COMMENT

Competition, Quality of Care, and the Role of the Consumer

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THERE IS LITTLE EVIDENCE OF ANY RELATION, either positive or negative, between competition and the quality of medical care, and the existing data amount to even less than an examination of the literature on the topic would suggest. For want of data, analysts often use HMO market shares or, more recently, increased "managed care" shares as a proxy for market competition. These variables are not the same as competition, however; they may also not even be correlated with each other. Clearly, the emergence of HMOs has altered provider behavior and has led to a dramatically different health insurance market, but HMOs are neither a necessary nor a sufficient condition for market competition among providers.

Although many had expected that laws encouraging the growth of HMOs would, in fact, lead to increased market competition and, with it, cost containment, whether this has occurred is very difficult to prove (Miller and Luft 1997). A factor more directly linked to market competition is the degree of sensitivity to price, which begins in the insurance market and reflects, to a degree, the role of the employer. For example, if employers provided employees with a choice of plans (not

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necessarily HMOs) and a fixed contribution, or if they offered a single plan but were willing to switch insurers for small price differences, then the insurance market would be more competitive. When insurance markets are highly competitive, then health plans are more sensitive to price differences between providers, and they place competitive pressure on them. This effect can take place without a significant HMO presence in the market. Similarly, we have witnessed markets with a large HMO presence that did not have this competitive dimension because of lack of price sensitivity in the insurance market.

Thus, although the presence of HMOs may seem a convenient proxy for degree of competition, comparing markets with different levels of HMO market shares, looking at a market over time as HMO shares increase, or comparing the quality of care provided to HMO and non-HMO enrollees does not necessarily tell us the effect of market competition on quality. Indeed, depending on the accuracy of quality-of-care measurement, the last comparison may tell us more about the effect of potential nonrandom selection into HMOs than about the effect of being in the HMO. It is much more expensive and difficult to obtain true measures of increasing market competition, but that is what we must do to answer the question about the relation between market competition and quality of care.

To complicate things further, the word "competition" means different things to different people. Most entrepreneurs will tell you that as long as another seller is present or has the potential to enter the market, the two, or more, entities "compete on the basis of price." However, competing on the basis of price, with no controls on the quality or content of the product, does not lead to the desirable outcome that economists often associate with competition. Economic theory predicts increased efficiency and better *value* for the consumer's dollar. Using the Institute of Medicine's definition of quality, "value" means increased likelihood of desired health outcomes for the same cost. Without further information about provider behavior and quality changes, however, witnessing increases in price sensitivity and decreases in utilization or cost measures does not tell us whether efficiency is increasing. Unless we know what form of competition is taking place, we cannot conclude that the market will take us where we want to go.

Some form of competition is certainly taking place. Employers and other purchasers of group health insurance have introduced competitive forces into the marketplace in a variety of ways by increasing their

demands for low prices, improved services, and better information. They have been willing to change health plans to get what they want, to band together as purchasing coalitions, and to use competitive bidding. We need to talk about these pressures, about how insurers and providers are responding, and whether competition should be reined in to assure a minimal level of quality of care.

The Role of the Consumer

Consumers can play an important role in forcing providers to offer services of acceptable quality. To do this, however, they must be able to assess quality. And there's the rub. Even if consumers were able to judge the interpersonal and amenity aspects of quality, they usually lack both the information and the knowledge necessary to judge whether the *technical* quality of the product is unacceptably low (Chalkley and Malcomson 1998). This inability is at the heart of why many policy makers and analysts fear that an increase in consumers' price sensitivity, or even in their awareness of the interpersonal and amenity aspects of quality, will cause providers to reduce technical quality in order to cut prices.

Note that this notion of trading quality for reduced costs assumes that we are already at the point where we cannot get more of one without giving up the other (Donabedian, Wheeler, and Wyszewianski 1982). Many believe that we are nowhere near this frontier, where the only way to decrease costs in response to increased price sensitivity is to decrease quality. If they are right, then with the appropriate incentives, added to professionals' interest in quality, we can cut costs and raise quality at the same time. However, at some point we will have to deal with the question of how much more customers are willing to spend for quality, and what aspects of quality they are willing to pay for.

The Role of Information

Considerable time and attention are being devoted to the role of information and how we can persuade providers and plans to be more responsive to consumer preferences. However, allowing consumers to dictate

the terms of quality may not be desirable. Relying heavily on individual consumer choice to guarantee technical aspects of quality may not be a reasonable strategy.

It may not be either practical or efficient to educate consumers to the degree that will enable them to make the best choices for themselves and thus to send appropriate signals to providers about how to allocate resources. Gathering the data necessary to measure technical quality accurately is very costly; designing, developing, and then disseminating these data in an unbiased and useful fashion, costlier still. At the level of simplification and aggregation necessary to be understood by the average consumer, such data are not likely to be meaningful and may in fact lead to worse decisions. The distortions in resource allocation resulting from misinformation or the misuse of accurate information are rarely discussed, but they are not inconsequential.

Conveying information about quality in situations where there is product variety and imperfect and costly information is not unique to health care. There are multiple mechanisms for conveying information to consumers about quality: warranties and money-back guarantees; voluntary and mandatory licensure and certification; disclosure; reputation; and price (Stiglitz 1990). For any of these signals to work, however, they must not only distinguish between high- and low-quality providers, but they must also be too costly for low-quality providers to acquire. The costs of some of these signals can be quite high. For example, Iglehart reports that Dr. William L. Roper, then Prudential's chief medical officer, revealed that they had spent "millions of dollars . . . in NCQA accreditation" (Iglehart 1996, 997). In certain cases, the costs may be prohibitive for some high-quality providers, thus weakening the effectiveness of the signal.

To date, consumers have relied mainly on various agencies and accreditation bodies to assure some minimum level of quality through licensure and certification. Only recently have we moved to disclosure of data (mainly of HEDIS measures and other related report cards) directly to consumers, thereby placing the burden of evaluation at their feet. High-quality providers have an incentive to invest heavily in these signals only if consumers can understand the signal and alter their purchasing decisions accordingly. Whereas employers may decide which plans to offer or subsidize based on these data, to date individual consumers have not been very receptive to information on the quality of plans, hospitals, or physicians (Chernew and Scanlon 1998). Recent

surveys indicate that cost remains the most important criterion in selecting plans, both for employers and employees, and that price is ranked by plans as the most important factor for success in the marketplace (McLaughlin 1997).

Another important plan attribute that consumers want is a broad choice of providers (Tu and Cunningham 1977). Plans are getting the message to expand their networks, but it is not clear how much consumers are willing to pay for choice. To date, they have not been charged more for this expansion. If, in fact, broad choice (in the context of managed care) turns out to be expensive, then we will soon discover the extent of consumers' willingness to pay for it.

One implication of this switch to broader choice of provider is that the association of a particular provider with a particular plan is no longer relevant. If Dr. Jones is included in the networks of all the health plans in the community, then her treatment of patients will show up in the quality scores of many health plans in the area and thus will not constitute a basis for comparing them. The individual signal is lost, and the group signal hides potential variation within the group.

As with any signals, there are incentives for misinformation. The incentive to cheat depends in part on what the plan stands to gain from doing so and in part on the probability of detection. An audit by the Health Care Financing Administration of a sample of HEDIS measures collected by Medicare managed care plans uncovered major problems with the data, ranging from inaccuracies to incomplete reporting (Williams 1998). Studies by several states and independent consultants of submitted report cards have revealed similar problems. These could be the result of intentional efforts to mislead, or they could stem from inadequate data management systems. Consistent and extensive auditing will improve the quality of the data, as will enhanced data management systems. Both mechanisms are expensive. As Barzel (1985) noted in his discussion of the provision and use of signals, "What is costly, however, is not the cheating per se; rather, resources are devoted to cheating and to its prevention which sharply distinguishes the outcome from that obtained in the [perfectly competitive] world."

The act of acquiring the signal, preparing for an accreditation body, or gathering data necessary for report cards, for example, may have a positive effect. Internal performance measures can motivate change within the plan or institution. Several studies have indicated that hospitals and physicians alike may improve the quality of care they provide, either as

a result of gathering the data or in response to receiving report cards (Longo et al. 1997; Rainwater et al. 1998).

Conclusion

The effect of competition on the quality of care is difficult to ascertain. Increasing the reliance on disclosure to individual consumers for quality assurance brings with it the likelihood of misinformation and the accompanying cost of verification and enforcement of truth telling.

We must start discussing the costs and benefits of providing reliable, useful information for consumers versus establishing some kind of standard. In addition to the problems of relying on providing more information for consumers to guarantee an acceptable level of technical quality, in many situations the overwhelming majority of consumers, if they had all the facts, would make the same decision in any case. It may be possible to save them the cost of acquiring the facts through the strategy of making the decision for them by setting a standard. Standards are also relevant in areas where there is one option, or where there might be little choice of plans. Finally, because "consumers may be quite reluctant to search for a lower-priced provider if they cannot measure quality well, establishing a base floor for quality, as licensure does, or graduations of quality, as voluntary certification does," may in fact be necessary for effective cost-containing market competition to take place (Phelps 1997, 548).

Of course, standards have an important down side if they are poorly thought through, and they can be hard to determine. Devoting attention to the process of standard setting, and ways to avoid the standard setting we have seen in the Congress and the state legislatures, may be more fruitful than focusing solely on ways to improve the dissemination of data to consumers.

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