Health Care:
Getting the Right Amount at the Right Price

by Laurence S. Seidman*

During the past decade, the consensus among health policymakers appeared to be that significant government regulation and planning would be required to hold down the cost of health care and make it more easily accessible to the less well-off members of society. Although full-fledged national health insurance was not enacted, important steps were taken in that direction. The issue for many policymakers was not whether comprehensive NHI should be legislated, but only in what form.

Recently, however, government regulation and planning in the health industry, as in others, have come to be viewed with increasing skepticism. A market-oriented approach recommends itself more and more to policymakers. The next few years promise to witness a fundamental clash of opposing strategies, which may decide the direction of the health sector for the rest of the century.

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HOSPITAL COSTS: DECADES OF HIGH GROWTH

Since the beginning of the drive for national health insurance, an overriding consideration has been cost, and cost remains uppermost in the minds of many of today's health-care reformers.

Hospital cost growth has substantially outpaced the rise in the consumer price index (CPI) for three decades. In the period from 1950 to 1965 (prior to the enactment of Medicare and Medicaid), cost per patient day in short-stay hospitals increased 8 percent per year, while the CPI increased 2

percent. From 1965 to 1976, cost per day increased 12 percent, while the CPI increased 5 percent. While half of the price rise came from an increase in resources used—increase in the quantity, quality, and style of service—half of it came from rising costs for labor and other inputs for hospital care. This unusually rapid cost rise has led many critics to ask whether care is being provided as efficiently as it might be—that is, whether consumers' preferences are being reflected accurately in the assignment of resources and whether those resources are being used in such a way as to get as much care out of them as possible.

Efficiency, however, is only one side of the health sector issue. The other is equity. Although the typical patient is able to pay for a hospital stay through insurance, some inadequately insured households remain unable to do so, and they continue, each year, to have great difficulty affording the medical care they need. When hit with catastrophic illness, they suffer severe financial hardship.

Medicare for the elderly and Medicaid for the poor were enacted in 1965 to reduce the number of such households. Yet important gaps still remain. Universal major-risk or catastrophic protection does not yet prevail in the U.S. Thus, both efficiency and equity issues remain on the health policy agenda.

While lack of health insurance is the source of inequities in providing care, observers of the health scene trace efficiency difficulties to the payment of bills by third parties through health insurance plans.

HEALTH INSURANCE SPREADS

Over the last three decades, the share of the national hospital bill paid by third-party insurers—private and public—has increased strikingly. In 1950, half of all hospital revenues from patient care came from insurers. By 1965, the third-party share exceeded 75 percent. Today, nearly 95 percent of the national hospital bill is paid by insurers.

For the *average* hospital patient today, hospital care is free: the bill a patient runs up is irrelevant to him financially, because the insurer will pay 100 percent of it. (The physician's fee generally is not fully covered, so the patient will pay a fraction of the MD bill). Thus patients have no incentive to care about the cost of their own hospital care. But such care cannot be free to society, because it consumes real resources. In the end, all households collectively pay for hospital care in large part through their health-insurance premiums.

The situation is similar to restaurant bill-splitting. Suppose a large group goes out to dinner, and it is agreed, in advance, that the bill will be split without regard to each person's individual order. What happens? Each person realizes that his *own* order will have little effect on his financial burden, which will depend largely on what everyone else orders. So some probably will inflate their orders, and the result is an inflated bill.

In effect, the U.S. hospital system is financed by bill-splitting. Through insurance premiums and taxes (for Medicare and Medicaid), the citizens split the bill. It is therefore little wonder that when the MD decides whether to admit his patient to the hospital, which hospital to use, what tests to run, and how long to extend the stay, he generally ignores cost. His patient would not want him to consider cost, because it has no effect on his own financial burden.

There is a broad consensus that because patients and physicians lack incentives to keep costs down, too many people end up demanding too much care, driving the cost up too high. The disagreement is over what to do about it.

THE REGULATORY APPROACH

Until recently, the dominant view among participants in the health policy debate was that government should act to bring health care within the reach of all by making it free to everyone. Free-care advocates recognized

that their approach would remove incentives from patients and physicians to weigh cost. But they counted on government regulation and planning to fill the vacuum and encourage efficient resource use.

Over the past decade, several methods have been tried or proposed to promote efficiency. The basic problem is that with free care there is excess demand—demand that it would be wasteful and thus inefficient to satisfy fully. The first method of eliminating waste is to limit supply; the second, to limit demand.

How can supply be limited? One method is to require hospitals to obtain certificates of need from regulators, in advance, before expanding facilities or acquiring new technology. Certificate-of-need programs were begun in various states and have been authorized under the Health Planning Act of 1974. A second method is to limit the growth in revenue permitted of any hospital. The Carter Administration proposed a hospital cost containment measure which would have limited revenue growth to approximately 9 percent per year. But this proposal has not been enacted into law. So far, attempts to limit supply haven't been notably successful.

The attempt to limit demand has taken the form of utilization review. In 1972, Congress authorized the creation of Professional Standards Review Organizations (PSROs), composed of physicians in each local area, to review cases that appeared to use hospital facilities wastefully. It was hoped that PSROs would pressure MDs to reduce demand for hospital facilities on behalf of their patients. PSROs, however, haven't made a major dent in hospital cost growth either.

Thus it isn't surprising that some critics of free care and regulation have focused on the cost issue, even going so far as to argue that having a free-care system guarantees that the share of GNP going to health costs must continue to grow, and grow significantly. It needn't, though. Other countries using the regulatory-planning approach have demonstrated that, despite free care, supply limitations can succeed in containing the health share of GNP. In Britain, for example, where the government owns and operates the hospital system under the National Health Service, the health share of GNP is roughly half that in the U.S. (5 percent instead of 9 percent).

Cost containment, however, is not the same thing as efficiency. It is just as inefficient to devote too few resources to a given sector as it is to devote too many. Efficiency requires achieving just the right level of care, where further expansion entails a cost not justified by the benefit to the users. Moreover, efficiency requires that a given total supply be allocated among users according to the urgency of each one's demand.

The shortcoming of the regulatory strategy is not that it cannot control total cost effectively. Evidence from abroad shows that in some cases it can. Rather, the central weakness is that there is no effective way to register the true preferences of each consumer. As a result, it is difficult to determine the proper growth rate of cost and the allocation of scarce supply among individual consumers.

In virtually all other sectors, where each person pays according to his own use, consumers self-regulate. We seldom worry about whether the growth rate of cost in sector X is appropriate, because we know that each consumer must balance cost against benefit. But in the hospital sector, there is no incentive for self-regulation. Each MD knows that his insured patient wants the best and most, regardless of cost. MDs transmit these inflated demands to the system. Without consumer cost sharing, how can the regulators and planners assess the true intensity of patient preferences?

In such supply-constrained health systems, clear emergencies usually are handled with the urgency they warrant. But many medical conditions that may require hospital service are not clear-cut emergencies. With limited hospital capacity, it is not obvious that those

with the most urgent nonemergency demand will obtain the limited supply. Waiting lists and queues for elective treatment are a common feature of many regulated, free-care systems, such as the British National Health Service.

Thus all in all, the regulatory approach doesn't offer an easy way to decide how much care to provide and who should receive it.

A MARKET-ORIENTED STRATEGY

At the end of the last decade, an alternative approach began to challenge the regulatory strategy. Although advocates of this market-oriented approach concede that the market does not function effectively in the hospital sector, they believe that it can be restored to reasonable health. Moreover, they contend that achieving equity and restoring the market mechanism can be made compatible.

Advocates of this strategy believe that the source of the current market failure in the hospital sector is misguided Federal tax policy. For several decades, Federal tax treatment has encouraged employers to shift the compensation package away from cash towards comprehensive, costly health insurance.

Consider an employer who has decided to raise compensation per employee by $100. If he pays this increase in cash wage or salary, the $100 will be taxable income; after payroll and income taxes, the employee may perhaps keep $70. But if the employer instead buys the employee $100 of additional health insurance, this form of compensation will not be regarded as taxable income for the employee. Thus the choice facing the employee is to take $70 more in cash or $100 more in insurance. The tax exclusion of insurance obviously biases employee choice in the direction of insurance.

Undoubtedly, the intent of Congress in excluding insurance benefits from taxable income was to encourage households to obtain adequate major-risk protection so that they could afford the care they needed even if struck with a catastrophic illness. The crucial feature of the Federal tax exclusion, however, is that it is open ended. Rather than being limited to an amount sufficient to buy major-risk protection, it applies without limit. Thus employees have been encouraged to seek, and employers to provide, first-dollar, shallow hospital insurance—insurance that covers all care from the first dollar spent, with no provision for patient cost sharing. Such high premium first-dollar coverage does more than assure major-risk protection; it makes hospital care free for the typical patient.

The crucial first step, then, in the market-oriented strategy is to remove the substantial tax bias towards shallow insurance. In a recent session of Congress, several bills were introduced that would place a cap on the tax exclusion so that only part of the insurance benefit would be excluded from taxable income. An employer contribution above this cap would be included in the taxable income of the employee exactly as if it were cash salary.

But wouldn't it be politically impossible to set the cap at a level lower than the benefit level employees are receiving now? It might seem so, but the incentives can be arranged in such a way as to induce employees to choose lower benefit levels. The trick is to give cash payments under the cap the same tax advantages as benefits.

As proposed in a bill introduced last year in Congress, employees could be allowed to keep cash tax free below the cap should they choose less costly insurance. Suppose, for example, that the cap were set at $1,200 for a workplace where previously the comprehensive insurance premium was $1,200. If an employee preferred to switch to a less costly policy with an $800 premium, he would be permitted to keep the difference ($400) tax free.

An alternative would be to count the entire contribution of an employer as taxable

income for the employee, but to enact a new health insurance tax credit for all households. The key feature of the credit is that it would be a fixed-dollar amount for a household of a given size and income regardless of how much the household spent on insurance. The household no longer would be subsidized for purchasing insurance above the amount of the credit.

It seems likely that if tax reform removed the bias towards insurance, many employees would prefer a shift in their compensation package back toward cash. Without the tax subsidy, many probably would prefer insurance with a more moderate premium, even though it would require moderate patient cost sharing (deductibles and coinsurance). Major-risk coverage would continue to be purchased, but high-premium insurance that makes hospital care free would be much less common.

Physicians soon would recognize that the average patient no longer is covered fully for hospital care. Of course the typical patient wouldn't nag his doctor about costs while on his stretcher in the ambulance. Nevertheless, the recuperating patient would receive a bill and would bear a fraction of the cost. Anticipating the impact on his patient, the average MD would try to avoid unnecessary cost.

The new sensitivity of MDs to cost would be transmitted to hospital managers. Under free care, a hospital manager has no incentive to try to provide a given quality at lower cost, because MDs and patients regard cost as irrelevant. With cost sharing, MDs would prefer hospital A to hospital B if A provided the same grade of care at lower cost. Thus, insurance with cost sharing ultimately would transmit pressure for efficiency to producers, just as it does in other sectors.

Removal of the tax subsidy not only would promote efficiency under traditional fee-for-service (FFS); it also would remove an obstacle against health maintenance organizations (HMOs). Prepaid HMOs, such as Kaiser on the West Coast, give providers an incentive to limit cost because they are prepaid a fixed sum, regardless of service rendered, in contrast to fee-for-service. HMO supporters believe they can capture an important share of the health sector if households are not subsidized when they buy high-premium FFS insurance. Removal of the tax subsidy would make HMOs, if they are more efficient and less costly, more attractive to consumers.

If the market-oriented strategy works as advocates envision, it should improve efficiency. And an income-related, last-resort tax credit would ensure that all households have income-related major-risk (catastrophic) coverage. The tax credit would assure equity, while the repeal of the tax exclusion would promote efficiency.

Consider, for example, a household with $20,000 of income. Whether or not it has private insurance, it might have to bear the first $2,000 (10 percent of income) of expense (excluding any expense of an insurer on its behalf) before being eligible for a tax credit. It might then be entitled to a credit equal to 80 percent of its additional expense, until it has borne $3,000, or 15 percent, of its income. At that point, it would be entitled to a 100-percent tax credit on additional expense.

The credit would provide an out-of-pocket ceiling equal to 15 percent of income. Whatever a household's private insurance coverage, the tax credit of last resort would assure major-risk coverage. Moreover, the credit would be refundable, so that a low-income household would receive a check from the IRS if its credit exceeded its tax liability. Thus the income-related refundable credit could replace Medicaid.

No policy prescription, on health care or anything else, is likely to scrape by without criticism, and this market approach to health care is no exception. What are the typical objections?

SOME CRITICISM

Critics of the market-oriented strategy

give several reasons for their skepticism.

For one thing, they doubt that removing the tax bias toward shallow insurance in fact will reduce the prevalence of such insurance. They believe households strongly prefer first-dollar coverage and would pay high premiums even without the tax advantage. Advocates reply that one reason why the tax advantage was originally enacted was the concern that, without it, many people might choose cash over even major-risk insurance.

Also, critics doubt that insurance contracts with cost sharing would affect either physician or hospital behavior even if those contracts became widespread. They contend that MDs, not patients, make the decisions, and that they will be unaffected by the financial impact on their patients. But even today MDs often consider financial impact in the few areas where it matters to the patient. MDs sometimes tell patients for example: "I will put you in the hospital where your insurance will fully cover you, even though I could treat you as an outpatient, where it would cost you more." MDs know that patients appreciate such concern.

Finally, some critics fear that cost sharing would impose severe burdens on households unable to afford it. Those critics surely are correct that removing the tax bias alone might well produce hardship and would do nothing to protect households with little or no private insurance. But the income-related last-resort tax credit can address these concerns. Whatever the cost sharing under a private insurance policy, an income-related credit can ensure that every household receives enough assistance to afford the care it needs without hardship.

CONCLUSION

Most other countries have adopted a regulatory-planning approach to the health sector. Free hospital care has been accepted as necessary for equity, and regulation has been relied upon to promote efficiency. Until recently, this strategy appeared to be the dominant one in the U.S. as well.

An alternative, however, has emerged to challenge the regulatory approach—a market-oriented strategy. To promote efficiency, this strategy would reform the tax treatment of private health insurance to remove the bias toward shallow, first-dollar coverage. With the tax exclusion curtailed, many employees would shift over time to less costly insurance that includes patient cost sharing. With hospital care no longer free to most patients, physicians would begin to weigh cost, and hospital managers would respond to this new sensitivity on the part of MDs.

The market-oriented strategy would promote equity though an income-related last-resort tax credit that would ensure an out-of-pocket ceiling related to household income for all households, whatever their private coverage. The tax credit is a modern policy instrument that enables assistance to be provided according to income while preserving confidentiality.

The debate over health care provision will be resolved one way or another in the next few years. Its outcome will determine the direction of the health sector for the rest of the century, with important implications for social welfare. It is a debate worth watching carefully.

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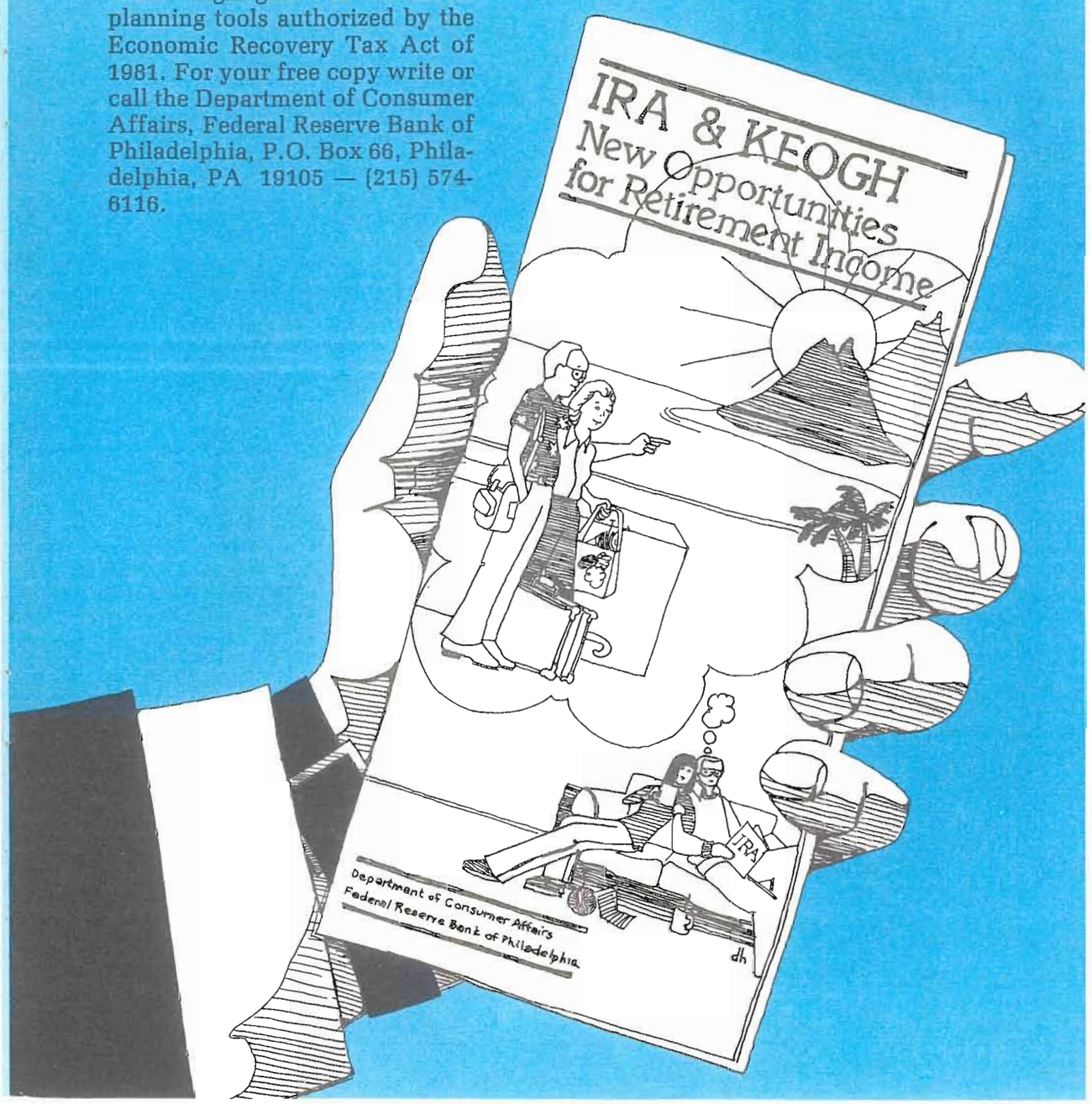

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