Consequences of Price Controls

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Markets can be distorted and controlled by various forces. One of these forces, monopsony, is well known. A monopsony is the state where a single (or highly dominant) supplier in the market is able to set prices at levels above those of competitive environments. Equally powerful but far less familiar is the monopsony—the state where there is one single buyer in the market. By dint of his market power, a monopsonist is also able to set prices at levels that would not be found in competitive environments.

**FEDERAL GOVERNMENT AS A MONOPSONIST**

Monopsony can be subtle but powerful. Consider the role of the federal government in the health-care marketplace. There are no explicit wage and price controls on physicians, but these controls have been effected implicitly. The federal government purchases such a large share of all health care it is often able to effectively dictate not only the prices it will pay, but also the market price, the prices paid by other payers. For many procedures used disproportionately by Medicare patients (eg, total joint arthroplasty), the government's "offer" becomes the de facto market standard. Using monopsony powers, the federal government has effected a program of wage and price controls on physicians.

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This policy of wage and price controls on physicians is unwise. It hurts the very constituents represented by the government when it purchases health care, namely, the ill who consume the care and the taxpayers who pay for it. It is also unlikely to save much money as physicians' fees comprise only a small fraction of all spending, perhaps 20% of the total. Most health-care spending goes to hospitals, vendors, and administrative overhead. Were Congress to pass a bill that outlawed all physician charges, the nation's health-care spending would decrease, by definition, by at most 20%. Thus, even if output were to remain the same, a law abolishing all payments to physicians today would bring total spending back to only 1997 levels.

Of course, output would not remain the same. Harsh restrictions on physicians' fees would promote a drastic reduction in the amount of care provided. At a reduced rate of pay, physicians will choose to spend their time at some task other than patient care.

**ECONOMICS OF SUPPLY AND DEMAND**

There have been times in history when people were resentful of the high prices they paid for admittedly valuable goods and services, and petitioned the government to restrict these prices. In all such cases, the effect of restricting prices was to remove the incentive for suppliers to bring these goods and services to the market, and they didn't. The unhappy situation of high prices was replaced by the even unhappier one of shortage.

In their book on economics, Baumol and Blinder recount the story of wage and price controls imposed at Valley Forge during the Revolutionary War, which served to starve Washington's army. The controls set food prices at a level so low farmers refused to sell crops at all. After this debacle, the Continental Congress adopted a resolution stating that price controls "are not only ineffectual for the purposes proposed, but likewise productive of evil consequences" and suggested to the state legislatures such controls be suspended.

Despite such experiences, lawmakers have still tried marginal reductions on medical fees. These fees have been lowered not to the point that doctors would refuse to work, but low enough (continued on page 16)
(Guest Editorial continued) that perhaps some savings would be realized. Of course, the opposite was seen: these wage and price controls have been associated with ever-increasing spending.

To understand why this is the case, we must examine the role of wages and the amount of labor supplied, as well as the quirks in health-care spending that amplify the effects of doctors' actions. The law of supply and demand asserts that if the price of an item goes up, the supply goes up too—there is now a greater incentive for producers to bring the item to market. Likewise, if prices go down, so does supply.

**PHYSICIANS AS INCOME TARGETERS**

According to classic supply and demand theory, if physicians' fees were to go down, doctors would have less of an incentive to work, and thus should work less—a double savings for the health-care budget. Yet this savings is not seen in practice, because physicians tend to be "income targeters," that is, they tend to modify their work effort not to maximize their hourly wages, but rather to maintain a chosen overall income level, even if they have to work harder to do so (in technical terms, the supply curve bends backward). This target income hypothesis states that if physicians' fees are cut substantially, they may cease to work, but if the cuts are relatively slight, doctors would attempt to offset their lower unit wages with greater total output.

Income targeting has been demonstrated among surgeons, and it has been suggested that increasing one's volume is the apt response to lower fees. Still, some critics object to the concept that surgeons adjust their effort in response to payment. The argument is that income targeting is unethical, and to use this theory is to accuse surgeons of unethical behavior—of altering the indications for surgery for personal gain. That argument is just plain wrong: one can adjust efforts in response to income without altering one's medical indications one iota. Rather, one expands volume by expanding the extent of practice. For example, it has been shown that operative procedures are used by women less often than by men and by minorities less often than whites. An income-targeting surgeon need not change his or her indications for joint replacement, but rather actively recruit patients from underserved groups.

Given the phenomenon of income targeting, fee reductions for surgery can lead to greater overall spending. The reason for this paradoxical increase is that ancillary spending rises far more than fees are reduced. Lower wages for surgeons stimulate more surgical work and more ancillary spending. In many fields, orthopedics in particular, ancillary spending is a far larger piece of the budget than doctors' fees. A fee cut may save a dollar from the column representing doctors' fees, but will promote spending tens of dollars in other areas.

Consider total joint replacement. The 1998 Medicare payment to physicians for this operation was about $2000, but the total expenditure for a joint replacement was at least 10 times this amount. The payment to the hospital alone was nearly $20,000. Thus, if a decrease in wages (i.e., the fee for one surgery) of 10% were to be passed, a doctor who performed 100 joint replacement operations would seek to perform an additional 11 to bring income back to its prior target. This strategy would entail at least $220,000 in additional ancillary spending, even if spending on physicians' pay stayed flat. Considering the number of joint replacements performed in this country, this modest 10% fee reduction for only this procedure would cost Medicare approximately a billion dollars. Paying surgeons less can indeed cost more.

**CREATING THE PERFECT SYSTEM IS ELUSIVE**

Creating the perfect system for paying doctors remains elusive. Nevertheless, that does not mean we should ignore the flaws that are easy to see. Under current conditions, patients have little interest in the cost of their care. Typically, for today's patient, medical costs are an externality, i.e., paid with other people's money. Patients have little motivation to constrain their consumption.

On the other hand, insurance companies seem to pay inadequate attention to quality; they care about costs. In cardiac/thoracic surgery, where data on morbidity and mortality are available, third-party payers may not select surgeons on the basis of this information, but rather on price.

We need a system that realigns incentives—one where patients care about costs and insurance companies care about quality. We need a system where the inevitable tradeoff between quality, access, and cost (Kissick's "Iron Triangle") are made freely and justly. Such a system will earn its creator a Nobel prize in economics, and once devised, it will not be implemented in one step. We will get to the perfect system incrementally, if at all. The first stride in this right direction is to recognize that clumsy stopgap measures can make the problems worse. Price controls have consequences, and not always those intended.

**REFERENCES**