Halfway Competitive Markets and Ineffective Regulation: The American Health Care System

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Abstract. Since the late 1960s the U.S. has attempted to develop a strategy for controlling the rate of growth of health care spending. During the 1970s this strategy relied heavily on various forms of regulation. Some regulatory programs were partially successful in moderating spending increases, but they generated significant opposition—particularly from powerful provider groups, who successfully convinced Congress and the states to dismantle most of the regulatory structure and to substitute various forms of competitive approaches to controlling spending. Some of these competitive strategies have been successful in increasing the efficiency of subsections of our health system. But they too have produced "losers," and the government has been pressured to enter the system to minimize their losses. The net result has been a political stalemate between halfway competitive markets and ineffective regulation. With the rate of health care spending growth near historic levels, it is likely that the 1990s will bring a return to a stronger role for government regulation. But it is unlikely that we are any more willing to tolerate the negative fallout from regulation today than we were in the 1970s, and therefore we predict that the proportion of GNP going to health care will continue to grow throughout the remainder of this century.

A decade ago there was a perceived need to control medical care spending, which was increasing at a rate one-third faster than the gross national product (Waldo, Lent, and Lazenby 1986). There was a consensus among health care analysts that this spending did not provide equivalent benefits. Experiments with capitated forms of financing delivery of medical services, such as health maintenance organizations (HMOs) had shown that the use of resources (principally hospitals) could be reduced and personnel used more efficiently with no apparent ill effects on patient care (Enthoven 1978). In addition, sociological and other studies of health suggested that public health measures, personal lifestyles, and social and environmental conditions were in many respects more significant determinants of aggregate health than use of medical services.

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At the time, Altman and Weiner (1978) characterized the use of regulation to contain medical inflation and real growth in the medical sector as a "second-best" alternative, one that was necessary—if not desirable—because of the nature of medical care and the way it was financed. Regulation was needed because market forces could have only a marginal impact on medical spending at best. The ineffectiveness of market forces was due to the existence of extensive insurance coverage, which made patients largely unresponsive to costs and to government subsidies of insurance and medical education; this in turn artificially increased the demand as well as the supply of medical services. Other factors also made sole reliance on market mechanisms inappropriate. Patients do not behave like ordinary consumers; they depend on physicians to make crucial choices. And physicians, because of their training and their role as patient advocates, tend to do as much as possible for their patients. While much has changed in the medical care sector, these characteristics have not.

A factor present a decade ago which has since changed is that organized buyers of medical services (such as commercial insurance companies and Blue Cross and Blue Shield plans) either lacked sufficient market power to require hospitals and physicians to limit their costs or did not use it. With no significant checks, these institutional and organizational arrangements promoted extraordinary growth in the medical sector and corresponding increases in expenditures. However, neither planning nor regulation as typically practiced were very successful in controlling the expanding medical care sector in the face of strong opposing incentives for key actors to continue their existing behavior. Since 1977, even these modest attempts at regulation have been sharply cut back. Several states that had rate-setting programs have eliminated them; others, including New York, have made them less restrictive.

In the last decade incentives, markets, and competition have been used more often than regulation. For example, private insurers, in part pushed by their large corporate clients, have used a variety of means (including some reduction in medical insurance coverage) to effect change in the medical care market. These changes have been significant and have generally increased efficiency. Yet despite the increased use of market forces, the medical care sector is still not a competitive market—rather, it is characterized by "halfway" markets. Government shapes the context within which markets function, both by supporting them and by keeping them under rein. While the delivery of medical care is overwhelmingly private, government at all levels directly finances more than 40 percent of this care and indirectly subsidizes the rest through various tax incentives. Government also structures market activity through various forms of regulation—some that promote and others that constrain or halt the market's activities. Government's involvement in medical markets is so ubiquitous that much of it is taken for granted, even by advocates of market competition.

The halfway character of medical markets and regulation reflects our indecisiveness about two approaches to social policy. Government regulation and

competitive markets are alternative ways to allocate medical services, control cost and quality, and choose social priorities. Each method has its loyal adherents. Those who favor competitive markets believe that liberty and the public good flow from private sector and individual initiatives with decentralized decision-making and a limited role for government. Those who favor tighter government control believe that liberty and the public good stem from democratic control and collective self-determination (Vladeck 1981). However, because of the nature of the American political system and the special characteristics of the medical care sector, neither of these approaches has been able to prevail. We seem to lack the political will to have either a competitive market system or an effective government regulatory approach. Instead, we vacillate between the two approaches. We allow some markets to exist, but insist that the government structure and monitor their performance. If the market does not provide a solution acceptable to powerful interest groups, political pressure is brought to bear for government to do something—and it often does.

There is no doubt that government intervention limits market activities. If we view efforts individually and consider only the short run, regulation often distorts markets. But viewed in a larger, longer-run context, regulation can often promote and foster markets. For example, licensing professionals reduces consumer uncertainty over the quality and nature of medical service. Consumers can assume that the practitioner is competent, which lowers their information costs. This assurance makes patients more willing to avail themselves of medical services, particularly in new or unknown areas. In this respect licensing, and many other seemingly restrictive regulations, promotes markets. To the extent that regulations limit choice, they are like budgets that allow market activity but make it subject to contraints. Such restrictions on particular market activities preserve the institution of the market.

However, two of the most sought-after features of markets—competition that reduces price and budget constraints that control spending—are notably absent or diminished in medical markets. Regulations that raise minimum standards contribute to the lack of price competition. But there are more fundamental distortions that prevent the optimum functioning of medical markets. Many people believe that medical care is a special service that should be allocated largely based on need (Fein 1986). The uncertainty and risk of many medical problems prompt patients to demand extra precautions in diagnosis and treatment, and the physician's ethic promotes the same tendency. Given the complexity and ambiguity of medicine, it is always possible to expend further resources in precaution, diagnosis, or treatment. Further, the presence of extensive insurance makes patients and providers much less sensitive to prices. Therefore, there is rarely a reduction in the demand for medical services when prices rise; neither do providers lower their prices when faced with greater competition.

These characteristics of the halfway competitive markets and ineffective regulation in medical care have fueled the growth of medical expenditures, which

continue to grow at rates that far exceed the growth in national income. In this evaluation we will elaborate on why neither increased competition nor conventional government regulation can succeed in controlling medical care spending. Although tough budget regulation can control spending, it would force the country to face many difficult distributive choices and to incur substantial social costs—choices and costs which the country has preferred to avoid (Blendon and Altman 1987).

The limited effects of increased competition in controlling medical care spending

In the last decade the public and private sectors have employed three market approaches to controlling medical care spending (Meyer 1983). One strategy focused on the role of consumers, increasing the prices they pay and their choice of insurance policies. Another strategy relied on HMOs and other alternative delivery systems that compete with traditional providers. A third strategy used the market power of organized purchasers of medical services to demand more favorable payment arrangements.

Insurance and consumer copayments. Prompted by studies showing that consumers reduce utilization of services when they bear a share of the costs, insurers and employers sought to make consumers more cost-sensitive (Newhouse et al. 1981). Insurance companies designed policies that made more frequent and extensive use of deductibles and copayments, thereby requiring patients to pay more from their own pockets for each service (Hewitt Associates 1984). Some employers subsidized only the least expensive insurance plan as a benefit and required employees to pay the additional expense if they chose a more expensive plan. Another option permitted employees to decrease their medical insurance coverage and to use the savings for other forms of fringe benefits. These changes reversed a fifty-year decline in the percentage of medical expenses paid by patients at the time of care (Waldo, Lent, and Lazenby 1986). But despite these changes, more than 70 percent of all medical expenditures are still reimbursed by public and private third-party payers (Gibson and Waldo 1984).

What is most striking about these consumer incentives is that they have been restricted to a rather narrow corridor, usually at the high-cost end of the market. This produces competition of sorts, but not the kind that occurs for most other services or products where options range from inexpensive to expensive. The new market incentives only promote competition between high-quality benefit packages or delivery systems and higher-quality services and benefits. Such competition does little to reduce the expense of basic coverage, and it may even encourage the market to sell policies that carry additional protection. Since insurance policies still largely insulate patients from most costs, the increased use of consumer incentives has at best only a marginal effect on resource utilization or expenditure control.

True competitive markets have not been allowed to develop in health insurance because Americans do not want to significantly decrease their insurance coverage. Employees generally want greater benefits rather than lower costs. They express this preference both through their choice of insurance policies and through the political process. Furthermore, a significant majority of the public supports the idea of government extending medical insurance to the approximately 35 million Americans who lack coverage (Sykvetta and Swartz 1986). Many provider groups also support such reforms because they are currently forced to pick up or shift the cost of uncompensated care to other payer groups, a task that is becoming harder as competition and regulation reduce the flexibility of providers to set their own charges (Etheredge 1986).

Recent legislation has supported the trend towards increased insurance. Federal legislation passed in July 1986 requires employers to keep former employees enrolled in their group insurance policies for up to three years at cost, provided that the former employee pays the premium.[1] Congress is close to passing legislation that would have the federal government provide expanded Medicare coverage for catastrophic acute medical care, including prescription drugs.[2] Other legislation introduced in the 99th Congress would require employers to provide a basic level of health insurance for all their full-time employees and cover all citizens against the high cost of long-term care.[3] Several states (such as Massachusetts) are considering various systems of universal medical insurance coverage.[4] Whatever the outcome of these proposals, in the future there will probably be more rather than less medical insurance in the United States, and we are likely to see a resumption in the long-term downward trend in the percentage of medical expenses paid directly by the patient.

HMO competition. The HMO strategy has also had limited success in reducing overall medical care spending. HMOs have been able to reduce their own costs by cutting down the number and duration of hospitalizations (Luft 1984), but only a small portion of these savings have been reflected in lower medical care spending overall. Some of the HMO savings from reduced hospitalization have been offset by increased utilization of outpatient services, because HMOs typically include more outpatient benefits than traditional insurance does (Luft 1985). They do so because the public generally prefers HMOs that offer extensive services over HMOs with low premiums. In addition, federal and state governments require HMOs to provide certain benefits.

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1. Consolidated Omnibus Reconciliation Act of 1986, 29 U.S.C. § 1161 (1986).
2. Medicare Catastrophic Loss Prevention Act of 1987, H.R. 2470, 100th Cong., 1st Sess. (1987).
3. Minimum Health Benefits for All Workers Act, S. 1265, 100th Cong., 1st Sess. (1987).
4. An Act Establishing the Massachusetts Health Partnership, S. 1690 (1986). An Act to Make Health Care Available to Citizens of the Commonwealth and to Make Certain Other Improvements in Health Care Delivery Systems in the Commonwealth, H. 6000 (1987).

As a result of those more extensive benefits, many HMOs have costs that are higher than traditional insurance and must therefore charge premiums that are above those of competing commercial or Blue Cross insurance. Even HMOs with lower costs often keep their premiums close to traditional fee-for-service plans (Luft 1985). HMOs are not compelled to underbid traditional insurers by a large amount in order to create an incentive for consumers to switch. Moreover, HMOs often prefer to compete for customers by using marketing strategies and by offering additional services, lower copayments, or better location rather than lower premiums.

Some of the ways HMOs compete appear to have shifted costs among payers and increased total spending for medical care. There is evidence that some HMOs are marketing themselves to encourage a favorable selection of patients—that is, patients for whom care is less costly on average (Wilensky and Rossiter 1986; Butler et al. 1987). They offer services (such as well baby care and sports medicine) that attract young and generally healthy people; they locate in neighborhoods that are middle class; and they do not cater to people who have high-cost illnesses or are in high-risk groups. Consequently, fee-for-service insurers are often left with the patients who have high utilization rates and who require expensive care. Group insurance is usually experience-rated, so employers pay the full costs for these employees. But since employers do not benefit proportionately from their lower-utilization employees who join an HMO, their total medical insurance expenses are higher (Etheredge 1986; Luft 1985).

While there was some initial evidence that the presence of HMOs in a market lowered the costs of competing providers, more recent evaluations suggest otherwise. A recent study of HMOs across 25 standard metropolitan statistical areas between 1971 and 1981 found that competition, as measured by degree of market penetration, had no significant impact in reducing overall hospital costs (Merrill and McLaughlin 1986). Another study of HMOs in Hawaii, Rochester, and Minneapolis/St. Paul concluded that the overall reduction in hospitalization was most plausibly attributed to factors other than HMO competition (Luft, Maerki, and Trauner 1986). A third study of the impact of HMOs in Minneapolis/St. Paul between 1977 and 1982 concluded that the decreased use of hospitals could not be attributed to HMOs since it paralleled national trends (Johnson and Aquilina 1986). And a fourth study of the Twin Cities' marketplace for medical care concluded that in the 1979–1981 period HMO competition had no effects on hospital costs per admission (Feldman et al. 1986). It does not seem reasonable, therefore, to rely solely on HMO competition to significantly reduce the overall cost of medical care in the future.

Prudent purchaser programs. Faced with increases in their expenditures for medical care, large firms that self-insure and insurance companies have embarked on their own cost-containment campaigns (Sullivan and Ehrenhaft 1984). Whereas in the past insurers paid bills as they received them, they now are active purchasers deciding which expenses to reimburse. In general, the strategies used in

prudent purchaser programs are similar to those used by government. The private sector has experimented with HMOs and other alternative delivery systems such as preferred provider organizations (PPOs) and with awarding contracts on the basis of competitive bidding. They have used their purchasing power to demand more favorable terms of payment and greater provider efficiency. But ironically, the most significant change is that payers are becoming involved in "managing" the delivery of medical care—an activity similar in character to regulation.

One example of such private-sector regulation is the use of preadmission certification programs. Under these programs patients do not receive the full benefits of their insurance policy for inpatient care or outpatient surgery unless their physician seeks and receives prior approval from the insurer. Insurance companies have also developed protocols for common diagnostic tests. When physicians order tests that do not fit the protocols, the insurance company does not reimburse them. Such utilization review programs build on the experience of Medicare's professional standards review organizations (PSROs). Some limited evidence suggests that a well-operated program can save between 8 and 10 percent of total premium dollars (Gertman 1987).

Another way the private sector regulates payment is through administered contracts (Goldberg 1976). Purchasers establish detailed rules, standards, and procedures to monitor providers as part of their contracts for the delivery of the services. Purchasers now also ask providers to supply them with data on utilization rates, medical outcomes, and details of their medical practices. Some firms have issued requests for proposals to prospective providers that include detailed specifications of the kind of practice, medical outcomes, and services they want.[5]

A final way prudent purchaser programs achieve savings is by obtaining more favorable terms of payment. Because large insurers or groups of insurers indirectly purchase large volumes of services, they have been able to extract discounts from providers. Providers grant such discounts because they expect that purchasers will channel more patients to them; the smaller profit margin per patient or service is compensated by the guarantee of a larger market share.

These private-sector initiatives have been successful in adding much-needed incentives for a change in medical practice. However, in total they have not had a significant bearing on total spending for health care. It is also important to remember that much of this new market activity by private firms could not have come about without two important government interventions. First, in the late 1960s and early 1970s the federal government established programs to increase the number of physicians (Wallack 1981). The ready availability of large numbers of new physicians who are willing to work in new types of delivery systems or who are willing to accept tougher payment schedules has permitted many of the prudent purchaser programs to function. Second, PSROs and the new profes-

5. Honeywell is an example of a corporation undertaking such a program.

sional review organizations (PROs) have provided important data on utilization and methods of monitoring provider performance.

Competition and market reforms in perspective. Although the growth of market competition has brought and will continue to bring a measure of increased efficiency in the delivery of medical care, spending will not be substantially reduced. Due to the halfway nature of markets that exist in the medical care sector, increased competition will not produce savings as great as those that are realized when market competition is more robust. Markets sometimes force producers to compete over price, but most often they compete in other ways. Moreover, efficiency gains in the provision of medical care do not always result in reduced spending for purchasers.

An important limitation of all the market competition strategies used to control spending is that there are many significant forces increasing expenditures other than the inefficient use of medical services (Schwartz 1987). These forces are unaffected by any efficiency gains produced by market competition. Among these cost-generating forces are a growing population; the increasing size of the oldest age cohort, which uses more medical services and long-term care; the increasing medicalization of social problems; and, in the future, the growing AIDS epidemic.

That medical care spending has not abated during the last decade can be seen in Figure 1. In the period 1976–1987, medical care spending increased by almost 80 percent above the level of inflation. This growth also far exceeded the growth in the country's national income (as measured by GNP). In 1976, medical care spending stood at 8.5 percent of GNP; by 1987, it had grown to 11.2 percent. The figure also shows that the rate of growth in real spending (the slope of the cumulative growth line) was relatively stable from 1979 to 1983. In 1984, there was a small but noticeable decline in the growth rate, reflecting in part the impact of the more aggressive behavior of private payers and the federal government. However, the cumulative growth rate resumed its pre-1982 level in 1985 and continues to follow that pattern today.

A similar picture emerges from an analysis of the spending levels for hospital care (Table 1). Prior to 1983 and the start of the Medicare prospective payment system (PPS) and many of the prudent purchaser programs of private corporations and insurers, total revenues (spending) for all hospital services were increasing at a rate of 7.3 percent after adjusting for inflation. This was the average annual rate during the 1976–1982 period. On a per admission basis, the annual average growth in spending was 5.2 percent. The first three years after 1982 were marked by a significant downturn in the growth in total spending for all hospital care, particularly 1984 and 1985. But in 1986 this downturn was reversed, and in the last two years spending levels appear to be close to pre-PPS levels. Much of the reduction was the result of a drop in hospital inpatient admissions, as can be seen

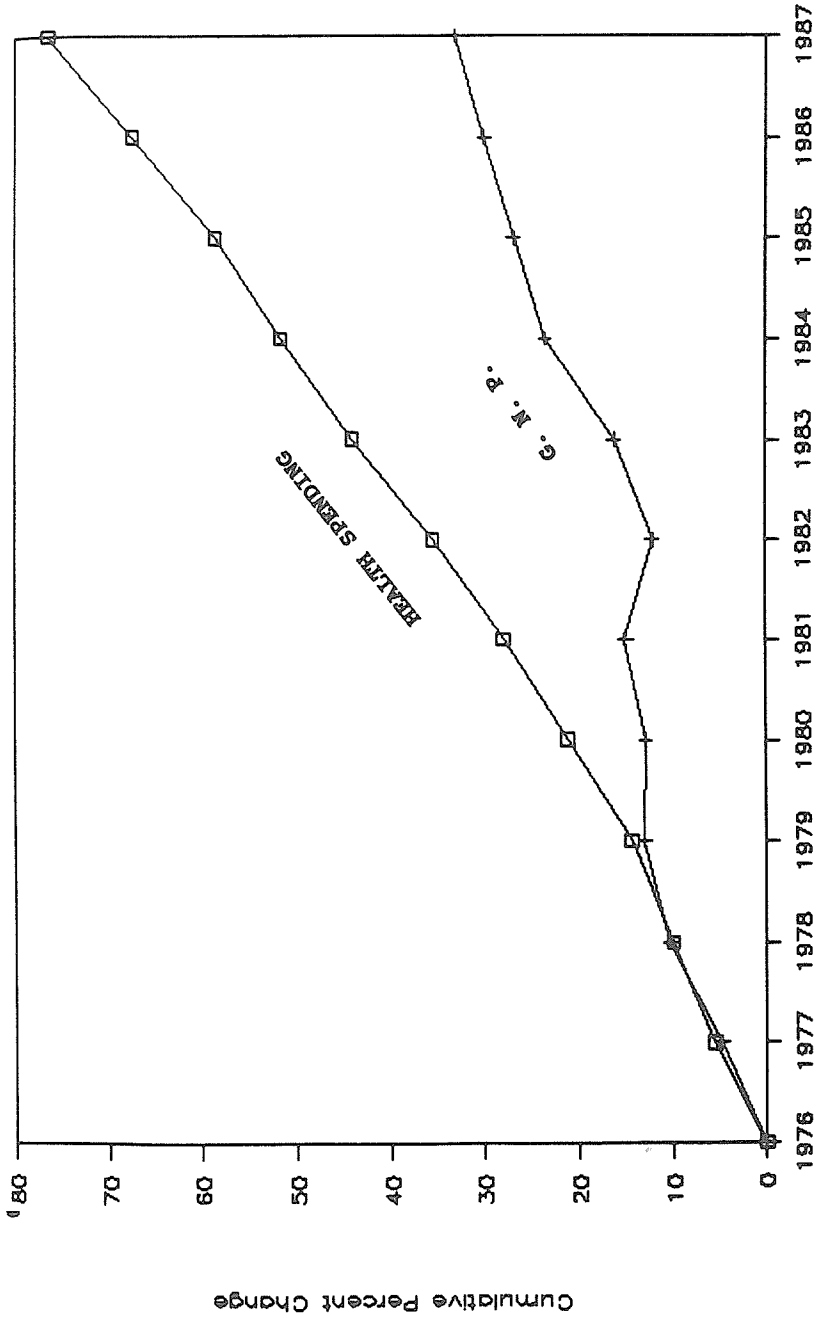

Figure 1. Growth in Health Spending and GNP, Adjusted for Inflation

Source: Prepared by the staff of the Prospective Payment Assessment Commission, Washington, DC, Spring 1987.

Table 1. Percent Change in Hospital Revenues, 1976–1987 (Adjusted by the Consumer Price Index)

Year	Total Revenues	Inpatient Revenues	Outpatient Revenues	Other Revenues	Inpatient Revenues Admission	Outpatient Per Visit
1976	13.6	13.9	17.2	−0.1	10.2	13.5
1977	9.2	9.2	12.8	0.3	6.4	6.3
1978	4.7	4.0	8.2	8.9	3.6	7.7
1979	2.3	2.1	3.0	5.4	−0.6	3.4
1980	3.7	3.7	5.1	−0.4	0.9	2.0
1981	7.7	7.1	9.5	13.3	6.3	8.0
1982	9.6	9.5	11.3	6.7	9.5	10.1
Average increase 1976–1982	7.3	7.1	9.6	4.9	5.2	7.3
1983	6.8	6.4	11.0	2.2	7.0	8.0
1984	1.7	0.3	9.3	3.8	4.2	7.8
1985	2.4	0.0	14.3	8.5	5.1	9.3
1986	6.7	4.9	15.8	2.8	7.1	6.7
1987[a]	6.3	4.7	13.3	9.8	5.5	7.2
Average increase 1983–1987	4.8	3.3	12.7	5.4	5.8	7.8

a. Estimate based on the first ten months of 1987 compared to the first ten months of 1986.
Source: American Hospital Association National Panel Survey. Prepared by the staff of the Prospective Payment Assessment Commission, Washington, DC, Spring 1987.

by the relative stability in the growth in spending per admission and the sizable increases in the growth in real spending for hospital outpatient care.

Regulation as a strategy for controlling spending

In the previous section we explained why market processes alone have not and cannot bring about substantial control over medical care spending in the current American economic and political environment. Will government regulation do any better? We do not think it likely. This is because our halfway markets in medical care limit the effectiveness of regulation as well as competition. As a general rule, we have not allowed our regulatory system sufficient authority over the levers of spending to be effective in controlling total medical expenditures.

Health planning and regulation. The regulatory approach of the 1970s was implemented by a network of planning bodies called health systems agencies (HSAs) which were established by federal legislation. Their aim was to control the formation of expensive new capital projects, such as the building or renovation

of a hospital and the purchase of new equipment costing more than $150,000. No new major hospital expansion or capital expenditures were permitted without a state-approved certificate of need.

From the beginning, HSAs were severely constrained by their lack of direct control over hospital reimbursement and the state regulatory apparatus. At the state government level, HSAs had to contend with organized opposition from hospitals and other providers that had more resources and better trained staffs and that were waging a single battle while each HSA fought many. In contrast to the concentrated interests of providers, the HSAs represented the diffuse interests of consumers and HSA board members, who were unaccountable to the public (Marmer and Marone 1980). The combination of these factors tilted the outcome of political fights against effective regulation.

Conflicts over the goals of health planning also made it difficult to control spending. HSAs had a broad planning agenda. Some groups wanted to control costs; others wanted to improve access to medical care; still others wanted to expand and improve institutions. The multiplicity of goals made the pursuit of spending control difficult and gave additional ammunition to providers who opposed controls. Providers could always reasonably argue that important goals were being thwarted by regulation and then find ways to get around the most restrictive provisions.

The closest the federal government came to giving any public agency control over the reimbursement of medical care institutions was during the period of the economic stabilization program (ESP) from 1971 to 1974. Even then the control was over what hospitals and physicians could charge for their services, not what they could spend. Nevertheless, ESP was successful in limiting spending for hospital care. Just prior to the ESP period, hospital costs per admission grew by 11.2 percent; during ESP the growth rate slowed to 8.5 percent. After Congress ended the control program in 1974, hospital and total medical care spending returned to pre-ESP levels (Altman and Eichenholz 1976).

Regulations that increase costs. Not only did government regulations established in the 1970s fail to control spending effectively, but they also often contributed to increased costs by raising standards, by ensuring quality and safety, or by promoting social justice. The attentive public responded to this kind of regulation—which is often beneficial—not only by accepting it, but by clamoring for more.

The extent of such regulation is enormous. State laws require insurers to maintain a minimum amount of reserves to pay beneficiaries. They can also prohibit the sale of any policy that does not have rate structures, benefit packages, and prices they approve. For example, medical insurance for a particular disease (such as cancer) is often disallowed on the grounds that it takes advantage of people's fears and does not provide useful protection. States license physicians, nurses, and other practitioners, and government funding for education helps regulate en-

try into these professions. Rules of legal liability require negligent practitioners and institutions to pay damages. Medical experimentation must conform to a special review process. Hospitals must afford doctors procedural due process before terminating their privileges. And new drug and medical devices must be approved by the Food and Drug Administration before they can be marketed.

A host of other regulations are directed not just to the medical sector but to all business. For example, the employment relationship is bound by rules protecting collective bargaining, providing unemployment benefits, establishing minimum wages and maximum hours of work, and prohibiting child labor and preferential treatment on the basis of race or sex. Also, just as other businesses do, medical providers must comply with laws governing commerce (such as the Uniform Commercial Code), property law, and laws regarding the sale of securities, insolvency, and the rights and obligations of the business owners.

Rate-setting regulation. Government regulation failed to control spending in the 1970s not because regulation can never work but because the form of regulation used did not account for or use financial incentives and because there was insufficient political consensus for enforcing effective regulation (e.g., rate setting). Yet there is evidence that rate setting can be effective in controlling hospital spending. In a comparison of medical expenditures from 1976 to 1984 between six rate-controlled states and the rest of the nation, Schramm et al. (1986) reported that there was an 87 percent larger increase in expenses per hospital admission in unregulated states than in regulated states. If savings are calculated by the reduction in inflation from the national average, the six states saved approximately $8 billion. The annual per capita hospital expenses in the six rate-control states showed increases of 33 percent for the period 1972–1976, while the growth rate in the nonregulated states was 38 percent.

New York State in particular has demonstrated that when a political body really faces a serious fiscal crisis it can create and administer an effective medical care spending control program (Schramm 1986). For several years, New York brought down the growth rate of medical care spending. But without the spur of its fiscal crisis, it is doubtful that even New York would have been able to muster the political consensus required to implement such a program.

Prospective payment as partial budget regulation. One innovative form of budget regulation is Medicare's prospective payment system, which uses financial incentives and allows providers latitude in managing their resources. However, the driving force of PPS is not consumer choice but government, which manipulates reimbursement to get hospitals to change their practice patterns. PPS is closer to an administrative price scheme than to either price control or a competitive market (Ginsburg 1987). Under PPS, government establishes a payment rate for each diagnosis-related group (DRG), leaving the hospital and physician

to decide how to manage resources. Hospitals therefore have a financial incentive to use resources in a more parsimonious manner.

PPS has produced significant short-run improvements in medical practice and utilization. Hospitals have developed management information systems, evaluated their expenditure patterns more carefully, economized in their use of resources, and shortened the average length of patient stay. Numerous procedures that were performed in hospitals in the past are now done on an outpatient basis, a change that health planners advocated for years without success. But while this system has produced reductions in the spending rate for inhospital care, much of these savings have been used to finance more outpatient and home health care. Further, as shown in Table 1, the most recent data show that even hospital inpatient costs are beginning to approach pre-PPS levels.

PPS is a prime example of regulation that makes use of incentives and market process, and it has made progress toward controlling hospital costs and changing institutional behavior. But PPS does not control reimbursement for procedures performed outside hospitals. The combination of prospectively setting hospital reimbursement rates and reimbursing outpatient care on the basis of customary, prevailing, and reasonable fees has created what might be called the "squeezed balloon" effect. By squeezing spending on inpatient care, the system has created a bulge in spending at the opposite end—outpatient and home care. Though PPS has produced change, it can only have a limited impact on total medical expenditures because it only affects part of the system.

Budget regulation: An effective solution?

Since the use of both increased market competition and conventional government regulation have had only limited success in controlling medical care spending, what is to be done?

Spending for medical services can be controlled in three ways (Fuchs 1986). One approach is to improve efficiency in the provision and allocation of services. A second approach is to reduce the prices paid for the materials and services used in medical care, which implies paying producers and providers less. A third approach is to reduce the volume of services provided or to shift the balance from high-cost to low-cost services. Both regulatory tools and market mechanisms can be used to implement these three strategies. But given the halfway markets in medical care, without some kind of systemwide control the use of market mechanisms and/or regulation is unlikely to be more effective than it has been in the past.

Is there a point in the spending spiral where medical costs will become so large that payers of care—both public and private—will stand up to the political pressures of providers and patients and demand effective cost control? It almost happened in the early 1980s, and there were some real changes in the delivery system. But several years of reduced general inflation and high corporate earnings have

blunted the aggressive behavior of payers. There are indications that the rate of growth of medical spending is returning to pre-1982 levels. Insurance premiums are again rising by 10 to 20 percent (Medical Benefits 1987). The percentage of GNP going to medical care has risen from 10.5 percent in 1982 to 11.2 percent in 1987, and unofficial estimates for 1988 predict that it will approach 11.5 percent, or over $550 billion (ProPAC 1988).

There is no question that budget regulation can control spending. The experiences of Canada and Britain suggest that it can produce dramatic results (Evans 1987). The issue is whether we are willing to accept the negative consequences entailed—and "we" means everybody. Access to care would be limited somewhat for most Americans, although those who use the system the most (the elderly and the poor) will be most vulnerable. Such limitations could be across the board or focused on certain high-cost technologies, particularly those that are used during the last months of life. Quality of care might also suffer. In Canada, strict budgets did not produce measurable harmful reductions in services because they were able to focus these efforts on limiting the amount paid to providers. But our provider groups are politically much stronger, and therefore reduced spending is unlikely to be borne by them alone.

The strongest impetus for controlling spending in the Canadian system was the federal government's decision to limit its contribution to each province. This decision forced provinces to absorb the full impact of increases in spending beyond a tight predetermined level. With this political backbone in place, the provinces became much tougher in imposing restrictions on their physicians and hospitals. But in the U.S., the political situation will almost certainly differ. In spite of the studies suggesting that it is possible to substantially reduce medical spending with no negative impact on the quality of care (Eddy 1987), it is likely that even small reductions would be opposed due to perceived (as opposed to technically measured) quality deterioration. Even though independent assessments have not turned up many examples of serious reductions in the quality of care under PPS, consumers and providers have voiced serious concerns. These concerns have been enough to cause Congress to legislate important changes in the PPS system and to threaten even more far-reaching changes. Under a budget control system, Medicare and Medicaid beneficiaries would become "quality of care" watchdogs that would pressure legislators and the executive branch to provide what they (and their medical care providers) believe is a decent level of quality. This will require funding and could undermine budget control regulation in the most direct manner—by increasing the budget.

Both the major virtue and the major drawback of budget regulation is that it forces explicit choices about the allocation of resources and consideration of social priorities. This is a virtue because it brings to light choices that otherwise are not seen or are intentionally avoided; it is a drawback because facing such choices is a difficult and painful process. There may be no generally agreed-upon goals, or such goals may be sufficiently vague and ambiguous that translating

them into specific policies and funding decisions is inherently controversial. This is the stuff from which political conflict is kindled.

Over the past two decades the United States has undertaken numerous regulatory and market-oriented programs to limit spending, but these have been partial and fragmented. Often, just as the programs have verged on becoming effective, groups that would be adversely affected have exerted political pressure to protect their interests in ways that undermine the program. Economically and politically we want to have our cake and eat it, too. Thus we allow a political stalemate to support halfway competitive markets and to produce ineffective regulation in medical care.

However, increased spending is not inevitable, and we do not need to accept a totally governmental regulatory system to bring about a balanced rate of spending. We believe that it is possible to structure a system that permits many of the advantages of competition to remain but overlays competitive markets with a tougher, more effective regulatory system. One might have expected the current level of spending already to have forced such difficult social choices. But so far the nation has either avoided the tough trade-offs required or decided that the benefits of open-ended medical spending outweigh the social costs of its control. It is not clear that we really want to control spending. At the moment, spending 15 percent of the GNP for medical care by the year 2000 is clearly a possibility.

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