Good and Bad Models of Market Reform for Managed Care

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The demise of President Clinton's health care reform proposal raises an obvious question: How will the nation pursue the dual goals of increased efficiency and fairness in the health care system? There is general agreement that the health care industry is not producing good value for the money. This chapter discusses the effect of alternative reform policies on managed care, especially aspects that are underemphasized or absent in the public debate. The following points guide the discussion:

- The key to national health goals is cost control, and a little is not enough.
- The key to cost control is increased productivity, not trimming of fat.
- The key to increased productivity is market reform, not controls.
- The key to national market reform is local market reform.
- The key to local market reform is consumer information and incentives, not restriction on plans and providers
- The key to consumer information is outcomes assessment.

The main caveat for managed care* providers and executives is that reform will determine their future—

* *Managed care* is an arrangement in which providers accept independent supervision to ensure that quality and cost goals are met. A *managed care organization* has such arrangements. A *comprehensive care organization* has all providers necessary for patient care. An insurance plan that covers only managed care arrangements is a *managed care plan*. A *purchaser* is any party, private or public, who buys or finances health care for beneficiaries: private or public employers, labor trusts, trade associations, Medicare, and Medicaid. Insurers and claims administrators are not purchasers because they do not finance care; they are third parties who receive funds from purchasers to pay providers.

as well as whether they have one. Managed care organizations are not the inevitable development of a modern health care system. Their organization and practices—indeed, their very existence—depend on the larger structure of the health care system—a structure that policy will change. Managed care has fared poorly in countries with unconducive system structures. If public policy makes the wrong choices in the United States, managed care organizations will face the same eminent failures as in Canada and Europe.

Public policy can have prejudicial and adverse effects on managed care in two major ways: (1) by using economic controls, whether in a pure single-payer model or in other models of market reform, and (2) by choosing the wrong model for market reform. If the restrictions are too severe, managed care may not be able to maintain quality and contain cost. If it fails at either or is merely too slow, public impatience surely will lead to even more stringent restrictions and controls that further threaten its effectiveness and viability.

To ensure its future, managed care cannot simply survive or prosper; it must serve the public interest well in terms of access, quality, and cost. Private purchasers and government are far from finished with intervening in health care, and only promising performance can ensure sympathetic intervention in the future. Busy providers and managers must schedule time from the pressures and risks of pioneering managed care arrangements to influence purchaser and government policy. They must know which models of market reform are conducive to their own good performance and prosperity—the topic of this chapter.

Managed care is not beneficial per se; its benefits depend on the structure and incentives of the larger health care system. If incentives are sound, managed care will perform well. Indeed, with proper incentives no arrangement of providers offers greater prospects for high-quality care at low cost. But if incentives are perverse, managed care, like all other provider arrangements, must perform perversely in order to survive, despite the good intentions of providers and managers. For example, in the present unsound market a major effect of managed care has been to transfer revenues and control from providers to managed care entrepreneurs with little assurance of greater quality or economy for consumers and purchasers. Beneficial performance counts little in the present system.

Ideally, public policy should aim market reform solely at the structure and incentives of the marketplace itself (see below), not at the producers. It should place no restrictions on the entry, exit, size, form, or practices of provider organizations in the market other than the minimum to ensure public safety. Then providers and managed care organizations are free to choose the form and practice that they think will best satisfy the market. If the market structure and incentives are sound, the market will select the optimal arrangements and practice that yield quality and economy far better than policy could prescribe or coerce. This is not only the best approach for policy; it is also the best environment for managed care.

Unfortunately, the three most frequently discussed market reform models—the managed competition model favored by moderates, the insurance reform model favored by conservatives, and the local purchasing agency now pursued by purchasers—fall short of satisfying these criteria. They either fail to reform the current unsound market adequately or place such serious restrictions on competitors that their performance is doubtful. If these competition models fail to control costs or simply prove too slow, government and purchasers will add economic controls or go entirely to single-payer controls—the death knell for managed care. This chapter discusses the shortcomings of controls and of the three most frequently discussed market models and then advances a fourth reform model, called "Buy Right," that may well prove superior for both public interest and managed care. Managed care organizations can help to install this model now in local health care markets; they need not await national policy decisions. The more progress locally, the more likely the model will enter national policy in the future.

THE KEY TO NATIONAL HEALTH CARE GOALS: COST CONTAINMENT

All strategies start with goals. A reasonable set of goals for national health care and insurance reforms is as follows:

- **Universal access.** All Americans should have improved access to health care and coverage.
- **Quality.** Health care and coverage should offer superior outcomes, financial protection, and patient satisfaction, all of which preferably improve steadily over time.
- **Equitable financing.** The cost burden should be shared fairly among consumers, group purchasers, and taxpayers, and each party's share should be affordable, reflecting ability to pay.
- **Cost containment.** Expenditures for national health care and coverage should be at or below their present 14% share of the economy—preferably at a more internationally competitive 9% or 10%.
- **Other priorities.** Health care reforms should not compromise other national priorities, such as economic growth, jobs, and debt reduction.

Few Americans would quarrel with any of these goals if all could be achieved simultaneously. The health care reform debate is over means not ends, especially which ends to sacrifice if no means can achieve all goals together.

The central issue is cost containment. Every other issue hinges on how well cost can be contained: the generosity of who and what are covered, the burden of who pays, and the risk of endangering other national priorities to finance health care reform. For two reasons cost containment is far more difficult than most people grasp. First is how strong it must be. It will not come from merely weeding medical and administrative fat from the system. Second, it should not be done at the expense of other health care goals. Cost is easily contained in adverse ways: restricting eligibility, cutting benefits, pricing people out of care and coverage, or rationing, which limits quality and access. Universal coverage, equitable financing, and superior quality and access are priority goals of national reform. And they are practical objectives for the private sector; good care and coverage are part of holding a competitive workforce. Most firms can go only so far in cutting these goals to control cost; if they go too far, pressure will mount for government to step in and solve the problem at the expense of business.

How much cost containment is enough? Consumers, business, and government already spend far more on health care than they can afford in terms of other equally pressing priorities. Spending for health care is not bad per se; overspending for health care at the expense of other vital human needs is harmful. Given other urgent priorities, the nation simply cannot afford to spend any more of its gross national product (GNP) for health care. Other nations with equal or superior health levels cover all citizens at 10% of a much smaller GNP. Yet 15% of Americans remain uninsured, mainly because of high cost. And with health care at 14% of GNP, every American good and service now goes to market bearing a 4–5% cost burden for redundant health care —funds that would be better spent on improving the product. American competitiveness is the goose that lays the golden eggs for all public and private priorities; health care reform must be affordable to the nation and business as well as consumers. Hence successful permanent cost containment requires:

- **For the nation:** national health care expenditures must at least be held at their present 14% of GNP and preferably reduced to a more competitive 10%.
- **For each purchaser:** the rise in cost per beneficiary must be held at or below general inflation—not just one year but every year.

Anything less means that investment of resources in health care will increase faster than the ability to pay for them; the cost problem remains unsolved. No single purchaser has a cost strategy equal to this goal.

THE KEY TO COST CONTAINMENT: INCREASED PRODUCTIVITY

In fact, there are only two ways to spend less on anything:

- **Budget cutting.** Spend less by cutting value. In health care, cut access, quality, and coverage in various ways to reduce cost.
- **Increased productivity.** Get more for less by strong, constant increases in productivity. In health care, get steadily better health results for less cost.

Clearly the key to cost containment without harm to other goals is the second approach: productivity. With budget cutting, the cost goal can be met only at the expense of access, quality, and coverage. With good productivity, the nation can have it all: high access, high quality, universal coverage, and much lower cost. Yet productivity has yet to enter the health care reform debate in a serious way.

The present bitter gridlock on health care reform occurs precisely because increased productivity has been assumed to be infeasible or overlooked. Without productivity, one must take something out to put something in; the conflict revolves around which goals to short-change to achieve the remainder. Some advocates demand universal coverage and worry about cost later, ignoring the fact that voters have made patently clear their unwillingness to support any new tax-and-spend program. Others demand no new coverage until cost is contained, ignoring both that the public wants universal coverage and that, properly done, reform is the most powerful tool for cost containment. In the middle are those who try to balance cost with other goals: this or that benefit, this or that tax, universal vs. limited coverage, rationing (which cuts access and quality) vs. no rationing, and so on. There is no objective way to decide such questions. With sufficient increase in productivity, they would not arise.

Too many people entertain the notion that removing fat from the present health care system will contain cost without eroding other goals. It will not. To demonstrate this point, one needs only to divide all health care into "fat" and "lean," or services that are overpriced or medically inappropriate and services that are neither. Suppose that 30% of present services are fat, as many experts estimate. Suppose that all this fat were excised—a radical "fat-tectomy" on the health care system, so to speak. The result would be a major saving. The flaw is that trimming fat is a one-time-only strategy. The cost of the fat is rising, but so is the cost of the lean (perhaps not as fast as the fat, but substantially faster than inflation). In just 4 or 5 years the rising cost of the lean would completely negate all savings from the removed fat. Then how will cost be held? As no more fat is left to cut, the only course is to cut the lean—to ration technology, to make patients stand in line, to understaff providers in obsolete facilities, and to cut research. Cost is contained at the expense of other goals.

Fat removal is even less effective in practice than in theory. Removing the fat has a cost, low at first but ever increasing. When the cost of removal offsets savings, further fat removal is uneconomic. Nor does the fat stay out. The same incentives that led to the fat in the first place still operate on providers; the fat must be forever policed against or it will return. Reducing administrative fat has gained vogue lately. Ironically, most of the recent alarming rise in administrative cost appears to be due mainly to purchasers trying to police against fat and providers trying to thwart them. A fat reduction strategy will be lucky to remove half of the fat, and the continued cost to police against its return will eventually more than eat up the one-time savings of removal. Hence "fat" reduction cannot permanently contain cost except by continually cutting value—and improved value is the other vital goal of health care reform.

The following analogy illustrates the difference between fat-cutting and increased productivity. There is only so much to be gained from improving efficiency in an existent car or computer. One does not produce the improved Ford Taurus sedan by removing the fat from the earlier Ford Fairlane. Rather, one reinvents the product, the production process, and then the company to support the change. This reinvention is what the car and computer industries as well as the broadcasting, agriculture, watch-making, and others are doing. A true increase in productivity will demand no less of providers: radical reinvention of their product, their practice, and their organization, not once but regularly, to treat more patients with better results at lower costs.

The potential for increased productivity in health care appears great. If all providers were as productive as the few most efficient and effective, cost would fall almost 30% and quality would rise without inventing anything new. But this is not the end. The best providers have hardly been pushed; indeed, they have achieved good productivity despite strong perverse incentives to the contrary from the health care system. American medicine is highly inventive. Given the right incentives, innovation can steadily raise effectiveness and reduce cost—instead of the reverse, as now—quite as much and as fast as in other productive industries.

Why is steady productivity so strong in many other industries but not in health care? None of these industries require government controls, huge consumer purchasing agencies, or a vast bureaucratic apparatus. The answer is powerful incentives for producers to offer both quality and efficiency, whereas the incentives for providers in the current unsound health care system are just the reverse: they punish providers for productivity and reward them for costliness.

The way to induce productivity is not to coerce providers into efficient practice and organization. They must resist, for the perverse incentives will punish any that respond. The correct strategy is to reverse the perverse incentives, which arise not from providers but from how purchasers and patients buy health care. Thus, purchasing reform—that is, restructuring how purchasers and patients buy health care—can create powerful new incentives for providers, rewarding better care at lower costs. Then, as in other sound industries, providers will restructure themselves for productivity in their own interest, without the need for superfluous government interference, structures, and restrictions.

In short, productivity is the key to cost containment. Any proposal for health care reform or private sector strategy for cost containment must (1) radically restructure providers for strong and steady increases in productivity and (2) radically reform purchasing to create incentives that reward providers for productivity. Otherwise, it will fail to achieve one or more goals of health care reform, if not all.

THE KEY TO INCREASED PRODUCTIVITY: MARKET REFORM

The present health care system suffers from severely declining productivity. Gains in quality and access are far outstripped by rising cost; the gains are also uneven—quality varies greatly, and providers are maldistributed. The primary underlying cause of such serious symptoms is market failure: the current health care and insurance markets violate the conditions required by economic theory for sound competition. This violation creates powerful, perverse incentives that reward providers for high costs and punish them for efficiency. There are but two basic ways to correct market failure:

- **Market reform:** Install in the unsound market the set of structural conditions required by economic theory for sound competition.
- **Economic controls:** Counter unsound market incentives with regulation of price, revenue, budget, utilization, and franchise.

The key decision in health care reform is to choose which strategy will best ensure productivity as well as fairness. This choice requires understanding the difference between sound, unsound, and controlled markets.

Sound vs. Unsound Markets

The terms "sound" and "unsound" market have precise meanings. Adam Smith and his successors did not say, "Get government out, and the market will be well." Rather, they stated that only if a certain set of structural conditions are present will a market be sound; the unseen hand will guide competition to maximize consumer well-being. This can be proved mathematically and is amply confirmed empirically. But with serious violation of one or more conditions, termed market failure, the mathematical proof fails and the market is unsound. The unseen hand will guide competition somewhere else, usually much against consumer interest, as the viciously cost-raising competition in the current unsound health care market so amply attests. The health care market, far from an economic outlaw, is malperforming exactly as economists would predict from its unsound structure. In other words, the beneficence of markets is not a self-evident axiom; it is a theorem depending on prior conditions. The cure for an unsound market is to install the following conditions set out by economic theory:

1. *No price setters:* adequate number and variety of producers and buyers so that all are price-takers; no buyer or seller monopoly or oligopoly.
2. *No collusions:* no overt or covert collaboration by either producers or buyers to affect prices or restrain trade; no seller or buyer cartels.
3. *Freedom of entry and exit:* new producers can easily enter the market , and uncompetitive producers can fail.
4. *Buyer information:* easily available, objective information for buyers to compare competing products and producers on quality and price.
5. *Buyer value incentives:* proper incentives for buyers to weigh price as well as quality in choosing products and producers.
6. *Government oversight:* proper market regulation to ensure maintenance of the preceding and other desired conditions (e.g., antitrust, truth in advertising, product safety, fair distribution of merit goods).

Note that the sixth condition, proper government oversight, arises because the five other conditions do not occur naturally in most markets. In other words, laissez-faire and sound markets are incompatible: *most natural markets are unsound, and most sound markets are artificial.* The required conditions must be deliberately imposed and maintained by public policy. If government does its job well, the market stays sound and serves the public well. If government performs poorly, the market goes astray. Like a football game without rules or referee, it quickly becomes a brawl and the cheaters win. Therefore, the six conditions for sound markets must be installed and maintained.

Currently health care markets violate most if not all of these conditions. Let us explore how amenable they might be to reform. The first three conditions can be met in most local health care markets. In most local markets and overall nationally, there are ample provider competitors, roughly 20% more than a truly efficient, superior system would require. Localities with too few providers would gain from sound competition in glutted areas, which would drive the surplus to areas of shortage. In the least populous areas, which cannot support competitors for most products, let alone health care, social pressure is more important than competition; if armed with good consumer information, it ought to suffice in most cases. Antitrust tools are now available to minimize collusion. And entry should not be a problem if the reform strategy makes ample room for small new provider competitors to get started in any area.

The next two conditions, consumer information and incentives, are the sticking points. They are the most widely and seriously violated conditions in health care. Their absence is the primary cause of malperformance. They are also the most difficult to correct for two reasons: (1) no consumers, purchasers, insurers, or providers can obtain simple, clear information comparing providers in terms of quality and cost, and (2) most insurance plans lack either means or rewards for consumers to choose better providers at lower costs. If these two conditions cannot be sufficiently corrected, market reform is not feasible in health care, and the only recourse is controls.

Failure to distinguish between sound and unsound markets has led to much confusion in the health care debate. Control advocates cry, "Health care competition has failed!" An unsound market fails? Adam Smith knew this 200 years ago. Conservatives cry, "Let the market work!" Let an unsound market continue? Competition in such markets harms consumers, as the cost-raising competition of the current unsound health care market so amply attests. And only sound markets are self-correcting; unsound markets require intervention. Any proposal for universal coverage based on market reform must implement in a practical way each of the conditions required for a sound market. Any proposal for market reform that violates one or more of these conditions has a poor scientific basis; there is no reason to presume that it will work. Policymakers can readily check any market-based proposal for health care reform for inclusion of all conditions and reject or amend proposals that fall short.

Sound vs. Controlled Markets

Which approach is more likely to ensure strong, continued increases in productivity—sound markets or controlled markets? Empirical research is overwhelming: sound competitive markets, if truly sound, are far and away the most powerful device for productivity. (Sound means that each required condition is present.) No other arrangement comes close. True, sound markets in practice are far from ideal; without government vigilance they can become rapidly unsound. But even with flaws they have proved superior to all alternatives in terms of quality, productivity, innovation, and responsiveness to consumers.

In contrast, controls are found to be weak promoters of productivity in every industry and country that has used them. Controlled markets have important uses, but increased productivity is not among them. Because of poor productivity, cost containment in controlled markets can come only from budget-cutting: rationing, waiting lines, postponed modernization of facilities and technology, and other cuts in quality and access. Such conclusions are scientifically sound: the empirical and theoretical evidence is now so conclusive that even the Russians concede it. Thus market reform, if feasible in health care, is decidedly the strategy of choice.

One of the great natural experiments supplies the empirical evidence. After World War II most developing nations shunned "materialistic" capitalism to leapfrog their way to prosperity with controls. Only a handful adopted western-style markets, and most had a natural counterpart that tried controls: West Germany vs. East Germany, West Europe vs. East Europe, South Korea vs. North Korea, Hong Kong or Japan vs. China, the U.S. vs. the U.S.S.R. Ten years after the war, little difference could be discerned, 20 years afterward, the market nations appeared perhaps ahead; and 40 years afterward the market nations were indisputably far ahead, with the difference growing faster every year. Fifty years afterward, the eastern bloc threw in the towel and abandoned controlled markets to attempt sound competition. A host of studies in smaller, more controlled cases yield similar results. The superiority of sound over controlled markets is empirically well established.

Some control advocates argue that health care is different and does not follow ordinary economics. Not so. The economic theory of controlled and sound markets is not specific to product; any product to which controls are applied or for which sound market conditions

can be installed will produce the respective predicted behaviors. One of the promising omens for market reform is how well providers respond to market incentives. U.S. providers are malperforming exactly as economists predict from the unsound health care market. And changes in various local markets have produced exactly the expected change in provider behavior. Providers in controlled markets in other countries also behave exactly as economists predict from that country's controls. Because providers follow market incentives so well in both unsound and controlled markets, there is every reason to expect that they will behave as predicted if the market can be made sound.

Control advocates cite studies showing that controlled foreign health care markets are more efficient than the present U.S. system. This is hardly a surprise. The present U.S. system violates all of the required economic conditions for sound competition, creating powerful perverse incentives that punish providers for efficiency and reward them for costliness. Even controlled markets are better than this. The fallacy of such studies is that they do not compare controlled foreign health care systems against sound competitive systems. If the Soviets compared their controlled markets only with other controlled economies or with their past, they were no doubt better off. Only when they looked to the west could they see the terrible price that they had paid for a flawed system. Similarly, all of the world's health care systems appear markedly inferior to what the few best providers show is possible, The U.S. is the last major nation that can attempt health care market reform. If the U.S. ignores market reform for controls, there will be no market benchmark against which to compare controlled health care. Neither the U.S. nor the world will know how superb health care may have been.

The real caveat to market reform is that no country has attempted a sound health care market. Hence the feasibility that the conditions for sound competition can be adequately installed in health care remains empirically unproved. Nonetheless, the prospects are good. The present unsound health care market is neither natural nor necessary. Promising strategies for reforming the health care market are available (see below). To declare a priori that they will not work is like concluding that the moonshot would not work because it had not been done before. Market reform deserves a serious trial.

If sound markets prove infeasible in health care, there is no recourse but controls. Despite their distinct inferiority to sound markets, controls would be superior to the present unsound U.S. health care system; the empirical evidence is plain. But controls ought to be approached reluctantly. Sound markets are so superior to controlled markets in productivity—the sine qua non for national goals—that every effort should be made first to make them work in health care. Controls should be a back-up strategy, a last resort, if market reform proves infeasible after good effort.

Why Controls Fail to Increase Productivity

The example of the eastern bloc should help to dampen the enthusiasm of the proponents of managed care for controls. The troubling point about control advocates is their continued faith in controls despite the overwhelming objective evidence to the contrary. With the eastern bloc abandoning controls for sound competition, never have the limitations of control been more apparent. Yet advocates do not come to controls reluctantly, they push them eagerly. Their rationale is that providers are doing the wrong thing and government should step in to make them fly right. The notion seems so simple—what could be wrong with it? The answer is that controls are inherently flawed. They exemplify the adage that for every complex problem there is a simple solution that is wrong. Controls have become the "collective farm" of traditional American liberalism.

Some control advocates believe that controls will work if they are better conceived and more strictly enforced. Not so. The flaws are inherent, and the ultimate proof is empirical: nowhere have controls performed for as long as their authors intended. The Soviets, despite

significant power, intelligence, and motivation, failed to reform their unproductive industries with controls after 50 years of the most intensive effort. The democratic socialist countries have increasing problems with productivity in their public industries, redeemed mainly by the good performance of private industries and markets. The economic theory behind these empirical results is compelling.

The formal theoretical case against controls is powerful but tedious; thus only a few intuitive arguments are presented. The principal source of increased productivity is not weeding inefficiency from an existing system, an important but limited one-time saving; it is periodic, major overhaul of industry that reinvents the product, production process, and organization of producers. Industries hate such overhaul because it alters power, status, income, habit, and belief—all of the reasons that people resist change. In sound markets, such major restructuring is commonplace. Industry is powerless to stop it; even General Motors and IBM have been humbled. But in controlled markets, major industry restructuring is rarely observed. Why?

The first argument is simple. When the future is put in competition with the present in a political process—and controls are a political process—existing industry has the power and money to resist change. But when the future is put in competition with the present in a sound market, informed consumers know which products offer value for money and vote for the future by their choices. The future has the power, and industry is helpless to stop it.

The second argument is that controls vest reorganization of industry in a small group of regulators, whereas sound markets vest it in the entire industry. Control advocates attribute poor performance to faulty technology, incompetent management and, especially, self-interest and greed. Accordingly, disinterested regulators must direct the choice of new technologies and coerce the industry to use them. This notion is unfounded for two reasons. First, it is a profound error of policy to overlook that all people, whether in public or private life, have self-interests. The use of regulators does not eliminate self-interest; it only alters the mix. Second and of even greater importance, no small group of people, be they regulators or a single firm, can possibly know as much as a whole industry, and certainly not enough to reorganize the industry for productivity. Intelligence and altruism are not limited to the public sector. It is unreasonable to assume that industry experts are too dumb or greedy to identify or use efficient technology or need the help of policymakers to do so. Their motivation is not stupidity or greed; it is recognition that unsound system incentives reward them for doing what they are now doing and punish them for doing anything else. This is why providers ignore efficient technology promoted by government unless they can pervert it to raising costs and why they game any controls for efficiency; given present system incentives, if they did not, at least 20% would be out of business, and the most efficient would be the first to go. Sound markets impel reorganization by incentives that capture the self-interest and expertise of the entire industry. The optimal designs are not predivined by the limited knowledge and falsely presumed disinterest of a few regulators. Rather, from all efforts of all firms, the market discovers the few that are optimal and spreads them across the industry by consumer choice and competition. It is impossible to get a Honda out of General Motors by controls, particularly if the regulators have never seen a Honda.

The poor productivity of controls is due to inherent flaws in both principle and practice. The greatest single flaw is that correct prices cannot be predicted. Economics defines "correct prices" as those that maximize consumer well-being. They have little to do with cost or fairness; they function solely as signals telling consumers where to maximize value and producers what consumers want. They change rapidly, often daily, as supply and demand vary. Correct prices arise in sound markets between willing buyers and sellers, yet no way exists to know them in advance. But in controlled markets, prices must be set in advance. Government can only guess at correct prices, using clues from industry costs that

have little to do with correct prices. And the rapidity with which correct prices change cannot be duplicated by any regulatory process. Hence controlled prices are soon seriously out of line with correct prices, sending wholly misleading signals to consumers and producers. Consumer well-being will perforce be far short of maximum.

In practice, the situation is much worse. Price schedules are set in a political process. Public interest is not the primary consideration; legislative, bureaucratic, and industrial self-interest are highly operative. The political difficulty of arriving at a consensus on administered prices is exceeded only by the difficulty of gaining a new consensus to alter the prices. Even conscientious regulators do not and cannot know the correct prices that will guide radical industry reform for productivity. And they are well aware that a wrong guess can plunge the industry into chaos, injurious to the public as well as the political future of the regulators. Hence they tend to be cautious toward change. Less conscientious officials are even more conservative. Legislators and bureaucrats are well aware of the perks that come from sitting on a price schedule panel that holds the future of a rich industry in its hands. They know the rewards of assuming the industry's point of view and the penalties if they do not. The industry, because of its single interest, has much money, time, and motivation to help favorable officials and to penalize unfavorable ones. The public, because of its many interests, does not. Cozy relations seldom require outright graft. Graft is usually a minor aggravation that sells newspapers while the real story goes unnoticed. For these reasons, administered prices usually reflect existing industry cost and practice and are seldom altered much or fast. As the British say, this year's prices are last year's prices adjusted for inflation plus an allowance for scandals. And that is why so many controlled industries remain locked in the forms that they had when controls were first imposed.

Empirical evidence confirms this argument. Radical restructuring for productivity, common in sound markets, is rare or unknown in controlled markets. The last goal that the U.S. should have is to freeze its inflationary health care system in its present form. The effect of false price signals on providers is pernicious. With no way to know correct prices, government will guess too low on some services, which become "losers" even for the most efficient providers, and too high on others, which become "winners" that pay excessive profit. The average of all prices may be too high, bloating the system, or too low, short-changing patient need. Conscientious providers will provide the services that their patients need, even if such services are losers, but to make ends meet, they must pump out extra winners that otherwise they would not do. (Clever providers easily find "medically appropriate" reasons.) Less conscientious providers will simply avoid losers or refer such patients to someone else and pump all of the winners that they can get away with. Either way, efficient, effective care of patients is sacrificed to the artificialities of the price schedule, and the distortion worsens with time. Europe is full of such distorted practices, each nation reflecting its own price schedule. The rigidity of administered prices guarantees that the distorted pattern in each country persists for years; it precludes major restructuring.

Controlled markets thus follow a predictable course. The first 5 or 10 years are a "honeymoon period" when controls appear to work as desired because they weed out obvious inefficiencies in an existing market industry about as well as sound markets. But sound markets then restructure the industry for large gains in productivity. Controls seldom do. The two strategies start to diverge. Without productivity, controls cannot get more for less; they can get only less for less. They can contain cost only at the expense of cutting access, quality, or coverage. They may be better than unsound markets, but compared with sound markets they increasingly suffer predictable problems that worsen the longer that controls persist. Quality, efficiency, responsiveness to consumers, and innovation erode, whereas rationing, waiting lines, shortages and surpluses, and obsolescent technology and facilities grow. Cost may or may not grow, depending on the political will of government. But with

little power to increase productivity by restructuring, the other ills are unavoidable; the only variable is how fast or slow they worsen.

The honeymoon period makes controls particularly seductive to politicians. The authors are long retired, honored by a grateful public, before worsening problems show what serious problems the system faces. And the public is quite apt to blame their political successors. Moreover, in health care, if all countries have controlled systems with similar problems, people will think them normal; they will not know how much they lost. If the U.S. ignores reform of the health care market for controls, we will spend 50 years trying to make them work before market reform—perestroika—again becomes thinkable.

PROBLEMS WITH CURRENT PROPOSALS FOR MARKET REFORM

Any proposal for market reform must offer a practical way to install the six required conditions for sound competition. It must do so in both the health care market and the health insurance market, because the two interact so strongly and both are currently unsound. The two most frequently discussed models of market reform are "managed competition" and "cost-sharing insurance reform." In addition, many employer coalitions are pursuing a third market model based on employer purchasing organizations. Unfortunately, these models appear deficient. They both under- and overspecify the market; that is, they lack one or more of the required conditions for sound competition and/or impose additional conditions that are not required.

Managed Competition

Most proponents of managed care favor managed competition, believing that managed care organizations will fare best under explicit preferences for managed care plans. This strategy is likely to succeed only in the short term. The deficiencies of the model will lead to poor performance that in the longer term promotes public interventions and controls inimical to good managed care.

Managed competition mandates that all consumers and providers must be in large competing managed care plans and that consumers must belong to a purchasing agency (termed a sponsor) that offers a choice plans. Both the Clinton plan and the State of Minnesota adopted variants of this model. The insistence on large plans with 10,000 enrollees or more precludes sufficient competitors—thus violating the first market condition—for at least the third of the nation in small cities and rural areas. A reform strategy that precludes sound competition in at least one-third of the nation can hardly be considered satisfactory.

Furthermore, insistence on large plans discourages entry—the third market condition. Hence competition will be weak in a much larger portion of the nation. Entry is difficult because of the high capital and management demands of large new plans. Indeed, precipitous implementation of so many large plans would make sponsorship feasible for only large insurers, now eyeing provider revenues with interest. Their track record does not support the wisdom of handing over the nation's providers solely to large insurers.

Such obstacles to entry seem artificial, because sound competition and well-managed care appear possible among smaller provider units within more conventional insurer arrangements (see below). Such opportunities are made difficult or precluded in most managed competition proposals. In fact, one may worry that large comprehensive regional and national managed care plans are a transitional form with substantial dis-economies of scale, an artifact of presently scarce capital and know-how. Just as national supermarket chains proliferated when capital and know-how were scarce but gave way to smaller, more efficient regional and local supermarkets as capital and know-how became industrywide, so comprehensive managed care chains may give way to smaller, more efficient local organizations

and arrangements. It would be ironic if a market model meant to foster optimal managed care artificially limited the market to overlarge, inefficient managed care plans.

The large purchasing agents (sponsors) in managed competition models also appear superfluous and restrictive. They appear superfluous because large purchasing agencies are unnecessary in other sound competitive markets such as cars and computers. They appear restrictive to entry because purchasing agencies in essence franchise who can enter and exit the market. Cozy relations between franchising agencies and large wealthy firms wishing to exclude new competitors are not rare. In addition, failure of a large plan may be politically intolerable, leading the franchise agency to prop up poor plans.

The Clinton plan goes far beyond most managed competition models and makes its purchasing agencies a vast bureaucratic monopoly with powers of economic control well beyond simple franchising. These agencies appear even more superfluous and unwise—superfluous because a truly sound market does not need economic controls and unwise because economic controls are inimical to sound competition. They inherently distort correct price incentives and so destroy productivity. Sound markets need proper regulatory oversight to maintain the required conditions, but economic controls are inapposite. The great danger in the Clinton plan is regulatory capture. Because managed competition precludes sound competition in one-third or more of the nation, the Clinton agencies will have to use economic controls for this third from the outset. If managed competition fails to contain costs in the remaining two-thirds or is merely slow in doing so—not unlikely, given its violation of required market conditions—the existence of this large regulatory apparatus makes it likely that the same controls will be rapidly extended to the rest of the nation. The entire health care system—one-eighth of the national economy—would fall under government controls. Clinton may come to Washington with brave new ideas for health care competition, but apparently the policy staff who designed his plan lacked his conviction and confidence in markets and sandpapered the plan into controls.

The final, most serious shortcoming of managed competition proposals is that they remain vague about the chief cause of health care market failures, namely the virtual absence of consumer information for comparing providers in terms of quality and cost. Report cards on providers and plans are much discussed, but what the information will be and whether it will clearly inform consumers about which providers and plans do better for less remains uncertain. Proposals mention some of the correct data (and some of the wrong data) but not in a way that lends confidence—as if they had most of the right letters (and many wrong ones) but not in the right order to spell the word they wish. In fact, they may not even know what the word is. The most disquieting sign is that few data from the government's research on provider assessment are of any use to consumers. It is aimed at regulators and providers, and there is little talk to redirect it. Provider and regulator information are not among the market conditions; only consumer information is required. Proper consumer information is too difficult to obtain and too important to market reform to be tacked on after the fact. If this need were understood clearly, managed competition proposals would spend far less time spelling out restrictive structures for plans and sponsor agencies and much more time spelling out the content and arrangements for consumer information. Indeed, if adequate consumer information is feasible, there appear to be much simpler, more widely applicable, and sounder market models than managed competition.

Cost-Sharing Insurance Reform

An alternative proposal is insurance reform that combines medical savings accounts with large deductibles and coinsurance in individual insurance policies and eliminates group-rated premiums. This approach is championed by certain conservative groups. It has the virtue of not forcing all consumers and providers into large managed care plans. But

such insurance has never proved popular in the private market and so faces an uphill battle politically. Advocates attribute its unpopularity to tax biases for group insurance, which are corrected in all market reform models. But its technical inadequacy is that it overlooks many of the required market conditions in both health care and insurance markets. It chiefly addresses consumer incentives and ignores consumer information. There are much easier and more acceptable ways to establish proper consumer incentives than large coinsurance and medical savings accounts. In addition, any market that fails to give consumers adequate means to know which providers and plans do better for less is unsound; it cannot create beneficial competition.

Employer Purchasing Organizations

A third reform approach is being pursued by many local private business coalitions. Unfortunately, in most of these coalition firms do not unite to install the required conditions for a sound local health care market. Instead, they unite locally in a large monopsonistic purchasing organization that uses combined purchasing power to leverage price discounts and utilization controls on providers. This model is not true market reform, because the required conditions for sound competition are ignored; rather, it is private control of price and use. Whether exercised by government or private purchaser coalitions, such controls work poorly. Savings will prove limited and temporary, and the policing effort will prove permanent and ever more demanding. Ultimately firms will be disappointed by the results.

Furthermore, in many areas with large employer purchasing organizations, health care organizations have responded by consolidating into a few plans so large that they can exercise counter private and political clout on purchasers. Health care is a large segment of any local economy, and local business sells it many goods and services. By threatening to change suppliers of computers, bank accounts, dry goods, construction, real estate, and so on, large health care organizations have been able to neutralize much employer action. These new health care organizations, largely a creature of ill-advised employer efforts at market reform, are a new interest group emerging on the health care scene, independent of both business and providers. They do not usually improve quality and efficiency, for the unsound market rewards neither. They simply capture an increasing share of patient and premium revenues that used to go to doctors and hospitals in the form of profits and salaries.

Ironically, large employer purchasing organizations are anticompetitive; they violate the second condition that neither providers nor purchasers may collude to restrain price and use. Small purchasing organizations can aid a sound market by helping small employers who cannot afford full-time personnel to ensure that employees have proper information and incentives to choose providers who do better for less. A purchasing organization can perform this task. As long as no one purchasing organization dominates the local market, this model does not violate the collusion condition. But if there is only one large purchasing organization, so dominant that it can impose price and use requirements on providers and plans under threat of boycott, the result is a clear restraint of trade. Not only will it work poorly; it also may prove illegal if challenged in court.

The shortcomings of the present market reform models indicate that a new, simpler, more effective model is needed, one that can be used by both private purchasers and public policy. It must satisfy each of the six requirements for sound competition, apply to most of the nation, and minimize superfluous bureaucracy and restrictions.

THE KEY TO NATIONAL MARKET REFORM: LOCAL MARKET REFORM

Any approach to market reform must ensure that all six conditions for sound competition are present in both the health and health insurance markets. Because the health care

market is the more seriously unsound and difficult to correct, discussion begins with health care market reform. Health insurance reform is simpler, but it must be made compatible with health care market reform. Because the two markets interact strongly, an incompatible insurance reform strategy may destroy good health care market reform. Hence the insurance strategy should be designed only after the health care strategy is decided. (Congress and states, take note.)

The smallest unit for reform is the local health care market, defined as the smallest area within whose border resident patients seek the bulk of their care from resident providers. Health care is largely produced by local providers for local patients. Local providers must respond to the particular incentives of their local market. The incentives in other markets make little difference because local providers get too few patients from those areas. Hence, if market reform is fully implemented in only one local market, providers in that area must alter their behavior to adapt to the new incentives, even if other local market areas remain unsound. In other words, to reform the health care system, it is not necessary to change the entire nation or an entire state at once; it is necessary only to change one local health care market at a time—a metropolitan area, smaller city and environs, or greater rural community, whose residents seek most of their care from local providers. This concept is counter to the conventional wisdom that health care reform can occur only by national change.

Unfortunately, the local market is indeed the minimal unit for reform. It would be simpler and easier if market reform could proceed provider by provider or purchaser by purchaser, but such is not the case. Instead, purchasers in a local health care market must unite areawide to install the required market conditions. In other words, one purchaser, be it an employer or Medicare, cannot reform the health care market by actions solely within its own benefits program. Rather, in each local market in which it has beneficiaries, a purchaser must join with the majority of purchasers in that locality to reform the local health care market. Market reform proceeds locality by locality, not purchaser by purchaser.

The only leverage that one purchaser has on one provider is the fraction of the provider's patients who are covered by the purchaser. No matter how large a purchaser may be regionally or nationally, it is rare that one purchaser has even 5% of a local provider's patients. Thus, one purchaser alone has little leverage on any given provider. A provider cannot make radical change for only 5% of his or her patients. The purpose of market reform is to create such powerful incentives for quality and economy that, to attract and hold patients, providers must periodically reinvent their product, production process, and organization to improve quality and efficiency. But one provider cannot make such major change in practice and organization for a fraction of his or her patients; the provider must restructure for all or none. If only one purchaser makes the necessary reforms in benefits, only 5% of local provider's patients buy for quality and economy; the remainder still buy for costliness under traditional insurance. The provider cannot afford to make any major change for efficiency when 95% of his or her patients reward costliness. At most the provider can offer a few discounts and use a few fewer services for the 5%. This is mere fat trimming, a limited saving at best, not the periodic major change necessary for strong, steady increases in productivity. On the other hand, if all purchasers in a local market area install the necessary reforms in benefits, all patients of every local provider may choose providers for quality and economy. Any provider who does not steadily improve quality and economy loses patients to providers who do. Provider competition for patients under these new incentives soon leads all providers in the local market to transform radically their practice and organization for self-interest, just as in other sound markets.

Purchasers must unite market by market to create the leverage for major provider restructuring. Market reform cannot be initiated by providers, only by purchasers. The market incentives for providers are not created by providers; they are created by purchasers and

patients. Until purchasers reform the market, no provider can afford to restructure for efficient practice; purchasers will only punish the provider and reward competitors. Providers can change only after purchasers reform the market; then they must change or go out of business.

This analysis shows why business coalitions have had such limited success with cost control and market reform. Most firms continue to work independently, each firm for itself. Market reform cannot happen in this way. The answer is local purchaser coalitions *if and only if* they use the right strategy. They must unite to install the required market conditions, not to create a monopolistic local purchasing organization to control price and use.

THE KEY TO LOCAL MARKET REFORM: CONSUMER INFORMATION AND INCENTIVES

The powerful incentives for productivity in sound markets arise from the six conditions for sound competition. Approaches to market reform differ by how and how well they install the six conditions in practice. It is not necessary to show that a sound health care market maximizes productivity; economic theory ensures this result. It suffices to show whether a reform model adequately installs each of the conditions in a health care market. Purchaser coalitions can sue the Buy Right model for local market reforms that appears to satisfy the six conditions in a particularly simple and effective way. It has acquired the name Buy Right because it reforms the way in which purchaser coalitions and patients buy care and coverage. It appears highly advantageous to good managed care. The local Buy Right model can be the basis for a national strategy simply by extending it to all localities nationwide. Thus it also offers purchasers and proponents of managed care a positive national reform strategy, wholly compatible with their private strategy and interests, to advocate to Congress and the states.

Buy Right recognizes that the peculiarities of health care make two of the conditions—consumer information and incentives—particularly difficult to install. The violation of these two conditions accounts for the bulk of perverse incentives plaguing the current unsound market. Correcting the remaining conditions—sufficient competitors, no collusion, free entry, and adequate public oversight—has ample precedent in other markets and is readily solved once the two difficult conditions are resolved. Hence the first emphasis in Buy Right is to ensure adequate consumer information and incentives.

Consumers presently lack information to compare providers in terms of quality and cost. Under most present insurance plans, they lack any incentive to choose cheaper, good providers even if they had information to identify them. Buy Right creates in each local market a local voluntary agency to assess and report the quality and cost of area providers to area consumers. (The feasibility of such assessment is the crucial element of Buy Right; it is discussed in the next section. This section assumes its feasibility and examines the consequences.) Buy Right also installs proper incentives in all insurance plans and employee benefit programs in the local market. Such incentives reward consumers for choosing providers who are not only better but cost less. The incentives do not vary by service, but by the costliness of the provider, which is known from assessment agency reports.

Consumer information about provider quality and cost must come from objective, reliable sources independent of providers. Certainly, providers may assess and advertise their own performance, but consumers can no more rely on such statements than on an automaker's assessment of its cars. Buy Right does not rely on government agencies for such objective assessment. A monopoly, public or private, is a poor idea. Public agencies become unresponsive to purchasers and patients, do not know local markets well, and are politically vulnerable to provider pressure. Experience with state data agencies appears to confirm such concerns. Buy Right sets up a purchaser-sponsored voluntary agency in each local

market, assisted but not controlled by area providers, that contracts with one or more competing private assessment firms to do areawide assessment. Assessors must publish their methods for critique in medical journals; competition is based on proprietary software and quality of service. Each area may choose its own assessors and methods. An industry of competing private assessors is more likely than a monopoly public agency to be responsive and to improve its methods. Agencies hire the assessors whom they deem best and replace them at pleasure. Field tests of Buy Right have successfully established local agencies in several areas (most notably Cleveland) that have shown their capacity to obtain and assess the required data.

Buy Right addresses the four remaining market conditions as follows:

1. It counters collusion by proper antitrust oversight.
2. It ensures ease of entry by allowing provider units of any size and form to compete, either within conventional insurance plans (now with proper incentives) or between managed care plans; this approach enables competition even in less populous areas that cannot support a single comprehensive managed care plan, let alone several competing ones.
3. It ensures sufficient competitors in areas of provider shortage by sound competition in areas with an excess of providers, driving the surplus to areas of shortage; for this reason, local market reform is best implemented first in areas of surplus.

One does not need the formal proofs and assurance of economic theory to see intuitively the effects of the six market conditions. In essence, Buy Right does not argue with providers or try to control their internal affairs. It simply identifies which providers give better care at lower costs and rewards them with patients. It does so by giving patients the means and incentives to identify high-value providers and to choose them over providers of lesser quality or efficiency. This strategy forces all providers to compete for patients by steadily improving quality and economy. They cannot pad their incomes by performing costly services of little value, because informed consumers can see rises in cost but not in quality and switch to other providers. Thus proper consumer information and incentives reverse the perverse incentives for providers in the current unsound market. When providers see managed care arrangements that encourage competitive quality and economy in the new market, they will voluntarily initiate or join such arrangements to gain patients.

Proper consumer information both enables the remaining conditions for sound competition and simplifies the strategy:

1. If consumer information can identify the quality and costliness of any provider unit—solo fee-for-service provider, group practice, hospital, HMO, or managed care plan—provider units of any size are free to form in the market and compete. The new incentives of consumer choice can then be applied in any form of conventional insurance or managed care plan. Thus providers need not be restricted solely to huge capitated managed care plans. This solves both the entry problem and the problem of sufficient competitors in smaller markets and obviates undesirable strictures on size and organization of providers and plans.
2. If consumers indeed have simple, clear information to identify which providers and plans do better for less, they need no huge purchasing sponsors or bureaucratic apparatus to act in their behalf; they can decide for themselves. They need only an agency that provides the required information. The agency does not regulate providers, who are free to organize and practice as they think will best attract patients; it simply reports their performance to consumers. This approach greatly simplifies the strategy, obviating the need for sponsor purchasing agencies or any vast control apparatus, and frees providers and plans of bureaucratic interference.

Such features define the key distinction between Buy Right and managed competition. Managed competition is a generalization of the original HMO strategy, broadening the

range of allowed competitors by embracing the entire spectrum of managed care plans rather than only the more narrowly defined HMOs. The broader range permits the stringency of provider management to vary from highly integrated, prepaid group practices to insurance plans with some degree of price and utilization management; it also allows consumers varying flexibility in provider choice, from the complete lock-in of HMOs to use of out-of-plan providers at varying degrees of cost under preferred provider plans. Competition can then sort the optimal arrangements preferred by consumers. Provider competition occurs mainly among plans—the set of providers in one plan vs. the sets in other plans. Unlike Buy Right, competition among individual providers within a single plan is largely absent.

As one of the early workers on the managed competition model—along with Kerr White, Paul Ellwood, Clark Havighurst, Scott Fleming, and Alain Enthoven—I believe that it was an ingenious pioneering model for its time. It was the first model to make competition a practical alternative to controls, and it changed the course of policy. But in the early 1970s the assessment systems now available to compare adequately individual providers in terms of quality and cost simply did not exist. Managed competition brilliantly sidestepped this lack by staging provider competition among plans; at least the cost (and to a lesser extent the quality) of plan providers as a set could be made apparent to consumers. But if it has become feasible to assess and compare the cost and quality of providers in units of any size in which they care to compete, it is also possible to stage provider competition within as well as among plans. In particular, providers can compete with each other directly within conventional insurance plans (now with proper incentives); some may wish to compete as solo units, some as small or specialty managed care organizations, and some as members of comprehensive care organizations. Of course, they also may form or join managed care plans and compete against providers in other plans and conventional insurance. The point is that they are now free to choose for themselves, on the basis of market advantage rather than coercive policy. Buy Right eliminates the need to conscript all providers and consumers into plans specified by policy. Restrictions on provider and plan arrangements are removed and consumer choice broadened; this powerful simplification is much closer to the ideal reform principle: to aim reform solely at making the market structure sound and to leave providers and plans within the market as free as possible to adapt to the market incentives. Then informed consumers will select the optimal mix of provider and plan arrangements better than public or governmental policy.

In short, if its requirements for quality assessment are feasible, Buy Right rigorously satisfies all conditions for sound competition and is widely applicable to most of the nation, yet avoids controls, restrictions, and vast bureaucracies. It thus appears simpler, more attractive, and more effective than other models of health care market reform.

THE KEY TO CONSUMER INFORMATION: OUTCOMES ASSESSMENT

The crucial question is whether Buy Right is in fact feasible. There is ample precedent for the feasibility of Buy Right's proposed actions for all conditions except consumer information. Even its incentive condition is now widely demonstrated. Coverage that rewards patients for choosing certain providers over others has become widespread, and provider behavior alters as expected under such incentives. But in the absence of proper consumer information, no one knows which providers truly provide better care at lower costs; thus the market remains unsound. Hence the feasibility of Buy Right finally rests on the feasibility of consumer information.

The conventional wisdom is that quality of care can be judged only by experts—if at all—and is incomprehensible to consumers. Conventional wisdom, however, may be wrong.

It rests on erroneous traditional notions of quality and the health care product. Once the health care product and quality are properly defined, the answer is—with high probability but not certainty—that providers can be assessed in terms understandable to consumers, well enough to drive a sound market.

Redefining Quality, Cost, and the Health Care Product

Modern quality science defines quality as statistical conformance to the product that consumers seek. Hence the first step is to define the health care product properly. The health care product is misdefined as services; in practice, both price and quality are based on services. But consumers do not seek services; they endure them. They seek relief of a health problem, in ways satisfying to themselves. The correct health care product, then, is health results and patient satisfaction, not services. Satisfaction must be included because health care includes caring and responsiveness as well as health results.

Services are not a product; they are a cost. The more services that a provider uses to obtain a health result, the more costly and inefficient he or she is. Paying for services (inputs) as though they were an output is the major source of the current perverse incentives for providers. The conditions for sound competition are predicated on a correct definition of the product; no market can be sound that misconstrues its product.

Quality and cost of providers can now be properly defined. The better a provider's health results and patient satisfaction in comparable cases, the higher his or her quality; the particular services used are not relevant. Similarly, cost of the product is not the cost of this or that service; it is the total cost of the outcome, from the time of the first patient contact with the provider for a specific health problem until the outcome (i.e., patient results and satisfaction) is measured. The lower a provider's average total cost per outcome for comparable patients, the less costly he or she is. Several points about outcome-based definitions of quality and cost deserve note:

1. Providers can be compared only for comparable patients, that is, patients with similar problems of similar severity when they first contact the provider. Otherwise, providers treating sicker or more complex cases would be judged unfairly to have poorer outcomes and higher costs.

2. As quality science demands, these definitions are statistical: quality is not defined for a single patient but rather as an average of all of the provider's patients. An analogy makes the point. If a man buys a car and it is wonderful, did he get a high-quality car? In the popular sense, yes. But in the scientific sense, he simply got a good result. If everyone else who bought the same make and model got equally good results, he got high quality. But if everyone else got a lemon, he did not get high quality; he just got lucky. Quality is the ratio of good results to all results; it is a batting average.

3. Unlike services, provider outcomes are readily understood by consumers. When they seek a provider, what they really wish to know is the provider's batting average for similar patients: what percentage of patients were cured; what percentage had complications; what percentage still have mild or severe symptoms; what percentage are dead; what percentage would recommend the provider to other patients; what is the expected cost—all of these elements compared with other providers treating similar patients. The example Consumer Guide (in the Appendix) typifies what is possible now and mentions what should be possible in the future. In contrast, traditional service-based definitions of quality are not only poorly understood by consumers, they are also largely irrelevant. Assessing health care by services is like trying to assess a car by rating the quality, appropriateness, and cost of each part. What does "appropriate" mean when each part depends on every other? Nor do high-quality parts alone make a high-quality car; it depends on how they fit. And in health care, nobody tells the patient how many services (parts) are in the pile, let alone whether

they add up to a good outcome (car). Consumers buy cars well, even though they do not understand parts, because they have ample information about the car. It is time to assess health care more like other complex products—by the quality of the overall product rather than of the parts.

4. Consumers cannot judge a provider's quality for their own experience or by asking neighbors any more than they can judge the quality of a baseball hitter by going to a few games. The batter or provider may have been lucky or unlucky on that day. One can know the quality of batter or provider only from objective observers who see the whole season or all patient outcomes and report the relevant averages. This is already done in baseball; it must now be done in health care. Too many market models stress only cost incentives, as if consumers could determine quality on their own. They cannot. Expert independent assessors must routinely measure each provider's outcomes and report the batting averages, adjusted for initial severity of complaint, to consumers. Any market reform model that does not will fail.

5. The outcomes-based definition is superior to peer review, in which providers judge quality by the appropriateness and competence of services; the long-term outcome for the patient is seldom even known. Peer review is akin to judging a baseball batter by having expert hitters rate the mechanics of his swing without bothering to measure his batting average. Such outdated methods have allowed wide variation in provider quality. For example, in almost any large city, comparable patients are 50% more likely to die in the worst hospital than in the best. The numbers in the Consumer Guide are real and, unfortunately, typical. Because outcomes are not routinely measured, much medical practice is irrelevant to patient outcomes; some are actually harmful. Providers cannot improve their product if they do not routinely assess their batting average for outcomes and cost.

6. Internal assessment, whether by peer review or outcomes, has little incentive power. Providers are free to ignore it if they wish, and many have done so. In contrast, informing consumers of provider batting averages increases incentive to improve. When consumers know the outcomes of providers and choose accordingly, providers can no longer tolerate antiquated internal assessment. As in every other industry driven by informed buyers, providers will set up internal quality and cost control and make it effective.

Applying Outcomes Assessment in Markets

Can provider quality and cost be determined well enough by outcomes assessment to drive a sound health care market? The answer is not a simple yes or no, but a question of degree. To drive a sound market adequately, it must be technically feasible to measure such batting averages for the majority of patient care and revenues in a local market. Any large unassessed portion would allow providers to inflate revenues for such such care unduly, as now. On the other hand, sound markets do not demand assessment with perfect precision—no market has such consumer information. It suffices that methods be fair and accurate enough to steer patients toward broadly better providers and away from worse. As methods improve, smaller differences in provider outcomes will become measurable with increasing precision.

Current methods of outcome-based assessment are relatively primitive, and perhaps only 40% of patient care and revenues can be adequately assessed at present. These methods are sufficient to initiate Buy Right, but they will not be adequate to drive a sound market unless expanded. However, the obstacle to date has not been improved technical methods; to the contrary, it is the absence of incentives for demanding assessment. Medical journals are full of outcome methods, crude but better than anything used in current practice, all dying for want of use. Buy Right attacks this obstacle at its source by creating strong purchaser and patient demand. Providers themselves will demand improved methods once they find

that patients choose providers by such methods. Already in demand and use are rapidly improving assessment methods.

Can outcome batting averages be extended to the great majority of patient care and revenues? Space does not permit presentation of so complex a technical issue, but my own work and extensive discussion with experts indicate no obstacle, at least in principle. Present progress offers high prospects, but, like the moonshot, success cannot be fully assured until a trial is made.

An example typifies the many issues and novel practical solutions. The greatest present lack is batting averages for the results of primary and preventive care. Consumers can be given health status questionnaires when they enroll in an insurance or managed care plan to provide an initial risk assessment. Subsequent questionnaires at reenrollment and after several episodes with providers can measure later outcomes. Batting averages for comparable patients can be constructed for providers. If preventive care and early detection do not occur because a patient has not contacted a provider, (e.g., children without immunization, late-stage cancer), the plan itself can be held accountable. Conventional insurers may correctly protest that they are not health care plans like HMOs, legally responsible for the actions of enrollees and providers. But, like the government's car crash reports, consumer reports can hold them commercially (not legally) accountable by reporting averages and showing which plans foster better preventive care and detect illness sooner. Insurers may ignore this information if they wish; but odds are that, like automakers, they will not.

REFORM OF THE HEALTH INSURANCE MARKET

The final piece of the model is reform of the health insurance markets, which Buy Right effects via an overarching principle. Once society declares that health insurance is a merit good available to all, insurers may no longer compete by creaming off the healthy and refusing or pricing the sick out of the market or by limiting essential benefits that leave beneficiaries uncovered for large medical expense. Rather, insurers must now compete by risk reduction, not risk selection.

Risk reduction means giving beneficiaries assistance and incentives that foster (1) healthier lifestyle, (2) proper use of health care, and (3) choice of providers who produce better outcomes at lower cost. Buy Right applies this principle in pursuit of three aims:

- Ensure that the insurance market does not distort the health care market.
- Ensure that the health insurance market is sound.
- Ensure that both the health care and insurance markets are fair and affordable to all Americans, independent of income and personal circumstance.

Current insurance distorts the health care market primarily because most coverage lacks incentives for patients to choose better providers at lower costs. Buy Right corrects this distortion by placing consumer incentives in insurance policies. But two further characteristics of the insurance market compromise such incentives: (1) an insurer can distort local incentives by subsidizing premiums in one market from premiums in others, and (2) supplemental insurers (e.g., Medigap) can destroy the incentives in primary care by insuring its deductibles and coinsurance. The supplemental plan covers but a fraction of the cost it adds to primary plans when such incentives are removed.

Buy Right insurance reform addresses both problems. To remedy the first, it requires that premiums reflect only the cost of providers used by consumers. Hence premiums of each plan in any local health care market are required to reflect only the cost of members in that market, not those of members in other markets. For the second problem a number of remedies are possible. Forbidding supplemental coverage to consumers seems too harsh.

One remedy is to permit primary plans, as a condition of coverage, to refuse all reimbursement for any service covered in whole or part by a second insurer; the second plan must then pick up the entire amount and reflect the cost in its own premiums. Alternatively, supplemental insurers may be required to arrange coordination of benefits with the primary insurer, so that the primary insurer's incentives are protected. Buy Right asks states to amend insurance laws to establish such requirements.

The second Buy Right aim is to make the insurance market sound. There are two main violations: (1) tax laws distort the true cost of insurance to consumers and purchasers, and (2) consumers lack information about the quality and cost of competing plans. The present income tax subsidizes health insurance regressively. The well-to-do enjoy high subsidies, the poor and uninsured none at all. Firms and employed groups are subsidized but not individuals. The original purpose of these poor incentives—to encourage health insurance—was outgrown long ago and is entirely outmoded by universal coverage. The remedy is tax reform, replacing the present individual and employer tax exclusion with a flat or progressive tax credit for all persons. Then purchasers and employed consumers have no perverse tax incentives to overspend on health insurance relative to wages and other benefits, and poor people—along with all individuals—share fairly in any tax subsidy. Also, simply by adjusting this one number—the value of the tax credit, which alters the tax subsidy for consumer out-of-pocket premium and service price incentives in all coverage equally—Congress can equitably lever national health expenditures downward to any level desired.

The remedy for the second problem is good information. Buy Right specifies that its local assessment agencies must rate good plans as well as providers in each locality. Quality of a plan's coverage is defined by its performance in each dimension of the coverage product: financial protection, responsive service, and, now explicitly, quality of care and risk reduction. Protection is rated by how well a plan covers consumers against both undue acute and chronic expense. This rating can be reported to consumers by two profiles for each plan, showing for any given out-of-pocket expense what percentage of beneficiaries paid more than that amount in 1 year and over 3 years. Service is freedom from red tape and hassling of patients for unpaid bills; it is measured by reported beneficiary satisfaction. Quality of care is measured by reporting a plan's batting averages on outcomes for comparable patients. Risk reduction is reported by various measures reflecting how well the plan fosters healthy habits, preventive and early care, and choice of efficient providers. Measures may include for each plan the percentage of smokers, heavy alcohol users, nonexercisers, nonimmunized children, and the like at initial enrollment vs. 2 years later. Reported cost should show both premiums and average out-of-pocket expenses. Such data inform both consumers and purchasers and foster sound competition among plans.

The third Buy Right insurance reform aim is equity or fairness, which has two parts: (1) ending current risk selection practices by insurers and (2) subsidizing the poor in the new reformed health care and coverage markets. The first part must ensure that the cost of insurance is spread fairly over all buyers and does not fall disproportionately on small firms and on sick, self-employed, and nonemployed individuals, as now. The second part must help people who cannot afford even a fair share because of low income.

The first aim is achieved by state insurance reforms that forbid selective practices and enhance fair sharing of risk. First, no insurer may segregate the sick from the healthy in separate plans. Technically this may be done by forbidding insurers to write more than "one book of business" for persons and groups under 500 lives in any local market. Second, no plan may exclude anyone for health reasons in any local market with universal coverage. (This requirement is enacted only after universal coverage, when all persons must carry qualified insurance. Before universal coverage it may impose hardship on plans, because many healthy people now choose to go uncovered, whereas the sick seek coverage.) Third,

once the health status of beneficiaries is measured at initial enrollment by local assessment agencies, premium tax formulas can redistribute revenue among plans in each local market by risk, making risk selection of little economic advantage.

Buy Right handles the second aim, subsidies for low-income persons, through a universal coverage card. Once universal coverage is established in a local market, every qualified plan in that market issues all enrollees the universal card. Any uninsured person is required to join a qualified plan when he or she seeks care. A qualified plan is any insurance or health care plan that government certifies as capable of handling its minimal universal benefit package. Because an unlimited number of plans can be certified as long as they demonstrate capability, there is little restriction on entry to the market and little need for bureaucracy. The card constitutes proof of qualified coverage and must be accepted for payment for any provider. In addition to identifying the person and plan, the card carries in its magnetic memory, without face identification, any subsidized status to which the member is entitled. The plan bills any purchaser in the usual way. But in billing a member for any out-of-pocket share of premiums and service cost, the plans bills the subsidized portion to the government and only the balance to the member. The subsidy pays a greater percentage of this expense for lower-income enrollees at any schedule that government deems fit. Thus both out-of-pocket premiums and plan financial incentives in the form of deductibles and copayments do not fall unaffordably or unduly on low-income persons.

The subsidies constitute most of the cost of universal coverage and can be financed in any way that government deems proper. Growing savings from market reform eventually should lessen the cost to all parties. However, certain factors ought to be considered:

1. Employers should be given incentive to maintain the present private sector share of health insurance expense. Otherwise they may be tempted to drop out under universal coverage, creating a severe financial problem. Equally dire, no strong private sector blocs would be allied with government in cost control; facing voters alone, government is vulnerable to bread-and-circus mentality. The strength of the two sectors together is greater than of either alone.
2. Government should avoid mandated employer benefits and wage taxes, which discourage new jobs and new ventures and violate the goal of protecting other national priorities.
3. As universal coverage will make Medicaid unnecessary, states also must be given incentive to maintain their current share of the cost by participating in universal coverage.

Finally, the Buy Right strategy for insurance market reform does not have to proceed concomitantly with its strategy for health care market reform. Indeed, implementation would be far safer financially if health care market reform preceded insurance reform, extending coverage to the uninsured. The public has made amply clear that it wants universal coverage but will not tolerate another huge tax-and-spend proposal with massive deficits. By holding off universal coverage until health care market reform begins to moderate cost and installing it first only in localities where market reform is working well, the financial safety of universal coverage would be assured. Moreover, the offer of local universal coverage as a reward for effective local market reform may act as a powerful incentive for localities and spread reform across the country at perhaps the safest practical speed. With the public demanding fiscal responsibility, this may be the most fruitful course left to achieve universal coverage.

CONCLUSION

Current proposals for health care reform offer such questionable prospects and side effects that the United States needs a new direction. Buy Right may offer this new direction. It appears simpler yet more likely to perform well on all national health care goals than other

proposals because of rigorous adherence to proven economic principles. Its freedom to organize, practice, and reimburse health care without meddlesome bureaucratic strictures merits the attention and support of purchasers, providers, and the managed care industry.

But Buy Right rests on a crucial proposition: by outcomes assessment the quality and cost of providers and plans can be evaluated and reported to consumers well enough to drive a sound market. Like the moonshot, this proposition cannot be fully evaluated until it is tried. The less true it proves, the less feasible and effective Buy Right will be. But current evidence suggests that the feasibility of Buy Right is at least as great as any of the alternative proposals, all of which have equally significant uncertainties. Yet no other proposal would appear to work as well, even if well implemented.

Buy Right deserves serious trial. Opponents who declare that it cannot work simply sentence the nation to the alternatives or to continue in the present system. Either unhappy prospect ought to dispose most parties to try to make it work. Fortunately, the nation need not make an immediate all-or-nothing decision for two reasons:

1. No matter which market reform or control strategy is chosen, all require better assessment methods for comparing provider quality and cost. Perhaps all sides can agree that, while the national reform debate proceeds, the government should launch a major effort for research and development of such methods and foster their widespread use. This would improve both cost and quality of health care and any final national health plan.

2. Buy Right need not be implemented everywhere at once. It may be initiated in a dozen or so localities and spread to other localities and finally nationwide only if and as fast as its problems are worked out and its performance is deemed satisfactory. This seems to be a more practical and prudent way to implement reform, whether with Buy Right or any other strategy, than precipitous, massive implementation nationwide.

My final remark is to managed care professionals. Good providers and managed care organizations are likely to prosper best in good market models. In bad market models, bad providers and managed care organizations are more likely to prosper than good ones, and the final result is likely to be controls for all. The regulatory sun will then shine equally on the just and the unjust, which, as the experience of other nations suggests, bodes ill for the future of managed care.

Managed care providers and plans cannot win simply by opposing bad reform; such a negative strategy ensures only that a bad reform proposal will ultimately prevail. The only way to counter bad reform is to support energetically a good reform strategy that satisfies the needs of providers, plans, and purchasers as well as public interest.

If the industry is persuaded that Buy Right is the most promising market model for both national health goals and managed care, there is much that it can do. Providers and plans cannot initiate Buy Right without purchaser action. Private purchasers can initiate Buy Right reform in local markets at any time; they need not wait for government. Managed care organizations should prod them to begin and vigorously support their effort. Indeed, this may make an excellent marketing strategy for managed care organizations. Installing consumer information and incentives, while far from quick or easy, would improve greatly the local market for good managed care. Furthermore, it would allow the industry to advocate a superior national reform strategy consonant with everyone's interests. Finally, it would ensure good managed care performance in terms of cost and quality—the best protection for the long-term future of patient care.

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APPENDIX: CONSUMER GUIDE TO AREA HOSPITAL CARE
Rated on Quality and Cost for Comparable Patients

TYPE OF CARE: **Adult Nonsurgical Coronary Admissions**

Guide to the Ratings: Hospitals are compared on cost and two measures of short-term quality for adult nonsurgical coronary care: hospital deaths and serious complications. All terms are fully explained in the Guide text. (Future Guide editions will also include patient outcomes reflecting longer-term quality, such as patients still having symptoms at 1 year and measures of patient satisfaction.) For each measure, three numbers are presented. The third number, called the "index," is used to compare hospitals. *The index shows in percentage terms how much better or worse a hosptial performs than the area average for comparable patients.* For example, a hosptial whose death rate index is 100% is at the area average for patients comparable to its own. A hospital with an index of 115% has 15% higher deaths than the area average for comparable patients. The lower its index, the better a hospital's quality in avoiding deaths.* The index for cost and the index for deaths plus complications are similarly interpreted. The first number under each measure is the hospital's actual rate for adult nonsurgical coronary patients: respectivley, billed charges per admission, deaths per 1000 admissions, and the sum of the death rate and complication rate. The second number is the rate that would be expected for this hospital were it performing at the area average for comparable patients. The third number, the index, is simply the hospital's actual rate divided by its expected rate, showing in percentage terms how much better or worse it performs than expected. Because some hospitals get sicker patients than others, a hospital's actual and expected rate may be compared ony with each other, not with rates of other hospitals. It is the index that takes these patient differences into account, and so it is used to compare hospitals directly. In the table, hospitals are ranked from best to worst in order of their quality in avoiding both deaths and serious complications.

Rating Symbols: denote how far a hospital is above or below the area average for comparable patients (= 100%).

⊖	20% or more below	excellent
○	10% to 19% below	good
○	9% below to 9% above	average
○	10% to 19% above	fair
●	20% or more above	poor

Ratings of Area Hospitals on Adult Non-Surgical Coronary Care

HOSPITAL	COST: Charges Per Admission. actual rate	expected rate	index	PATIENT OUTCOMES: Death Rate. actual rate	expected rate	index	Death+Complication Rate. actual rate	expected rate	index
A	$2370	$2890	82% ⊖	42	53	79% ⊖	55	66	83% ○
B	2550	2833	90% ⊖	52	62	84% ○	68	77	88% ○
C	3010	2840	106% ○	42	52	91% ○	60	66	91% ○
D	3800	2880	132% ●	40	49	96% ○	60	63	96% ○
E	2450	2780	88% ⊖	52	50	103% ○	62	65	96% ○
F	3420	2803	122% ●	51	49	103% ○	64	62	102% ○
G	2810	2960	95% ○	65	60	108% ○	80	76	105% ○
H	2900	3120	93% ○	85	71	119% ○	99	89	111% ○
I	2670	2750	97% ○	65	53	122% ●	78	69	113% ○
J	3050	3240	94% ○	126	102	123% ●	151	126	120% ●

Source: CPS analysis using 1984 Mediqual data and method of classifying comparably ill patients at admission.
*Notes: Index differences of 5-10 percentage points or less are not significant. Expected rates may vary slightly depending on classification method for comparably ill patients. Actual rates may vary slightly due sample size.