown to the economic mass and scale of a large industrial nation. Only a handful of entire nations produce more total wealth than we Americans spend on health services. An entitlement approach to health care requires not only the public resources to deliver the promised entitlement, but the government authority and managerial capacity to direct this gargantuan activity centrally. The sad reality is that American government lacks both of these capacities. A society of passive claimants of a health care entitlement will never feel a corresponding obligation to conserve the society’s scarce health care resources.

Under competition, America moved away from an entitlement framework for health policy toward the spreading of economic risk and responsibility for health cost and quality among all participants—patients, physicians, health care managers, employers, insurers, and the government. Five years along in this process, the redistribution of economic responsibility is only partially accomplished. Some participants (such as the uninsured) bear far too much responsibility for health costs, while others bear too little. Finding the appropriate and equitable balance of economic responsibility seems to be a policy objective well worth pursuing, given the likelihood of continuing scarcity of public dollars.

Policymakers should look to competitive forces not as a substitute for a health policy, as some Reagan-era policymakers seemed to do, but as a tool to stretch their limited resources to help those important popula-
tions the government has promised to protect. Market mechanisms, incentives, and economic accountability alone will not solve the major structural problems of the American health system. But continued innovation and creativity, and the courage to employ those innovations to act as a catalyst to health system changes, must be the policymaker’s brightest hope of meeting our society’s unmet health care needs. Though critics who wish to see competition fail have been quick to herald a return to the failed strategies and tired rhetoric of the past, competitive forces in the American health system continue to offer the most promising avenue of health system reform.

NOTES

2. Ibid., 25.