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Perverse Incentives in Health Care

By John C. Goodman

Our public-school system and our health-care system may seem as different as night and day. Yet both systems share something in common: Mediocrity is the rule and excellence, where it exists, is distributed randomly.

In both cases the reason is the same. There is no systematic reward for excellence and no penalty for mediocrity. As a result, excellence tends to be the result of the energy and enthusiasm of a few individuals, who usually receive no financial reward for their efforts.

Research by John Wennberg and his colleagues at Dartmouth Medical School suggest that if everyone in America went to the Mayo Clinic, our annual health-care bill would be 25% lower (more than \$500 billion!), and the average quality of care would improve. If everyone got care at Intermountain Healthcare in Salt Lake City, our health-care costs would be lowered by one-third.

Of course, not everyone can get treatment at Mayo or Intermountain. But why are these examples of efficient, high-quality care not being replicated all across the

country? The answer is that high-quality, low-cost care is not financially rewarding. Indeed, the opposite is true. Hospitals and doctors can make more money providing inefficient, mediocre care.

In a normal market, entrepreneurs in search of profit would solve this problem by repackaging and repricing their services in order to make customer-pleasing adjustments. Yet in health care, contracts and prices are imposed by large impersonal bureaucracies. The individual physician has virtually no opportunity to offer a different bundle of services for a different price. As a result, very little entrepreneurship is possible.

Sometime in the early 20th century, lawyers, accountants and most other professionals discovered that the telephone was a useful instrument for communicating with clients. Yet even today, consultations with doctors by telephone are quite rare. Sometime in the late 20th century most other professionals discovered email. Yet only 21% of patients exchange email with their physicians; of these, slightly more than 2% do so on a frequent basis.

One would be hard-pressed to find a lawyer in the U.S. today who does not keep client records electronically. Ditto for accountants, architects, engineers and virtually every other profession. Yet although the computer is ubiquitous and studies show that electronic medical record systems have the capacity to improve quality and greatly reduce medical errors, no more than one in five physicians or one in four hospitals have such systems.

Why has the practice of medicine (as opposed to the science of medicine) changed so little in the modern era? The reason is because of the way we pay for medical care, particularly the way we pay doctors. At last count, there were about 7,500 specific tasks Medicare pays for. Telephone consultations are not among them. Nor are email consultations or electronic record keeping. What is true of Medicare is also true of Blue Cross and most employer plans.

Things are made worse by the fact that patients do not usually pay for health care with money; they typically pay with their time instead. As in Canada and most other developed countries, health

care in the U.S. is mainly rationed by waiting, not by price.

When the doctor's time is rationed by waiting, the primary care physician's practice is usually fully booked, unless the practice is new or located in a rural area. As a result, there is very little incentive to compete for patients the way other professionals compete for clients. Because time -- not money -- is the currency we use to pay for care, the physician does not benefit very much from patient-pleasing improvements and is not harmed very much by an increase in patient irritations. Bottom line: When doctors and hospitals do not compete on the basis of price, they do not compete at all.

Where third-party payment is the norm, markets tend to be bureaucratic and stifling. But in those health-care sectors where third-party payment is rare or nonexistent, the market is vibrant, entrepreneurial and competitive.

Take cosmetic and Lasik surgery, for example. In both markets, patients pay with their own money. They also have no trouble finding what is virtually impossible to find for other types of surgery -- a package price covering all aspects of the procedure. People can compare prices,

and in some cases quality. Providers are competing on price and quality and competition pays off. Over the past decade and a half, the number of cosmetic procedures grew sixfold along with numerous technological innovations of the type that are blamed for rising costs everywhere else in health care. Yet despite tremendous growth and technological change, the real price of cosmetic surgery declined. Over the past decade the real price of Lasik surgery fell by 30%.

The market for prescription drugs is another area where a great many people are paying out of pocket. In response, Rx.com was the first online outlet that began competing based on price and quality (they make fewer mistakes than local pharmacies). Wal-Mart's new policy of offering a month's supply of generic drugs is yet another example. Can anybody imagine Wal-Mart offering the same deal to Blue Cross?

Perhaps the most spectacular instance of a health-care product developing outside the third-party payment system is the walk-in clinic. These can be found in shopping malls and drug stores in the upper Midwest and they are spreading like wildfire around the country. They post prices. There is very little waiting. They maintain records

electronically. The quality of service is comparable to traditional primary care at half the cost.

I know what you're probably thinking. Markets may work for certain specialized services; but can they work for run-of-the-mill hospital surgery? Medical tourism is proving that the answer is yes. If you're willing to leave the country you too can have access to efficient, high-quality health care. In India, Thailand and elsewhere around the world, facilities are offering U.S. citizens virtually every kind of procedure for package prices, covering all the costs of treatment, and sometimes airfare and lodging as well. These prices are often one-fifth to one-third the cost in the U.S. and care is often delivered in high-quality facilities that have electronic medical records and meet American accreditation standards.

One part of our health-care system (the part where third parties are absent) is teeming and bristling with entrepreneurship and innovation. In the other part (where third parties pay the bills), entrepreneurship has been all but extinguished. How can we make the latter more like the former?

Public and private efforts to reform the health-care system have been actively underway

for the past two decades. The results have been disappointing, to say the least, and they all have one thing in common: They focus on the demand side of the medical marketplace.

Managed care, practice guidelines, pay-for-performance -- each of these short-lived fads involves buyers of care telling the providers how to practice medicine. Does no one notice how strange this is? In normal markets, buyers do not instruct sellers on how to efficiently produce their products. Even the HMO movement is a demand-side reform in this context. The HMO doctor is just as trapped as the fee-for-service physician and just as unable to rebundle and reprice his services in innovative ways.

Some believe that health savings accounts (HSAs) will radically reform the health-care system. Yet this is also a reform that focuses on demand, not supply. Even with an HSA plan in hand as you approach the doctor's office, you should know that your insurer has already spelled out what services will be paid for,

which ones will not and how much will be paid. HSAs, therefore, will not free doctors to take advantage of telephone, email, computerized records or any other truly innovative service. Like school vouchers, HSAs create new freedom on the buyer side without loosening the shackles on those who produce. The reform is commendable. But real innovation must come from the supply side of the market.

One would think that health insurers and employers would find it in their self interest to break the mold. To the extent that entrepreneurs raise quality and lower price, the insurance product itself should become more attractive to potential customers. The trouble is that the entire third-party payment system is completely dominated by government (principally through Medicare and Medicaid). Private insurers tend to pay the way the government pays and providers who break Medicare rules in order to better serve the patient risk being barred from the entire Medicare program.

A possible way out of this morass is to start with government. Under the current

system, Medicare and Medicaid stifle entrepreneurial activity and financially punish efforts to lower costs or improve quality. Why can't these agencies reward improvements instead? Suppose an entrepreneur offered to replicate the Mayo Clinic in other parts of the country -- potentially saving Medicare 25% of costs and improving quality of care along the way. Medicare should be willing to pay, say, 12.5% more than its standard rates in order to achieve twice that amount in lower total costs. That would leave the entrepreneur with a 12.5% profit -- an amount that one would hope would encourage other entrepreneurs to enter the market with even better ideas.

Once government agencies jump-start the entrepreneurial process in this way, private insurers are likely to follow suit. In this way, government could promote entrepreneurship, instead of stifling it.

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