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Clarifying The Competition Strategy

To the Editor:

Two articles in the special issue on “The Managed Care Revolution” (Health Affairs, Summer 1988) graphically highlight a fundamental error in analyses of the competition strategy in health care.

First, Alain Enthoven’s article (“Managed Competition: An Agenda for Action”) cogently summarizes the principal concepts of the competition strategy that emerged more than a decade ago. At the heart of the strategy is the elementary but oft-ignored market principle that provider markets are largely devoid of price competition, and that market reform therefore requires the introduction of the positive incentives for efficiency and service provided by provider price competition.

Second, the article by Jon Gabel and colleagues (“The Changing World of Group Health Insurance”) begins by referring to the work of Enthoven and others in developing a competitive strategy, but then ignores the heart of that strategy: provider price competition. Instead, the authors mistakenly assume, without explanation, that managed care is synonymous with the competition strategy. The contrast between Enthoven’s article and the managed care definition of competition is stark. Managed care has little, if anything, to do with provider price competition.

For example, Gabel states, “The good news for competition advocates in 1987 was that managed health care became the mainstream of group health insurance, with over 60 percent of Americans enrolled in either an HMO (health maintenance organization), PPO (preferred provider organization), or managed fee-for-service plan.”

To the contrary, for competition advocates this is both “no news” and “bad news.” It is “no news” because enrollment in managed care plans is irrelevant to provider price competition. As Enthoven notes, 55 percent of employers pay the entire health insurance premium for their employees, and that “in such an environment, even if HMOs are offered, there is little or no price competition.” It is “bad news” because it is yet another example of the misapplication of the competition strategy.

Unfortunately, such misapplication is common in health policy analysis, where everything but provider price competition seems to pass for the competition strategy. Gabel and colleagues refer to studies that make the basic mistake of using HMOs as a proxy for competition, and that conclude that HMOs and therefore competition will result in only one-time savings over conventional insurance. As Enthoven also makes clear, HMOs are not a proxy for provider price competition.

More recently, Luft and Robinson remarkably turned the competition strategy on its head by analyzing as “competitive markets” hospital markets where nonprice competition prevailed. They found hospital costs were higher in such “competitive” markets, and concluded that competition thus leads to higher costs (“Competition and the Cost of Hospital Care, 1972 to 1982,” Journal of the American Medical Association, 19 June 1987).

Ironically, we knew at least a decade ago that nonprice competition among providers results in higher costs; this is what led the
competition strategy to focus on the need for provider price competition. Thus, if anything, the Luft/Robinson article confirms the basic tenets of the competition strategy, yet it reports the exact opposite.

Given the frequency with which the competition strategy is misunderstood and misapplied, I developed a provider price competition/positive incentive index in an effort to encourage sound analysis of its central tenet. Contrary to the "good news" reported in the article by Gabel and colleagues, my index shows that the competition strategy affects less than 10 percent of providers and consumers in most markets. Enthoven also specifically states that, "Few, if any, communities have experienced real competition of efficient closed-panel plans." Further, *Modern Healthcare* confirms both of us, stating that even today we are just seeing "the first indications of price competition in health care" (22 July 1988, p. 38).

It is my hope that this special issue of *Health Affairs* will mark a turning point in the proper analysis of the competition strategy for health care so ably and precisely stated in Enthoven's article.

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The Quality Of Patients’ Ratings

To the Editor:

Although I agree with most of the conclusions reached by Allyson Ross Davies and John E. Ware in "Involving Consumers in Quality of Care Assessment" (*Health Affairs*, Spring 1988) I disagree with their opinion that "the weight of the available evidence suggests that interpersonal features of the encounter do not obscure consumers’ ability to distinguish levels of technical quality." The authors base this conclusion heavily on results of videotape manipulations of technical and interpersonal care in provider/patient interactions. Viewers of these staged interactions have rated the care delivered consistent with the intended manipulations.

As an investigator in a study that used this videotape methodology (the American Board of Internal Medicine study noted by Davies and Ware, p. 45), I find this "evidence" to be of limited value. The manipulations are so extreme and the process of viewing a videotape so removed from an actual provider/patient interaction that these data should be regarded cautiously. These studies only indicate that viewers can correctly recognize artificial differences in medical care portrayed by actors.

Davies and Ware note the high correlation between consumers’ ratings of interpersonal and technical quality of care, but they indicate that these correlations need to be compared to what is true in the real world to evaluate whether bias is present. This is certainly worthwhile advice, but even without knowledge of "reality," the weight of evidence suggests that patients make little if any distinction between interpersonal and technical quality of medical care when rating their own provider, especially when rating a specific visit.

A confirmatory factor analysis I conducted of patient satisfaction measures revealed a correlation of 0.90 between latent variables representing interpersonal and technical quality of care. Analyses of a patient satisfaction survey indicated that ratings of interpersonal and technical quality could not be distinguished. Similarly, visit-specific ratings of interpersonal and technical quality in a study reported by Ware and Hays were indistinguishable.

Ratings of periodic satisfaction also demonstrate that patients have trouble separating interpersonal and technical quality of care. Analyses of the Medical Outcomes Study Patient Satisfaction Questionnaire show that three of the ten items designed to measure technical quality and five of seven designed to measure interpersonal quality correlate as highly with the interpersonal and technical quality scale (within two standard errors), respectively, as they do with the scale they were hypothesized to represent. Multitrait/multimethod analyses revealed a lack of discriminant validity between measures of "quality" (technical quality) and humaneness (interpersonal...
quality) of care.\(^5\)

Even after allowing for the possibility that technical quality and interpersonal quality of care are correlated in the “real world,” the weight of the empirical evidence suggests that patient ratings do not provide programmatically useful distinctive information about these two dimensions of care.

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NOTES


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