Perspective: Medicare Price Controls: The Wrong Prescription

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Perspective

Medicare Price Controls: The Wrong Prescription

Debates over trust fund solvency and budget savings have obscured the real questions about Medicare reform.

by Stuart M. Butler

The current debate on Medicare is wretched because most proponents of a position do not set out clearly the principles and economic philosophy on which they believe the program should be based. Instead, the pattern usually is to discuss changes in the program merely in terms of “budget savings,” without much indication of how the reform would begin to change the nature of the program. The paper by Theodore Marmor and Jonathan Oberlander is refreshing because the authors insist on discussing basic principles and economic philosophy. That does not make them correct, of course. Indeed, by laying out their framework so bluntly, they do us a service by exposing the weaknesses of more hazy and incremental reforms that start from a similar view of the world.

In comparing vouchers with their own plan, Marmor and Oberlander get to the heart of the real debate that should be taking place. It is not a debate about the Hospital Insurance (HI) trust fund. The central dispute is over two questions that should be asked even if the trust fund were projected to be in balance forever. First, should Congress determine and then budget how much taxpayers should contribute to Medicare, or should Congress continue to promise retirees that society will guarantee them a certain set of benefits, regardless of cost? And second, which economic system is more likely to achieve an efficient and just Medicare program—the system of central planning or the system of markets and consumer choice? Marmor and Oberlander answer these questions by painting a glowing picture of how a complete regime of central planning, with tighter price controls and budgets, could enable the promise of defined Medicare benefits to be achieved at reasonable cost.

The Dark Side Of Price Controls

- Quality. The first problem with the authors’ answer is that it is absurd to suggest that using price controls to hold down costs will not reduce quality. A vast literature on price controls shows otherwise and underscores simple economics: When the government forces someone to charge less, be that person a landlord or a doctor, that person will react by providing less. I spent thirty years living under Britain’s National Health Service and can attest that there is no secret to the “success” of Britain and other countries in holding down costs through controls. Patients simply get less time with their doctor, wait longer, and have reduced access to services. Indeed, if this were not so, we would have found in price controls the Holy Grail of economics, and controls would be adopted throughout the economy. If Marmor and Oberlander were right, we could just pay restaurant chefs, fire fighters, and brain surgeons less and enjoy the same quality of service.

- Fraud and politics. Moreover, controls

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encourage gaming and the politicization of health care. It is hardly necessary to describe the huge incentives for providers to be “creative” with payment codes and service levels when a controlled payment is perceived to be out of line with market conditions. Indeed, the more frequent doctor visits cited by the authors are not evidence of the superiority of the European systems, as the authors contend, but an unwelcome side effect of controls. As I discovered in Britain, when regulators pay a doctor less for seeing a patient, he or she simply responds by ordering more, but shorter, visits.

The history of price controls in health care, like controls elsewhere, is for the system of controls to become more elaborate and comprehensive as the bureaucracy tries desperately to reduce the opportunity of providers to manipulate controls or to go outside them.

Politicization naturally follows from this system because the financial well-being of providers turns on the administered prices set by government and the regulations governing medical services, rather than the normal economics of satisfying a customer. That is why the shape of Medicare today is determined so heavily by provider lobbying. That in turn tends to empower entrenched interests at the expense of competitors with new ideas. The result is less management and service innovation in Medicare than in the rest of the U.S. health care system. By giving even more power to central planners, Marmor and Oberlander would only make this situation worse.

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Vouchers Versus Price Controls

Marmor and Oberlander are right to identify vouchers as the antithesis of their approach to a reform of Medicare. But they paint a simplistic picture of what a voucher can be. The term voucher can in practice mean many different things. As distinct from a cash subsidy, a voucher can only be used to purchase certain things and so is compatible with at least a core of defined benefits. But a voucher does not have to be a fixed amount for each person. It can be adjusted according to certain factors, such as categories of medical risk. A voucher system also can be adjusted according to income, for instance. This means that it can be designed to provide the most financial help to persons who really need it. Price controls on providers, by contrast, cannot do this and so are a crude and indiscriminate way to help the elderly poor.

Benefit levels. The very nature of the budget and regulatory approach proposed by Marmor and Oberlander thus would reduce, not enhance, Medicare’s ability to maintain any particular level and quality of service. More likely it would lead to the “hollowing out” of benefits, similar to the result in the countries the authors speak of so highly. Saying that you have the right to a daily meal in a restaurant is not really a defined benefit if the quality of the food steadily declines and you have to wait longer and longer between courses.
limit based on the average cost of a group of plans. Thus, the federal worker is somewhat insulated from medical inflation yet still has the incentive to seek value for money, which is a characteristic of vouchers.

The other caveat is that although vouchers do mean a shifting of some financial risk to patients, so does the proposal advanced by Marmor and Oberlander. The difference is that in the case of a voucher, this shifting is transparent, whereas in their proposal, the shifting of risk is hidden. In a controlled system, risk is in the form of quality and access limits, including waiting times, that force patients to pay for additional services if they wish to maintain a constant level of total care. In a system like that of Britain or Canada, patients run the risk of having to turn to the private sector when controls reduce the effective value of government-sponsored benefits.

- **Responsiveness to beneficiaries’ demands.** The second central feature of a voucher system is that medical resources are allocated and financed according to the demands of individual beneficiaries, using vouchers in a market. This is the antithesis of Marmor and Oberlander’s system of central budgeting and price controls. Instead of trying to suppress the role of prices as a market signal, a voucher approach uses flexible prices to provide incentives for beneficiaries and providers to adjust their behavior to ensure that limited resources are used in innovative ways that satisfy the desires of beneficiaries.

- **Managed care.** Because of these features of a voucher system for Medicare, Marmor and Oberlander’s objections miss the mark. Vouchers do not presume that Medicare beneficiaries should be moved into managed care. The structure of Medicare in the future will depend entirely on how well competing innovative structures satisfy beneficiaries holding a voucher. In fact, the success of centrally planned systems, not voucher systems, depends on the power of planners to restrict both the choices of patients and the innovation of providers.

There is also nothing inherently “unfair” about the way in which vouchers affect people who enroll in high-cost plans, either out of necessity or preference. To be sure, voucher or capitation systems will become more effective as we find better ways to measure medical risk in setting the amount of the voucher. Fortunately, our ability to measure and adjust for risk is steadily improving. On the other hand, the potential effectiveness of Marmor and Oberlander’s proposal faces the far more daunting conceptual problems associated with trying to manage and control the entire complex Medicare system.

**Wrong Proposal, Right Debate**

Marmor and Oberlander’s proposal thus is the wrong prescription for Medicare. But they are engaging in the right debate. It should be a debate about the nature of the Medicare contract itself and about the appropriate economic foundation for Medicare. This is the discussion that should be conducted by the Medicare commission, on the pages of America’s newspapers and journals, and on the floor of Congress. Marmor and Oberlander are right to contend that the phony debate over trust fund balances and budget savings has for too long obscured the fundamental questions at issue.