

Are Market Forces Strong Enough To Deliver Efficient Health Care Systems? Confidence Is Waning

Many health care market participants are now willing to consider strong governmental intervention to repair the health system.

by **Len M. Nichols, Paul B. Ginsburg, Robert A. Berenson, Jon Christianson, and Robert E. Hurley**

PROLOGUE: The landmark Community Tracking Study (CTS) has for nine years put the functioning of U.S. health care markets under a high-powered microscope. It has conducted periodic interviews in sixty communities with 60,000 households and 12,000 physicians, and additional surveys of employers and insurers. The CTS zooms in on twelve representative markets with site visits every two years that have produced nearly 2,700 interviews with local health system leaders. In a testimony to the study's prestige, the Federal Trade Commission began the first two of its comprehensive hearings last year on competition in health care with framing presentations by senior CTS staff.

That makes it difficult to ignore the sober findings described in the following essay. In about 1,000 interviews during the latest round of site visits, CTS investigators found deep skepticism about the ability of market-based reforms to produce urgently needed improvements in the efficiency and quality of the nation's health care system. As much as these predominantly private-sector leaders dread the prospect of deeper interventions by government, few of them seem to be able to imagine other alternatives.

An exceptional team presents these findings. Len Nichols (lnichols@hschange.org) is a former senior adviser at the Office of Management and Budget who is now vice president of the Center for Studying Health System Change (HSC), which conducted the CTS. His coauthors are HSC president Paul Ginsburg, former executive director of the Physician Payment Review Commission; Bob Berenson, senior fellow at the Urban Institute and former acting deputy administrator and director of the Center for Health Plans and Providers at HCFA (now the CMS); Jon Christianson, chair in health policy and management at the University of Minnesota's Carlson School of Management; and Bob Hurley, associate professor of health administration at the Medical College of Virginia. Perspectives by Stuart Butler and Alain Enthoven round out the discussion.

ABSTRACT: Our paper draws lessons for policymakers from twelve communities as we identify the power and limits of general market-based strategies for improving the efficiency of health systems. The vision of market forces driving our system toward efficiency attracted politicians, policy analysts, and practitioners in the 1990s. Today some policy advocates profess even more faith in unfettered market forces. Market participants in the twelve communities in the Community Tracking Study, however, have become doubtful, and our analysis confirms the logic of their pessimism. Major barriers to efficient market outcomes exist amid growing willingness to consider renewed government interventions.

THE QUEST FOR GREATER EFFICIENCY in the delivery of health care services is eternal in a country that spends far more on health care than any other, consistently has growth in spending that outstrips that of income, is unable to provide insurance coverage to at least 15 percent of its population, and ranks poorly among industrialized countries in systemwide measures such as life expectancy and infant mortality.¹ Add to this our quality problems, and it is hard to be complacent about the value U.S. citizens receive for their health care dollars.² Inefficiency also puts a very high public-sector price tag on universal coverage, which helps polarize the politics of this issue.

A technically efficient health care system would only deliver care that improves health status and in a way that minimizes the use of society's resources. Unnecessary care and inefficient modes of delivery would be minimized or eliminated, and health care cost growth would be commensurate with improved quality and effectiveness of care.³ The U.S. system is far from efficient in this sense, as is well known.

Since the mid-1950s most Americans have obtained health insurance through an employer, although after Medicare and Medicaid began in 1965, the public role in coverage and payment policy has been important and contributed to the complexity, equity, and perhaps inefficiency of the health care system we have today.

Two stylized and starkly different visions of how to obtain greater value for each health care dollar spent have long been debated in the United States. One would have individuals replace employers as decisionmakers for insurance coverage. Current proposals of this type would have tax credits for individuals replace the current tax preference for employer contributions to health insurance, with minimal government regulation of insurance and health service markets. The polar-opposite approach is now summarized as "Medicare for All," by which is meant a publicly financed, single-payer health system in which government sets payment rates, makes coverage decisions and determines through other public mechanisms the amount of resources going into the health sector. Proponents of both visions claim that their system would maximize clinical value per dollar spent and that the amount of care delivered would be appropriate.

The managed competition vision, articulated most eloquently and often by Alain Enthoven, promised a kind of "third way" to make the employer-based sys-

tem work better.⁴ The government would play a regulatory role in structuring a market in which employees would supplement a fixed employer contribution to choose among all health plans offered in their community. This would enable market forces to promote efficiency in health care delivery, as consumers would face true marginal cost differences when choosing among plans, and plans would be forced to compete for price-sensitive consumers. This vision was attractive to some political and health care leaders who shied away from expanding governmental power but were also aware of some basic problems—asymmetric information, adverse selection, moral hazard, and providers' market power—with unfettered health care and health insurance markets. The Clinton administration espoused many managed competition principles in its proposal for broad reform.⁵ Even after the reform legislation failed in 1994, many health policy analysts expected local health systems to develop integrated delivery entities that would engage in a semblance of managed competition.

Typically, all analyses of health system reform address the same key question: What and how much can markets do alone, and how much help might they need from government to produce more efficient outcomes or a more equitable distribution of health care resources? As we enter another season of broad debate about the structure of health care financing, the Community Tracking Study (CTS) site visits of the Center for Studying Health System Change (HSC) can make a unique contribution to analyses of the power and limits of market forces.

The CTS is a longitudinal study that tracks changes in local health care systems nationwide. Researchers conduct site visits to twelve randomly selected and nationally representative communities every two years to interview leaders of the local health care system about changes in the organization, delivery, and financing of health care and the impact of those changes on people. First-round site visits were conducted in 1996–97 and provide a baseline for tracking change. Subsequent visits were conducted in 1998–99, 2000–01, and 2002–03. A total of 2,690 interviews have been conducted in the twelve markets since 1996, with 1,000 interviews conducted in the most recent round.

In each round of data collection, researchers have focused on the interplay among providers, plans, employers, and public policy that determines coverage, access, cost, and quality in the local community. This focus has allowed us to analyze market conditions and outcomes as well as to interpret respondents' expressed views in the context of a larger picture of comparative health system evolution.

In this paper we report respondents' views on the state of market forces and their potential to promote efficiency in health care. We then describe key barriers to health system efficiency that affect their markets and underlie their views. Finally, we discuss alternative models for policymakers to consider while being mindful of the lessons learned in the CTS communities. The lessons are the joint products of the respondents' views and our analysis.

Respondents' Views On Competition's Potential

There is broad consensus among market participants that without major change in our health system, health care costs and premiums for comprehensive coverage through broad provider networks will continue to rise much faster than wages or incomes. Many respondents are worried about both the consequences of this trend for people and the potential for ill-conceived reactive policy.

We were struck by how many of our respondents—especially those traditionally not predisposed to seek larger roles for government—echoed sentiments similar to the following. An insurance broker said, “The delivery system is a mess. The sectors don’t talk. No one wants to change. The government must do something.” A surprised benefit consultant reported: “There now is a lack of resistance to government involvement.” And capturing a sentiment expressed in many different ways, one local policymaker said, “If the private sector can’t figure all this out, it’s scary to think that we might actually end up running to government—I mean, HCFA!—to do it.”

The theme of “everyone feels constrained from changing his own behavior” cut across many respondents’ views. Some kind of intervention stronger than what has been tried before is thought to be necessary to force change. At the same time, there was general recognition that “fault” lies all around and that all sectors—including public programs—need to change their behavior for high-quality, effective health care to become more affordable in the long run. Perhaps it is this recognition of shared blame and shared self-interest in the status quo—plus a growing awareness in each community that health care creates jobs and contributes to local economic health—that has led a diverse array of leaders to begin to look to government as a focal point for a solution, at least as a convener or referee among stakeholders with diverse interests.

Our interviews are not detailed surveys of how respondents would change the system, so it is not surprising that there were no clarion calls for specific reforms. And, of course, different actors see the main problem in different ways, some worried more about shifting costs from public programs to private payers than about the uninsured and safety nets, and others the opposite. But there is a pervasive sense that efficient health care systems will not come into being without some kind of wise policy intervention. At the same time, respondents do not expect such a policy development in the near term.

Barriers To Efficient Health Systems

So why are many current market participants now so pessimistic about the potential for private market forces to improve the efficiency and outcomes of their health systems? Our analysis of respondents’ comments and of local market evolution over the past seven years in the CTS sites has enabled us to identify four major barriers that contribute to this pessimism.⁶ The first two might be labeled “facts on the ground,” and the last two are more like behavioral realities that affect other

key elements of competition potential.

■ **Providers' market power.** One key prerequisite for market forces to drive health systems to efficient outcomes is vibrant price and quality competition among providers underneath competition among health plans for employer and employee enrollees. Managed competition theorists assumed that existing excess capacity and buyers' pressure on providers to adopt technically efficient practice styles would keep providers in general and hospitals in particular vulnerable to increasing demands from more accountable health plans. This pressure for efficiency is blocked if providers have substantial market power, by which we mean the power to dictate terms to health plans on the premise that their absence from a network would make the network unattractive to consumers.⁷ In other words, market power arises from the absence of effective substitutes. Providers' market power leads to high service prices and less pressure to provide technically efficient care and no more. Indeed, some powerful hospitals have been able to use their power to block innovations that, arguably, would make markets more price-competitive, such as tiered hospital networks. The Partners system in Boston, for example, has successfully blocked tiered networks by refusing to contract with any plan that would place them in a tier other than the preferred one.

Power can stem from strong consumer preferences for specific hospitals or doctors based on reputation. It can also derive from small numbers of providers in either the overall market area (two systems dominate the Cleveland market) or submarkets (Indianapolis has less concentration overall, but each submarket is dominated by a particular system). Consolidation of hospitals and single-specialty medical groups over the past decade has created or solidified this condition in many markets. Lack of excess capacity is further increasing market power. A "tool" that was supposed to counterbalance providers' market power—objective quality comparison data—has not been produced with sufficient credibility to lay audiences or even professionals to permit real provider competition to occur. And even this tool is effective only where there are multiple providers from which to choose. In the absence of consensus data on quality, informal and historical patterns of reputation effects continue to hold sway, and there simply is no countervailing power.

■ **Absence of potentially efficient provider systems.** The expectation that integrated delivery systems (IDSs), led by either hospitals or physicians, would develop to take responsibility for efficiently delivering health care to an enrolled population has not been realized. In many cases, what made sense on paper—that is, putting together disparate organizations—has not worked in practice. Also, demands for broad networks, driven by the backlash against managed care, have made it difficult for delivery systems to focus on a defined population and have contributed to the decline in capitated plan payments to providers. Large multispecialty physician organizations appeared to have the most success in taking risk for an enrolled population, but they exist in few communities. Most physician markets are

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fragmented, and practices remain organized in small, single-specialty groups that cannot bear capitation risk beyond their own services, so the potential to implement payment incentives for economizing on global resource use is still limited at best.

In some markets such as Orange County, Miami, Indianapolis, and Phoenix, physician groups accepted risk for both physician and other services, often through joint ventures with hospitals. Orange County is unique among the twelve CTS communities, with health maintenance organizations (HMOs) not losing market share and considerable delegation of risk and care management from health plans to multispecialty group practices and independent practice associations (IPAs). Orange County’s uniqueness is probably the result of the combination of the long-standing presence of multispecialty group practice and health plans (such as PacifiCare) that were built around the business model of delegation to physician organizations.

■ **Employers’ inability to push the system toward efficiency and quality.**

Employers had some success in lowering the costs of their health benefits in the early 1990s when they embraced restrictive managed care plans. Premium trends briefly approached zero in the mid-1990s, reflecting both greater plan price discounts from providers and declining use of medical services. However, employers’ responses to their workers’ complaints about managed care restrictions led to decisions that undermined plans’ ability to produce continued cost savings. These changes included broader provider networks, direct access to specialists, and fewer authorization requirements. Extremely tight labor markets during the late 1990s made employers highly responsive to their workers’ complaints about managed care. Labor markets are looser and premium trends are higher now, but our 2002–03 site visits uncovered little indication that employers are interested in returning to restrictive managed care.

Although employers embraced managed care, they never structured their participation in the manner outlined by managed competition theorists. Most employers do not offer a choice of plans, and far fewer make fixed-dollar contributions for their employees’ health insurance.⁸ The current tax preference for employer contributions to employees’ health insurance discourages employers from imposing defined-contribution policies, since it subsidizes more costly plans at the same rate as less costly plans. For those offering choice, many employer respondents reported that they have reduced the number of plans they offer. The strong preference for broad networks by large, heterogeneous workforces has also meant that offerings by different carriers have become more similar. So instead of offering plan options that feature competing, mutually exclusive provider networks—a central tenet of managed competition theory—employers have focused

on offering an HMO and a preferred provider organization (PPO), often from the same carrier and with similar networks.

Employers are less active today in working with their peers to influence health care in their communities than many observers expected them to be in the early 1990s. Since most examples of community activity have been from large employers that are headquartered in the community, waves of corporate mergers have meant fewer instances of potential leadership of this type. Lack of success of earlier efforts may also be a factor.

Employers are responding to recent large premium increases and looser labor markets by “buying down” the actuarial value of their benefit packages, mostly by increasing patients’ cost sharing at the point of service. Yet most employers revealed to us little confidence that these changes will be adequate to force a meaningful slowing of cost trends. Nevertheless, employers have taken the other available strategies off the table. This attitude probably reflects a number of factors, such as workers’ preferences and limited potential for provider competition over costs and quality. Some analysts, such as Enthoven, have long pointed to the structure of tax subsidies for employer-sponsored health insurance as an important factor in employers’ lack of initiative to contain costs.

■ **Insufficient health plan competition.** Vigorous health plan competition did not develop as expected and as required for market forces to engender more efficient health care systems. The vision was for tightly managed HMOs with distinct provider networks to compete on service delivery quality and price. But the managed care model is less conducive than the traditional indemnity business is to carrier competition because of its relatively higher fixed costs and barriers to entry. The fixed costs of systems to manage care, establish a brand name, and develop a network make it difficult for small plans to be viable. The substantial costs of creating a provider network mean that entry into a market requires a large investment of money and time. Thus, barriers to entry are higher, and the number of managed care plans any market can sustain will be fewer compared with those of traditional indemnity insurers.

Over the past few years PPO products have gained market share from HMOs. This has reflected demands for fewer restrictions and, recently, the fact that the PPO model lends itself better to benefit structures with more patient cost sharing. But PPOs are less committed to managing and coordinating care and are less adept at using the few mechanisms that are at their disposal. PPOs are also less able to create and maintain the practice style conformity that provider networks strive for to deliver care efficiently.⁹

Note also that HMOs that cannot or will not restrict their networks are effectively in the same position as PPOs. In addition, broad overlapping networks undermine consumers’ ability to perceive meaningful quality differences among health plans. Therefore, competition devolved into which health plans had the greatest market share and thus could extract the greatest price discounts in ex-

change for patient volume, or which had the most attractive combination of customer service and administrative costs.

This did lead to low premium pricing designed to increase market share, which in turn helped hold premium increases below the medical cost trend in the mid-1990s while price discounts then helped sustain market share.¹⁰ However, health plans' ability to achieve greater and greater provider price discounts diminished over time, as relative market power shifted in favor of providers. The key to extracting provider price discounts is a plan's ability to shift patients from one provider to another. With pressures from customers to offer provider networks that included all of a community's important hospitals, plans' ability to threaten to move patients evaporated. This led to diminishing price discounts.

Employers and providers today in many of the CTS markets see little prospect of major insurer entry into their markets. Although partly a reflection of the health insurance underwriting cycle (for the past few years carriers seeking to increase their profit margins have been focused more on exiting markets in which they have done poorly rather than entering new markets), it also reflects strong entry barriers in most markets. During the early and mid-1990s there was considerable local HMO creation and entry into local markets by national for-profit HMOs purchasing local plans and expanding them. Seattle's HMOs flourished initially, and entry occurred in Little Rock and Syracuse. But in some markets entry was made difficult by exclusive arrangements between locally dominant insurers and key hospital systems (Little Rock and Greenville, for example). While the underwriting cycle probably accelerated plan exits once prospects appeared less promising, recent memories of entry and rapid exit from local markets by major national plans have raised barriers for the next set of would-be entrants even higher, because "new plans" have lost credibility with providers and employers alike.

Models And Prospects For The Future Of Managed Competition

Our purpose is not just to add to the literature of "how and why managed competition failed," interesting and important though that pathology may be.¹¹ We also want to focus on the future, the central point being that few local-market participants remain optimistic that market forces will be strong enough to improve the efficiency of our health system without some kind of governmental intervention. Here we draw lessons from the collective experiences of the twelve CTS communities to comment on which kinds of governmental interventions seem most consistent with market realities and therefore might be more likely to facilitate efficient health care systems. In doing so, we rely primarily on responses to two questions that appeared on all of our interview protocols: (1) Over the past two years, did the health care market in [this site] evolve as you expected, or are you surprised by how events played out? What turned out as you expected and what surprised you, if anything? (2) Is there anything else about [this site] that we

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haven't covered that would be important for our research team to understand? If so, what?

■ **Managed competition, redux.** We do not expect serious managed competition to be resurrected. Employers are clearly reluctant to either direct workers to provider systems seen as more efficient or even pose strong incentives for workers to make such choices. Indeed, even those who would be receptive to offering their employees a choice of competing plans with unique provider networks do not see this option being offered in the marketplace. This effectively removes most tools health plans had to influence providers' practice styles, and providers (like all sellers) never saw as much to gain from increased price and quality competition as from higher revenue streams. Thus, the “third way” of managed competition as articulated in the early 1990s is probably dead as a system reform engine, although related elements will remain and evolve. For example, tiered network products, in which patients pay higher copayments to use higher-cost or lower-quality providers (as opposed to health plans), are a developing attempt to provide incentives for consumers to reward efficiency. But they are developing slowly.¹²

■ **Consumer-driven health plans.** One product innovation that is receiving considerable attention would elevate the importance of individual choices: consumer-driven health plans. This term has become so widely used that many different concepts masquerade under its banner, but the core idea is that having insurance policies with much more patient engagement in payment and choice of providers (based on information regarding providers' prices and quality) will induce patients to make more economical choices.¹³ This engagement stems from higher cost sharing at the point of service as well as an account that can be drawn on to meet out-of-pocket obligations or rolled over and saved for the future. Aside from directly lowering premiums (which employers and employees share in roughly 3:1 proportions), consumers' engagement in choice of providers and shouldering more of the payment burden is portrayed as the key to the widespread adoption of efficient practice styles and techniques, which may lower health care cost growth in the long run.¹⁴

While acknowledging that employers are “inching toward defined contribution” with sharply increased cost sharing, CTS respondents were mixed at best on the prospects for consumer-driven products to transform or even affect the health care delivery system. Many saw virtue in greater consumer involvement, but most saw greater cost sharing per se as a longer-run tool to help convey the true cost of health care services to patients. All in all, the vast majority of respondents did not see consumer-driven health plans as the panacea for reducing health care cost growth and increasing value per private health care dollar spent.

■ **Remaining policy alternatives.** So, if the absence of price- and quality-based

provider competition is the dominant reality in most markets today, and if re-managed competition and consumer-driven health plans are not likely to provide immediate solutions, what is an ambitious and serious policymaker to do?

This paper is not the place to advocate a specific health system overhaul strategy, but we can offer the observation, based on repeated site visits to the same twelve communities, that the path to a more efficient health care system is blocked by a lack of effective competition among providers. Thus, it seems clear that any policy solution must create more effective countervailing power than employers and employee/patients—alone and in conjunction with their agents, the managed care organizations—have turned out to be. Two sources of countervailing market power that might improve the efficiency of health systems on at least an interim basis were mentioned by a number of respondents: vigorous antitrust enforcement and economic regulation.

Antitrust enforcement. Some respondents wondered where antitrust policy has gone, as the potential for real competition has collapsed around them. In fact, the Federal Trade Commission (FTC) was fairly active in the health care arena during the 1990s, but it has lost a series of cases trying to stop hospital mergers, and this has stifled its capacity to prevent consolidation and increased provider market power. Appellate courts did not agree over whether nonprofit corporations, which most hospitals are, would exercise market power once acquired, and thus the FTC often could not prove its case for anticompetitive effects as it (and many observers) expected. Courts have also displayed reluctance to establish tight geographic boundaries in their review of what constitutes a hospital market. These court rulings have emboldened many hospitals to consummate mergers they might not otherwise have considered, given the large local market shares that resulted.¹⁵ In 2002 the FTC announced that it might challenge some hospital mergers retrospectively, drawing on actual pricing data to examine whether consumers have been harmed. It conducted a wide-ranging series of hearings during 2003 on various areas of antitrust enforcement in health care, presumably to communicate its increased interest in fostering competition. A recent study of hospitals and antitrust law put our main points quite well:

Attempts to prevent hospital mergers are simultaneously the most visible and the least successful aspect of public antitrust enforcement...By and large, federal enforcers brought cases that from a textbook perspective should have prevailed. The failure of these cases confirms the practical limits of law and economics in health care, as well as the continued importance of hospitals as [local] social institutions.¹⁶

Antitrust policy can prevent outright price fixing, but hospitals with market power have no need to break the law to set high prices. A quiet monopoly is perfectly legal. Antitrust policy might prevent some additional consolidation but cannot create competition where few competitors exist. Some markets, especially small and even midsize markets, are always going to have only a few major hospitals or hospital systems. Health care markets remain and will likely forever be local, and population limits, search and transaction costs, and the natural attach-

ment of patients to specific providers all limit the power of antitrust policy to create competition among providers. What good antitrust policy can do is create the conditions under which the degree of competition that is feasible, given the size of the market, may take place.

Economic regulation. Specific references by respondents to “more regulation” were almost uniformly negative in context, at least among employers, plans, and providers. Still, the absence of feasible alternatives to cost control led various respondents to mention more direct government involvement in health care markets as inevitable. Sample quotes include the following:

I think the pendulum is swinging back. What will happen is that they [the providers] will beat everyone up and then the government will come in and regulate. It's crisis management. It's not great, but it's the way we govern and manage [health care]. It's all reactive. The cost escalation is just puzzling; why it's 20 percent in health care and 4 percent everywhere else. I worry that all of a sudden employers and employees will wake up and say we can't afford this any more and opt for a government program of some kind.

The type of regulation or government program these and other respondents envisioned or feared was not specified. Tools for economic regulation of health care include rate regulation and explicit limits on resources going into health care. Hospital rate regulation was in effect in a number of northeastern states from the 1970s into the 1990s and continues in Maryland today. Research showed some success in containing costs, but it was abandoned as a result of pressure from Medicare prospective payment (implemented in 1984) on hospitals to contain costs and managed care plans' success in negotiating substantial discounts. In addition, the shift toward deregulation in many parts of the economy made hospital rate setting appear anachronistic.

Limiting capital investment in hospitals under certificate-of-need laws was far more pervasive than hospital rate setting, but probably less effective. It too eroded through the 1990s, but some states are considering reinstating or reinvigorating it in response to construction of physician-owned specialty facilities, which has posed a competitive threat to community hospitals.

In markets with a high concentration of hospitals or health plans, we have seen informal regulatory mechanisms at work. For example, Partners in Boston has made extensive efforts to justify to the community the rate increases it is seeking from health plans. Also, to contain costs, Excellus Blue Cross and Blue Shield in Syracuse has refused to reimburse for care in certain ambulatory facilities.

If formal regulatory approaches were developed, they would probably differ from the older ones by having a larger role for market forces. For example, they might require providers to participate in certified quality data consortia as well as tiered network products. This is happening informally in Syracuse, where the Hospital Executive Council is working with Excellus to develop and report hospital-specific measures of patient volume, use, and outcomes.

For dominant insurers, more activist regulation could require higher medical loss ratios, since this would increase the chances of passing cost savings achieved

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through bargaining power along to consumers. Alternatively, countervailing market power against insurers could be created through regulations that dictate rules of issue (for example, guaranteed issue for certain types of groups or products) or premium variance restrictions that in essence force a degree of risk spreading—defined to be in the public interest—that the monopolist insurer and its preregulation customers would not willingly choose. These rules redress market power disparities but stop short of single-payer governmental control of the health care system.

Regulations of this kind would represent an attempt to rationalize health care delivery using governmental power to set rules that would help counter dominant local economic power. The difference between this and the prototypical single-payer system, however, is that the regulatory apparatus in a sense superimposes the terms of trade between two “willing” classes of private entities, sellers and buyers, to mediate differential power. However, by imposing rules on two willing parties, regulation also creates incentives for its failure. Many willing buyers (such as young and healthy insurance purchasers) and all sellers would prefer to create a market transaction at an unregulated price. Self-interest in avoiding regulation on both sides of a market is notoriously difficult to suppress and enforce.

In a single-payer approach, in contrast, the government becomes the monopsonistic-buying-power half of the market itself. Proponents argue that single payer is the one system capable of fully rationalizing health care delivery based on scientific evidence, cost-effective delivery modes, and so forth, with maximum equity for all consumers and less provider paperwork burden than systems with myriad payers require, as well as the “socially decided” amount of investment in health care facilities and research and development.

But government’s having buying power is not the same as government’s using that power aggressively. Under a single-payer system, as in any regime of complete price regulation, government assumes responsibility for the financial well-being of providers, so its ability to squeeze rates is tempered by providers’ ability to make the case that access and quality would suffer. Medicare has struggled with this tension ever since its inception. It is even more difficult to imagine how a U.S. single-payer system could address use of services, since previous attempts to limit U.S. health care resources have not been successful.

Given how emphatically the nation rejected substantially more government involvement in health care decision making via the Clinton Health Security Act, it is a testament to the extent of malaise among private health care market participants today that a willingness to reconsider major government involvement surfaced frequently in our interviews during our 2002–03 site visits. At the same time,

many respondents quickly added caveats such as, “But we can’t say that out loud.” Thus, the next system overhaul discussion period is likely to be long, for much political and educational work will have to precede any consensus decision to intervene in particular ways.

Common Threads

One common thread through all current policy-response alternatives is the need for state-of-the-art evidence-based medicine and technology assessment information, as well as for data comparing quality among providers, so that consumers, providers, insurance sponsors (governments and employers), and health plans can make informed choices about how to design insurance policies and whether to seek specific services in specific patients’ cases. This is a necessary but not sufficient condition for the consumer-driven, regulatory, and single-payer approaches to work well. It is also a prerequisite for a reinvigoration of latent employer market power. Recent calls for more investment in our health information infrastructure may have considerable importance.¹⁷

Since this information has public-good characteristics, for us to get enough of it, government must invest in research and facilitate collaboration among private professional specialty societies and quality-rating or accreditation bodies. Political constraints on public-sector dissemination can be severe, so an important and multifaceted private-sector role in comparative information dissemination is also essential.

At the same time, no one should think that comparative quality and effectiveness information alone are the long-awaited silver bullets for our health care system. Much of medical practice remains in gray areas without unambiguous scientific evidence and is likely to remain so for quite some time. Hard choices about competing resource uses and social values in the face of irreducible uncertainty lie ahead.¹⁸ Better data on quality and effectiveness would improve the knowledge base underlying these choices, but the choices will be hard in any case.

What is palpable across the twelve communities we studied is the recognition that private market forces are limited in their ability to achieve social objectives in health care services, and a growing sense that a broader conversation about what to do next should begin soon. This conversation may find more willing participants than would have been possible four to six years ago.

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NOTES

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- Medicare Beneficiaries, 1998–1999 to 2000–2001,” *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
3. In a “technically efficient” health care system, *unnecessary care* could be defined by neutral health professionals on the basis of expected clinical value added. This might preclude some services that some consumers might value and thus is not the same concept as an economically efficient system. Economic efficiency elevates consumers’ sovereignty above the judgment of “experts” and might entail more or less total resource use than minimizing the cost of delivering objective clinical value. We adopt the technical definition of *efficiency* in this paper, for we think that it is closest to what most commentators mean when they discuss an efficient health care system.
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 5. P. Starr and W.A. Zelman, “A Bridge to Compromise: Competition under a Budget,” *Health Affairs* (Supplement 1993): 7–23.
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