Guest Editorial

Procompetition Legislation: The Moral Dilemmas of Untested Assumptions

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The escalating costs of medical care must rank high on any list of today's seemingly insoluble social problems. So frustrating is this problem that it goads us, in desperation, to "do something." Unfortunately, that "something" may become disastrously self-defeating if its human costs and ethical impacts are not sufficiently weighed.

We do not know whether or not this will be the case with current proposals to control medical costs by legislation that encourages consumer choice and provider competition. The economic assumptions on which they rest have yet to be put to the test of reality. Whether they will achieve the goals their enthusiasts promise is therefore highly problematic.

Even more problematic, and in the long run more significant, is the potential effect of procompetition proposals on the care of patients and the ethical behavior of physicians. These questions seem sure to be obscured in the clash of economic theories and political ideologies that has characterized the debate thus far.

As the debates warm up, it is well to examine some of the assumptions upon which the ethos of competition rests, the dilemmas created in their application, and the impact they will have on professional ethics.

The theory. The procompetition line of argument runs as follows: Rising costs result from irresponsible overutilization of medical services and technology engendered by insulation of providers and consumers from the financial consequences of their overutilization.

Government restrictions and entitlements as well as the reimbursement structure and tax exemptions of health insurance contribute to this insulation and it is to be stripped away by taxing employer contributions, modifying Medicare and Medicaid benefits, encouraging co-insurance and deductibles, and vigorously fostering competition among providers.

With the insulation gone, providers and consumers will feel the financial pain of overutilization. Consumers will shop around and buy only what they need at the lowest costs. Providers will innovate and cut costs to hold their share of the market. Inefficient providers will be driven out. The market will operate like markets in other commodities and services. Prices will fall, efficiency will rise, and incentives will return.

Throughout all of this, it is averred, quality and accessibility will be sustained. Moreover, the poor, the elderly, the disabled, and the young, as well as the marginally poor, will not be disenfranchised. Indeed, to reassure the public on this point, some of the proposals insist on legislative safeguards against "skimming off" the profitable, low-risk, affluent patients.[1] The paradox of having to regulate competition on the one hand and free the market for untrammeled action on the other is eloquent testimony to the internal contradictions of procompetition theories. Obviously,

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there is something about health care that is not prudently left to market forces.

The assumptions. The untested assumptions in these beguiling schema are many. Only a few can be mentioned here.

For one thing, there is the belief that Americans will purchase health care as they do any other commodity. The transaction with the physician is thus likened to that with the grocer or automobile mechanic. But we do not know whether consumers will shop around for the cut-rate plan when their health is concerned. Will not the tendency be for some to move up to broader coverage, purchasing beyond their means as many do even now with so many other consumer goods? Others may simply postpone or avoid the investment. Anyone who has cared for the sick knows that although health may be a low priority for the well, it becomes the top priority for the ill. How many Americans will forget this and leave themselves exposed to the risks of the cheaper plan? Illness is too unpredictable in time, place, and severity for such fine calculations. Americans may settle for the lower priced, lesser car, but they are not likely to accept the lesser surgeon or hospital as a conscious choice.

Even if we accept the assumption that health services are no different from buying cars or household appliances, what evidence is there that competition will assure quality and accessibility? The evidence points heavily to the contrary, as rising prices and deteriorating quality of goods and services attest at every turn. Market forces tend to profit making, not service. Is the free-market principle of "caveat emptor" to be suspended for health care? If so, how, and at what price?

The principle of choice assumes that, annually, consumers will be able to make the best selection among competitive plans. But how will the consumer distinguish between a no-frills adequate plan and a cut-rate dangerous one? Will not competition spawn the usual confusing variety of standard packages with a list of options and a set of deluxe and super-deluxe models? Who can be trusted to advise the purchaser? The provider whose interest must be profit? Some consumer protection agency—an anathema to the proponents of untrammeled market forces? The fine-print exclusions under the present system are warning enough of the difficulties of choice, even for educated people.

There can be no doubt that provider overutilization of hospitals, tests, and procedures is excessive, but does this justify the assumption that competition will bring utilization more closely into alignment with actual need? May it not lead to underutilization? Cutting corners may advance the physician's interest but be more costly for the individual than overutilization, especially if a remediable illness is missed.

The only lasting and safe antidotes to overutilization are diagnostic elegance, rational therapeutics, and physicians for whom competence is a moral imperative. In fact, some of the most blatant examples of provider overutilization occur in just those fields of medicine where entrepreneurship is most in evidence.

Some practical dilemmas. Let us grant for a moment that most of the assumptions of the procompetition advocates are valid. Yet they still present significant moral challenges for all physicians, especially those in primary care and family medicine. They will see those patients who opted for the wrong or lesser plan, or did not opt for any plan, or used up their vouchers. They will see patients when they are ill, in need of help, and unable to pay for the care they need. In certain locales these may be the majority of patients a hospital or physician is called on to treat. How many such patients can a physician be expected to help in a competitive system? Profits are crucial to survival. It is hard enough now to get physicians in many cities to see Medicaid patients. How will the poor fare with hospitals that must show a profit to obtain a good bond rating if they are to ever make the capital improvements they may need? What kinds of decisions will be made in a system that rewards physicians who turn over large volumes of patients at lower costs per patient?

Clearly, it is the first contact physician who will be left with the casualties of the competition ethos—those at the margins of society who are usually in need of more medical care and who are most likely to buy the most minimal coverage or to put off the expenditures for the remote possibility of illness. The public reluctance to invest in preventive medicine is evidence enough of the precedence of current desire over remote benefit.

Some moral dilemmas. More serious than the tenuousness of its assumptions or the potential inequities of its application are the subtle transformations in professional ethics that an ethos of competition must inevitably produce. We must acknowledge that a disturbing number of physicians already regard medicine as a business. Procompetition legislation will just reenforce their least commendable motivations.

For the majority of physicians the canons of competition must conflict with the canons of traditional medical ethics. Competition makes fiscal survival, not service and obligation, the motive of the relationship with patients. Covenant gives way to contract, law replaces ethics, and self-interest becomes a primary rather than secondary motive. These tendencies are already too manifest in the profession. They are the basis for the Federal Trade Commission ruling that medicine is indeed a commercial enterprise, and professional ethics constitute only a self-serving device to assure monopoly of the market.

Are physicians and patients ready to accept the implications of a business ethic in a relationship that is of its essence unequal? It is hard to visualize a just contract negotiation in which one party is vulnerable and in dire need of the other party's services. Illness compromises the whole person; every weakness is exposed.[2] Trust is an essential ingredient in healing. The well patient may be able to negotiate the health contract that is most to his benefit. What happens when he becomes ill and that contract proves inadequate?

There have always been physicians who put self-interest first. But at least they did so in defiance of a strong tradition that teaches otherwise and acted as a restraint on all but the most blatant violators. Once we determine medicine to be primarily business and exalt competition, these restraints will be almost totally ineffectual. Those with weak moral convictions will "go along" because everyone else is doing the same.

Even before the passage of legislation we can see some of the implications of the competitive spirit at work. Here are some measures presented with approval by the coauthor of one of the most popular legislative proposals (HR 850):

> Hospitals are starting to emphasize sales as well as service. Some offer potential patients chances on vacation trips or moneyback guarantees. In the Twin Cities, hospitals aggressively market beds in bulk at big discounts to prepaid plans.
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> The Blues in Boston give new mothers cash bonuses for checking out of the hospital quickly. A plan in Philadelphia pays patients for going home after a less than average length of stay. Safeco's United Healthcare rewarded doctors who cared for patients on less than the per capita budget amount. Blue Shield in Northern California lets patients share in the savings if few health claims are filed.[2]

While finding these measures commendable, the author regrets that: ". . . there are limits to how much can be achieved unless some of the basic rules that now inhibit true price competition are changed."[2]

We may interpret all of this as a resurgence of the "innovative spirit," or an invitation to hucksterism or to manipulation of the vulnerability of the sick for profit. The public and the profession must decide. What is clear is that the uninhibited use of business tactics will radically alter not only the structure of the system but also the motivations and ethics of hospitals, physicians, and all who profess to help and heal.

Cost escalation is a real problem crying urgently for solution. The procompetition advocates should not be faulted for their imaginative suggestions. They have at least been specific in their recommendations. Ultimately all of us must decide if their solutions are more damaging than helpful to the human ends for which the health care system exists. How we decide will also determine what kind of a profession and even what kind of society we want to be.

These are matters in which the primary care and family physician have a special obligation. They are in the front line and inevitably will bear the brunt of inept economic strategies. Like their military counterparts they will see the casualties long before the news reaches the social policy planners. It is their responsibility to monitor the human costs of distant strategic decisions—an urgent, difficult and often thankless task, but an inescapable one.

References

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