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In the current health reform debate, consensus seems to be developing around a market-based model of “managed competition” to control costs. There is continuing debate, however, about whether and how to use traditional regulation in situations where a competitive model may not work, or as a transition to a market model. A small number of health reformers continue to advocate a rate-regulated, single-payer model. Thus, the question of how regulation or competition may affect hospitals and other providers remains a critical one.

In their paper, “Competition versus Regulation: Its Effect on Hospitals,” Gerard Anderson, Robert Heyssel, and Robert Dickler admit that their conclusions must be qualified by a number of “very significant” caveats. They have not adjusted for external stimuli, for changes in patient origin, or for changes in demographics, quality of care, health status, scope and extent of insurance coverage, and a range of other factors for which there are not adequate controls.

In addition to these methodological problems, I would add other caveats. While their efforts to gather data are admirable and a necessary first step, I reluctantly conclude that the caveats undermine the validity of their findings. Here I discuss several critical problems.

Some Concerns

First, the authors focus only on hospital costs because both the regulatory and competitive strategies they are observing have targeted this sector. Health care is full of cost shifting, and hospitals are not immune. How do these various strategies affect use of outpatient services, such as procedures in physicians’ offices or ambulatory care centers? Do various controls on hospitals spill over into other sectors of the medical services community?
Do changes in these controls over hospitals reduce hospital expenditures but increase or decrease overall spending? Surely a model that increases overall spending should not be imitated, even if hospital lengths-of-stay or other utilization measures decrease. Aggregate health spending is the only fair economic measure, especially when so much change is occurring across care settings. In other words, diagnosing a problem by looking at only one organ rather than the whole organism is faulty.

Second, to draw conclusions from the authors’ findings, we need to look at outcomes, not just costs. Our goal in implementing a reform strategy should not be simply to reduce costs “at all costs.” We need to apply outcomes measures to determine the effect on the overall health of the community. An exclusive focus on costs could lead to inappropriate policy interventions.

Observations From Minnesota

My concerns about Anderson, Heyssel, and Dickler’s conclusions go deeper than methodology. I have watched the evolution of the health care market in Minneapolis/St. Paul for eighteen years, the last fourteen of those years as a health policy expert in the United States Senate. Most of what I know about health comes from observing the creative trends in my own home state of Minnesota.

The hospital environment in Minnesota has been more competitive than regulatory. However, we cannot draw conclusions about the success or the failure of the “market” model from this region, because we have not had a sound market for health care. As Walter McClure has pointed out, two conditions of a sound market that are missing in health care are (1) objective consumer information on the quality and cost of the health care product, and (2) consumer price sensitivity. To achieve a truly sound market, it is necessary to have purchaser reform, not just delivery reform. Purchasers of care must have the market power they need to get the seller to compete on both price and quality.

It is true that the Twin Cities have made major changes in the way that medical care is delivered. There has been a development of integrated health maintenance organization (HMO) systems and a consequent rise in hospital mergers and collaborations. While these events may have led to more efficient forms of service delivery and lower utilization rates, which I take to be a good thing, they have not necessarily affected the prices charged because buyers have remained relatively price-insensitive.

We will never know how well a market will control costs and produce quality until we have empowered those who purchase care. Reform proposals—such as underwriting reforms, health insurance purchasing coopera-
tives (HIPCs), federal standards for accountable health plans, and the requirement of comparable information on price and quality for a standard benefit package—would work to reform the buyer side of the marketplace. Until those reforms take place, as well as antitrust and liability law reform, one cannot assume that Minneapolis/St. Paul or any other health care marketplace is truly competitive.

Because I find market failures in the Twin Cities does not mean that I support a regulatory alternative. Quite the contrary. As a senator who has participated in the legislative creation of Medicare’s prospective payment system (PPS) for hospitals and the resource-based relative value scale (RBRVS) for physician fees under Medicare, I am very familiar with the impact of price controls on health care services. The recent testimony of Phillip R. Lee, head of the Physician Payment Review Commission (PPRC), on the volume response of some specialists to the imposition of RBRVS should be the nail in the coffin of price controls in health care. Lee reported that following the introduction of payment reductions for physicians’ fees, “the procedure-based internists . . . increased their volume of services . . . sufficient to recover 90 percent of the income lost due to price reductions. That is a volume response that is not necessarily appropriate care.”

Regulating the prices of medical services simply does not work. It leads to excessive micromanagement to prevent gaming of the system and, ultimately, will lead to lower-quality care. Price controls have never succeeded in dynamic areas of the economy; it is naive to think that they would work in the health care sector.

Our policy goal in health reform is universal access to affordable, superior-quality care through a system of universal coverage of financial risk. Given our severe budget deficit, we do not have unlimited resources to spend, Thus, we need to make sure that our uninsured and underinsured persons receive the care they need, but we need to pay less for those services. The only way that I know to do that is productivity. No regulatory model guarantees productivity. The only force that guarantees productivity is a sound market. A sound market requires competition among sellers for the attention of informed buyers. Competition will lead to more efficient service delivery at lower prices. That’s productivity.

In saying this, I do not mean to imply that there should be no government intervention in the private marketplace. The role of government is not to set and administer prices; rather, it is to ensure that the competitive marketplace works. In health care, this means that government needs to set the rules for the marketplace. It also means that government must establish the infrastructure to prevent other forms of market failure, by mandating that information be provided to buyers, establishing minimum benefits, and
setting rules for insurance underwriting.\(^4\)

We have seen the limits of price regulation to control costs, and Maryland is one such example. We have much less experience with sound markets in health care. While Anderson, Heyssel, and Dickler’s conclusions have some explanatory value, I do not believe that we can choose our strategies for reform on this basis. We need to look deeper and farther for answers. And, because we do not have perfect information, we need to take a small leap of faith. When I am making that leap, my experience, expertise, and instincts all lead me in the direction of competition.

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**NOTES**

3. P.R. Lee, testimony before the U.S. Senate Committee on Labor and Human Resources, 17 December 1992.