

Competing to Death: California's High-Risk System

Competition in California has cost lives and money. Shifting care out of hospitals reduced hospital spending relative to other states, but overall health spending per capita rose to the second highest in the nation in 1990. High spending coexists with low rates of coverage — the state ranks seventh in percentage of people lacking insurance. Hospitals have closed emergency rooms and other unprofitable services while marketing duplicative and often unnecessary services to the well-insured. With real free markets unattainable in health care, California's competitive rhetoric has rationalized growing inequalities and higher costs. The market's invisible hand has picked Californians' pockets and endangered both rich and poor.

By Deborah Socolar, Alan Sager, and Peter Hiam

Advocates of greater competition in health care often point to California, where competition is deeply rooted and prevalent, as a success story. For example, one study asserted that after three years of competitive hospital payment, "these policies are dramatically reducing the rate of increase in total hospital costs and revenues. . . ." (Melnick and Zwanziger, 1988)

But evidence gathered by various investigators reveals that price competition in California has failed to contain costs, and has increased many types of waste, while reducing both access and quality for all citizens of the state. This evidence should deter those working to reform health care in other states from importing the techniques used in California.

The major advantage of competition in health care, advocates say, is

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that reliance on a free market would contain costs by rewarding with more business the efficient caregivers and insurers that could charge lower prices.

Competition in health care is a constellation of activities that both manifest and reinforce attention to price and profit. Demanding that hospitals bid down their prices, payers contract selectively with individual hospitals. Health Maintenance Organizations (HMOs), insurers, and hospitals fight for patients through marketing and advertising. Each payer tries to shift costs to the others. A large for-profit hospital presence spurs competition, as does a high market share for HMOs and preferred provider organizations (PPOs). Non-public hospitals feel pressure to cut unprofitable services and minimize care to non-paying or low-paying patients. These practices feed on one another.

California appears to have been a relatively competitive state early in the 1980s. For example, HMO market share, the most frequently used

measure of the competitiveness of a state's health care services, was 16.8 percent in California in 1980, but only 4.0 percent nationally (Inter-Study, 1991).

But 1982 California legislation markedly intensified competition. One law gave Medi-Cal (Medicaid) authority to solicit bids and contract only with selected hospitals. State government sought these privileges to reduce its own expenditures. Private payers, fearing resultant cost-shifting by hospitals, won. Public and private payers alike tried to justify cutting their spending on hospitals by asserting a belief that competition would improve hospital efficiency.

Soaring Costs

California's ranking in hospital expenses per capita, seventh among the states in 1980, dropped after competition intensified — to 12th in 1985 and 16th in 1989, analysis of American Hospital Association data indicates (AHA, 1981, 1986, 1990b).

Even so, Robinson and Luft (1988) found that all-payer rate regulation in Maryland and Massachusetts was more effective in containing costs.

Worse, slower California hospital cost increases have been offset by rapid increases in nonhospital costs. Hospital spending per capita in California rose by 95.4 percent between 1980 and 1989, but nonhospital total personal health spending per capita rose 145.3 percent (calculated from AHA 1981, 1990b, and Families USA Foundation, 1990).

Thus, Californians' estimated total personal health spending increased from 16.7 percent above the U.S. per capita average in 1980 to 19.3 percent above in 1990. Ranked third highest in the nation in 1980, the state climbed to second by 1990 (Families USA Foundation, 1990).

In California, managed care and competition have failed to limit growth in spending.

Neither managed care nor competition has saved money, national data show. Massachusetts and California, the two states with the largest dollar increases between 1980 and 1990 in total personal health spending per capita (Families USA, 1990), are also the two states where 1990 HMO market share was highest (InterStudy, 1991).

California's health spending increase was 21 percent above the national average. Across states, health spending increases and HMO market share correlate at 0.55 (Pearson correlation, $p < 0.0001$). Although this does not demonstrate causation (high enrollment states

may have turned to HMOs because of high costs), managed care and competition at least have failed to limit growth in health spending.

The 1980s nationally saw much more competition and public and private micromanagement of clinical services. Yet the annual increases in real health spending per capita (adjusted for the non-health GNP price deflator) rose from 3.8 percent in the first half of the 1970s to 5.4 percent in the second half of the 1980s.

More Uninsured

Despite its high health spending, California covers substantially less of its population than does the nation as a whole. Rising costs mean so that fewer Californians can afford care and insurance, reliance on competition also has diminished access by undermining hospitals' willingness to accept uninsured or unprofitable patients. A Californian's chance of lacking health insurance was one-third higher than the national average. In 1990, 22.1 percent of California's under-65 population was uninsured, or 5.8 million people (Employee Benefit Research Institute, 1992). Had the national rate of insurance prevailed, roughly 1.5 million more California residents would have enjoyed coverage.

Furthermore, in the two states with estimated per capita 1990 health costs that bracket California's — Massachusetts and New York — far less of the population was uninsured (Families USA, 1990). In 1990, California ranked seventh highest among the states in the percentage of its people who lacked health insurance, while New York ranked 27th and Massachusetts ranked 40th (EBRI, 1992). If California residents had been insured at

the average of the Massachusetts and New York rates, roughly 2.5 million more Californians under 65 would have been covered.

The percentage of Californians below age 65 who were uninsured in 1989 "represents a substantial increase over the rate in earlier years." Using comparable data for 1979 and 1989, that percentage rose by less than one-fifth in the nation as a whole, but more than one-third in California (Brown, et al., 1991).

Los Angeles, Orange, and San Diego counties ranked 1, 5 and 7 among the 30 largest U.S. metropolitan areas in the proportions of their nonelderly populations that were uninsured in 1989. Fully 33 percent of Los Angeles County residents under age 65 were uninsured (Brown, et al., 1991).

Lack of insurance in California is not a problem for the poor alone. Fewer employers offer health insurance in California than nationally (Brown, et al., 1991). In 1988, the percentage of uninsured Californians aged 19 to 54 who were full-time, full-year workers was one-seventh higher than for the nation (41 percent versus 36 percent). For those with incomes over 200 percent of poverty, the percentage of people without insurance in California was nearly half again as high as the national percentage (U.S. General Accounting Office, 1991).

Medi-Cal Cuts

Suffering continuing fiscal crises, state government has tightly limited payments for hospital care of Medi-Cal clients. "For the first three years of [selective] contracting, the state successfully... maintained a 'no net increase' policy for aggregate hospital contract expenditures" (Mennemeyer and Olinger, 1989). Per-

sisting low payments, along with stringent oversight of admissions and patient stays (Kerr, 1986), have deterred many hospitals from bidding to serve Medi-Cal patients.

In 1982, when competition began, another state action helped cut hospital spending, but it had a high human cost — 250,000 medically indigent adults (MIAs) were dropped from Medi-Cal, and counties became responsible for their care. The state promised to contribute 70 percent of its former spending, but has not done so (Weintraub, 1990). After the switch, Lurie et al. (1984) found more deaths and uncontrolled hypertension with increased risk of death; Brown and Cousineau (1987) found sharp drops in inpatient and outpatient utilization for newly uninsured MIAs.

Underserved Poor

Uninsured and underinsured patients have had increasing difficulty obtaining medical care from both public and nonpublic providers, although for very different reasons. Instead of fostering efficiency, competitive pressures tend to deter nonpublic caregivers from serving unprofitable patients.

As the state's Health and Welfare Secretary and the head of the California Association of Hospitals and Health Systems (CAHHS) have conceded, the need to hold prices down to attract HMO contracts and well-insured patients has made many nonpublic hospitals less willing to cross-subsidize care for uninsured and Medi-Cal patients (California Association of Catholic Hospitals, 1987; Olszewski, 1988).

Hospitals that serve such patients have been struggling (California Office of Statewide Health Planning and Development, 1986; California

Association of Hospitals and Health Systems, 1989). For example, a proprietary hospital, San Diego General, closed in bankruptcy last year; its predominantly minority community now must travel much farther for care (Clark, 1991). Growing reliance on Medi-Cal increases county facilities' financial vulnerability (Pittman, 1992). The influx of uninsured patients into historically underfunded public hospitals has further strained their further straining their finances and ability to provide adequate care. A 1991 nurses' strike in the six Los Angeles County-run hospitals and 48 clinics focused on chronic understaffing. Today, "near-chaotic working conditions" and low pay mean that about 20 percent of budgeted nursing positions in area public hospitals are unfilled (Girdner, 1991).

In 1989, a Marketplace Task Force of CAHHS reported "delays in receiving care among the uninsured and Medi-Cal recipients. . . . Many do not get care," and when they do, "nearly all of them spend less time in the hospital than do sponsored patients" (CAHHS, 1989). Because so many are unable to obtain even basic care, people die needlessly (Health Access, 1991). Growing competitive pressures and public underfunding have resulted in problems in several areas:

1. Emergency Care. Poor and uninsured Californians now find it far harder to obtain emergency care than before competition intensified. Nonpublic hospitals are more reluctant to provide even emergency services for uninsured and underinsured people. A Fresno physician and five patients testified before the state legislature about permanent disabilities resulting from "denials of emergency orthopedic care and follow-up in private hospitals. . ." (California

Legislature, Special Committee on Medical Oversight, 1986).

At a private Kaiser Permanente hospital in Los Angeles, the average emergency room wait was about 45 minutes, a 1987 study found, but at county-run Martin Luther King/Drew Medical Center it was six to eight hours (Dallek, 1987).

Because of lengthy waits, many emergency room patients left without seeing a physician.

At the emergency room of Los Angeles County's Harbor/UCLA Medical Center in 1990, overcrowding had increased for several reasons, including "a shortage of beds. . . transfers of uninsured patients from private hospitals, a rising number of trauma patients. . ." (Baker, Stevens, and Brook, 1991). That study and another at San Francisco General Hospital (Bindman, et al., 1991) found that, because of lengthy waits, substantial numbers of emergency room patients were leaving without being seen by physicians. This harmed patients, since nearly half of those who left were deemed by triage nurses to need prompt evaluation. Bindman et al., concluded, "emergency room overcrowding in public hospitals is closing the only door through which many of the poor and uninsured gain access to health care services."

Los Angeles County public hospitals, with their high patient volume and soaring numbers of victims of violent trauma, have been used for several years by the U.S. Army as training sites for its physicians (Girdner, 1991).

2. Inpatient Care. Inpatient services for poor communities also ap-

pear especially stressed in Los Angeles, where all county hospitals face critical staff and equipment shortages. Caregivers at King/Drew reported, "it is not uncommon for patients to suffer burst appendices, because of hospital-caused delays in getting patients into surgery. . . ." At Harbor/UCLA, "patients die or become inoperable while waiting for our surgical services. . . ." (Dallek, 1987).

In 1989, Los Angeles County public hospital occupancy was untenably high, ranging from 85 to 94 percent at the four hospitals for which data were available. Excluding these hospitals, the countywide rate was just 61 percent (AHA, 1990a).

3. Ambulatory Care. For low-income and uninsured patients, access to ambulatory care, both primary and specialized, often is inadequate. "As the number of uninsured persons soars. . . clinics up and down the state are limiting their caseloads, increasing financial barriers, or building lengthy waiting lists" (Health Access, 1988).

Many uninsured patients travel considerable distances because private hospitals will not see them; 40 percent of patients at the Contra Costa County hospital, for example, live in Richmond, which is two hours away by public transportation (Health Access, 1988).

Public clinics lack sufficient resources to meet the need. In 1990, new patients had to wait two months on average for appointments in primary care clinics at San Francisco General (Bindman, et al., 1991). In Los Angeles, county clinic patients arriving after 7:30 a.m. sometimes must be turned away (Dallek, 1987).

Specialty clinics at Los Angeles County hospitals are dangerously overloaded. Caregivers cited waits of two months for diagnostic tumor biopsies, and "eight months or more"

for new cardiac patients. "We reschedule people who should be seen every one to two weeks at three-to six-month intervals" (Dallek, 1987).

Long waits have "rationed [people] out of their health care just as effectively as if [the hospital had] shut the door" (Anderson, 1986).

Needless pain and deaths result. An Alameda County caregiver reported, "At minimum I have seen 50. . . patients at this hospital who had to get a foot amputated as a [preventable] side effect of diabetes" (Health Access, 1988).

4. Prenatal Care and Obstetrics. In 1988, California ranked 35th among states in the percentage of births with timely prenatal care (Center for the Study of Social Policy, 1991). Even high-risk pregnant women waited on average three or four hours at Los Angeles County's Women's Hospital, often for a five-minute visit. Obstetrical bed shortages at three public hospitals in Los Angeles County have meant women sitting in wheelchairs for hours after delivering, and babies "delivered in the halls" or by "only an unsupervised intern" (Dallek, 1987).

Danger for All

Because caregiver increasingly respond to purchasing power, the logic of competition has pushed many hospitals to close unprofitable services, even when badly needed. Hospitals also aggressively "demarket" or avoid attracting uninsured and Medi-Cal patients. In a low-income area of Los Angeles, the University of Southern California's new University Hospital was "designed primarily for patients with private insurance. It lacks an emergency room, the traditional point of entry for poor people. . ." (Wielawski, 1991).

California's competitive system, however, has undermined the availability, quality, and affordability of care not only for poor people. "The entire population is at increased risk," the CAHHS Task Force concluded. "Many hospitals have downgraded basic emergency services to standby status and closed trauma centers and obstetrical units to maintain economic viability" (CAHHS, 1989). Northern California now has only one trauma center outside of San Francisco (Robinson-Haynes, 1990). By March 1990, the Los Angeles trauma care network retained just 12 hospitals out of 23 original participants (Weintraub, 1990). Four times in January 1989, more than 12 Los Angeles hospitals had "simultaneously closed their emergency rooms or trauma centers to ambulances. . . ." Such "emergency gridlock" has arisen across the state — in San Jose, Oakland, and elsewhere, endangering everyone (Health Access, 1991).

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Competition fosters waste, especially by shifting resources into providing what is remunerative, not what is needed. Centinela Hospital in Los Angeles, for example, expanded sports medicine while downgrading its heavily used emergency services (Health Access, 1991). Price is not the only basis of competition; to attract insurance contracts and well-insured patients, hospitals add equipment and departments, and engage in costly marketing (Kim, 1989).

Prestigious and profitable services have proliferated. Today, Los Angeles County has more magnetic resonance imagers than all of Europe (CACH, 1991b). "The growth in tertiary cardiac services," one observer noted, "... suggests that selective contracting... may even promote service expansion so that a hospital appears as 'full service' to potential contractors" (Johns, 1989).

This can be dangerous as well as inefficient. Over one-third of California heart surgery units do fewer than the 150 cases yearly recommended to maintain quality. "One-eighth of California hospitals with heart surgery programs had significantly high death rates for heart bypass patients in 1987..." (Steinbrook, 1989).

California's certificate-of-need program was terminated in 1987. Statewide hospital occupancy in 1990 actually decreased slightly from 1983, when competition intensified. Although competition is supposed to improve efficiency, not-for-profit hospitals added 3.3 percent more beds during the 1980s, even while their census fell by 6.4 percent (AHA, 1981, 1984, 1991).

While low occupancies persisted, "the number of competitors for erstwhile hospital patients continued to increase... 'Recovery centers'... to keep patients up to three days after what used to be outpatient surgery... [were] sold as an escape from hospital overhead costs" (Kinzer, 1989). But diverting profitable patients to non-hospital services means hospitals now have higher overheads per patient, while Californians also must pay for the new facilities. Systemwide costs thus increase.

High costs and visible, wasteful duplication in the private sector associated with competition inevitably reduce political willingness to

pay yet again for a parallel public sector, no matter how badly needed.

A Desire for Change

After California adopted competition, David Kinzer, the late president of the Massachusetts Hospital Association, observed that legislative leaders there "frankly acknowledged that they had introduced 'a two-tiered system of care'" (Kinzer, 1983).

California labors under a unique conjunction of high costs and low coverage, and the state's reliance on competition bears much of the blame. No other state spends so much on so few.

Frustration abounds. The Marketplace Task Force of CAHHS has concluded, that "competition" is falling short of anticipated goals of policy makers, patients, and providers" (CAHHS, 1989). The California Association of Catholic Hospitals is now urging consideration of a "public utility" model of payment for health care (CACH, 1988, 1991a).

A 1991 Gallup poll found 74 percent of Californians thought the state should offer coverage to everyone who lacks insurance (cited in Brown, et al., 1991). Consumer and physician organizations are each campaigning for their own access expansion legislation (Inman, 1991).

Competition has not saved money overall in California. With genuine free markets unattainable in health care (Sager, Socolar, and Hiam, 1991), the rhetoric of competition has rationalized higher health costs and growing inequalities. By cutting needed care for the poor, it has cost lives. It has wasted money and injured patients by increasing services of marginal value and competence for well-insured Californians. In all these ways, the mar-

ket's invisible hand has been picking Californians' pockets.

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