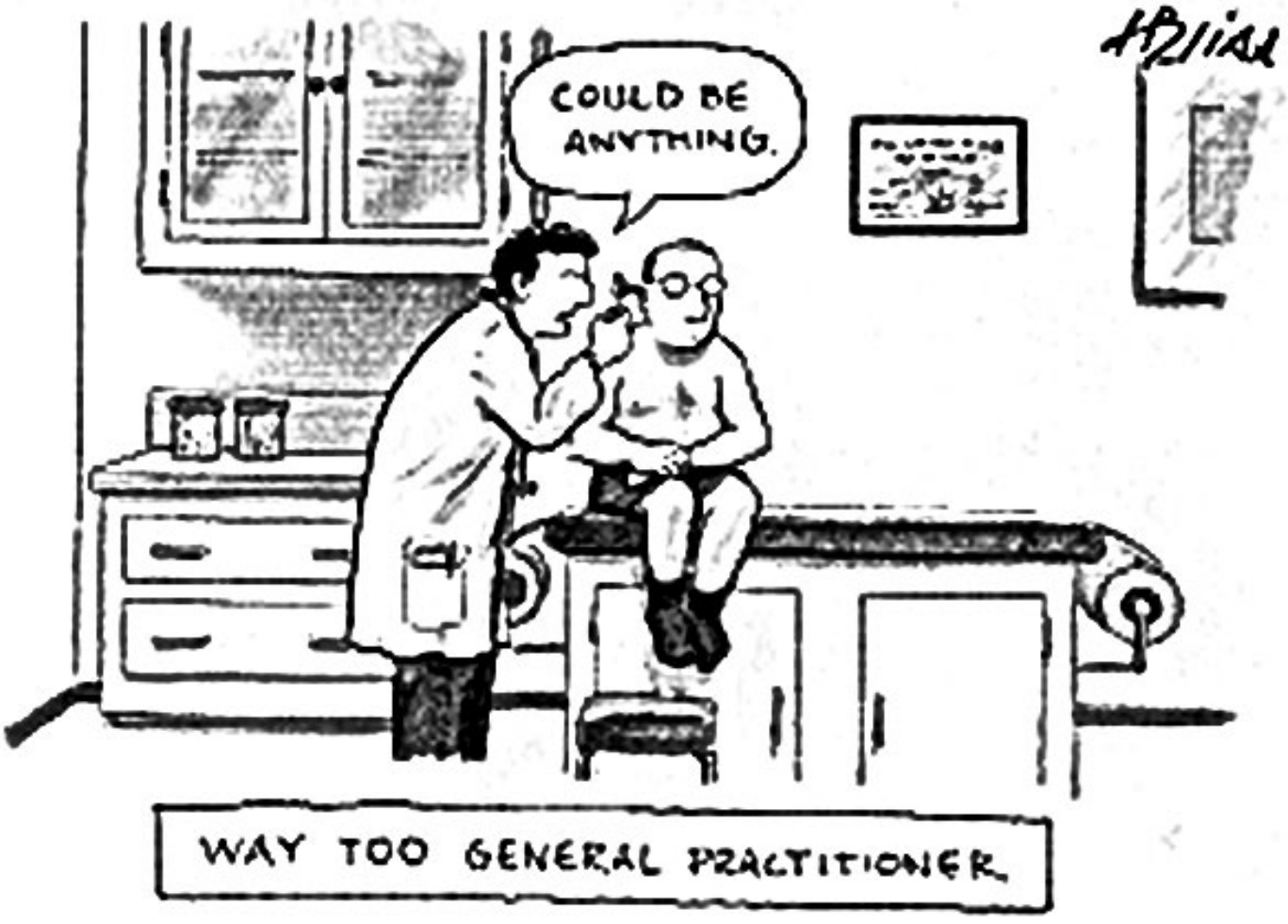
The Market for Physician Services

PH 126: Introduction to Health Economics and Policy
UC Berkeley

February 19, 2008

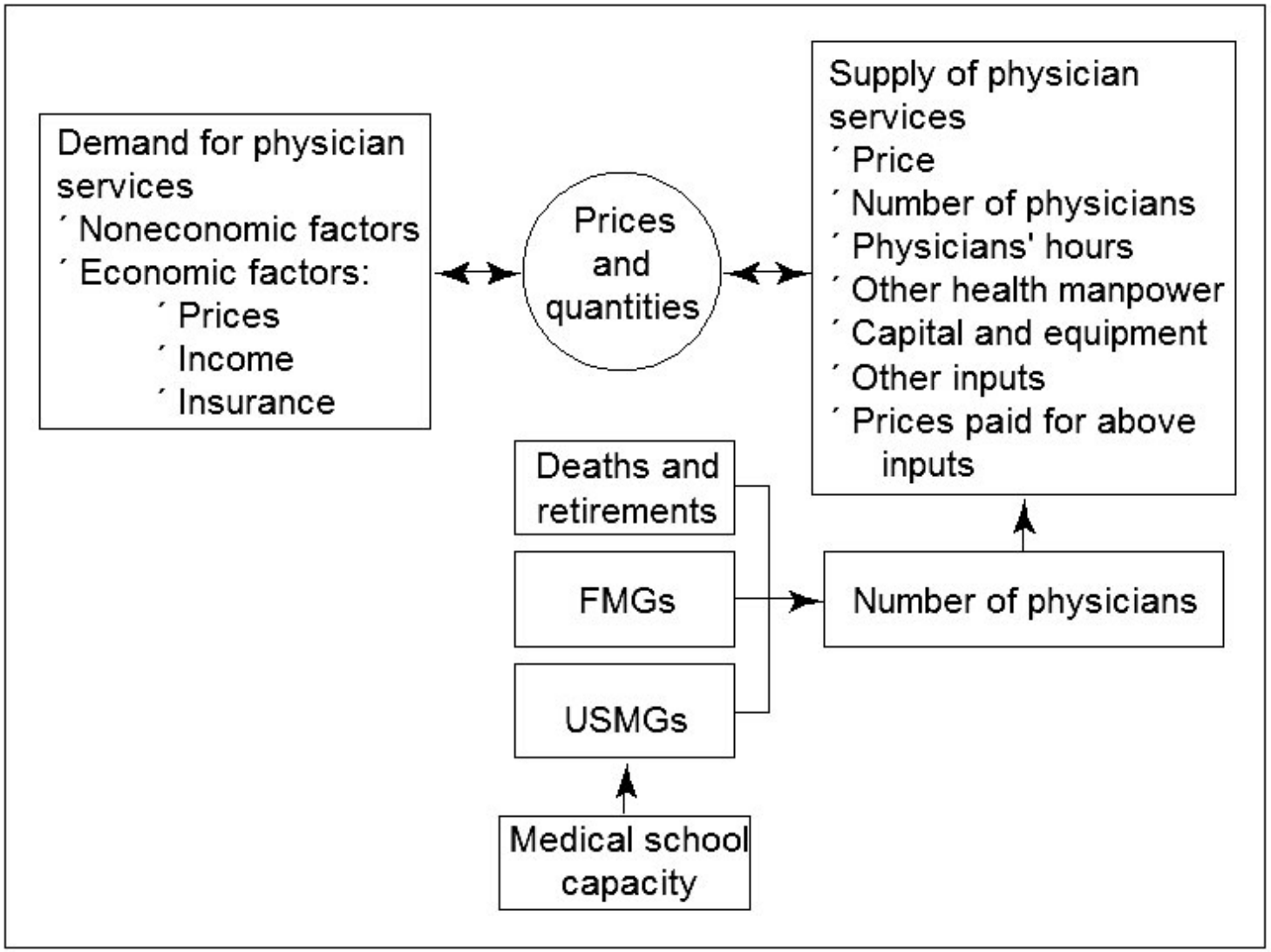
Outline

First, a cartoon



From *The New Yorker*

An overview of the physician services market



The structure of physician firms

Physicians often band together to form group practices. There are several reasons why doctors prefer this structure.

- Economies of scale
  Sharing inputs (aides, office space, volume discounts, . . .)
- Reputation effects
  Physicians are better able to evaluate fellow physicians than patients.
- Reduction of income variability through income sharing
- Increased market power in insurance negotiations

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This market structure is known as *monopolistic competition*; each physician is a monopolist over his unique bundle of services, but the bundles offered by different physicians are substitutable to a certain degree.

Competition among physicians

Prior to 1982, physicians engaged in a variety of anti-competitive behaviors via medical societies (bans on advertising, price-setting agreements, ...). During that year, the Supreme Court decreed that physicians are subject to antitrust laws, thus ending most of these practices and increasing physician competition.

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He points out that calls for professional licensing are always justified by appealing to the public interest and almost always comes from the profession itself.

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This process is known as *rent seeking*. Physicians receive the benefits of market power and, because there are relatively few physicians, they are able to organize to secure these benefits. Benefits to patients are diffuse and consumers are less likely to band together due to "free riding" problems.

Medical licensure

Friedman notes that this process manifests itself in two ways in the medical profession:

- Control licensure and admission to medical schools directly
- Make the licensing and admissions processes so onerous that few attempt to become doctors

He believes that the latter is more important.

Medical licensure

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Additionally, doctors will want to augment their monopoly power by bringing more and more procedures under the auspices of licensing (do you need a license to draw blood? check height and weight? give massages?).

Medical licensure

He offers an elucidating quote bringing these ideas together:

> *Would it not [. . .] be absurd if the automobile industry were to argue that no one should drive a low quality car and therefore that no automobile manufacturer should be permitted to produce a car that did not come up to the Cadillac standard[?]*

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His policy prescription?

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Why?

> *It renders special groups impotent to prevent experimentation and permits the customers and not the producers to decide what will serve the customers best.*

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Patients trust their doctors and receive excess treatment.

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If doctors already have plenty of patients, earn sufficient income, and have scarce time, they may not prescribe much more than necessary. But, if doctors want to increase their income or do not have enough work, they can increase the amount that they prescribe to their patients. This is called *supplier-induced demand*.

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Insurance companies can use the same techniques to combat this supply-side version of moral hazard as they do the demand-side variety. Additionally, they can offer profit sharing opportunities to their doctors or only work with doctors that have shown restraint in prescription (preferred providers).

Supplier-induced demand

Doctors, however, likely maximize utility, rather than just profits. If they get utility from administering correct treatments, then supplier-induced demand is mitigated.

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Hence, physicians may be encouraged to seek out more non-Medicaid patients as a substitute for the lower-priced Medicaid patients.

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Physicians are price-takers in the Medicare market—they can't withhold supply to raise prices as they can in the non-Medicare market.

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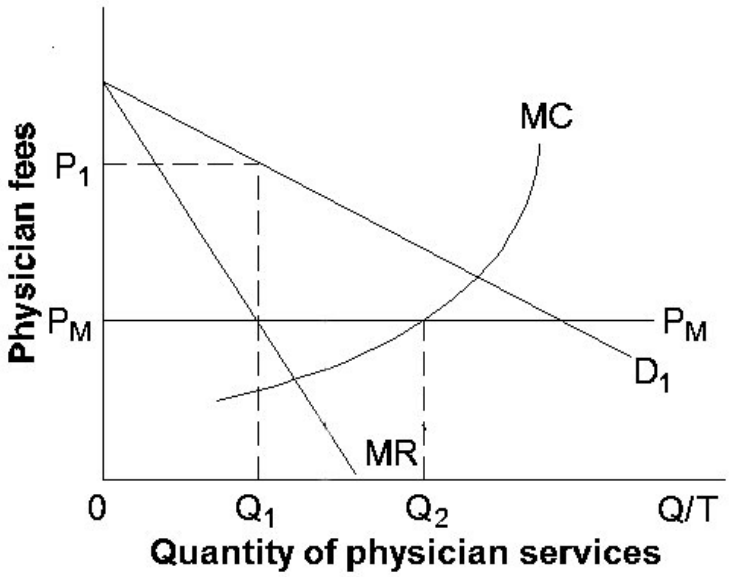

Given that physicians have some market power, they will see non-Medicare patients up until the marginal revenue of seeing this group is equal to the price that the doctors receive from Medicare (i.e., until marginal revenue equals marginal cost). This quantity is Q_1.

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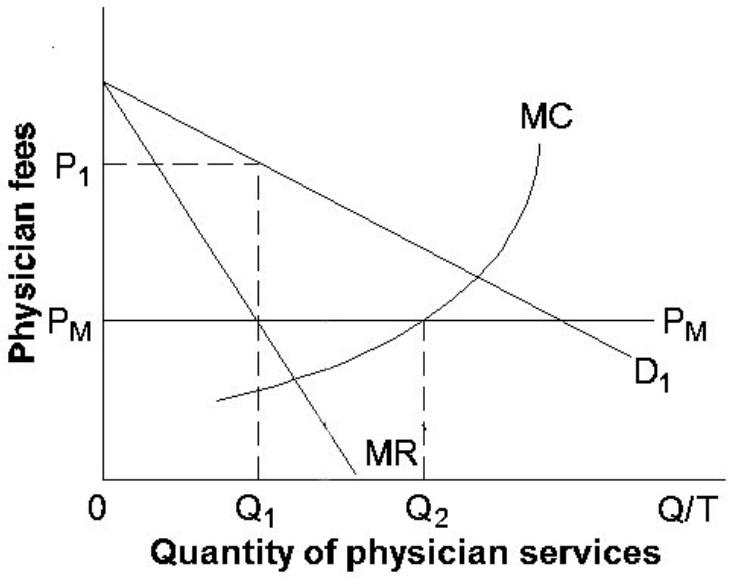

Then, physicians will treat Medicare patients until the price of treating these patients is equal to marginal cost (remember, physicians are price-takers in this market). This quantity is $Q_2 - Q_1$.

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Reallocation would be prevented if physicians were allowed complete freedom in balance billing.

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The government adds together:

- Work component (time, skill, . . .)
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Notice: None of this calculation takes into account changes in **demand** for specific treatments.