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Introduction

This volume contains papers presented at the second Frontiers in Health Policy Research Conference, held on 11 June 1998, in Bethesda, Maryland. The goal of this conference, like the one held the year before, was to bring together academic economists investigating topics in health policy, and journalists, researchers, legislative staff, and other government officials whose work directly touches upon health policy. This series of conferences is designed to promote discussion and communication among these groups, helping to ensure that the results of ongoing policy-relevant research conducted by leading health economists will be known to a broader community that could incorporate the information into health policy.

The work reported in this volume addresses a set of issues that have grown more important and timely as turmoil in health care markets and growth in the number of elderly Americans continues: the productivity of health care; the effects of managed care on costs and outcomes of health care; the implications of the rise of for-profit health care providers; and the costs of medical care at the end of life.

The commonplace observation that the United States spends more per capita on health care than any other country leads inevitably to the question: do U.S. expenditures for health care represent "good value" or are they wasteful? There is some evidence to support both answers to this question; many observers decry waste and excess in American health care, but others point to the wide availability of "high-tech" health services that are costly yet appear to be effective. The truth may lie somewhere between these two views, but health care productivity, especially at the national level, defies easy measurement.

In an ambitious effort to answer this question, Elizabeth Richardson and David Cutler compare measures of health and illness in the

United States in 1950, 1970, and 1990. They perform a cost-benefit analysis to assess the dollar value of the changes in health that occurred over the decades. Typical measures of population health, such as life expectancy, are narrowly defined, and may not be good measures of the quality of health care. Life expectancy at birth, for example, is highly sensitive to changes in infant mortality rates, which themselves change with the age of the mother, whether she smokes, and several other aspects of maternal behavior and the social environment. Cutler and Richardson propose broader measures of health that enable them to produce economic benchmarks.

Their chief measure of health status, "health capital," is a global measure of health-related well-being that is sensitive to changes in quality of life as well as mortality. They estimate the changing amount of health capital, and its value, by combining national statistics from several sources. They also place dollar values on changes in health capital, enabling them to determine the benefits of rising health expenditures over time have been commensurate with their costs. Their provocative findings—which suggest that some of the health expenditure growth has contributed to improvements in health capital, and may represent a very good value—and conclusions will surely stimulate more debate and research in this area.

The early years covered in Cutler and Richardson's analysis apply to a time when there was little managed care in much of the United States, and the environment for new medications and medical procedures was "technology-friendly." The growth of managed care may, according to some commentators, have brought the technology-friendly era of U.S. health care to a close. They claim that greater price sensitivity in the purchase of health care has made the returns to investments in innovative medical technologies smaller and less certain. Under traditional fee-for-service (indemnity) health insurance, neither consumers of health care nor the physicians and hospitals providing care had an incentive to limit health services. Under managed care, particularly when it takes the form of capitation, providers may face financial penalties for expenditures on the care of their patients. Some studies have found that managed care did indeed slow technology adoption, but others reported that managed care had no effect. Laurence Baker and Joanne Spetz track changes in the dissemination of expensive, specialized services like cardiac catheterization, organ transplantation, and magnetic resonance imaging in specific hospital markets. To do so, they develop an index of technol-

ogy availability in U.S. hospitals and implement a market-specific measure of managed care penetration to assess the impact of managed care on technology adoption between 1983 and 1993.

Unlike previous investigators, they seek to measure the effects of managed care on the dissemination of technologies overall, rather than specific technologies. Their findings suggest that managed care does not have uniform effects on technology adoption, apparently varying with time and affecting the adoption of some technologies more than others.

The spread of managed care is only part of the changing organization of health care markets. Other striking changes are the consolidation of health care providers and the expansion of for-profit hospitals and other health care providers, which are subject to different rules and tax treatments than traditional providers. Takeovers of nonprofits, mergers, and investigation of billing practices are among the topics that have come to public attention in recent years. These events have reawakened interest in a question that regulators, lawyers, and economists have long discussed: how does the performance of for-profit and not-for-profit hospitals compare? Do different missions truly lead to different behaviors and differences in community service? Frank Sloan, Gabriel Picone, Donald Taylor, and Shin-Yi Chou investigate these questions, focusing on the effects of not-for-profit status on costs and quality of care. They explore outcomes of elderly Medicare beneficiaries who have suffered from one of four major acute health problems: hip fracture, stroke, coronary heart disease, or congestive heart failure. They investigate whether the ownership status of the hospital in which the Medicare beneficiary is admitted for one of these conditions affects either health or economic outcomes.

Sloan and colleagues apply methods to distinguish the effects of not-for-profit status and other closely associated hospital characteristics, such as the hospital's teaching status. Among their findings are that Medicare beneficiaries admitted to major teaching hospitals have lower mortality rates than those admitted to other hospitals, and that Medicare payments for home health care and physicians' services are greater for patients discharged from for-profit hospitals. These findings suggest for-profit hospitals have been relatively adept at responding to shifting financial incentives under Medicare, which increasingly favor the provision of home health and other nonhospital services. They also raise a provocative question: is the growing

popularity of for-profit hospitals compromising the quality of care while increasing costs?

Concern about changes in the composition of health care providers arises not only from for-profit status, but also from consolidation and mergers, which can occur among not-for-profit organizations as well as for-profits. Legal battles over proposed mergers have been prominent in recent years. Merging institutions often claim that consolidation is necessary to achieve productive efficiency, eliminating duplicative services and excessive administrative costs. Critics claim that mergers are primarily a vehicle to increase the market powers of hospitals and hospital networks. If this claim is true, consolidation increases revenues to providers but does not lower costs or improve other aspects of performance. To evaluate the most important consequences of consolidation, Daniel Kessler and Mark McClellan apply principles of merger evaluation to hospital markets. Such principles can be unusually difficult to apply to health care markets, because the geographic extent of the market varies with the specific service and other hard-to-measure characteristics, and the products and services themselves are not easily defined. Thus standard tests of market concentration do not readily apply in health care markets. The presence of health insurance, which subsidizes care, and differences between the information available to health care providers means that standard tests for competition do not have the same implications as in markets for other goods and services.

Kessler and McClellan describe innovative methods for addressing these challenges. After developing measures of market concentration suitable for hospitals, they assess whether changes in concentration, which reflect loss of competition, are associated with improvement or worsening outcomes. Their results have implications for antitrust regulation of mergers, suggesting that mergers have complex but potentially worrisome effects.

For many years, concerns about their disproportionately high health care expenditures have directed interest toward Medicare recipients at the end of life. Average expenditures for Medicare recipients in the final year of life are about six times as great as average for beneficiaries. Is much of this care "futile"? Concern about the appropriateness of typical hospital care for persons with diseases that appear to be fatal has also stimulated changes in reimbursement for and availability of end-of-life services. In the past, Medicare beneficiaries usually died in an acute care hospital after an extended period

of time, or at home with minimal formal health care services. But in recent years, Medicare reimbursement procedures and other changes have led to greatly increased use of Medicare-covered home health care and hospice services. Hospice care, like much home health and nonacute hospital care, is designed to meet the needs of dying patients, who are known to generate disproportionately large costs of care. How has use of these services by dying Medicare beneficiaries changed over time? How has it varied by disease? Does recent experience suggest that these services have helped save the Medicare program money by displacing hospital care and other costly services?

To address these questions, Thomas MaCurdy, Mark McClellan, and I linked Medicare claims files from 1988 to 1995, examining trends in the location of death, days of use of services, and expenditures for the care of beneficiaries in the final months of life. We separately examine trends in the treatment of beneficiaries with common diseases in which death is predictable and occurs over a period of months (e.g., lung cancer) and in which death is often sudden (e.g., heart attack).

Our findings suggest that services targeted toward dying patients may have substituted for acute care services, like hospitals, but only to a limited extent. There is little evidence from our study that liberalization of benefits for nonhospital care results in savings to the Medicare program.

As these studies demonstrate, a closer look at the data can give a nuanced picture of health care markets. That picture often casts doubt upon the conventional wisdom. As we confront the ongoing challenges of rising health care expenditures and projected Medicare program deficits, such information can contribute greatly to the policy discussion.