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Competition Based on Quality of Care

By: John C. Goodman **August 22, 2012**

Lack of quality competition is in part the result of certain characteristics of healthcare quality. What we call core quality is not a variable at all. As I wrote in my recent book *Priceless: Curing the Healthcare Crisis*, it is the result of other decisions made by the providers. Since the vagaries of medical practice are many and since the decision calculus of doctors will often differ, this allows for considerable quality differences. Beyond this core level, quality improvement is a decision variable, and improvements are costly. However, since it is difficult and costly for patients to secure quality data on their own, information about quality typically comes only from the providers.

Such communications are unlikely, however, unless by means of quality improvements, providers are able to shift demand (and, therefore, revenue), sufficient to pay for those improvements. In general, this is not the case.

But why don't providers with superior quality take advantage of that fact and advertise it to patients? In other words, why doesn't quality competition arise in healthcare the way it does in normal markets?

Imagine a health market where supply is restricted and where demand exceeds supply at a zero (or nominal) money price—both for the market as a whole and for individual providers. Under these conditions, which roughly describe most primary care practice, the provider's time will tend to be rationed by waiting. Improvement in the quality of care (if perceived or communicated) will potentially increase demand—maybe even attracting new patients. However, the increased demand will be initially reflected in increased waiting (higher time price), which in turn will cause some of the initial group of patients to see the doctor less often. On the other hand, a decrease in quality of care (again if perceived or communicated) will diminish demand and lead to shorter waits (a lower time price), thus inducing some of the remaining patients to see the doctor more often.

Since the doctor's time is already fully allocated, and since the fee is fixed, in neither circumstance will the physician's revenue be much affected. The same principle applies to amenities. In the face of rationing by waiting, amenity improvements will not in general increase the provider's income, and amenity degradation will not in general decrease it.

So in comparing two practices—one that predominantly relies on price rationing to clear the market and one that relies on rationing by waiting, we would expect both amenities and quality of care to be higher in the former than in the latter.

“I practiced for 30 years without knowing how long patients waited to see me,” says Robert Mecklenburg, a doctor who is now at Virginia Mason Medical Center in Seattle. Can you imagine the owner of a retail outlet in any other market admitting that he has no idea how long his customers wait before being served? In a normal market, a storeowner with that attitude would not survive for ten minutes.