

**A Social Contract for 21st Century Health Care:
Three-Tier Health Care with Bounty Hunting**

Uwe E. Reinhardt

James Madison Professor of Political Economy

Princeton University

Introduction

After the spectacular demise of the Clinton health-reform plan in 1994, it was commonly said that health reform in the United States is dead. That is not an accurate assessment. Health reform in the United States is not dead. It is not even half-dead. Rather, half of it is totally dead and the other half is very much alive.

The part of health reform that died in 1994 is the decades-old American dream that all Americans would one day have comprehensive health insurance and share a single-tier health system that would “remain” simply the “best in the world.” American politicians of all ideological stripes had always sworn allegiance to that dream—at least for public consumption. It turns out that it was not so much a dream as a pretense. That pretense has ended, at long last, with the official embrace by the United States Congress of an income-based health system that will ration health care quite severely for Americans assigned to the bottom tier and not at all for Americans in the upper tier.

The part of health reform that survived are two major shifts in the control over health care. The first is a major shift of market power from the supply side of the health sector to its demand side. The second is a transfer of control over the cost and quality of health care away from government to private-sector regulators—the executives of the managed-care industry. This second shift has come to be known by the rather elastic concept of “managed care.”

Although physicians, hospital leaders and other providers of health care had traditionally decried the heavy hand of government in health care and had pretended to yearn for “the market,” they are discovering to their dismay that private regulators are much tougher, much more capricious and much less easily manipulated than is government. Indeed, the objectives and methods of these private regulators remind one of nothing so much as the nation's legendary bounty hunters who, to this day, step in with their roughly hewn methods where the arm of government fails.

This managed care revolution appears to have stabilized health spending in the United States, albeit at slightly below 14 percent of the gross national product, still far in excess of health spending in other nations.¹ Alas, in the short run the American health-care revolution will make life much harder for the nation's 40 million or so uninsured citizens, most of them members of low-income households and about one third of them children. The cost controls now applied by the private regulators will squeeze out of the health system the many hidden cross subsidies by which the doctors and hospitals had hitherto financed their charity care for the uninsured. The more successful the private regulators will be in controlling health spending for

¹ K. R. Levil, H. C. Lazenby, and L. Sivarjan, “Health spending in 1994: slowest in decades,” *Health Affairs* 15:2 (1996): 130-44, and G. J. Schieber, J. P. Poullier and L. M. Greenwald, “Health system performance in OECD countries, 1980-92,” *Health Affairs* 12 (1993): 100-12.

the insured, the more likely will they destroy this important, tacit insurance system for the nation's uninsured.

In this essay, I shall provide a commentary on these developments and offer some speculation on the nature of 21st century American health care. I shall begin, in the next section, with a description of the distinct social ethic that drives health policy in the United States. The willingness of the nation's policy making elite to tolerate what Europeans would decry as glaring “inequities” in health care is widely regarded in other developed countries as a major shortcoming of the American health system, but it also explains why that system is able to experiment so boldly with novel approaches in health insurance and health-care delivery.

After this review of the distributive ethic underlying the American health system, my focus will shift to a new style of cost- and quality controls in that system. These methods are as yet in the formative state and applied only in certain parts of the country—notably in California. The idea of “managed competition,” as it had been espoused by the so-called Jackson Hole Group² and in the Clinton health-reform plan³ remain just that, mere ideas that may or may not become a reality. In the meantime, the American health sector remains in a state of great turmoil,

² See, for example, P. M. Ellwood, A. C. Enthoven, and L. Etheridge, “The Jackson Hole initiative for a twenty first century American health system,” *Health Economics* 1:3 (1992): 149-68.

³ *President Clinton's Health Care Reform Proposal and Health Security Act, as presented to Congress on October 27, 1993* (Chicago, IL: Commerce Clearing House, Inc., Report No. 773, November 1, 1993).

with a noticeable backlash among the public, in the media and in state legislatures against certain features of “managed care.”⁴

In the concluding section of the essay, I shall attempt to extract from my review some lessons for European policy makers. I shall argue that much can eventually be learned from the doings in the unfettered health-care laboratory across the Atlantic, but that nations spending so much less on health care than does the United States have the luxury to sit back until the United States has paid the price of its early and reckless experimentation. If the United States health system will eventually produce policies worth emulating, they are apt to lie more in the sphere of quality control than in the sphere of cost containment.

In any event, in view of the distinct social ethic that drives American health policy it is prudent always to view American health policy as a Trojan horse in whose belly hide principles and methods that Europeans might find seriously wanting. If Europeans do wish to marry certain techniques of “managed care” and of “managed competition” to their more egalitarian concept of “social solidarity,” they would be well advised to start with a careful reading of the much maligned Clinton plan, which tried to do just that and which, therefore, was found so offensive by many well-to-do Americans in positions of power.

The Move Toward a Three-Tier Health System⁵

⁴ D. Azevedo, “Will the States get tough with HMOs?,” *Medical Economics* 73:16 (1996): 172, and W. Guglielmo, “How health plans are fighting back,” *Medical Economics* 73:16 (1996): 185.

⁵ This section draws on U. E. Reinhardt, “Turning our gaze from bread and circus games,” *Health Affairs* 14:1 (1995): 33-6.

Whatever one may think of the torturous debate that led to the demise of the Clinton plan, that debate did settle a decades-old wrestling match over the proper ethical foundation for American health care. For purposes of discussion, one can crystallize that ideological battle with a straightforward, fundamental question:

To the extent that our health system can make it possible, should the child of a gas station attendant have the same chance of a healthy life, and the same chance of a cure from a given illness, as does the child of a corporate executive?

If one posed this question to random samples of Canadian or European legislators and business executives, the overwhelming majority of them would answer it firmly in the affirmative, and not just for public consumption. We would judge that response sincere, because these nations' statutes at all levels of government concretely express that professed view, as does the actual operation of their health systems. All children and, indeed, all adults in these countries have comprehensive health insurance coverage, even for preventive care. The entire health system within their nation is open to all of members of society, on roughly equal terms.

(Although in some European countries—e.g., the United Kingdom and Germany—close to 10 percent of the population have private insurance, for the most part that coverage purchases better amenities and not health care of superior clinical quality.) Each family's financial contribution to health insurance is decoupled from the health status of its members and is based strictly on the family's ability to pay.

As public opinion surveys have consistently shown, if one posed that same question to a random sample of Americans, most of them would answer it in the affirmative as well, and most

of them would feel quite sincere about their response, at that moment.⁶ But the nation's laws belie that response, as does the structure of the American health system. Public opinion polls and political stump speeches aside, there is in the United States much less of a consensus than there is in Canada and in Europe on the social ethic that should govern the distribution of basic human services—be it in health care, in education, or in justice.

Americans sometimes pretend that this lack of a consensus on social ethics is rooted in the “heterogeneity” of American society, by which they seem to mean mainly its diverse racial and ethnic composition. Ethnic heterogeneity may be part of the explanation, but it is unlikely the whole explanation for this lack of consensus. More probably, it reflects primarily economic heterogeneity, that is, a relatively wider dispersion of family income and wealth than is typical of other industrialized nations.⁷ That dispersion appears to have spread more rapidly in the United States during the last two decades than it has elsewhere.⁸

If one asked Americans the question raised above not in a public opinion survey or public forum, but only after first giving the respondents a strong dose of truth serum, one would be likely to receive rather more varied responses, which would be rooted along a wide ideological spectrum. The nation's decades old struggle over health reform really has been a delicately

⁶ See, for example, U. E. Reinhardt and H. Taylor, “Does the system fit?,” *Health Management Quarterly* (1991): 2-10.

⁷ In this connection, see, for example, K. Bradsher, “Gap in wealth in U. S. called widest in west,” *The New York Times*, April 17, 1995, A-1 and D4.

⁸ See, for example, “Inequality: for richer, for poorer,” *The Economist*, November 5, 1994; 19-21.

camouflaged fight over what particular bandwidth of that ideological spectrum should govern the American health system. That dispute was decisively settled in 1994, at least for a while.

The ideological spectrum on health care

At one extreme of the ideological spectrum concerning health care are the many Americans who do view health care as purely a *social good* that is to be shared by all who need it on roughly equal terms, regardless of the individual patient's ability to pay for that care. That view implies the collective financing of health care, strongly guided by the distributive hand of government. Naturally, this school of thought would answer the question raised above in the affirmative, and just as firmly as would most Europeans and Canadians.

At the other extreme of the spectrum, however, are Americans who view health care as essentially a *private consumption good* whose procurement and financing are the individual's responsibility, except perhaps in truly catastrophic cases. Often, but not always, this view is reinforced by the clinical theory that many if not most modern diseases are rooted somehow in the individual's own behavior—that illness is not just bad luck beyond the individual's control, but an integral part of the individual's life-cycle consumption choices.

The notion that health care is just another consumption good has been nourished over the decades by the writings of libertarian scholars. For example, Milton Friedman, the prominent Nobel Laureate economist proposed in *The Wall Street Journal* of November 19, 1991 that an ideal health system would be one in which “every U.S. family unit [would] have a major medical insurance policy with a high deductible, say \$20,000 a year or 30% of the unit's income during

the prior two years, whichever is lower.”⁹ Even if one assumes that Friedman meant this to be 30 percent of the household's annual income averaged over the last two years (it is not clear that he does), his prescription would still call for a deductible of \$9,300 on a household with the median family income of \$31,000 in 1991.¹⁰ It may be worth noting that Friedman expressly thanks Chicago economist and fellow Nobel Laureate Gary S. Becker and economist Thomas Moore, former member of President Reagan's Council of Economic Advisors, for assistance with his article. One may doubt that prominent European economists would offer that kind of normative prescription for their health systems.

Slightly to the left of the Friedmanesque extreme, but far to the right of the egalitarian school, sits the working majority of the United States Congress (and, possibly, of the American people as well). That majority tends to view health care as similar to other basic commodities, such as food, clothing, and shelter. The adherents to that ideology do concede that the incidence of some catastrophic illnesses lie totally outside the individual's control. Furthermore, they are prepared to guarantee every American access to at least a basic minimum of critically needed health care in catastrophic cases of illness. But central to that school of thought is the idea that the quantity and quality of health care received by individuals can properly vary with their ability to pay for that care, just as the quality of a child's education has traditionally been allowed to vary systematically and quite visibly with the parents' income class (an idea still alien to countries, such as Canada or Germany). To be sure, one may doubt that this school of thought

⁹ M. Friedman, “Gammon's law points to health care solution,” *The Wall Street Journal*, November 12, 1991.

¹⁰ U. S. Bureau of the Census, *Statistical abstract of the United States 1994*, 114th. edition (Government Printing Office: Washington, D. C., 1994): Table 708, 464.

would ever openly proclaim that, to the extent that the health system can make it possible, the child of a corporate executive may legitimately enjoy a better chance of surviving a given illness than the child of a gas-station attendant. But, implicitly, that school of thought countenances precisely such a state of affairs.

In the great health-care battle of 1993-94, the “health-care-is-just-like-food” people triumphed over the President and his allies, who had sought with their plan to extract a roughly egalitarian distribution of health care from a market-driven health-care delivery system. It must be said, of course, that in developing their reform plan and in trying to sell it to the Congress and to the American people, the President and his team of advisors made countless tactical (and often tactless) errors that truly astound even outsiders otherwise well disposed to the President's social ethic. But surely the President's most serious error was to take the American people at their word when they profess allegiance to an *egalitarian* distribution of health care (or of any other human service, like education or justice). Much of the bureaucratic complexity of the President's plan was driven in by his strong emphasis on an egalitarian distribution of health care. It is now clear that Americans will not tolerate the redistribution of income from the upper- to the lower third of the income distribution that would be implied in a more egalitarian health system. Nor do they seem ready to countenance the administrative apparatus necessary to enforce such a redistribution.

Although the “health-care-is-just-like-food” school won its battle squarely, they cannot be said to have won it fairly. Instead of stating their quite legitimate ideology forthrightly, for public scrutiny, they couched it in carefully chosen code words typically borrowed from the

economics profession,¹¹ such as “the economic efficiency of free markets,” the virtue of “individual responsibility,” “empowerment” to exercise “free consumer choice,” “the freedom to be insured or not,” and so on. On the surface, these code words have a mellow ring, but anyone able to cut through that jargon will recognize in it advocacy of income-based rationing of health care. Practically, these code words mean that the preferred American health insurance system is one that empowers well-to-do Americans to allocate their ample budgets between health care and other things as they see fit and that empowers poor Americans to do likewise with their meagre income, plus whatever subsidies Congress may or may not bestow on them. It is evident now that these subsidies will range from extremely meagre to nothing.

Rationing in the American health system¹²

Americans have long looked askance at the Canadian and European health systems, because the nations are said to “ration” health care. There is no doubt that these systems do ration health care, either by the queue, or simply by limiting the array of novel technology made available by the health system.

Now it is true that, during the past three decades or so, the bulk of well-insured Americans were spared rationing of any sort in health care. For one, the American health system has long

¹¹ U. E. Reinhardt, “Economics,” *Journal of the American Medical Association* 275:23 (1996): 1802-4.

¹² This section draws on U. E. Reinhardt, “Rationing health care: What it is, what it is not, and why we cannot avoid it,” in S. H. Altrnan and U. E. Reinhardt, eds., *Strategic Choices for a Changing Health Care System* (Chicago, IL: Health Administration Press, 1996), 63-100.

been beset by excess capacity all around. In principle, there was no immediate need for rationing access to that abundance for anyone who was well insured. Furthermore, for the insured, the financial incentives faced by doctors, hospitals and other providers of health care under the traditional fee-for-service system generously rewarded the unrestrained use of whatever capacity was in place. It is therefore not surprising that the majority of Americans came to think of rationing health care as an un-American activity.

For the millions of low-income Americans without health insurance, however, rationing by income and price has always been a fact of life, with well documented ill consequences for their health. Although the charity care available to them when they are critically ill does constitute a haphazard, universal insurance system for catastrophic expenses, it is well known from the literature that these Americans often face severe rationing of care.¹³ It is true not only of preventive and routine health care for less than critical illnesses; it is true also for critical care.¹⁴

The social ethic and the associated policies that now drive American health policy officially sanction this income-based rationing of health care. There will be at least three distinct tiers of health care, each with its own rules for rationing.

¹³ J. Hadley, E. P. Steinberg, and J. Feder, "Comparison of uninsured and privately insured hospital patients," *Journal of the American Medical Association* 265:3 (1991): 374-79.

¹⁴ A. L. Kellerman, "Too sick to wait," *Journal of the American Medical Association* 266 (1991): 1123f.; D. W. Baker and C. D. Stevens, "Patients who leave a public hospital emergency department without being seen by a physician," *Journal of the American Medical Association* 266 (1991): 1085; A. B. Bindman et al., "Consequences of queuing for care at a public hospital emergency room," *Journal of the American Medical Association* 266 (1991): 1091.

The Bottom Tier. Uninsured Americans who are poor or near poor—chiefly families of people who work full time at low wages and salaries—will have to rely on the current patchwork of public hospitals and clinics. These publicly financed institutions will be sorely underfunded, as they always have been, thus forcing severe limits on their physical capacity. Such limits, in turn, will beget the long queues that have always been the classic instrument of rationing. Lack of funding will also limit the technology available to the physicians working in these public institutions. Honest people will call this budget-driven withholding of technology rationing as well.

The Middle Tier. The employed broad middle class will be enrolled in health plans that can control the providers of health care through selective contracts with them. Fundamental to the ability of these plans to write selective contracts with providers is their ability to limit the patient's choice of provider at the time illness strikes, a limitation that had hitherto been thought unthinkable in American health care. Among these health plans are the established health maintenance organizations (HMOs) that had long been a feature of the American health system; but the plans also include newer forms of “virtual” organizations, that is, freestanding facilities bound together by contract and by a computer information system. These plans will be budgeted prospectively, on a per-capita basis, through competitively bid premiums. They inevitably will come to withhold some care that patients and their physicians might judge desirable, but that the health plan's management finds too expensive relative to the expected medical benefits. Clearly this is a form of rationing.

The Upper Tier. Finally, for well-to-do Americans who find private-sector rationing through strict practice guidelines intolerable, there will continue to be the open-ended, free-choice, fee-for-service health system without rationing of any form, even in instances where additional care

is of dubious clinical or economic merit. Many well-to-do Americans will demand no less, and they will always have it. Furthermore, they will continue to have it on a fully tax-deductible basis (for employed Americans, employer-provided health insurance is not counted as part of taxable compensation), a tax preference to the rich that no economist would ever defend, but that no politician would dare to remove.

That upper tier, incidentally, will be the natural habitat of the tax-favored *Medical Savings Accounts* (MSA's) that are now so popular among conservative policy makers in the United States. Under that approach, households would purchase catastrophic insurance policies with deductibles of \$3,000 to \$4,000 a year. To meet these out-of-pocket expenses, households would be permitted to deposit an annual amount up to the deductible in an MSA that would be fully vested in the family. These contributions would be fully tax deductible, which means that, in terms of foregone after-tax income, given medical procedures would actually be much cheaper for high-income families in high tax brackets than they would be for low-income families in low tax brackets. Europeans, more accustomed to the notion that a family's annual outlay for health care should be based on its ability to pay, probably will marvel at the distributive ethic built into this particular American innovation.

America's politically powerful elderly so far have been able to defend their much cherished, free-choice, tax-financed coverage under the federally financed Medicare program. That program, however, is likely to be transferred in the near future to control by private managed-care entities as well. Since 1965, Medicare has been a *defined benefit* program under which the elderly were promised a defined set of medical-care benefits which Congress had to procure from the private delivery system at whatever dollars that system managed to extract from the government. Under that open-ended system, the financial risk of health-care cost

inflation was borne entirely by the tax payer. Legislation passed by the 104th Congress (elected in November of 1994), but vetoed as part of a larger budget package by President Clinton, would have converted Medicare into a *defined contribution* program under which Congress would effectively issue the elderly fixed, annual, risk-adjusted vouchers with which they could then purchase a variety of different, private insurance plans (mainly managed-care plans) or elect to stay in the old Medicare program. Expenditures under the latter, however, would be constrained to a fixed annual per-capita budget as well, simply by cutting fees to the providers of care to keep within that budget. Such reduction in fees might eventually turn providers away from the traditional program.

At this time, less than 10 percent of the elderly are enrolled in private managed-care plans. Furthermore, they still have the right to shift back into the traditional Medicare at any time they find their managed-care plans unappealing. It is reasonable to assume, however, that the next Administration and Congress will cooperate to implement something like the reforms envisaged by the 104th Congress. If so, Medicare will eventually drift apart by income class as well, with the well-to-do elderly covered by open-ended, private fee-for-service plans (including *Medical Savings Accounts*) and the rest in managed-care networks. Whether the old Medicare program will survive long in that world is anyone's guess at this time.

It must be left for study by political scientists whether this politically dominant vision for American health care faithfully reflects the independent preferences of the so-called “grass roots,” or whether it is merely being foisted on bewildered plebs by a small, powerful, policymaking elite that knows how to manipulate grass root “preferences” through skillfully structured information and outright misinformation. *Newsweek* columnist George Will, for example, had ominously warned readers that “there would be 15-year jail terms for people

driven to bribery for care they feel they need but the government does not deem 'necessary'.”¹⁵ It is difficult to reconcile that warning with the overarching Section 1003 of the Clinton plan in which it is stated that “Nothing in this Act shall be construed as prohibiting the following: (1) An individual from purchasing any health care services.”¹⁶ As the *Economist* reported in late 1994, so successful were the opponents of the Clinton plan in alarming the public that an elderly woman implored a southern senator: “Please stop that Clinton plan, Senator. I don't want the government in my Medicare.”¹⁷ As noted above, since its inception Medicare has been a government financed and administered program.

Whatever the case may be, however, it is clear that the United States is unlikely ever to move the single-tier health system that had always been endorsed officially, by every politician, for public consumption. A case can be made for admitting it openly and for making the quality of the bottom tier the main concern of government health policy, leaving the rest of the system to fend for itself. This will mean strengthening the federal Public Health Service and helping the states in funding their own public health facilities.

Cost Control Through Private Regulators

In the period from 1960 to 1990, annual health spending in the United States tended to outrun the growth of the non-health component of our Gross National Product (GNP) by about 3

¹⁵ G. F. Will, “The Clinton's lethal paternalism,” *Newsweek*, February 7, 1994, 64.

¹⁶ *President Clinton's Health Care Reform Proposal and Health Security Act, as presented to Congress on October 27, 1993*, 15.

¹⁷ “The weirdest year,” *The Economist*, November 5, 1994.

percentage points.¹⁸ On average, if the non-health component GNP rose by, say, 7 percent per year, health spending rose by about 10 percent. At this trend, health spending would rise from 12.1 percent of the GNP in 1990 to about 45 percent of the GNP by the year 2050.¹⁹ Clearly, that trend is not sustainable indefinitely, even in a wealthy nation.

Nor is that trend defensible. American business executives and government officials have long known that other industrialized nations spend considerably less on health care than does the United States, whether one assesses spending levels by the percentage of gross domestic product spent on health care or by per-capita health spending. Only Canada spends about 10 percent of its GNP on health care. Most other industrialized nations spend anywhere from 7 to 9 percent.²⁰

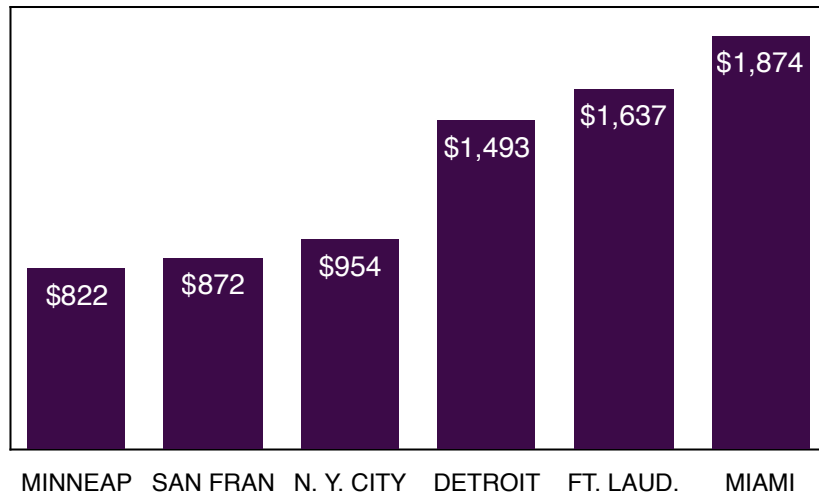
Those international comparisons, of course, have always been dismissed in the United States with appeal to the assumed superiority of the American health system. But one need not even look abroad, however, to question health spending levels in the United States. As is shown

¹⁸ V. R. Fuchs, "The health sector's share of the gross national product," *Science* 247 (1990): 534-38.

¹⁹ If X_0 denotes the fraction of the GNP absorbed by health care in some base year and d denotes the percentage-point by which the continuously compounded growth rate of health spending exceeds the continuously compounded growth rate of the rest of the GNP, then, if that differential d persists into the indefinite future, the fraction X , of the GNP absorbed by health care in some future year r is given by $X_1 = e^{df} / (e^{df} - 1 + 1/X)$.

²⁰ Schieber, Poullier, and Greenwald, "Health system performance in OECD countries, 1980-92."

in Figure 1, regional variations of per-capita health spending within the United States actually dwarf the international variations.



SOURCE: H. Pete Welch et al. *The New England Journal of Medicine*, May 4, 1993

Figure !: Medicare payments to physicians per Medicare Beneficiary, 1989 for outpatient and inpatient care (adjusted for regional differences in age, gender and Medicare prices)

Figure 1 shows spending per enrollee by the Medicare program, in 1989, on physician services in various American cities.²¹ These data have been adjusted for inter-city differences in the age-gender composition of the Medicare population and even for variation in the allowable charges Medicare paid physicians in 1989. They represent variations in services per capita. These and similar data raise the question how physicians in, say, Miami or Ft. Lauderdale would defend their much more resource-intensive treatment of the elderly relative to their colleagues' practice patterns in, say, Minneapolis, San Francisco or New York City.

American business executives and government officials who marshal the bulk of the financial resources that pay for health care²² in the United States had been asking that very question throughout the 1980s. Alas, no satisfactory explanation came forth from the nation's medical community. Small wonder, then, that they began to suspect enormous “fat” in the health system and cast about for ways to squeeze that “fat” out of the system. Small wonder, also, that these payers had lost faith in the medical profession's ability to manage the health sector in society's best interest and therefore began to look for external controls of the sector. There were basically but three approaches to that task.

First, the United States could have followed the example of other nations and let government become the chief agent of control. That approach does seem to work reasonably well in nations with parliamentary systems, in which the executive and the legislature tend to pull on one string. It appears to work less well in the United States, whose founding fathers

²¹ W. P. Welch et al., “Geographic variation in expenditures for physicians' services in the United States,” *The New England Journal of Medicine* 328 (1993): 621-27.

²² Roughly speaking, government currently pays for 44 percent of all personal health spending in the United States; employer-provided private insurance pays for about one third.

carefully saddled the government with so many checks and balances as to render it, at best, cumbersome and, more typically, impotent. Furthermore, the way political campaigns are financed in the United States and the lack of discipline within political parties makes it easy for moneyed interest groups to gut legislative attempts to control the cost and quality of health care, simply by concentrating their money and their lobbying efforts on a single powerful committee chairman who can block legislation from coming to the floor. While there is no consensus in the United States on a proper distributive ethic for health care, there certainly now is a consensus that government “just does not work.” Therefore, for the moment, broader government control over health care is not a viable option in the United States.

A second alternative to controlling health care would be to return that task to patients and their families. That is the idea underlying the *Medical Savings Accounts* (MSAs) described earlier. Although that idea appears to have enormous intuitive appeal among Americans who consider health care a private consumption good, it is not clear how well it would work in practice. The fact is that the bulk of health spending in modern nations is driven by relatively few catastrophic medical cases. In any given year, for example, about 10 percent of the population accounts for between 75 and 80 percent of all health spending.²³ Under the circumstances, one must wonder whether uninformed and typically very sick individuals, or their equally uninformed and anxious families, would ever be able to control the prices, the volume and the quality of their health care adequately. Even so, it is one approach now openly favored by conservative legislators.

²³ M. L. Berk and A. C. Monheit, “The concentration of health expenditures: an update,” *Health Affairs* 11 (1992): 145-49.

If neither government nor patients and their families can properly assume the task of controlling health care, one is left with the only other alternative: the use of professional regulators in the private sector. These regulators are the private health plans that sell health insurance policies on the one hand, and procure promised health care from only a select set of physicians, hospitals and other provider of health care, on the other. This arrangement implies, of course, that patients covered by that health plan must limit their choice of provider at time of illness to the select set of providers chosen by the plan.

Selective contracting lies at the heart of the so-called American health-care revolution, because it is the vehicle on which market power is moving from the supply side of the health sector to its demand side. Selective contracting affords the health plans better control over both the prices charged by health care providers for their services and the volume of services the providers package into the treatment of patients. It is widely viewed among those who pay for health care as the salvation of the American health system and by those who derive an income from patient care as its probable demise.

“Managed Care,” “Capitation” and “Managed Competition”

There are some 250 million people in the United States and probably as many distinct definitions of “managed care.” Before proceeding further, it may therefore be as well to explore just what might be meant by that much used but ill-defined term.

Table 1 presents a simple ordering of the economic arrangements between health insurance plans and those who provide health care to the insured. The table highlights the two major dimensions of those contracts: (1) how providers are paid, and (2) to what extent

there is direct, external control by someone over the medical treatments dispensed by the individual physician and hospital.

Table 1. Contractual arrangements between health plans and providers

Payment for providers			
Direct control over volume of services	Fee for service	Fee for service and capitation	Capitation
Tight	A	B	C
Some	D	E	F
None	G	H	I

Cell G in Table 1 represents the traditional economic arrangement in American health care. It is commonly referred to now as the “old fashioned indemnity plan.” Under this

arrangement, the providers of health care are paid on a fee-for-service basis, at prices largely dictated by the providers. There is virtually no direct or even indirect control over the volume of services going into the treatment of particular medical conditions. Individual physicians enjoy full clinical autonomy, and individual hospitals can operate as their executives see fit. No provider of care bears any financial risk for the morbidity of patients. That risk is borne by the insurer and, ultimately, by the premium payers. This arrangement, whose total lack of control had always astounded foreign observers, is now fast disappearing in the United States, although it is still more prevalent than is widely supposed, especially in the Southern states. Cell G represents the “unmanaged” segment of American health care.

At the other extreme in Table 1, in cell C, are arrangements under which an integrated network of health care providers—now commonly called a *Provider Service Network* (PSN)—is prepaid a flat annual capitation and then assumes the full financial risk for the insureds' morbidity. The traditional American health maintenance organization (HMO), such as the Kaiser Foundation Health Plan in California or the Health Insurance Plan of Great New York, fit this model. Naturally, to control the financial risk assumed by the PSN, it must exert direct control over the volume of services dispensed by its individual physicians and other provider-members. Cell C represents fully “managed” health care.

In between cells G and C are a host of alternative arrangements that now claim the label “managed care,” but are about as descriptive of the actual arrangement being so labeled as the term “animal” would be in the description of a Schnauzer.

Some health insurance plans pay primary care physicians by means of a prepaid annual capitation, pay hospitals a flat, negotiated per diem, and pay specialists fee-for-service. To control the volume of services dispensed by specialists, these plans may require

the physician to obtain by telephone authorization for any procedure whose cost exceeds a certain dollar amount. Typically, the other end of the telephone line is staffed by a nurse (backed up by physicians) who follow predetermined clinical practice guidelines. This type of arrangement falls into cell B of Table 1,

Still other plans fall into cell E of Table 1. These plans pay providers by a mixture of per diems, fee-for-service and capitation. They control the volume of services not in “real time” (i.e., as treatments proceed), but by means of periodic, statistical practice profiles for individual physicians, as has long been done in Canada and in Germany. Physicians whose average practice profiles are judged needlessly expensive are then warned and, ultimately, have their contracts with the health plan canceled—a process called “economic credentialing.”

Matters are even more complicated and confusing than is suggested by Table 1, as is shown in Figure 2. That sketch exhibits the money now from premium payer to the individual provider of health care within an integrated Provider Service Network (PSN). In principle, the health plan could compensate the PSN on a fee-for-service basis (link b), while the latter might budget its hospitals and pay its physicians salaries (links c to f). Alternatively, the PSN itself can be compensated by means of prepaid capitation (link b) and yet pay some of its member physicians under fee for service (links c to f). More commonly, however, the PSN will pay its individual physicians a capitation or salary, plus a bonus tied to the physician's ability to minimize the cost of treating patients.

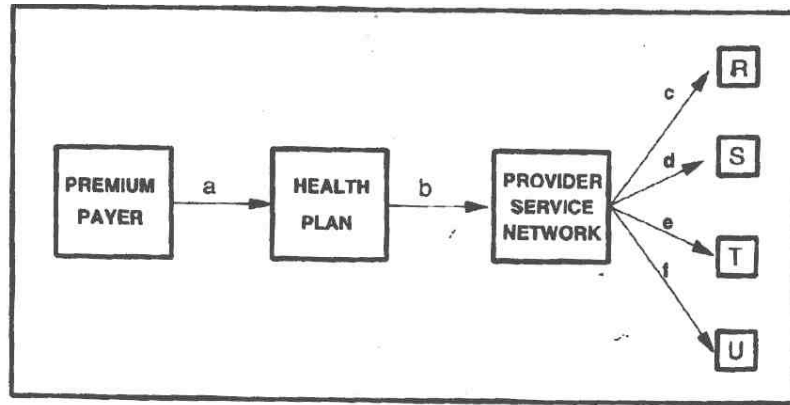


Figure 2. Financial arrangements with providers

Table 1 and Figure 2 may explain why there is such a high variance in the number of Americans reported to be “under managed care” at any point in time. Some analysts prefer to reserve the term “managed care” only for arrangements under which physicians are directly controlled by means of clinical practice guidelines, as the treatment of patients progresses.

Other analysts, however, extend the term to absolutely any insurance plan that relies on selective contracting of some sort—even if that contract achieves only price discounts, but does not involve direct interference in the ongoing medical treatment of patients. Some writers use "fee-for-service" and "managed care" as antonyms (which they are not) and "capitation" and "managed care" as synonyms (which they are not). A similar ambiguity, by the way, surrounds the term "health maintenance organization." As a popular adage has it "if you've seen one HMO, you've seen one HMO."

Finally, some writers confuse "managed care" with "managed competition," although they are quite distinct concepts. "Managed competition" refers strictly to arrangements by which someone—either the government, or the personnel department of a large employer, or a cooperative among employers—supervises and regulates the manner in which rival health-insurance plans compete for customers. It has nothing to do with "managed care." Although many of the competing health plans may, of course, employ managed care techniques, one could imagine "managed competition" strictly among old fashioned, unmanaged, fee-for-service indemnity plans. I shall return to the concept of "managed competition" further on.

Selective contracting as bounty hunting

It is not surprising that the imposition of selective contracting upon a health system that had for decades flourished under the virtually unmanaged, fiscally open-ended, old-fashioned indemnity contract will come as a great shock to those who directly or indirectly earn their livelihood from the provision of patient care. As noted in the introduction of this essay, and at the risk of being irreverent, one may liken the current scene in American health care to the

legendary American Wild West, replete with frustrated and frightened townspeople, an enfeebled sheriff and a rough cadre of private-sector “bounty hunters” ready to take care of the outlaws, for a high bounty, of course.

In this wild-west scenario, the “bounty hunters” are the executives of the managed-care industry. The role of the outlaws is played by the providers of health care, including the manufacturers who supply doctors and hospitals with equipment and drugs. The providers' bold raids on the treasuries of business, government and private households during the 1980s drove these payers to utter despair. Because the town's sheriff (speak: the government) seemed powerless in the face of these raiders—mainly because the townspeople allowed the sheriff to carry only a small-caliber gun, and, furthermore, put strict limitations on the use of that gun—the increasingly desperate payers ultimately sought help from entrepreneurial “bounty hunters”—the executives of the burgeoning HMO industry. The payers give the “bounty hunters” a flat annual payment per “insured life,” along with the license to go after the “economic outlaws” in any which way they can, as long as the raids on the payers' treasuries cease and the insured remain satisfied with the health care received through this process.

The “bounty” itself consist of the high prices traditionally extracted by the providers of health care in the United States from the hitherto hapless payers. It also includes the alleged excess utilization of health care in the United States which, of course, has represented income to the providers as well. The United States currently spends about \$1,000 more per capita on health care than could be explained simply by its higher per-capita income.²⁴ Even if only one half of that excess represented economic rents, the cost of carrying excess capacity in the system and

²⁴ G. J. Schieber, J.P. Pouillier, and L. M. Greenwald, “Health spending, delivery, and outcome in OECD Countries,” *Health Affairs* 12 (1993): 112-19, esp. Exhibit 4, 124.

the cost of excess utilization of health care, the total annual bounty represented by that waste would be about \$125 billion. Harvesting that bounty is an irresistible target for entrepreneurs and has become one of the nation's latest economic frontiers. Indeed, it is not at all surprising that one finds the penetration of HMOs highest in areas such as California, Massachusetts, and Florida, where per-capita health spending under the traditional fee-for-service system has been much above the national average. In those regions, the potential bounty seems the richest and the “bounty hunters” are now the most active. To mix a metaphor egregiously, in those regions health-care bounty hunting is like shooting fish in a barrel, so to speak.

The bounty hunters' armament. Unlike the sheriff (the government) who had to guard the town with a 22-caliber pistol loaded merely with rubber bullets, the “bounty hunters” carry into the “hunt” a powerful, double-barreled shotgun.

One barrel of this shotgun consists of the large pools of “insured lives” that the “bounty hunters” amass through their marketing blitzes or simply purchase on Wall Street, through mergers with other “bounty hunters,” at prices of up to \$1,500 per “insured life.” These prices are the discounted (present) value of the “bounty” that the “bounty hunters” expect to extract from the health system per “insured life” in the near future. Armed with these large pools of “insured lives,” the “bounty hunters” can extract steep price concessions from doctors, hospitals, and health-products manufacturers merely by threatening to divert parts of these pools of “insured lives” from these frightened providers of health care and health products toward more pliant providers. These price concessions are one major part of the “bounty.”

The second barrel of the “bounty hunter's” shotgun consists of the vast computer systems by which they monitor and control the doctors and hospitals within their territory (i.e., within their networks) and with which they seek adherence to rigorous practice guidelines. Application

of these guidelines yields the second source of the “bounty”: vastly reduced utilization of health services, especially inpatient care and the services of medical specialists. Individual practitioners whose statistical practice profiles deviate significantly and consistently from these practice guidelines are driven, with swift and rough frontier justice, from the “bounty hunters” territory. They are simply dropped from the roster of physicians employed by or under contract with the integrated health plans operated by the “bounty hunters.” As will be shown further on in this essay, a growing number of medical specialists may find themselves in this fix during the coming decade.

To be sure, along with the handsome “bounty” earned by the “hunters,” their massive advertising campaigns and their micro-management of health care do eat up sizeable chunks of the capitation premiums they collect from business and government. The typical “medical loss ratio” (the percentage of the premium “lost” to the purchase of medical care) of investor-owned HMOs now tends to range between 70 and 80 percent. But these high retention ratios are not a new burden on premium payers; they are carved out of the incomes of the providers of health care.

The premiums paid by business and government, which rose at double-digit rates in the 1980s, have now been stabilized, and many are reported to be decreasing. Overall, national health spending in the United States rose from 13.3 percent of the GNP in 1992 to “only” 13.7 percent in 1994.²⁵ As noted in the introduction to this essay, that is still much higher than spending by other industrialized nations (10 percent of the GNP or less). But the current spending level *is* below the ratio of 15 percent of GNP that had been predicted for 1994 only in

²⁵ Levil, Lazenby, and Sivarjan, “Health spending in 1994: slowest in decades.”

1993.²⁶ While that achievement will not impress Europeans, within the American context it is a victory of sorts.

Even so, the techniques of the managed care industry remain controversial even among the insured, primarily because of a perception—widely fanned in the media—that the managed care industry rations health care too recklessly.

The clinical practice guidelines currently used by the managed care industry typically are not the product of a consensus within the medical profession. Often they are produced by for profit entities and unilaterally imposed on patients and their physicians. Under the headline “Helping Health Insurers Say No,” for example, *The New York Times* recently described the medical practice guidelines developed by the private, Seattle-based consulting firm Milliman and Robertson, Inc.²⁷ Apparently, that firm's guidelines are now the most widely used guidelines in the private insurance industry. They prescribe a stay of not more than one day for a normal delivery and of not more than two days for a delivery by Caesarean section. They do not allow hospitalization for a mastectomy, and so on. These guidelines also prescribe under what conditions a patient may or may not have a cataract or tonsil removed or have a coronary bypass graft.

Evidently, these norms are very strict and are likely to deviate substantially from the treatment regimens individual practitioners will deem appropriate. Furthermore, they appear to be based in part on faulty economic reasoning, that is, on a confusion of the total cost of a hospital day with its incremental cost. There is the distinct possibility that, with their

²⁶ Congressional Budget Office, *Trends in health spending: An update* (Washington, D. C.: U. S. Government Printing Office, June 1993); 51, Table A-3.

²⁷ A. R. Myerson, “Helping health insurers say no,” *The New York Times*, March 20, 1995.

extraordinary emphasis on reducing the average length of hospital stays the guidelines actually lead the health sector to substitute, at the margin, relatively more expensive home- and nursing-home care for relatively cheaper hospital days.²⁸ Finally, these guidelines are extraordinarily intrusive—so intrusive, in fact, that New Jersey's staunchly Republican legislature and Republican Governor recently felt compelled to pass legislation that overrides these private-sector guidelines, at least for normal deliveries and Caesarean sections.²⁹ Many other states now follow New Jersey's example.

One cannot overlook a remarkable irony in these developments. Although Americans tend to think of Canada's and Europe's health systems as excessively controlled by government, in fact individual physicians in these countries feel far fewer direct intrusions into ongoing medical treatments than are suffered daily by their American counterparts. Canadian and European physicians would view the external micro-managing of health care American style as insufferable, although they admittedly do lack access to quite the abundant technology and other resources available to health professionals in the United States. The point is that the external controls imposed on Canadian and European practitioners by these capacity constraints, and by the statistical practice profiles, are much more indirect and impersonal than are American managed-care techniques. From the viewpoint of the individual practitioner, these indirect

²⁸ In this connection, see U. E. Reinhardt, "Spending more through cost control: our obsessive quest to gut the hospital," *Health Affairs* 15 (1996): 145-54.

²⁹ I. Nordheimer, "New mothers gain 2nd day in hospital: Whitman signs a bill to fight curbs on care," *The New York Times*, June 29, 1995, B1.

strictures seem to rankle less.³⁰ And because the controls used by private American health-care regulators so rankle both patients and physicians, government is openly invited by these two constituents to re-enter the health sector from which, apparently, the public had wished to see government banned only a year or so ago.

The preceding remarks should not be interpreted as a broadside against managed care in general, which may well turn out to be a highly constructive force in health care. After all, a highly positive byproduct of the current bounty hunting in American health care is the search it has triggered for best treatment practices.³¹ While managed care and the guidelines it uses will inevitably create friction and errors along the way, in the longer run these new management tools are likely to enhance the overall clinical quality of American health care and also control better its cost. They are also likely to reduce the inexplicably large variation in medical practice patterns across the United States.³²

The Plight of the Hunted. It is only natural that to the “hunted”—the doctors, the hospitals and their staff, the other providers of health care, along with the manufacturers who supply these providers with health-care products—the emerging market in health care appears as

³⁰ R. J. Blendon et al., “Physicians' perspectives on caring for patients in the United States, Canada and West Germany,” *The New England Journal of Medicine* 328 (1993): 1011-22.

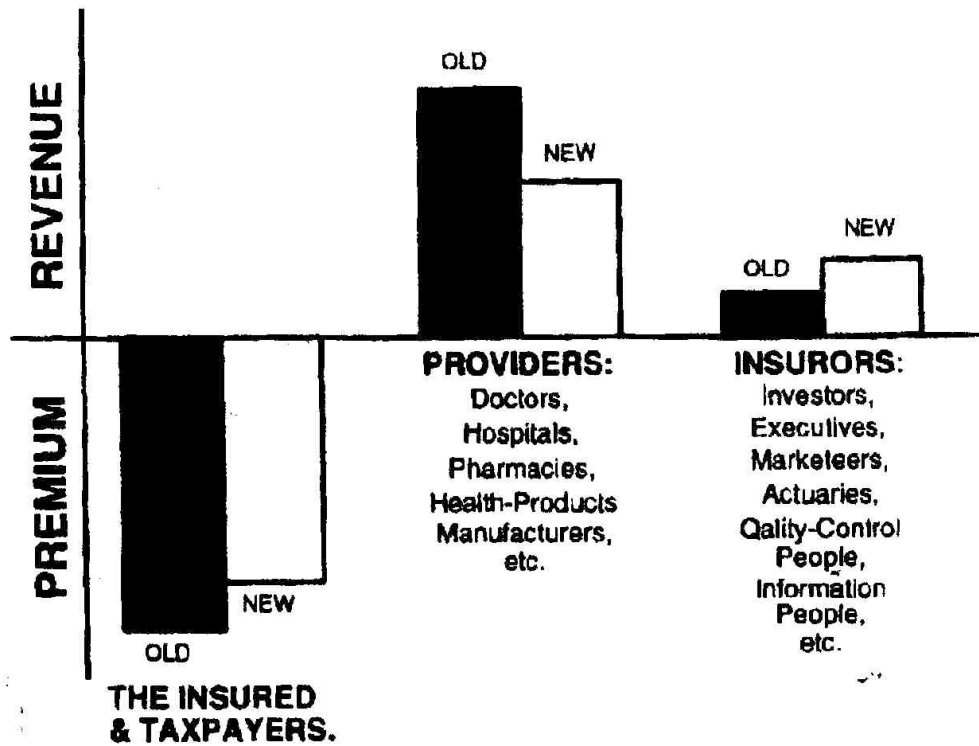
³¹ D. M. Eddy, “Practice policies—what are they?,” *The Journal of the American Medical Association* 263 (1990): 877-78, 880.

³² For an excellent summary of many of the studies yielding this finding, see R. H. Brook, and M. E. Vaiana, “Appropriateness of care,” (Washington, D. C.: The National Health Policy Forum, George Washington University, June, 1989).

the famous O.K. Corral of the Wild West's City of Tombstone (Arizona). These frightened providers may not quite understand why they deserve to find themselves in this awful corner.

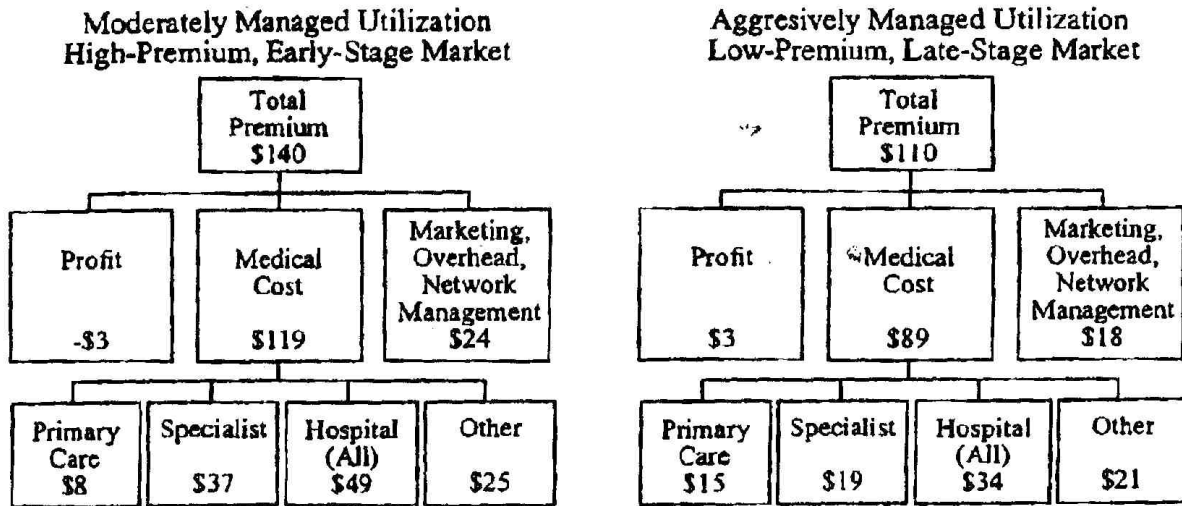
One can sympathize with them on that score. On the other hand, it should have been known to them that, sooner or later, society would seek to arrest the seemingly uncontrolled growth of national health spending and, if government would not be allowed to do so with its slow and deliberate methods, then society would engage private-sector regulators whose hands are much less tied and who need not take prisoners, so to speak.

Figure 3 illustrates in the abstract the redistribution of income likely to follow from this particular approach to cost control. Figure 4, based on research by the Chicago-based University Hospital Consortium, illustrates the economic effects of tightly applied, capitated managed-care concretely. First, the approach reduces health-insurance premiums below levels that would have been charged under the traditional fee-for-service system. A relatively larger portion of these now lower premiums, however, will be absorbed by the health plans to cover marketing, administration and profits. This leaves a substantially reduced flow of funds for those who actually care directly for patients or who manufacture the supplies and equipment used in the care of patients. It is the deal the providers of health care bargained for during the health-reform debate, or at least the deal they now must accept.



OLD means "old fashioned indemnity" and NEW means "selective contracting."

Figure 3. The redistribution of money under selective contracting



Source: HCIA database; Milliman & Robertson's UHC Actuarial Cost Model.
 Note: Premium are per member per month.

SOURCE: University Hospital Consortium, 1995.

Figure 4. Distribution of the premium under managed care

The fully intended slowdown in the growth of the health-care workforce, or its outright reduction, is likely to affect all types of *traditional* health professionals. For example, it is expected that the growing use of practice guidelines by the managers of the health plans will reduce quite substantially the number of staffed hospital beds needed per capita. Consequently, the number of hospital-based nurses and other support staff will be sharply reduced in the years ahead as well.

Sizeable staff reductions in the American pharmaceutical industry have already been underway for some time, as these manufacturers merge and downsize in response to the private formularies implemented by the health plans and the huge price discounts these plans are able to

extract from these manufacturers. The manufacturers of medical equipment experience similar pressures which they can evade only by more vigorous export activity.

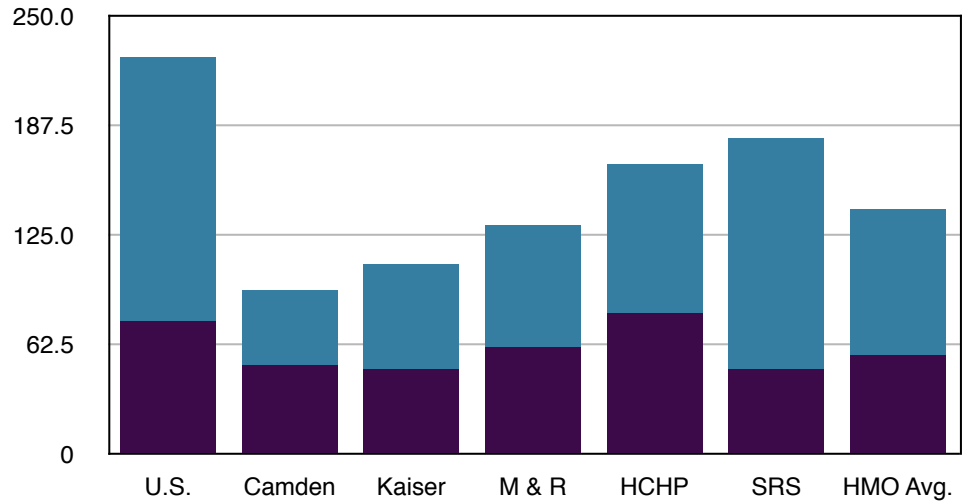
But the most severe impact of capitated managed care is likely to fall on physicians in direct patient care, especially on the nation's huge army of medical specialists. Empirical research suggests that, on average, well managed staff- or group-model HMOs can serve about 700 to 800 patients per physician, with a mix of physicians more heavily weighted towards primary care than is the existing supply of physicians. That number implies a physician-to-population ratio of about 125 to 140 physicians per 100,000 population. By contrast, the current overall ratio in the United States is about 180 physicians active in direct patient care per 100,000 population, if one excludes residents, fellows and physicians engaged primarily in teaching, research and administration.³³ Figure 5 illustrates this differential in physician requirements with data on several HMOs.

³³ The excluded physicians total about 56 physicians per 100,000 population. In this connection, see K. Rentraecster and D. Kindig, "Physician supply by specialty in managed care organizations," Testimony given before the Physician Payment Review Commission, December 9, 1993.

Number Physicians per 100,000 Population

Primary Care MDs in black

Specialist MDs in gray



Sources: Camden Group Actuaries, Kaiser, Milliman & Robertson Actuaries, Harvard
Community Health Plan, Sharp Rees-Stealy, University Hospital Consortium, 1994

SOURCE: David Burnett, M.D., University Hospital Consortium, 1996

Figure 5. Physician requirements under managed care

What impact managed care will have on the overall workforce situation in the United States depends, of course, on the degree to which tightly managed care has penetrated the American health system at any point in time. If one lets T denote the overall number of active physicians per 100,000 population available to the health system (currently about 180), H the average number of physicians required per 100,000 enrollees in tightly managed, capitated health plans (say, about 133, which corresponds to about 750 patients per physician), and x the fraction of the American population enrolled in such plans, then the number of patients left over per physician in the fee-for-service sector (P) can be calculated as follows:

$$P = \frac{100,000 (1 - x)}{T - xH}$$

If about half of the American population were enrolled in well-managed, capitated health plans ($x = 0.5$) that could handle about 750 enrollees per physician ($H = 133$), and if the overall physician-population ratio in the nation were $T = 180$ physicians per 100,000 population, then physicians remaining in the fee-for-service sector would have to earn their living from only about 440 patients at risk. At a U.S. average of 2.62 persons per household, this represents about 165 or so households per physician.³⁴ To earn their current average annual gross income of about \$350,000, fee-for-service physicians would have to extract from each such household about \$2,100 per year, just to maintain their customary net income level, which equals roughly 55 percent of gross income. That \$2,100 per household payable to the fee-for-service physicians under this scenario would have to come on top of the household's spending for all other health services. To put the number in perspective, traditionally total spending on physicians' services

³⁴ *United States Statistical Abstract 1990* (Table 55).

(i.e., on total physicians' gross income) has been only about 20% of total national health spending.

The fee-for-service sector would be severely stressed under that scenario; it might even collapse altogether. The economic pressure triggered by this development would be all the more acute for medical specialists who would be driven into the fee-for-service sector in relatively larger numbers, because lightly managed, integrated health plans tend to use a mix of physicians that is richer in primary care physicians and leaner in specialists than is the overall mix of physicians in the United States. The traditionally higher incomes of medical specialists, and the relatively higher rates of return to their own investment in education and training, would be unlikely to persist. The entry of specialists into the managed-care sector would be controlled by the integrated health plans, confronting physicians with the same harsh market constraint faced by other professionals (e.g., architects or college professors) who are employed rather than self-employed. The need to compete with the premiums quoted by the integrated health plans would also put a limit on the volume of services self-employed, fee-for-service physicians could bill. In the end, their incomes would be likely to move closer to those of primary care physicians, whose incomes can be expected to rise under managed competition, even if not to full equality.

In a recent paper on the future health workforce requirements under health reform, Jonathan P. Weiner has estimated that, if between 40 to 65 percent of all Americans were to receive their care from integrated, managed care plans and all Americans had health insurance, then by the year 2000 there would emerge an overall surplus of 165,000 patient-care physicians. Under the scenario modeled by the author, the demand for and supply of generalists would be

more or less in balance; but the supply of specialists would exceed demand by some 60 percent.³⁵

To be sure, organized medicine is trying hard at this time to take at least some of the wind out of the sails of managed competition. It does so by seeking from federal and state legislatures “any willing provider” laws, mandatory “point-of-service” options to be offered by health plans, and antitrust relief that will effectively allow physicians to unionize.

The “any willing provider” laws would force every private health plan in a market area to work with any physician willing to accept that plan's fees or capitation payment and to abide by that plan's rules. It is analogous to granting every American professor the right to teach at any university whose salary and rules the professor is willing to accept.

A mandatory “point of service” option would force each health plan to grant its enrollees the right to procure health care from doctors and facilities outside the plan's own network. Although there would be some (regulated) financial penalty to the patient, the health plan would have to pay for a substantial portion of the fees charged by outside physicians or facilities. It is analogous to granting every college student the right to take courses at any other institution and to have the university at which he or she is formally enrolled pick up a major portion of the tuition charged by these other institutions.

Finally, granting doctors the right to bargaining *collectively* over fees, capitation payments and other “rules of engagement” with the competing health plans in a market area would effectively rob the plans from acting as prudent buyers in the market for physician

³⁵ J. P. Weiner, “Forecasting the effects of health reform on U.S. physician requirements: Evidence from HMO staffing patterns,” *Journal of the American Medical Association* 272 (1994): 222-30.

services. It would convert the supply side of that market—the supply of physicians—into a traditional labour monopoly, which is the technically more correct word for “labour union.” Eventually, the strategy would convert the market for physician services into a bilateral monopoly. That market structure inevitably invites strict government regulation.

Evidently, these three forms of legislative relief now being sought by many state medical societies (and, in milder forms, by organized medicine at the national level) are designed to pump up artificially society's demand for physicians, beyond the numbers that would be needed under unfettered managed competition. The clear intent of these measures is to prevent the integrated health plans from attaining the lean staffing patterns assumed in Weiner's analysis and from extracting favorable fees from physicians.

While one cannot blame a profession for seeking thus to protect its economic fortunes—that is only human—it can be doubted that those who pay for health care, and the “bounty hunters” whom they have engaged, will easily accept the imposition of such legislative strictures on their joint quest for better cost control. In any event, it is unlikely that such strictures would eliminate completely the impending surplus of physicians—certainly not for specialists.

A more responsible public policy would begin by bringing the prospect of a growing physician surplus forcefully to the attention of every student entering college. Remarkably, the U. S. Department of Health and Human Services has not, so far, taken that responsible step. It has preferred, instead, to pursue heavy-handed regulatory strategies that would limit the overall number of medical students allowed to enter residency training and, furthermore, to regulate strictly the number of students allowed to train in particular medical specialties.³⁶

³⁶ For a more thorough critique of current, federal “health workforce” policy, see the author's “Planning the nation's health workforce: Let the market in,” *Inquiry* 32 (Fall 1994): 250-63.

A more promising route for the medical profession's comeback—certainly for regaining the profession's control of clinical practice—is actually being prepared for physicians by their current nemesis, the bounty hunters themselves. In some parts of the country, notably in Southern California, health plans that call themselves HMDs collect capitation premiums from an employer (e.g., \$140 per insured individual member per month, or PMPM in short) in return for the promise to provide the covered employees with all required, comprehensive health care in the coming year, usually including prescription drugs and mental health care. To avoid the substantial financial risk inherent in that contract with the employer, these so-called HMOs then transfer that risk fully to a large, multi-specialty medical group practice, which obligates itself to deliver or pay for all of the health care required by the insured (including services not produced by the group itself against a fixed capitation payment (say, \$100 per member per month). The so-called HMO then pockets the difference (\$40 per insured per month in our example)), acting in effect as a mere broker of risk, rather than as a risk taker.

It is reasonable to predict that, once the capitated, risk-bearing medical groups have mastered the task of risk management, they will try to supplant the insurance broker and contract directly for the premium with employers and with the government, pocketing in the process the sizeable broker's fee now earned by the insurance carriers. For that reason, many savvy health plans organized by insurance companies actually prefer not to pay providers by capitation, but instead to compensate them by steeply discounted fees per service, using the *divide-et-impera* principle that has served them so well. It is a fierce battle between physicians and insurers that has only just begun.³⁷

³⁷ See U. E. Reinhardt, "Will physicians take back medicine?," *Physician Executive*, August, 1996 (forthcoming).

The plight of innocent bystanders. Some innocent bystanders will be hit in the emerging shoot-out at health care's O.K. Corral: the millions of low-income families without health insurance. Their number appears to be growing at this time, especially among full-time workers in low-wage occupations.³⁸

Throughout this century, American politicians have evaded their responsibility regarding this problems simply by letting well-intentioned doctors and hospitals function as insurance carriers of last resort who then used price discrimination to cover their total costs. In the coming decade, as fierce and open price competition will limit the providers' ability to price-discriminate and as their overall profit margins will melt away, hospital boards all over the country will discover that in a Wild-West health care system nice guys tend to finish last. These boards are apt to impose tight budgets on the charity care their hospitals will offer the uninsured. Physicians and their families will come to the same conclusion and act likewise. Consequently, life for uninsured, low-income Americans is likely to become more difficult in the years ahead than it already has been in the past.

Ironically, that alarming development may yet be for the good in the longer run, harsh as they may be for some hapless Americans in the short run. Through the emerging shoot-out at the O.K. Corral, the “bounty hunters” are flushing the chronic social problem of the uninsured into the open where it can no longer be ignored by politicians. In the process, the “bounty hunters” may yet force American politicians to confront this lingering problem more forthrightly than they have in the past.

³⁸ P. Fronstin, “The decline in health insurance and labor market trends,” *Statistical Bulletin* 77 (1996): 28-36.

And what of “Managed Competition”?

As noted earlier, many Americans confuse the term “managed care,” which refers to the procurement of health services by health plans, with “managed competition,” which refers to the procurement of health insurance policies from competing health insurance plans. That confusion is regularly visited also on foreign observers traveling to the United States who import it to their home countries.

The central idea of managed competition is to force rival health plans to compete honestly and fairly for enrollees in the health insurance market. Fundamental to that process is accurate information that a properly informed consumer ought to have on each competing plan. These information requirements are vast. A family willing or forced to accept all medically necessary health care in the coming year from the select professionals and facilities associated with one particular health-care network faces a choice every bit as serious as choosing a particular mutual fund for the family's savings. Indeed, it is a more serious choice, not only because one literally invests one's own health into the chosen health-care network, but one also accepts a set of financial incentives that may reward the providers of health care handsomely for minimizing the resources going into the treatment of a given medical condition. By contrast, the managers of a mutual fund prosper chiefly when they have done well financially by their clients as well.

Managed competition presupposes an overarching organization that can manage the requisite flow of information to consumers. In the Jackson Hole proposal, such an organization is

given the generic name “sponsor.”³⁹ The sponsor might be a government agency.⁴¹ It could be the personnel department of a large employer or a cooperative established by a regional coalition of private employers.⁴⁰ Under President Clinton's health-reform plan, it would have been a state-wide health insurance purchasing cooperative (HIPC) established by state government and bound by a strict federal statute). This HIPC could even have been the health department of state governments (for the Medicaid program) or the Federal Department of Health and Human Services (were the Medicare program converted to managed competition among private health-insurance plans).

First and foremost among the information to be structured by the sponsor is, of course, the set of premiums charged by the various competitors for a common, standard package of health benefits. A well functioning system of managed competition would do away with the plethora of incomparable insurance products now facing American consumers—a system of carefully orchestrated chaos. But the sponsor would presumably also convey to consumers audited and properly structured information on the satisfaction of consumers already enrolled in the competing plans and on the reasons why consumers have left particular plans. Particularly illuminating would be satisfaction ratings by chronically ill enrollees in the various plans, because it is on those scores that noticeable differences among the plans would be likely to emerge. Ideally, the sponsor should retrieve this information from consumers directly, and not be content to accept on faith data gathered and submitted by the competing plans.

³⁹ Ellwood, Enthoven, and Etheridge, “The Jackson Hole initiative for a twenty first century American health system.”

⁴⁰ H. M. Somers and A. R. Somers, “Major issues in national health insurance,” *The Mitbank Memorial Fund Quarterly* April 1972: 177.

Ultimately, the sponsor would also assemble data on the clinical quality of the health care rendered by each of the plans on the sponsor's list. Such clinical-outcomes data might be used by the clinical experts who decide whether or not to feature a particular plan on the list of plans to be presented to prospective enrollees. Some of the information on clinical outcomes might even be passed on to consumers in a suitable form, although one must wonder whether the typical consumer will be able to interpret this highly technical information fairly.

A rudimentary example of such a sponsor is the not-for-profit Health Insurance Plan of California, a name probably chosen carefully because the corresponding acronym happens to be HIPC. The HIPC was established in 1993 by the State of California to serve the employees of that state's small business community. At this time it has over 100,000 enrollees. The HIPC publishes each year an attractive brochure for employees that features, for each of six market areas jointly covering all of California, the premiums charged by a set of HMDs and Preferred Provider Networks (PPOs) for two distinct, common benefit packages: a so-called "standard" package and a "preferred" package, the latter having lower co-payments and deductibles. The premiums quoted by the plans are listed separately for four categories of households (distinguished from one another by family size) and for seven distinct age groups. It is a very orderly and strictly supervised form of marketing health insurance. Since its establishment in 1993, the competition unleashed by this HIPC appears to have reduced the premiums quoted by the competing health plans year after year.⁴¹ Unfortunately, this HIPC has not so far ventured into the dissemination of information on consumer satisfaction or on the clinical quality of the care dispensed by the competing health plans.

⁴¹ A. Enthoven and R. Kronick, "A consumer-choice health plan for the 1990s," *The New England Journal of Medicine* 320 (1989): 29-37, 94-101.

Europeans traveling to the United States or listening to presentations by American enthusiasts for managed competition at European conferences often are left with the impression that managed competition is already in full bloom in the United States. In fact, it is not. Although a few large companies with sophisticated personnel departments—for example, the Xerox Corporation and General Electric—have made strides in furnishing their employees with information on the quality of the health plans on their menu, those cases are still rare. For the most part, American households are merely presented with large sheets of paper whose columns list competing health plans and whose rows detail covered benefits in a bewildering array. For each plan, there is the quoted premium; but there is no information on patient satisfaction, on the clinical quality of the care rendered by the plans or even on the background of the physicians in the plan. For the average American, managed competition in health care, like Communism and Christianity, remains mainly a theory.

In the future, however, this structured information may well become more readily available to consumers, in a great variety of forms. It may yet be made available by personnel departments in the material they distribute to their employees. It may appear on CD-ROMs and on on-line services that can be tapped into by personal computers. This so-called information highway will make it easy for consumers who are able to cope with it to gain the most detailed insight into a health plan of interest. For example, the system will enable consumers to find out how many operations of a particular kind Dr X has already performed, and how successfully, and where Dr X has gone to medical school or has been a resident.

Ironically, a major catalyst in moving the American health system toward more properly functioning managed competition may turn out to be the much maligned federal government. If the control of cost and quality of care under the federal Medicare program for the elderly is to be

turned over to private health plans, the elderly will no doubt insist on having available adequate and clearly structured information on the private regulators into whose hands they are to place their fate. To that end, the government will have to create an organization very much like the health-insurance purchasing cooperatives (HIPCs) envisaged in the Clinton plan. Once these HIPCs are functioning properly, they may well serve as a model for the private sector, as Medicare has in the past. At the risk of being politically incorrect, it may be noted that government has always been an innovator in American health care. The Diagnostic Related Group (DRGs) by which hospitals are paid were developed by government, as is the fee schedule by which the program pays physicians, a schedule now widely copied by the private sector.

Lessons for Other Nations

While Americans generally have been reluctant to seek useful insights from the health systems of other nations,⁴² Europeans regularly scout the United States health system for potentially useful clinical techniques or novel methods of health-care delivery.

There is, indeed, much to learn from the American health system, because it is probably the most innovative system anywhere in the world. Ironically, the key to that innovative bent is the absence of the principle of social solidarity that constrains health policy in other nations. Unfettered by the social ethic of solidarity, Americans can experiment in health-care delivery without much care for the often harsh side effects such experimentation may visit upon some American families, usually the poor. A case in point is the rapid and enthusiastic embrace of raw

⁴² See the Health Insurance Plan of California, *The HIPC Employee Brochure and Application*, 1993 and 1995.

price-competition as a regulator and resource allocator in health care in the United States, without first providing an orderly infrastructure for such competition along with a safety net for families likely to be trampled in such a system. One may think of the United States health system as the analogue of a laboratory in which experimentation is not much hampered by rules of safety. Much can go wrong in such a laboratory, and much will go wrong. At the same time, much can also be discovered there that could not be so easily discovered in more safety-conscious settings.

What, then, might Europeans and Canadians find instructive in the recent American experience?

One major insight might be that, while the concept of “managed competition” among private insurance carriers does not necessarily imply rationing of health care by income class, it nevertheless is a natural platform for an income-based health system. It was precisely the attempt to prevent rationing by income class that required so many pages of new regulations in the Clinton health plan. The further one is willing to depart from the principle of solidarity, the easier it will be to implement a health system based on unfettered competition among private insurance carriers. This is particularly so if a society is willing to tolerate “actuarially fair” health insurance premiums, that is, premiums tailored to the individual family's health status.

Americans are quite ambivalent on the issue of actuarially fair insurance premiums. Although some states in the United States have outlawed the practice of charging “actuarially fair” premiums, in the bulk of them that practice is perfectly legal. “Community-rated” premiums, averaged over the population of an entire state, are vehemently and successfully fought in those states with the argument that this practice forces healthy families to subsidize sick families through their insurance premiums. At the same time, however, premiums charged a

private employer are usually averaged over the employer's total workforce. Within the corporation, Americans do practice solidarity. Furthermore, no one has yet proposed to base the insurance premiums of the elderly on their health status.

Before even contemplating a move towards “managed competition,” Canadians and Europeans probably would explore policies needed to preserve as much as possible the principle of solidarity that has driven their health policies for so long. In the process, they will discover that solidarity cannot be preserved without some overarching body—such as a state-chartered health insurance purchasing cooperative (HIPC)—that regulates quite strictly the manner in which private insurance plans compete for enrollees. An essential tool for the operation of such a system will be risk-adjustment techniques that can compensate insurance plans stuck with relatively sick enrollees with funds diverted from health plans that end up with a relatively healthy clientele. At the moment, satisfactory risk-adjusters for this purpose do not exist; but there is much research on their development, in the United States and elsewhere.

A highly positive facet of managed competition, if it is based on competition among health plans that contract selectively with providers of care, is that society can hold these plans systematically accountable for the quality of the care they deliver to the insured. In the traditional fee-for-service systems of the United States, of Canada and of many European countries, not much progress has been made to hold individual physicians, hospitals and pharmacists systematically accountable for the clinical quality of their work, nor is there available systematic information on patients' satisfaction with these providers. It can fairly be said that, at this time, the United States is leading the world in seeking to develop the sophisticated information infrastructure needed to force that accountability upon the providers of

health care.⁴³ Much can be learned and harvested in that regard from observing this development within the American health system.

Are there useful lessons in the American approach to “managed care” as distinct from “managed competition”? That concept, it will be recalled, generally is thought to include both the bargaining over prices paid by health plans to the providers of health care and the external micro managing of the treatments rendered patients.

It can be doubted that the American health system can teach Europeans much about controlling the growth of health spending. Indeed, it is doubtful that the private health plans in the United States will be able to force upon physicians and hospitals prices lower than those already forced on providers in Canada and in the European nations. Even if the private bounty hunters in the United States could push even harder bargains than they do today, some thought should be given to the administrative chaos inherent in a system in which one hospital or physician may be forced to negotiate contracts with dozens of rival health plans, each with its own rules and prices and hidden financial incentives for physicians to minimize treatment costs.

Americans in general show a remarkable tolerance for paper shuffling and computer-spinning in health care. Indeed, if one measures “bureaucracy” by the amount of paper health-care transactions move in some private or public regulator's office, then it can fairly be said that

⁴³See, for example, D. Berwick, “The globalization of health care,” *Quality Connection* 5 (1996): 1-2. *Quality Connection* is a newsletter published by the Institute for Health Care Improvement in Boston, MA. In this editorial, Berwick deplores the penchant among Americans to brush aside as irrelevant to the American experience the performance of health-care facilities abroad that appear to be able to deliver health care of a high quality at costs much below those of comparable American facilities.

the American health system is by far the most bureaucratic and cumbersome health system in the world. For the sake of both their patients and providers, Canadians and Europeans should think hard before abandoning their much simpler pricing schemes for health care and before importing America's bewildering, costly computer-driven health-care bureaucracy.

More instructive than pricing policies, however, is the utilization review and quality control built into “managed care” American style. Ultimately, the objective of that endeavor will be to detect and continuously update best clinical practices within the context of what is called “disease management.” Properly practiced, disease management seeks to control not only the cost and quality of particular components of a medical intervention, but the overall cost and quality of the entire intervention taken as a whole. That larger purview, for example, will include among the cost of a treatment the absentee rate from work associated with different types of treatments.⁴⁴ At the moment, disease management is still in its infancy in the United States. It is an area, however, in which the American health system is likely to make major contributions.

Is managed competition among private insurance carriers a necessary condition for the practice of managed care within health plans? Managed competition among competing private health plans is a useful framework for managed care, but it is not an essential one. There is no reason, for example, why a provincial government in Canada could not regroup the province's health care delivery system into fully integrated provider networks that compete for enrollees against a capitation paid them by the provincial government. A similar system may very well develop in the United States for the Medicare program, In Germany, on the other hand, managed

⁴⁴ See, for example, the National Committee on Quality Assurance, *HEDIS 3.0--The Health Plan Employer Data & Information Set*, Exposure Draft developed under the Auspices of the Committee on Performance Management, Washington, D. C., July 1995.

competition probably would work through the already existing, semi-private sickness funds who, presumably, could contract selectively with networks of providers.

Finally, it is conceivable that, in the longer run, governments will tire of wrestling with the doctors and hospitals over fees and regulations. Governments everywhere may prefer simply to raise the funds needed to preserve social equity and to turn over these nasty tasks of cost and quality control to private regulators who stand ready to accomplish those tasks, for handsome fees, to be sure. Against that prospect, policy makers and policy analysts in other nations will continue to find the United States a fascinating, bewildering but ultimately instructive laboratory. It is hoped that this essay will have provided a fleeting but useful glimpse at that hectic setting.