SOME ASPECTS OF THE PRICING PROBLEM IN MEDICAL CARE

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Our subject involves some aspects in contemporary America of the pricing problem in medical care. The subject will be treated partly in terms of efficiency but more fully in terms of equity. The subject will be treated by a general economist who has become somewhat interested in the problems of medical care but who pretends to no expert knowledge about it. Perhaps for that reason I first seek to find out how well competition can function as an ordering mechanism in the medical market. Economists have over the years worried about the conditions which must be satisfied if the competitive principle is to be relied upon to achieve satisfactory results in any field of economic endeavor. Four sets of conditions are of crucial importance.

One condition stipulates that access to the calling or industry must be relatively open to persons or firms seeking new opportunities or unusually attractive returns. The free market tolerates attractive returns only because they are self-correcting through induced adjustments in supply. These adjustments in the field of manufacturing have been examined recently and have been found to be very effective in holding dispersion in rates of profit return to a manageable level.[1] How easily and with what facility can professional ability be transferred from related fields or be trained in response to favorable earning opportunities in medicine?

A second condition for the successful working of the competitive principle involves facility in dealing or toleration of rivalry in dealing and trade. It is well-known that the competitive process is weakened whenever retail outlets become attached to particular manufacturing firms and are not free to handle products of smaller or newer firms. Any tendency to bind customers to suppliers by long-term contracts or by purchase agreements will tend to restrict the play of the competitive principle. How goes it in this regard with the practice of medicine?

A third condition stipulates procedures for competition through the making of competitive offers for trade or service. The medieval market was careful to prescribe procedures of marketing in order to facilitate publicity of dealing and easy comparison of prices. Farmers habitually offer their product for sale to the highest bidder in what virtually amounts to an organized auction market. A building contractor will typically be prepared to examine a given building project and to prepare an offer stating the terms on which the project will be carried to completion. In many markets a kindred kind of confrontation is arranged. How is it in this respect with the practice of medicine?

A fourth condition for the successful working of the competitive principle relates to rationality of action or the completeness of knowledge by buyers and sellers of the needs for which satisfaction is sought and of the terms by which these needs can be met by the spectrum of available techniques and supplies. Economic knowledge is itself a great economic resource which has been underrated by most observers and analysts.[2] The distortions and wastes generated in those fluid product markets where a limited number of producers deal with poorly informed retail buyers was elucidated some decades back in a classical treatise.[3] The competitive principle and the profit motive can work magic where buyers are reasonably discriminating in their judgments and informed in their knowledge. But in fields where products are complex and disclose their secrets only gradually over time, where product variety has not been frozen into traditional forms but is in continuous technical ferment and where a sufficient number of buyers are inexpert and uninformed, the market principle can yield dust and ashes. How does it stand in this regard with the field of medical care?

We need not labor the case in responding to these questions. There are few commodity or service markets where the competitive principle is so poorly served. By established custom a medical customer is a "client" or a "patient" who becomes attached to a particular practitioner to whom he is supposed to be "loyal." He is not even supposed to see or contact other practitioners without a "referral." A survey of attitudes toward the use of health services showed that three out of four Americans would "never think" of going without a referral to a second doctor; and only three out of a hundred Americans went "several times" without referrals.[4] An admitted indelicacy deters probing except in very general terms into the price of service not yet rendered. Any explicit bargaining over rates or charges by exchange of offer and counter-offer is actually frowned upon--a take it or leave it attitude is enjoined.[5]

Moreover in one crucial respect medical practitioners have indulged in practices which few supporters of free enterprises would be prepared to tolerate: the right to price discrimination by charging higher fees for the same service to customers more able to pay. The practice is traditional and is expressly avowed.[6] The amount of discrimination has probably declined in recent years and there are indications that the principle involved is becoming suspect.[7] In other markets the principle except when expressly used by public agencies in public programs is regarded as odious and is prohibited by law. The principle is moreover not

consistent with the functional requirement of an orderly market which brings into existence a single scale of prices applicable to all buyers.

Perhaps this renunciation of the competitive process and its functional requirements only rationalized the inevitable. For in terms of technical knowledge the ultimate consumer was hardly in a position to be a discriminating buyer. Medical care is after all a branch of applied science with considerable uncertainity of outcome in terms of diagnosis and treatment. Little of this knowledge is readily accessible to laiety and no statistics of medical practice are ordinarily kept in a form which would enable patients to gauge medical achievement. The treatment of illness by magical means or through pseudo-rational procedures prevailed in traditional societies and traditional notions have persisted. The sick person is in a state either disabled or suffering. He is likely to be anxious about his condition and about the prospects for its improvement. He needs to be assured about the efficacy of any line of treatment and to have an unusual respect for his practitioner. Yet he is not qualified to assess the qualifications of different doctors.[8]

It is probably thus a blessing that the market has been disabled of the task of gauging quality and of making the requisite choices and selections. Broadly speaking these choices and selections are paternalistically assumed by the profession as organized under law through devices of the licensure and accreditation. Though this paternalistic system has recently been condemned by an extreme though consistent adherent of "free enterprise," it is hard to see a more viable alternative in view of the patent inadequacy of consumer knowledge.[9]

Certification of quality through the licensure and accreditation played an important role in building up the profession through collective action inspired by high ideals of excellence and a shunning of the second-best and the second-rate. Even if this confers limited advantages in treatment it facilitates therapy by reinforcing the feeling of confidence so crucial for recovery from many types of illnesses and by making it easier to endure suffering. But in the nature of the case the resulting set of "Cadillac" standards makes it difficult for new aspirants to enter the profession or to become attracted from kindred fields.[10] It appears that training facilities were also affected by a widely felt professional concern to limit quantity and to avoid "excessive numbers."[11] State governments provided very little guidance on their own. In consequence a relative shortage of medical practitioners has been permitted to develop. In the early 1950's over two-thirds of the applicants to medical schools--and these were a choice lot--were denied entrance.[12] Yet during the 1950's only six schools of medicine were built and medical graduates increased only 15%. Scarcity was indicated by the deteriorating ratios of practitioners related to gross population and by the fact that over the past years nearly a fifth of the new supply of medical practitioners were recruited from foreign medical schools. A full measure of the near desperate condition we are now in regarding access to the profession is yielded by the striking fact that the leaders of organized medicine despite their deep distaste for any federal intervention into medical markets put their endorsement on the proposal of the

Kennedy administration for federal subsidies to expand existing medical training facilities.[13]

Consider now the results of our evaluation of the medical care market in terms of accepted criteria for competitive market performance. You could only conclude that as a system of free enterprise the medical market has been a dismal failure. It never had a chance. Hamstrung by its own ethics, undermined by its own ideology, tied down by its own search for excellence and its dedication to professional achievement, constrained by its own recognition of the psychologic requirements of medical care, competition never has been the organizing principle around which the medical care market has been organized. Paternalism, authority and loyalty were rather the keynotes by which this market has been organized. Neither the practitioner nor the patient were accorded bargaining rights. Each was to render loyal service at fees which the doctor would assess on the basis of ability to pay. In effect the system was not competitive but feudal; and like all feudalism it concentrated great authority in few hands.

This concentration of feudal authority may have served the functional requirements of medicine but it obviously built up a tremendous potential for exploitation. Yet in practice this feudal system worked out not badly and produced in years past not an unreasonable level of medical earnings. These earnings were not restrained by the unselfish dedication of practitioners or their distaste for high fees. Practitioners were as capable as most men and women in deluding themselves as to their intrinsic worth and merit. What held down the earning potential of the profession was rather the inadequate economic base. The profession applied its immense economic power and earned most of its income by service to a small minority of families suffering illness or struck by serious disability. Fortunately, we do not all need medical care at the same time. In 1929, e.g., 41% of all medical charges were produced by 10% of the families with total medical service bills exceeding $250 in current purchasing power. The same dispersion and concentration of illness and billings is found today.[14] The ability to pay of the minority of families with the largest use of medical services will be impaired because of reduced earning power. Illness moreover is more characteristic of the aged and of those who are chronically sick. Hospital and nursing service has always had a prior claim on available liquid funds and families had to pay rent, grocery bills and meet other needs before payment of doctor bills. The doctor often had to wait for payment or to serve without compensation. There was thus more of a problem of providing an adequate income for practitioners than of restraining exploitation particularly by practitioners serving whole communities in the small towns of rural America and meeting the medical needs of the full range of social classes and individuals. The shared life of such a community--with its open neighborhoods, its public schools and common worship--transformed the local doctor into a community servant without the formal assumption of office.

If from this vantage point we bring under survey the trends of the past three decades, we can readily detect the drastic changes in the field of medical practice that have altered the situation we have described.

One of these changes has been in the making for many years but its effects have become more noticeable in recent decades, namely the steady shift of population from rural to metropolitan communities and the greater frequency of medical specialists. Fewer practicing physicians will take on the responsibility for medical service to a whole community. The specialist in the nature of the case yields a fragmented service to an anonymous public assembled chiefly on the basis of referrals. Some specialists practicing chiefly in hospitals hardly see their patients. The mobility and anonymity of modern American life has freed both doctor and patient from local neighborhood involvements. The community of residence is less and less distinctive in marking out the community of practice.

A second wave of change almost as striking has placed under public custody a large part of the burden of medical care for the needy and indigent. Abundant evidence indicated that a few decades back gratis work either dispensed freely or accumulated in the form of bad-debt losses or uncollected billings ran to between 25 and 40% of the physician's time and service.[15] Some of this remains today.[16] But the volume of it and need for it has been greatly reduced. Some twenty-two million veterans are covered by medical service programs which provide medical care for 114,000 patients daily at an annual cost of nearly 800 million dollars. Under the Social Security Act particularly as amended since 1950 medical care is provided by special arrangements for whole categories of persons under Federally assisted public assistance programs. Vendor payments are typically made to providers of service oftentimes on a per capita basis arranged with the local medical society. Total vendor payments under all public assistance programs amounted in 1960 to $514 million. While compensation to physicians for service rendered under these programs is based on reduced fees, the compensation replaces gratis work.[17] These programs were recently broadened by provision of federal matching grants for states undertaking to provide medical assistance to aged persons who would not qualify under old-age assistance programs (Kerr-Mills). Organized medicine has given this program its full support.[18] The program is operative in 25 states and promises in 1964 to provide benefits to some five hundred thousand persons.[19] While no complete solution to the problem of medical care for the aged, the Kerr-Mills program will help to scale down the need for gratis work by the medical profession.

The third wave of change has even been more potent in transforming the economic conditions of medical practice, to wit, the rise of voluntary private prepayment schemes by which expenses for hospital and surgical services can be financed through insurance. The story of the rise of these insurance schemes illustrates the vigor and creative response in American life. Our veneration for our way of life has not deadened all capacity to shape it anew. Two salient facts about these insurance schemes are crucial for our story. First, a high percentage, probably over three-fourths, of the able-bodied nonfarm population are now working under arrangements which enable them to purchase by monthly salary deductions and payments rights for themselves and for their family to needed hospital and surgical services. Secondly, these rights for hospital services for most insured

persons are tied to an indemnity-service contract which stipulates service benefits for individuals or families with incomes under specified levels and indemnities for those earning over these levels. The income levels were intended to provide medical service for the less poorly paid workingman. In 1949-50 it was estimated that only a quarter to a third of persons enrolled under Blue Shield schemes were eligible for service benefits. The fraction has probably risen slightly since then as income limits were adjusted upwards in the fifties somewhat faster than family incomes. But in fourteen Blue Shield plans there are no service benefits allowed at all. And in nearly all group insurance schemes with private carriers medical benefits are on an indemnity basis. In the main then pre-payment schemes takes care of most hospital bills but meets only part of the cost for surgical services. In most cases the surgeon can levy a discretionary surcharge.[20]

A final shift in economic condition has augmented the leverage exerted by the medical profession in their dealing with the public. This change owes to the development of high rates of personal income tasation with liberal exemptions and bracket rates starting at 20% and running up to 89%. As tax rates were stepped up taxpayers were permitted to deduct from income reported for taxation extraordinary medical expenses. Over time the rules for computing the deduction were liberalized and now permit deduction from taxable income of qualified medical expenses exceeding 3% of adjusted gross income up to certain overall limits. This deduction will reduce extraordinary medical bills by 20% for most of us but by a larger amount for families in the middle income brackets. In the last few years nearly eleven million taxpayers were permitted aggregate deductions between 3.5 - 4.0 billion dollars with a tax gain of nearly .9 billion dollars. The relief for the families involved was substantial.[21]

The implications of these changes in economic conditions as they bear on medical practice may now be noted. The changes affect the customer market for medical care in virtually all relevant respects. Through prepayment revenue is produced from the healthy as well as from the sick. Most wage-earner families are shifted from the medically indigent to the paying class. The needy are given public support. Tax easement is provided the well-to-do on their major medical bills. The drainage of hospital expenses no longer impairs ability to compensate physicians. Under these favorable conditions is it thus any wonder that average medical earnings rose nearly threefold between 1940 and 1950 and have apparently nearly doubled again in the decade of the fifties. The differential of medical over all professional earnings, found at 137-140% between 1929-1940, had risen to 162% in 1950 and in 1959 is probably somewhat higher.[22] Perhaps the medical practice in recent years calls for higher abilities than are used in other professional callings. Perhaps the investment in training or the effort expended in the job call for a higher earning level. I would doubt that on these or similar grounds so large a differential in practitioner earnings can be explained. This differential at least in part would testify to the special character of the medical market in recent years and to the revolution in conditions of medical practice.

The conclusions indicated for public policy are obvious and many of them are already recorded in the statute books. The most urgent and strongest conclusion relates to the need to step up the rate of supply of medical practitioners. At long last the Congress has finally launched a program to expand medical training facilities and to assist medical students. Public Law 88-129 authorized a three-year program of $175 million in matching grants to expand teaching and research facilities of medical, dental and related type colleges; $30.7 million was authorized for use in student loans.[23] The principle being conceded, we may expect a continuing federal responsibility in this field.

An equally praiseworthy line of action in President Kennedy's comprehensive health program involved encouragement of group practice. Group health programs chiefly under trade union auspices have played an important role in developing more efficient forms of medical practice. These programs under the control of lay and consuming groups have tended to develop a healthy "countervailing power" to that now wielded by organized medicine. "In order to encourage this trend," the President's 1963 Health Protection Recommendations stipulated, "particularly in our smaller communities and under the sponsorship of cooperative or other non-profit organizations I recommend legislation to authorize a 5-year program of federal mortgage insurance and loans to help finance the cost of constructing and equipping group practice medical and dental facilities."[24]

Many of the other provisions in the Kennedy health program--mental health clinics, community mental retardation facilities, hospitalization insurance for the aged under Social Security, strengthened health controls over foods and drugs--are desirable in their own right but do not meet the issue posed in this paper. This issue would seem to call for regulation with respect to the level of fee schedules and the abolition of the right to levy discriminatory charges. Much good could be accomplished by raising the income limits of the Blue Shield policies to a level which would provide service under the fee schedules for a larger proportion of the covered population. Perhaps as I have suggested in an earlier paper practioners could be permitted to file individual fee schedules which would meet certain requirements as to form, coverage and detail.[25] In any case the right and obligation of public control cannot be denied in a field of occupation endeavor where the competitive principle is so severely restricted and where a dangerous amount of economic power is concentrated in a few hands.

1. See George J. Stigler, Capital and Rates of Return in Manufacturing Industries (NBER 1963). "There is no more important proposition in economic theory than that, under competition, the rate of return on investment tends toward equality in all industries. Entrepreneurs will seek to leave relatively unprofitable industries and enter relatively profitable industries, and with competition there will be neither public nor private barriers to these movements." (p.54).

2. We owe to Frederick Hayek, the distinguished author of The Constitution of Liberty (1960), a classical treatment of knowledge as an economic resource in his essays, "Economics and Knowledge" and "The Use of Knowledge in Society," Individualism and Economics Order (1948).

3. See Edward Chamberlin, The Theory of Monopolistic Competition (1st ed. 1933) and the references thereto in my earlier paper, "Value and Price in Industrial Markets," Economic Journal, March, 1959, pp. 22ff.

4. See a 1955 survey conducted by the National Opinion Research Center, data presented and summarized in Mortimer Spiegelman, Ensuring Medical Care for the Aged (1960) Table 3.14, pp. 74ff.

5. Talcott Parsons, The Social System (1951), ch. 10, "Social Structure and Dynamic Process: The Case of Modern Medical Practice."

6. For a full treatment see my earlier paper, "Medical Care: A Public Utility," Land Economics, August, 1958, (pp. 208-218) 210 ff. For a similar line of analysis see Reuben Kessel, "Price Discrimination in Medicine," Journal of Law and Economics, October, 1959, pp. 20-53.

7. See my "Medical Care," p. 211n8 and the extended review in a volume that has influenced our line of analysis, Herman M. Somers, Anne R. Somers, Doctors, Patients and Health Insurance (Brookings Institution, May, 1961) pp. 52ff. See also the limited renunciation of the "surcharge" principle and income limits in the "reasonable charge" device used by Blue Shield in Wisconsin. Leon Applebaum, A History of Voluntary Health Insurance in Wisconsin (PH.D. Thesis, University of Wisconsin-Madison, 1959) pp. 130-37.

8. Parson, Social System.

9. Milton Friedman, Capitalism and Freedom (1962) ch. 9, "Occupation Licensure." Though recognizing that "The case of licensure is stronger for medicine than for most other fields, yet the conclusions I shall reach are that liberal principles don't justify licensure even in medicine and that in practice these results of state licensure in medicine have been undesirable."

10. Ibid., p. 153f.

11. The evidence for restriction of medical training facilities has been sifted and presented for the 1930's by two distinguished economists, Milton Friedman and Simon Kuznets, Income from Independent Professional Practice (NBER 1945), pp. 8-21. For the later period see Friedman's comments, Capitalism and Freedom, p. 160f; Somers, op. cit., pp. 119-129.

12. The ratio of admissions to applications rose from 1.7 - 1.9 in the Thirties to a peak of 3.5 (1948-9). See discussion and sources in my "Medical Care" p. 213f. After 1953 applications to medical schools diminished sharply built up gradually through 1956 and then declined through to 1961. See A.M.A. testimony in Medical Dental and Public Health Teaching Facilities. Hearings before the Subcommittee on Health, Committee on Labor and Public Welfare, Senate. August 22-26, 1963, pp. 113ff.

13. Ibid., p. 94.

14. "Medical Care," p. 212; Somers, op, cit., p. 214f.

15. "Medical Care," p. 215f.

16. Recent estimates for present day gratis work were prepared by a medical journal and summarized in a document prepared by the Department of Health, Education and Welfare (HEW), Medical Resources Available to Meet the Needs of Public Assistance Recipients (1961) pp. 64ff.

17. Ibid., pp. 1-43; "Medical Care," p. 216.

18. Health Services for the Aged under the Social Insurance System. Hearings before the Committee on Ways and Means, House of Representatives, July-August, 1961, vol. 3, pp. 1389-1398.

19. Congressional Record (CR), 1963, p. 2557.

20. Evidence for the earlier period was laid out or summarized in "Medical Care," p. 211n8. For the more recent period see the analysis and evidence in Somers, op. cit., p. 328ff. It is characteristic that organized medicine has indicated great concern over income limits and their administration. See Somers, p. 331ff; J. W. Garbarino, Health Plans and Collective Bargaining (1960), pp. 89-116.

21. See Internal Revenue Service, Statistics of Income: Individual Income Tax Returns for 1958. About 80% of all deductions for taxable returns are for returns with an adjusted gross income limit of under $10,000. For an extended analysis, See Harry Kahn, Personal Deductions in the Individual Income Tax, (NBER, 1960), ch. 7.

22. For earlier years see my "Medical Care," Table I, p. 212; for later years see Somers, op. cit., p. 201-208. Median incomes for medical net incomes as estimated by the journal Medical Economics doubled between 1951 and 1959.

23. CR, 1963, pp. 6441-6484, 6509-6534, 32, 463.

24. CR, 1963, p. 1837.

25. "Medical Care," pp. 213ff.