UNCONVENTIONAL WISDOM

The prior twelve columns in this series raised a number of crucial points too seldom heard in the national health insurance (NHI) debate. Here in summary form I tie together a generous baker's dozen in logical order, and compare them with the more conventional wisdom. I end with recommendations for NHI.

1. The key to NHI is cost control: a little isn't enough. The debate makes much of who and what are covered and who pays. Cost is often treated as a separable issue, resolved by excluding this benefit or that, rationing this service or that, etc. In fact the nation overspends for health care. Real cost will not stop rising until cost per person can be held at or below the percentage rise in general inflation, not one year but every year. Such powerful constraint will not come by trivial budget cuts. It intertwines with every other issue: eligibility, benefits, financing. None can be decided until an adequate cost strategy is chosen, then all must be decided consonant with it.

2. **The key to cost containment is productivity.** There are but two ways to spend less: *Budget cutting* get less for less by cutting value. *Productivity gain:* get more for less by steady productivity increase. NHI goals demand more for less. The only way to raise access, quality, and coverage while reducing cost is provider productlvity gain -- steadily more and better health results for less. Otherwise rising cost can only be contained by steadily cutting access, quality, and coverage...via rationing, waiting lines, benefit cuts, and the like...contrary to NHI goals. Productivity strategies merit more policy attention.

3. **The key to productivity is radical provider change, not trimming fat.** Contrary to much conventional wisdom, little gain will come from paring fat in todays system -- a one-time saving soon eaten up by continued escalation of the lean. Major gain is from producers regularly reinventing their product, production process, and organization...eg, the new Ford Taurus did not arise by trimming fat from an earlier model. Strategy must induce such provider change.

4. **The key to provider change is altered incentives, not direct intervention.** Too often governrnent tries to directly impose efficient methods and technology on providers. The idea that a handful of public officials can identify or invent efficiencies better than an expert industry is absurd. The reason providers ignore these improvements, unless they can pervert them to raise cost, is neither stupidity nor greed. Rather, present system incentives perversely punish them for productivity and reward costliness: were all providers as efficient as the few most efficient effective providers today, 20% would be out of business and the most efficient would be the first to go. Reverse these incentives and providers would radically restructure for productivity in their own interest far faster and better than policy could prescribe or coerce.

5. **The primary cause of health system malperformance is market failure.** The present health care market violates the required conditions of economic theory for sound competition. These violations create the perverse incentives on providers which reward runaway cost, highly variable quality, and maldistribution of providers. Conventional wisdom miscredits these system problems to such "causes" as high cost technology, insurance-induced demand, increased services to avoid malpractice, and aging of the population. Only the latter is a true cause, but it accounts for less than half a percent rise per year. The remainder are all symptoms, not causes. They are how providers raise cost, not why.

For instance: In sound markets...computers, cars, and so on...high technology is used to raise quality and reduce cost; only in medicine is it used for the reverse. Present inflationary insurance is neither natural nor necessary; it was forced on insurers by the earlier provider cartel, now broken. Efficient providers are not sued more, they are sued less. The true cause why providers use all these means to raise cost is that unsound market incentives reward them when they do and punish them when they don't. Trying to cure symptoms directly will always prove futile, for it leaves the flawed incentives unaltered. The proper strategy is to reverse the incentives by correcting the unsound market.

6. **The key to productive incentives is sound competition.** Economic research conclusively shows sound competitive markets the most powerful device for productivity gain ever discovered. Nothing else comes close. The great breakthrough of the Clinton Plan is that he is the first President to advance sound competition in NHI. The goal is not competition. The goal is superior care and coverage for all at a cost that individuals, employers, and the nation can afford. Sound competition, if feasible in health care, is simply the means... preferred because only it produces the productivity essential to goals. (To achieve equity, competition must be augmented by subsidies for the poor.) But no nation has ever attempted a sound market in health care. Though prospects appear high, feasibility can thus not be certain until tried.

7. **Sound and unsound competition differ.** Failure to make the distinction has caused much confusion. Liberals cry competition has failed. Of course competition in unsound markets fails; economists have known this for 200 years. Conservatives cry let competition work. Unsound competition will never work. Only sound markets are self-correcting; unsound markets are not. Sound markets are created by wise policy intervention, installing and maintaining *the SDC conditions required for sound competition:* sufficient competitors and buyers; no collusion by either; easy entry and exit by competitors; consumer information; consumer incentives; and proper government oversight. Any market reform proposal must be checked for all six conditions; if just one is absent, competition will remain unsound. Unfortunately the bold Clinton Plan comes up short.

8. **Controls are a second-rate strategy for productivity.** There are but two basic remedies for an unsound market, largely incompatible: I) *Market reform* reverses unsound market incentives by installing each of the required conditions for sound competition. 2) *Economic controls* counter unsound market incentives by a mix of price, revenue, budget, use, and/or franchise controls. Economic research proves controls

inherently weak at productivity gain; they cannot be improved by trying harder or smarter -- even the Russians now concede this. So they can hold cost only by growing rationing, waiting lines, and other cuts in access, quality, and coverage seen in foreign systems. However, if market reform proves infeasible in health care, controls are the only alternative. Experience at least shows them better than today's unsound health care market. But because controls undermine sound markets, they should be kept as a reserve strategy -- for use only if, and where, market reform actually falters.

9. **Both patients and providers obey normal economics.** Much conventional wisdom claims sound competition inherently infeasible in health care, and controls unavoidable, because it is doesn't follow usual economics: patients demand only the best but can't determine what it is, so providers can always raise cost. This is certainly true today, but only because the health care market is so unsound. Research conclusively shows patients change care-seeking behavior when given incentives to do so, and economize using any information they can get. The problem is they can't get basic information on which providers give better care for less, so the market remains unsound (market reform will alter this). Likewise providers behave in both unsound and controlled markets exactly as economists predict from the (flawed) incentives in each, and they change when the incentives change. Thus solid research predicts they will perform well in sound markets. I keep trying to persuade my liberal friends what a radical device sound markets really are, if government will keep them truly sound: Nothing forces producers to satisfy consumers like sound competition...even mighty GM and IBM have been humbled.

10. **The key to market reform is purchasers, not providers.** A system is controlled by whoever controls the crucial item in short supply. When doctors were in short supply, they could act as a guild (professional monopoly) to control the market. But doctors are now in gross surplus. Their monopoly power was broken when government doubled output of new doctors in the '70s. They no longer dictate the market, it dictates them: they consent to actions unthinkable twenty years ago. The crucial scarce item now is patients. But patients today have no means to exert power (market reform will change this). They are controlled by purchasers...the employers, labor funds, Medicare, etc. who provide their coverage. The power to make or break the market is now in the hands of purchasers and government, if either know what to do with it.

11. **The key to national market reform is local market reform.** The good news for purchasers is that to reform the health care market they do not have to change the entire nation or a state, they only need change their town. This conflicts with much conventional wisdom that communities are helpless and only Federal action can reform health care. Health care markets are largely local: patients seldom go outside their local area for most health care. So providers must follow the incentives of their own local market, not incentives in other localities. To reform a local market, purchasers need only install the six conditions for sound competition in the area. The bad news IS that they must unite to do this; they cannot work solo, firm by firm. The reason is, providers cannot radically restructure for productivity for only a fraction of their patients; they must change for all or none. If only one purchaser's patients seek better care for less, but the great majority remain covered by traditional insurance rewarding costliness, providers cannot afford to change. Hence one purchaser gains little if it alone undertakes reform;

it must enlist most local purchasers to do likewise. The good news is, they need not await government or NHI. They can contain cost now by locally uniting for market reform now.

12. **The key to local market reform is consumer information and incentives.** The two most severely violated market conditions in health care are lack of consumer information and incentives. All the rest are readily handled if these can be corrected. Patients must be given simple report cards on the quality and cost of providers and plans so they can make informed choices. And they must be given assistance and incentives in their coverage rewarding them for choosing better providers who cost less. To do this, purchasers must unite to set up a permanent local agency to measure and report on each area provider and plan. And they must help each purchaser install proper incentives in its local coverage. With such ample means and incentives, all area patients will seek better care for less. Providers must then compete on better care for less. *The new conditions reverse the incentives and make local competition sound.*

13. **The key to proper consumer information is outcomes assessment.** Patients do not seek services, they seek relief of a health problem. Hence information on services **is not** only poorly understood but irrelevant to consumers. Change in their health status from treatment, together with their satisfaction on how they were treated, is termed an outcome. Cost of the outcome is the total cost from first contact for the problem until the outcome is measured. As patients vary in initial severity and response to treatment, outcomes and their cost can be reported as batting averages for each provider and plan on patients with similar initial illness and severity: what percentage of a provider's patients improved, what percentage worsened or died, what percentage would recommend him to other patients, and what was his average cost per outcome, all compared to other providers treating comparable patients. Consumers understand and desire this information. Outcomes assessment by external assessors for consumers is often confused with internal assessment of providers by themselves; the two are different and need different methods. Only external assessment is required for sound markets. Internal assessment is not a required condition because it has no incentive power; providers do it seriously only when consumers are informed. Yet most current assessment research is on internal methods unuseful for consumer information. External assessment research ought be given high priority.

14. **The key to better, safer, and less costly NHI is staged implementation.** No matter the strategy adopted, NHI would best be implemented in tested stages via a blue ribbon Commission or Agency under Congressional oversight. It can start in a few voluntary test localities, be extended gradually to more and more voluntary sites, then finally be mandated nationwide when fully proven. Also, in each test locality the cost control strategy ought be installed first and seem satisfactory, before universal coverage is extended to the locality. These steps will minimize major teething problems and financial overrun, and confine them to just the test sites until they can be corrected. A Commission can make swift mid-course corrections all along the way, and Congress mandate the final Plan only when confident of it. In contrast, were the Plan legislated immediately nationwide, teething problems and financial overrun will cause enormous burden, with inadequate experienced staff to handle it; and legislated corrections will be slow and unsure. The unhappy disadvantage of staging, that a majority of Americans

must wait several years for NHI, appears outweighed by the virtual certainty of financial hemorrhage if not staged. Any cost control strategy will take a couple years assuming it works (providers can change **only** so fast), and much longer if it doesn't; but the cost of coverage starts immediately. This would sap all other national needs and priorities, many more important to health and wellbeing -- particularly of the disadvantaged -- than immediate universal care and coverage. Precipitous NHI begs for high failure. Staged NHI appears better, safer, cheaper, and ultimately faster.

The above points are almost too easily grasped. Firms are wise to seek expert help, as application to strategy design takes some experience. Some discussion points up the subtleties. I have admired the Clinton Plan for its sound principles, breakthrough emphasis on market reform, its forcing of the issue with a bold concrete Plan, and the President's stated willingness to adopt any better proposal that meets his principles. But in its specifics and complexity the Plan falls short: Consumers and providers are restricted to large managed care plans, precluding sufficient competitors for a third of the nation in less populous localities and obstructing entry in the remainder. And the most critical element, consumer information, rem~ins more a promise than well-considered specifics. Plan controls, applied simultaneously with market reform, will further underrnine sound competition. Last, the Plan is implemented nationwide at once, quite unrealistic for its overvast bureaucratic control apparatus. This draconian apparatus -- superfluous in all other sound markets -- suggests poor confidence or conviction in market reform; the Plan seems schizophrenic between the two. Its complications may stem from overlooking that, given proper consumer information, sound provider competition can occur within conventional insurance plans, not just between managed care plans; this opens up freedom of entry to smaller provider units and allows sound competition in most of the nation. Left unfettered, sound competition will almost certainly build far more integrated local and perhaps regional provider units and plans. But the huge plans imposed by the current Clinton Plan may be a transitional phenomenon that ends as know-how and capital spread, much as national supermarket chains in local food markets gave way to more local chains. Thus policy stress ought be on making market incentives sound, not dictating provider and plan arrangements. A reformed market will sort out much better than policy ever could, the optimal mix yielding better care for less. The Clinton Plan could rather easily replace its current approach with the new market reform strategy in points 11 - 13; it is consonant with all Plan principles yet simpler and sounder. States might also consider this strategy for state NHI plans.

Were private sector leaders to aggressively press the new local market reform strategy nationwide, it might favorably shape NHI as well as contain their cost -- parhcularly were they to ask the Administration to adopt the new approach and support the private movement with organized leadership, at which this President excels, and with demonstration authority for Medicare to participate as a public purchaser in local sites. This could get the market reform component of ~HI well under way, even should the formal legislative debate prove protracted.

But the new market reform approach ought be done right. It should foster consumer choice, not purchaser choice. ~By restricting employees to particular providers, the latter could also make purchasers liable for any malpractice). Purchasers should not unite locally to form large purchasing organizations that collectively leverage providers

on price or decide which to use. Small purchasing organizations, especially if two or more are in a locality, are fine; they can aid the market if they help small firms maintain proper coverage incentives, information, and assistance for employees. But *a single large purchasing organization covering 40% of a local market or more is anti-competlt~ve.* It violates the market condition that neither sellers nor buyers may collude to set prices. Hence purchasers should unite areawide only to set up consumer information and incentives, then let consumers make their own choices.

The above points suggest four major recommendations for consideration by the Administration, Congress, States, the private sector, and the public:

NHI should adopt a better simpler market reform strategy as its primary approach to cost and improved care, along the lines of points 11 - 13. *The private sector ought move on local market reform immediately* in its own and the public interest; it need not await NHI.

Controls should be kept in reserve, as in point 8, for use only where market reform proves infeasible after thorough effort. (Controls may also be used temporarily for initial savings in localities not yet engaged in market reform, if rescinded in each as market reform begins there.)

NHI should be staged, as in point 14, rather than implemented nationwide at once. But insurance and tax reforms that end present discrimination against the sick, poor, and individually insured can be enacted nationwide immediately and make their coverage more affordable. These need not await NHI's staged cost strategy and universal coverage.

Government should launch a major research program on external outcomes assessment immediately, as in point 13, and not delay while the NHI debate continues. Improved measures to inform consumers, purchasers, and government will be crucial to any NHI strategy...market or controls.

More information on any point can be found in previous columns. I hope the columns have proven informative, practical, and constructive.

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