Why neither competition nor regulation is the whole answer

by Robert M. Sigmond

SUMMARY. The full potential of competitive marketplace incentives and governmental regulatory incentives in the health field will be achieved only in effective interaction with voluntary incentives. This article examines the relationships among regulation, competition, and voluntary discipline and the implications of a balanced approach in health planning.

The health care field is in a constant state of change, reflecting new developments in science and society. Change occurs as individuals and institutions associated with all sectors of the field react to a wide variety of direct and indirect positive and negative incentives.

Some of these incentives are associated with competition and free-enterprise marketplace forces. These are quite important, because the ways that money changes hands inevitably have impact on human and institutional behavior.

Some of these incentives are associated with regulation and governmental police powers. These are quite important, because most of us still do respect the law and wish to avoid entanglement with legal processes most of the time.

Much current public policy discussion centering around health issues seems to imply that the only effective incentives are associated with marketplace competition, which ideally stimulates innovation, and government regulation, which ideally stimulates compliance and conformance. This perspective would assume that the key question is, What is the ideal balance between the two kinds of incentives?

But all effective incentives in the health field are not associated with the two forces of competition and regulation. As I see it, after accounting for competitive and regulatory incentives, there is still a very large balance left over. This balance of incentives that lie somewhere between competition and regulation and are frequently overlooked—especially by those who concentrate on "macro" formulations as contrasted with "micro" formulations—is the subject of this article. The question is not how to maintain a balance between competitive and regulatory incentives. The real question is how to maintain an effective balance among competitive, regulatory, and *voluntary* forces and incentives in a cooperative, community framework. Or, put another way, how to restore some balance into the national debate by renewed attention to voluntary forces.

Historically, until quite recently, throughout most of the health field, voluntary incentives associated with peer approval, pride of workmanship, avoidance of embarrassment, and altruism have taken precedence over financial gain and fear of penalties and punishment. Despite appearance to the contrary, voluntary incentives are still strong in the health field. This article will attempt to demonstrate that the full potential of competitive marketplace incentives and governmental regulatory incentives in the health field will be achieved only in effective interaction with voluntary incentives.

Government regulation and voluntary initiative. Three key points about the relationship between government regulation and voluntarism are frequently overlooked in current public policy discussions in the health field:

1. The success of any form of government regulation depends upon voluntary conformance by the vast majority. Prohibition against alcoholic beverages in the '20s is the best-known example. Current efforts by law enforcement officials to get the National Safety Council to promote voluntary adherence to the 55-mile speed limit so that enforcement can be effective are a more recent demonstration of the point. Most of us obey red lights in driving because it seems like the right thing to do, not because of fear of getting arrested. And so on. In any area of regulation, if most don't voluntarily behave in conformance with government regulation—because it seems right and proper to do so—the regulations usually can't be enforced.

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2. Government regulation is much easier to administer when the vast majority of those affected are voluntarily, for one personal reason or another, committed to tougher standards than government regulations. Here again, you can think of many examples. I learned the motor vehicle code in order to get my driver's license some years ago, but I don't keep up to date on these regulations, because I am committed to commonsense driving practices that I am positive are much more restrictive on me than the legal requirements.

3. Government regulation works

Robert M. Sigmond is adviser on hospital affairs to the Blue Cross and Blue Shield Associations. This article is adapted from a presentation at the Delbert L. Pugh Invitational Conference on Health Planning, Columbus, OH, October 1979.

best when formal voluntary *mechanisms* exist that maintain tougher standards than the law provides and that encourage and assist with voluntary adherence to higher standards than the law requires. Not only do most people avoid illegal littering in my neighborhood, but many belong to a civic association that promotes and helps organize action reflecting pride in our community and discourages action not in our neighborhood's interests.

These kinds of classical interrelationships between regulation and voluntarism have existed for many years in health. Physicians are licensed by the government but give little attention to licensure requirements, because they voluntarily adhere to higher standards of important voluntary organizations like specialty boards and colleges and hospital medical staff organizations. Most physicians are not worried about losing their licenses, but they do keep their records up to date for fear of losing their staff appointments in voluntary hospitals. Many hospital executives are barely aware of the government's licensure requirements, because they adhere to the standards of the Joint Commission on Accreditation of Hospitals, which are both tougher and more flexibly administered.

Generally speaking, government regulations with respect to quality, efficiency, effectiveness, safety, and community service can be safely disregarded by institutions with genuine commitments to these goals. In almost all instances, they can be disregarded because the institution meets the requirement and more; in other instances, the regulation is unlikely to be enforced in an institution that is clearly maintaining high standards.

Future changes in regulations applicable to various classes of health manpower can be forecast by observation of those regulations that are being routinely disregarded in the "best" hospitals. First-class hospitals started intravenous (I.V.) teams of nurses back in the 1940s, when starting an I.V. was clearly limited by law to physicians. Later, first-class hospitals started using I.V. technicians when I.V. administration was clearly limited by law to registered nurses. And so it goes! Such behavior would not have been tolerated in second-class institutions, but first-class institutions did not have to wait for the regulations to be changed.

Government regulation typically deals with the "outlyers," with marginal operations and bizarre behavior. In a responsible society, this is as it should be. Exceptions to this rule almost invariably reflect temporary breakdown in the normal workings of voluntary discipline and initiative.

When most of us with managerial or governance responsibilities in the health field think about regulation, we automatically think of government regulation. But if you ask a physician or a nurse or most other health workers, most of whom work for hospitals, *they know* who the regulator is. It's the person who signs their checks, the person who says no when they want a yes. For them, the managers are the regulators. The sooner we recognize that the key regula-

Quality and cost containment: you can't have the first without the second

With respect to hospital expenditures, the current interaction between voluntary and regulatory forces is most instructive. In 1976, hospital expenditures were rising at a rate that was clearly unacceptable. Various voluntary groups, such as the AHA and the Blue Cross and Blue Shield Associations, had developed cost containment programs that were beginning to have impact, but these were not coordinated or developed in the tradition of national standards. Furthermore, the accepted ideology of most voluntary leadership was that the country could have cost containment or high-quality, accessible care, but not both.

When it became clear that this Hobson's choice was untenable, the Voluntary Effort was created. The Voluntary Effort is important, because it signaled a basic ideological shift from the position that cost containment and decent care were incompatible to a sounder position that, with voluntary initiative and discipline, the country could have both. Following the initial success of the VE, in keeping with traditional voluntary-governmental interactions, the government revised its legislative approach so as to tie government regulation to demonstrated failure of voluntary initiative.

In the final analysis, we will get a handle on the cost issue when we take the next step—from (a) the original position that cost containment and decent care are an either-

Voluntary cooperation is the key to more effective competition and regulation in the health field

tion in health service is what management does in response to community and customer pressures, the better. Government regulation will and should always be there, but only applicable to the extent that the management of community institutions doesn't face up to society's expectations.

A New York study of the impact of government regulation on hospital costs concluded that it accounted for 20 to 25 percent of the entire bill. Of course, if all the regulations were removed, most hospitals would continue to incur all of the costs involved in meeting governmental regulations—and beyond—because almost all are required for sound hospital service, which takes precedence.

The keys to regulation are (1) individual self-regulation and discipline, backed up by (2) institutional regulatory mechanisms that encourage self-regulation and discipline, backed up by (3) voluntary standard-setting agencies that encourage institutional self-regulation and discipline, backed up by (4) governmental regulation to identify and, if necessary, punish the laggards. Voluntarism can't do it alone, because there will always be laggards who are a threat to society. But government regulation can't do it alone, because government must necessarily be concerned with equity and with formal processes, minimum standards, and measures of equity, which fall short of society's expectations. Everyone in society wants equity for all, and the best for his or her family in time of need. There's no way that government can meet those expectations, except in partnership with voluntary community cooperation.

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Marketplace competition and voluntary initiative. Five key points about the relationship between marketplace competition and voluntary initiative and discipline are frequently overlooked in current public policy discussions in the health field:

1. Advocates of competitive incentives frequently refer to the desirability of changing various interferences with the automatic working of the marketplace, like prepayment and insurance, so that we can return to an efficient marketplace approach to allocation of resources. But the fact is that there never was a time in this country when the marketplace played a significant role in price determination in the health field, particularly hospitals. Before so-called third-party payment, most people didn't pay, or paid very little. Voluntary philanthropy and Robin Hood philanthropy played a much larger role. There was little or no price competition—ever.

2. The "unseen hand," so important in marketplace theory, is almost inoperative in the health

or proposition, to (b) the current position that we can have both, to (c) the emerging position that a tough cost containment management program, like a tough medical records system, is an essential requirement for any program of effective institutional health service management.

When any service becomes as complex as health service now is, high-quality results require tough management, which means management of scarce resources, which in turn means containing costs within a predetermined management limit. Unlimited resources for each element of production necessarily result in weakened management and in breakdowns in coordination and continuity that inevitably affect quality and access adversely. When we reach the point in this country when no one would want to be associated with a hospital that lacked a solid cost containment program—just as no one would want to be associated with a hospital with poor medical records—then we will be able to develop an effective balance between voluntary and regulatory forces in the cost area.

We have much to do to create the rationale and the voluntary mechanisms that will be required to establish an effective balance between voluntary initiative and discipline, on the one hand, and government regulation, on the other, on the cost issue. We had better get on with it.—R.M.S.

field—when it comes to buying specific services at time of need—for reasons that are well known to economists. More attention to creating conditions for free-market price competition for specific health and medical services could be helpful, but it is not likely to have as significant impact as some think.

3. Competition among hospitals and other responsible health agencies for resources—physicians, nurses, capital funds, and so on—has been with us in quite intense form from the beginning. That's nothing new, and there's nothing wrong with it, so long as such competition is tempered by the necessity to respond to society's expectations. For a wide variety of well-known reasons, even this kind of competition for resources can be counterproductive in the absence of a commitment to areawide planning. Hospitals do compete—but not primarily on the basis of prices charged to sick people. We must find ways to ensure that such competition is socially productive, by channeling competitive drives within the guidelines of areawide planning. It's hard to do, but it can be done.

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4. The major traditional outlet for free-market price competition in the health field is in selling goods and services to community health agencies, especially to hospitals. This continues to represent the major potential for price competition. It is growing beyond the traditional goods and services to include contract services, even the entire management of hospitals for community boards, now the fastest growing segment of the investor-owned hospital chain industry.

5. Competition in selling health protection and insurance and health systems is nothing new. It has always been with us, and very intense, as all insurance salesmen know. By and large, Blue Cross and Blue Shield have won out in these competitive struggles, but not always. Price has played a part in these competitive battles, but it has not always been the primary consideration.

Fortunately, influential marketplace economists are pressing for greater price competition in selling health service systems, as contrasted with specific services. As far as hospitals are concerned, Blue Cross has been marketing hospital systems since it was started by Justin Ford Kimball in 1929 at Baylor Hospital in Texas. The sooner that hospitals join Blue Cross in marketing hospital systems competitively by the month, the better.

This notion inevitably leads us to go beyond capitation payment *by* the buyers to capitation payment *to* the sellers. Unless hospitals do begin to compete on a capitation basis, they inevitably will be severely squeezed as inpatient utilization continues to drop in the decade ahead.

A balanced look at incentives. When viewed in terms of the requirements of effective community health services, there are a wide variety of positive and negative incentives associated with the marketplace, with government regulation, and—equally important—with the goals and methods of operation of nongovernmental organizations and community leaders.

Everyone can be enlisted in an effort to rationalize our health services and make them more responsive to individual and social imperatives. It is in the complex give-and-take of money, resources, privileges, service, license, pain, punishment, and recognition that these incentives are found. Sensitive management of these give-and-take situations by all parties involved, with continuous regard to broad community interest, is the key to balanced use of incentives for change. With the help of areawide planning, every participant in the health system—whether as a consumer of health services, a paying agency, a philanthropic agency, a physician, a hospital, a medical school, a hospital or medical association, a union leader, a large employer or benefits manager, or what have you—can play a role in providing positive and negative incentives to others.

For hospital trustees, the implications of this analysis are clear. By their own example, trustees should challenge all elements in the system to think through their community and public service responsibilities as well as their self-service responsibilities, and trustees should help others to see how to link the two. With respect to competition, wasteful competition should be avoided, in contrast with competition to meet community standards—competition to break par rather than to break competitors. With respect to regulation, rigid regulation should be avoided whenever self-discipline and voluntary regulation can carry the day. Government regulation should be reserved for those who richly deserve that approach—and even then, that regulation should be carried out with a wide range of sanctions and rewards.

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