

Association of American Medical Colleges

**PRICE COMPETITION IN THE
HEALTH CARE MARKETPLACE**

"Issues For Teaching Hospitals"

Discussion Paper
Approved by the AAMC
Executive Council
March, 1981

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OVERVIEW

Many health economists, business groups, and legislators are advocating fundamental changes in health insurance and medical services to stimulate cost consciousness among providers (hospitals and physicians) and consumers (individuals enrolling in health plans and patients seeking care). These proposals are commonly referred to as the "competitive" approach to cost containment. One approach is designed to influence "consumer choice". It has three underlying principles: employers would be mandated or encouraged to offer multiple choices among health plans to their employees; employers would be required to make the same dollar contribution to an employee's premium regardless of the plan selected; and a dollar limit would be placed on the amount of the premium that could be treated as a deduction for tax purposes. This "consumer choice" level of competition is explicitly articulated in proposed legislation.

A second approach is directed at increasing "price competition" among providers. It assumes that consumer choice principles coupled with the repeal of existing regulations, such as health planning, PSROs, and cost-based reimbursement, would encourage individuals and health insurance plans acting in behalf of their beneficiaries to give greater consideration to hospital costs and physician fees when purchasing or contracting for health care services. As a result, those providing the services -- hospitals, HMOs, physicians -- would be stimulated to provide their services at the lowest possible cost. Although quality of care, access, and other factors might influence consumer decisions, it is presumed that an overriding concern for the price of medical services would bring about major cost savings.

Because there has been no wide-scale experience with consumer choice and price competition, it is not certain that these approaches would achieve their objectives. One could speculate that unit costs would be reduced, but total medical care expenditures might not show a corresponding drop. In fact, competition may actually increase total costs because individuals might choose to buy more rather than less third party coverage, and providers would have incentives to market more services and expand their operations. Although these outcomes would not necessarily be undesirable, they would be contrary to the postulated reduction in medical service expenditures that some proponents of price competition believe would occur.

Proponents of price competition have not addressed the potential implications of this approach for certain types of providers, patient populations, and the nation's supply of trained health manpower. If we are to retain the great strengths of our present system of medical care, the following questions about the possible consequences of competition must be posed and answered:

- Which institutions will be most negatively affected? Are those the ones that should be cutting back or closing their doors?
- What services will be encouraged? Will there be an excess of services that can be aggressively priced and marketed to healthy populations at the expense of services for the seriously ill and underserved populations?
- Who will treat indigent patients in the inner city, rural areas, or other locations if it is "bad business" to provide care in those environments?
- Will all patients, regardless of geographic location and financial status, have reasonable access to an adequate level and scope of services?
- Will sufficient incentives or standards exist to assure quality care when choices are presented in terms of their price?
- If some hospitals, in order to compete, are unable to fund depreciation expenses, will funds be available to ensure adequate re-capitalization in the health industry?

In other words, although price competition may stimulate prudent decisions by educated consumers and groups with purchasing power, there are no assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet reasonable needs of **all** of its citizens.

Teaching hospitals must be concerned about competition because their costs are generally higher than those of non-teaching hospitals. Many of the higher costs of teaching hospitals derive from their educational programs, the nature of the patient case mix, losses on charity care, and their role in the introduction of new and more effective methods for prevention, diagnosis and treatment into medical care. These activities are presently funded by patient care revenues. Under competitive pricing, individual consumers and the third parties, HMOs, and IPAs negotiating on their behalf may be unwilling to pay the cost of programs which provide long term rather than short term benefits. Thus, teaching hospitals may be placed at a distinct disadvantage, and their unique contributions to society

threatened. On the other hand, depending on how a free market system is structured, teaching hospitals may be very competitive in those areas of medical care that are not provided by other institutions.

This document provides a basis for assessing the potential impact of competition on teaching hospitals by:

- describing how policy makers and opinion leaders view teaching hospitals under price competition;
- describing price competition within the context of other environmental and health policy changes emerging in the eighties; and
- identifying the critical issues for teaching hospitals under price competition.

HOW THE POLICY MAKERS AND OPINION LEADERS VIEW TEACHING HOSPITALS UNDER COMPETITION

"I can't believe that economics will doom the greatest medical education system in the world. Price, after all, is not always the controlling factor. Hospitals also survive on their reputations, the quality of their medical staff, and their relationships with other institutions." (1)

J. Alexander McMahon
President
American Hospital Association

Although these remarks are reassuring, and the comments may very well be accurate, there is little evidence of any serious consideration given to the implications of price competition for teaching hospitals. *Paul Ellwood*, President, InterStudy, made the following remarks at the 1980 Council of Teaching Hospitals' (COTH) Spring Meeting (2):

Perhaps the most important and lengthy change required by competitive pressures will be to revamp the entire system of paying for medical education. For every teaching hospital, whether the teaching mission is cut back or expanded, intensified competition for patient care dollars will be played under a changed and reasonably well-defined set of rules for health delivery, and an evolving and less clearly defined method for funding graduate medical education.

Most teaching hospitals are located in communities with very high rates of hospital utilization, and are therefore, "easy marks" for organizations that can provide high quality care with even moderate reductions in hospital use.

I suspect that despite their technological supremacy, most teaching hospitals operate under inhibitions that will prevent them from starting the first (alternative health service) plan in town — inhibitions such as a superstar head of medicine who insists on autonomy, aggravating town/gown disputes; reluctance of the faculty to deliver primary care; and perhaps an unvoiced fear that users of your hospital may pay a high price for its leadership in research and education.

The lead time required to prepare academic institutions to be competitive may be from two to five years, and those entering the competitive market late must pay a high price to get back patients who have left them for the earlier competitors.

Clark Havighurst of Duke University, in an unpublished document titled "Competition in Health Services — An Equal Number of Questions and Answers," made the following comments about education, research, and charity care (3):

To a significant though unknown degree, university and some other medical centers are dependent on earning monopoly profits to finance educational and research endeavors. In a competitive world, these resources would undoubtedly be jeopardized. It should be no argument against competition, however, that it deprives the industry of discretionary funds with which it does things it regards as desirable. Nevertheless, new subsidies must be found to replace at least some of those that may be eliminated by competition. Resort to other sources of funding will bring subsidies into the open and will require new social judgments about the appropriateness of each. Society may be unwilling to continue subsidies at the rate they have been involuntarily provided in the past, and some worthy activities may in fact go unfunded.

Cross-subsidies within hospitals are currently financing a great deal of indigent care, and competition surely threatens the continuation of these subsidies. In the short run, decisions on certification of need can legitimately protect internal subsidies, but one has to hope that, in the long run, hidden financing will become unacceptable and will be replaced by new public subsidies.

Alain Enthoven, a leading spokesman for competition, has made the following comments about academic medical centers (4):

Today, a great deal of the teaching and research costs of academic medical centers are being piggy-backed onto Medicare and Medicaid patient care costs. However, I believe this funding strategy is going to fail.

I am in favor of accurately identifying the costs of teaching and research activities and defending each on its merits and getting it paid on its merits. I recognize that there are problems of joint products and joint costs, but they can be handled. Each function should be paid for on an open and explicit basis rather than in a covert way.

Eli Ginzberg of Columbia University expressed the concerns about price competition in the *New England Journal of Medicine* (5):

... I see nothing but trouble ahead if the nation's teaching hospitals are forced to compete with community hospitals in providing routine services, since the former's per diem costs are 1½ to two times as high as the latter's, as a result of their diverse output, which goes far beyond performing an appendectomy and involves such critically important societal goals as training the next generation of physicians and adding to the pool of knowledge and technique. Enthoven appreciates this challenge, but the CCHP (Consumer Choice Health Plan) has not addressed it adequately.

There is nothing in the theory of competition to ensure that the resources required by the poor and the isolated for essential medical care will continue to be available. The recent closure of an increasing number of inner-city hospitals raises a warning that may not be disregarded.

Walter McNerney, President of Blue Cross and Blue Shield Associations, cited several questions about the impact of competition on teaching hospitals in his recent *New England Journal of Medicine* article (6):

How do we avoid the virtual exclusion from the market of the academic medical centers offering the best and most expensive care? How would a price-competitive system accommodate the costs of educating physicians and allied health professionals?

While several Congressmen who support price competition have indicated that special grants would be provided to teaching hospitals to help support the costs of education, only the Gephardt/Stockman bill has explicitly stated how educational costs would be financed. Section 301 includes the following language (7):

The Secretary shall make grants to, or enter into contracts with, entities (other than educational institutions) to compensate them for not more than 70 percent of the direct costs of providing graduate medical education and training for nurses and other health care professionals through accredited educational programs, to the extent the Secretary finds such compensation is necessary to provide training for needed health care professionals. Such grants and contracts shall be made only with entities which are public or private, nonprofit, charitable organizations.

A summary of the views of those who have addressed the implications of market forces in health care for teaching hospitals suggests that:

- Because of the multiple and joint products teaching hospitals provide (i.e., education, research, tertiary care, and charity care), they do not fit neatly into competitive models. Although some believe that a competitive system can be devised that will treat teaching hospitals equitably, insufficient attention has been given to the implications of price competition for teaching hospitals.
- The societal contributions of the teaching hospitals, with the possible exception of educational programs, have largely been ignored by proponents of competition, and they have advanced no method to preserve these contributions.
- Charity care has been identified as a troublesome issue, but no one has carefully considered the implications of price competition on access to quality care for indigent patients.

COMPETITION WITHIN THE CONTEXT OF OTHER TRENDS IN HEALTH CARE

The proponents have argued that price competition can revolutionize the way health care is organized and provided, reduce the financial incentives perceived to stimulate increased costs, and lower costs while retaining or even improving quality and access to care. These claims are overly optimistic and probably misleading.

The organization and delivery of health care is a dynamic process which is continually responding to societal and economic changes. The American Hospital Association's (AHA) Environmental Assessment of the Hospital Industry for the next three to five years makes the following statements (8):

- The growth of multi-institution arrangements will enhance the coordination of services and the linkage of service systems. Increased interest in HMO development by hospitals and IPAs will focus on

what is the role of the existing providers in the development of HMOs, rather than whether an HMO is appropriate.

- The HMO model will be adopted or modified by some hospitals choosing to move away from the exclusive provision of traditional inpatient care and as hospitals explore new sources of revenue and utilization in conjunction with inpatient services. In some instances, this may involve new dimensions in the relationship between hospitals and other sponsors or participants in HMO activity, notably physicians and third party payers.
- Employers will attempt to reduce their outlays for health insurance by proposing modifications in third-party payment systems by offering cost-sharing insurance programs, health incentives, and health education programs to employees, and by participating in and sponsoring HMOs and other alternative delivery mechanisms.
- Physicians will increasingly work in multi-physician teams in treating patients. These teams may develop from group practices created by physicians themselves or from new staff organization methods in hospitals that increase the number of full-time employed physicians.
- The cost of research and teaching conducted at teaching hospitals will increasingly be recognized as a distinct element of the costs incurred by these hospitals. Alternative payment mechanisms will be explored to cover these costs, thus making the cost of patient care at teaching hospitals more readily comparable to costs at non-teaching hospitals.

Most predictions and prescriptions for the medical services of the future ignore quality of care. Pro-competition and regulatory approaches emphasize cost containment and do not provide adequate safeguards to assure the quality of medical care desired by people. As discussion and debate proceed on health care reforms, the following questions should be addressed:

- In the haste to stimulate competitively priced health plans, what assurances are there that access and quality will be of an acceptable level?
- Does the possibility exist, as Robert Heyssel has suggested, that if the fee-for-service system supposedly makes money by doing too much, is it not also true that some HMOs might try to make money by doing too little? (9)
- If primary care physicians, through their participation in prepaid health plans, become increasingly responsible and financially liable

for the total range of services provided to their patients, what provisions can be made to assure that they will refer patients for needed tertiary care?

- Is it possible to assure access to tertiary services by mandating health plan coverage and reinsurance to minimize disincentives to refer?

In theory regulation and price competition represent two very different approaches, but they are not as clearly separable as often portrayed and the potential of either, by itself, to mold the future of the medical services may be overstated. McNerney has articulated this point well by describing what he views as the four cornerstones of medical care in the eighties — regulation, competition, voluntarism, and innovation (6). Many of the changes described by AHA's environmental assessment are already occurring in areas without price competition or heavy regulation. These changes have taken place not because of new concepts on financing and regulating health care, but from economic realities. The potential benefits ascribed to competition or regulation by their advocates will be muted by the country's general economic, political, and social environment from which medical care cannot disassociate itself. Price competition could intensify comparison of costs and utilization among hospitals, experimentation with alternative delivery systems, examination of educational costs, more prudent purchasing of health insurance plans by employers, and regionalization of health services. Regulation might do the same through mandatory cost containment, PSROs, planning legislation, technology guidelines, and incentives for HMOs.

An evaluation of price competition must include but go beyond a discussion of the events that are likely to occur regardless of the financing and regulatory structure. The emphasis should be on the degree to which competition facilitates or impedes those changes and the identification of any events that can be uniquely attributable to price competition.

For teaching hospitals, medical schools, and medical faculty, the main question may be how to influence, anticipate, and organize for the possible changes. The potential for teaching hospitals to expand their relationships with community hospitals, nursing homes, ambulatory care sites, HMOs, attending physicians, medical school faculty, physician assistants, nurse practitioners, the community, and patients will have to be examined. However, given the number of organizations and personalities involved and the important and unique contributions to medicine made by academic medical centers under the current mode of operation, organizational changes may be difficult to achieve. It is within this broad context that the specific implications of competition for teaching hospitals should be addressed by teaching hospital administrators, medical school faculty,

and other participants in teaching hospitals and health professional education.

ISSUES FOR TEACHING HOSPITALS

Underlying the competitive models is the assumption that hospitals provide a single, relatively **standardized** product which is identifiable in terms of costs and quality. This assumption raises several issues for hospitals which have multiple products benefiting not only the individual patient, but society as a whole. Because these activities result in higher average costs, presently financed through patient care revenues, competitive pricing resulting from proposed legislation raises questions about the future ability of teaching hospitals to meet these multiple responsibilities.

Price competition may affect eight specific areas:

- Undergraduate Medical Education,
- Graduate Medical Education,
- Allied Health Sciences Education,
- Applications of Research,
- Tertiary Care and Case Mix,
- Charity Care,
- Ambulatory Care, and
- Faculty Practice Plans.

Undergraduate Medical Education

Total enrollment in U.S. medical schools, which has more than doubled since 1963, now exceeds 65,000. Since the late sixties, greater emphasis has been placed on primary care training. These two developments have created a dramatic increase in the number and variety of clinical clerkships. As a result, although the university-owned and primary affiliate hospitals are still the principal settings for clerkship training, numerous other community hospitals and ambulatory care settings now participate in undergraduate medical education.

There are both direct and indirect costs associated with the education of undergraduate medical students in the teaching hospital. The direct costs are related to the supervision of the patient care activities of the students. The indirect costs are related to the decrease in productivity as a consequence of the presence of a teaching program in the institutions (10, 11, 12). Both contribute to an increase in the operating costs of a teaching hospital as compared to those institutions without teaching programs.

In a more competitive market, community hospitals and ambulatory care institutions may discontinue their affiliations with medical schools. This would pose serious problems because their resources are essential to meet the clinical clerkship requirements of larger classes and to provide clinical experiences in primary care. A loss of affiliated hospitals would place a greater burden on the major teaching hospitals which might not have enough patients to meet the needs. In addition, students in all hospitals might be pressured to provide more service at the expense of their educational experiences.

Price competition may jeopardize the substantial contributions of volunteer faculty to medical education as pressure increases to maximize physician productivity. The volunteer faculty may reluctantly find that teaching time compromises efforts to be competitive. It would be unfortunate if competition did not provide incentives for voluntary physicians to continue their important role in clinical medical education.

Graduate Medical Education

There are approximately 65,000 residents presently in training. Total 1978-79 expenditures for housestaff stipends and benefits were about \$1.02 billion (13). About 80 percent of these costs, which average about \$2.4 million in COTH member hospitals, are funded from patient care revenues (14). In addition, there are direct costs of graduate medical education related to physician supervision, support staff, and educational space and equipment. There are also indirect costs and reduced productivity associated with residency training.

The direct costs of graduate medical education, which are larger and easier to quantify than those for undergraduate clinical training, will be carefully scrutinized under competition. Third parties, HMOs and others contracting with hospitals for medical services may not wish to share in these costs and thus may not permit subscribers to use teaching hospitals except for complex care not available elsewhere. Based on evidence from the past, it also appears that HMOs and other alternative delivery systems will be reluctant to participate in graduate medical education.

In a more competitive system, hospitals may have to reconsider the number and types of educational programs they sponsor. Since the number of entering residency positions is only slightly larger than the number of students graduating from U.S. medical schools, any substantial reduction would pose serious problems for graduate medical education which is an essential component in the education and training of a physician for independent practice. The high quality of our medical care would be compromised. In addition, the important contributions that residents make in the education of undergraduate medical students would be diminished.

Proponents of price competition must give more thought to the impact of their proposals on all levels of the continuum of medical education and training if we are to provide the next generation of well-trained physicians.

Allied Health Sciences Education

In addition to participation in physician training, teaching hospitals are the setting for a growing number of allied health education programs. This includes not only an increasing number of advanced nursing degree programs, but a large number of technical and specialist programs required to meet the manpower needs of the health care system. Although the total costs associated with these programs are difficult to estimate, many programs could not be sustained without hospital involvement. If educating allied health professionals adds to costs, what incentives will exist under price competition to continue support for these programs? Which hospitals will discontinue participation? Will we be able to maintain a socially-desirable mix of health professionals, or will profit-incentives skew demand for certain types of professionals in an inappropriate direction?

Applications of Research

As biomedical research advances medical knowledge, teaching hospitals have been the settings where this knowledge is translated into medical practice and disseminated to physicians and other health care institutions. The initial applications of new treatment modalities are unquestionably expensive, but can result in cost effective treatment in time. Considerable attention has been given to the proliferation and overutilization of some types of new technology. Perhaps not enough attention has been given to the contributions academic medical centers have made to vastly improving patient outcomes, using relatively cheaper, effective medical treatments. Some noteworthy examples include:

- Kidney transplantation which has proven to be more effective and efficacious than chronic dialysis for treating many forms of end-stage kidney disease.
- Development of chemotherapy for treatment of leukemia, lymphomas and other cancers.
- Bone marrow transplantation for treatment of aplastic anemia and myelogenous leukemia.
- Evolution of heart surgery for treatment of congenital heart disease, coronary blood vessel disease and conductive defects.
- Development of major trauma centers.

- Development of neonatal intensive care units.
- Development of antimicrobial vaccines such as pneumococcal vaccines.
- Development of joint prosthesis.

These new treatments are accompanied by large developmental costs associated not only with the specific program but with the total environment required to support evaluation of new treatment protocols. Initial applications are often not cost effective nor do they always result in improved patient outcomes. The financial incentives created by price competition will encourage use of only presently available treatments and not promote development and testing of new methods of treatment. This environment is not likely to be one in which clinical researchers will feel welcome and be encouraged to flourish.

Tertiary Care and Case Mix

Related to applications of research is the provision of regional, tertiary care services to seriously ill patients. Historically, these services have been provided by teaching hospitals. Present pricing and cost allocation policies in teaching hospitals often result in having the reimbursement for primary and secondary care subsidize tertiary services. Under price competition, teaching hospitals would have to modify these policies. Tertiary services would have to be priced significantly higher while routine care would have to be priced substantially lower.

With changes in pricing policies, teaching hospitals may be able to compete well in providing tertiary services because they have provided a leadership role in this area for many years. The presence of full-time, faculty physicians representing all specialties and supported by housestaff helps to ensure high quality care. Teaching hospitals traditionally are sources of the best, most advanced treatment available, and consumers are likely to demand access to these services even if the price is high.

Competing in secondary and primary care may be more difficult for teaching hospitals. The problem may be most difficult for urban teaching hospitals that have a large number of indigent patients having multiple, chronic problems, which may not require tertiary services but do demand more intense nursing services and more prolonged support services such as social service and discharge placement efforts. Even if these patients were provided a "voucher" to participate in a prepaid, capitation payment plan, many health plans would likely try to avoid these patients because of their generally more complicated health and social problems.

Caution should be used in developing policies under price competition that would severely limit the teaching hospital's role in primary and secondary care. Steps should be taken to ensure that phasing out routine levels of care would not also mean phasing out access to care for some patient populations. In addition, educational programs cannot be conducted in the absence of primary and secondary care, and it is unreasonable and impractical to believe that an added number of community hospitals would assume these educational responsibilities in a price competitive market. Furthermore the aggregation of intensely ill patients to the exclusion of a reasonable number of the less ill may make for such a stressful hospital work environment that recruiting and retaining staff become a problem.

Charity Care

Many teaching hospitals, particularly in urban areas, provide large amounts of service to the poor and near-poor of their communities. This care includes not only inpatient services, but ambulatory care on a large scale. Economically disadvantaged patients often pay no charge or a charge that is below cost. Hospitals remain financially viable by pricing services to full-paying charge patients at levels sufficient to subsidize the charity care. For hospitals to be price competitive, this cross subsidization would be impossible to maintain, and hospitals might be unable or reluctant to continue any extensive commitment to treating patients who are unable to pay.

If vouchers are provided to the indigent population, a portion of the uncompensated care problem would be lessened. However, many illegal aliens and others who for some reason are ineligible to receive a voucher would still have no source of payment for medical services. Furthermore, even if the indigent are provided vouchers, many may select low option plans with high out-of-pocket expenses they will be unable to meet when care is required. The combination of uninsured and underinsured patients would encourage a move away from a one class system of care back to a two class system. Market forces and price competition can only sharpen the incentives to provide more adequate services to those for whom payment is assured.

Ambulatory Care

Per visit costs of hospital-based ambulatory care and other ambulatory care settings participating in medical education are often significantly higher than the costs of office visits of community physicians. Many reasons for the differences are typically cited. Visits to teaching hospital clinics are often referrals with a wide range of complex problems that are costly to treat. Productivity is lowered due to the presence of physicians

in training. Many states and the Federal government have helped to offset these costs by providing grants for primary care training. For hospital-based ambulatory care, additional costs are incurred because of the cost reimbursement allocation guidelines which burden outpatient departments with overhead costs not present in freestanding clinics.

Most of the literature suggests that the presence of education in ambulatory or outpatient departments makes it very difficult for them to be self-supporting (9, 10, 11, 14). Rarely are fees or costs competitive with fees for office-based visits. Some will argue, however, that free-standing ambulatory care centers with educational programs can be productive, and in cases where the center is a source of inpatient business, the satellite can lead to increases in hospital inpatient revenue. Thus, the evidence is inconclusive, but it is clear that given current operations, some ambulatory care programs and primary care training sponsored by teaching hospitals and medical schools may suffer with an increased effect of market forces. However, it is imperative that teaching hospitals examine the organization and efficiency of their outpatient services to determine what it would take to succeed in a price competitive market. To the extent that productivity losses from education and indigent care are the problems, special consideration could be sought, but any other reasons for special treatment may be increasingly difficult to support.

Faculty Practice Plans

Medical schools are increasingly dependent on fees generated by the clinical service of the faculty. Faculty practice plan revenue now constitutes over 14 percent of all medical school revenue, up from 4 percent in 1967-68. Under price competition, health plans are not likely to evaluate physician fees for professional services in isolation from hospital prices. There will be an increased effort to price the package of hospital and medical services together rather than independently. Because the costs of hospital services in teaching settings are typically higher, pressures may be placed on physicians in teaching hospitals to reduce their fees so the package of services will be price competitive, or physicians may choose to admit their patients in hospitals where costs are lower. Either could lead to a decrease in patient volume and faculty practice plan revenue. This situation could also create incentives for physicians and dentists to leave academia for private practice or demand a higher proportion of the practice plan revenue. Either prospect would diminish medical school revenue and jeopardize educational programs.

Separate Funding of Unique Costs

Two generalizations may be drawn from the discussion of the above eight issues. First, teaching hospitals have a wide variety of products, many of which are produced simultaneously and involve more than the

delivery of inpatient hospital care. Second, all of these multiple responsibilities and the costs associated with them are related and interdependent.

Academicians, legislators, and third parties may be willing to acknowledge that teaching hospitals have made important societal contributions to the education of future physicians and the advancement of medical practice, and that these contributions do not fit easily into the price competition model. The commonly offered solution is to identify and separately fund these activities on their own merits. In effect, this approach argues for centralization and regulation of decisions for these activities, but decentralization, through price influenced market mechanism of all other decisions relating to patient care services. The provision in the Gephardt/Stockman bill authorizing grants "for not more than" 70 percent of the direct cost of graduate medical education is one example of how legislators might try to resolve this issue. Efforts to carve out and separately fund unique, socially desirable attributes of teaching hospitals should recognize potentially negative impacts of this approach:

- Separate funding of graduate medical education may limit the ability of medical schools and teaching hospitals to make local decisions about their residency programs. As Paul Ellwood has stated, "It's clear that whoever bears the cost of medical education will increasingly want to specify the numbers, types, and geographic distribution of those whose education is being subsidized." (2)
- Federal support for graduate medical education may be subject to the budget and appropriations process which could make such a fund vulnerable to any major efforts to cut federal spending. The level of funding would have to be renegotiated annually before a changing cast of decision-makers who would have varying perspectives and knowledge about graduate medical education financing.
- The administration of the fund could be extremely complex. How would the necessary funds be collected? How would those responsible for distributing the funds decide which hospitals would get support and what that level of support should be? Even if total funding is adequate, wouldn't individual hospitals be vulnerable to significant yearly fluctuations?

Numerous studies have attempted to separate the costs associated with education, tertiary care services, and research-related costs. No consistent estimates of these costs are available because there is no calculus that permits the allocation of costs for joint products simultaneously produced. Further study should be encouraged, but it should be recognized that the marginal costs of one activity cannot be evaluated from a policy standpoint without considering its relationship to other teaching hospital functions. A policy that would decrease the size of a residency program may also

mean a decrease in the scope of services available. A policy that would increase emphasis on primary care education cannot be done without access to patients with routine problems. A policy that advocates a high priority to develop advances in medical care necessitates not simply funds, but clinical fellows, faculty, patients, and other institutional resources. Any attempts to segment the unique characteristics of academic medical centers into measurable units run the risk of ignoring the fact that their contributions are the products of many inter-related programs, which together provide the environment and resources required for teaching future health manpower and advancing medical knowledge and practice.

SUMMARY

Creative solutions to problems in medical services are welcome, and advocates of price competition have made a major contribution to stimulating a re-evaluation of the status quo. Any legislation that would bring about reforms as broad as those advocated by price competition merit careful study. This document has reviewed the potential impacts of price competition on teaching hospitals. It is not a policy statement, but a document intended to stimulate further discussion of price competition which will result in constructive, sound recommendations to those responsible for charting the future course of the health care system.

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