Competition and Health Cost Containment: Cautions and Conjectures

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Competition makes for better health care. It's just that simple.
—DONALD S. MACNAUGHTON, Chairman of the Board, Health Corporation of America, advertisement in *The Wall Street Journal*, January 23, 1981

We have no valid basis from which to project the effect of competition on the traditional system.
—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (in U.S. House of Representatives, Interstate and Foreign Commerce Committee, 1972)

Any economist's assessment of the workability of competition is likely to have a highly provisional and even personal character and is likely to rest heavily on the ad hoc assessment of obvious alternatives in given situations.
—JOE BAIN, 1950 (quoted in Katzman, 1980)

LIKE OTHER WESTERN NATIONS WITH UNIVERSAL OR near-universal health insurance coverage, the United States has debated at length about public policies to contain health care costs. Unlike other western nations, however, the United States has shown intense interest in "market approaches" based on "incen-

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tives" and "competition." Two market approaches have received close attention. One would manipulate consumer cost-sharing, especially deductibles and copayments, in order to bring a larger share of the cost of health services to bear on consumers and thereby encourage them to shop around carefully for "efficient" providers when they seek care. The second approach would design incentives for consumers to join efficient, organized health care systems, usually health maintenance organizations (HMO) or some other variant of prepaid group practice (PGP).

Consumer cost-sharing is a familiar feature of United States health insurance—consumers pay directly about 32 percent of health care costs. Specifically, in 1979 consumers paid directly for 8 percent of hospital, 37 percent of physician, 73 percent of dental, and 84 percent of drug expenditures (Gibson, 1980:1, 8). Apart from various federal financing programs, however, cost-sharing in insurance has not been incorporated in public policy, much less made the foundation of a market approach to cost containment. Development of HMOs, on the other hand, has been the aim of various federal policy efforts since 1970, and the search for policies to enlarge the number of HMOs and HMO-like entities goes on earnestly.

These market approaches appear to share three basic assumptions: first, that more efficient health plans (whether innovations along traditional indemnity lines or organized systems like HMOs) would be developed on a large scale if consumer demand for them were stronger; second, that the presence of these efficient plans would introduce vigorous price competition into health care markets, and therewith cost containment without extensive public regulation; and third, that the major obstacles in the way of these desirable developments are public policies reflecting the failure of consumer-voters to recognize their true collective interest in less expensive health care arrangements.

Although the reasoning behind market approaches is largely theoretical and deductive—which is to say, conjectural—it has been advanced and elaborated in some quarters with evangelical zeal. This paper attempts neither to refute these propositions nor to argue against market approaches. Its purpose is rather to offer some cautions and counterconjectures, calling attention to political, institutional, and organizational considerations largely ignored or assigned to the sidelines in the individualistic images of the market advocates. This essay will argue that the translation of reformed incentives and demand

patterns into efficient health care organizations is by no means a simple or straightforward process, that there is now little basis for estimating the cost containment potential of competition among health care plans, and that the consumer's interest in efficiency—and therefore in new organizational forms and in competition—is very poorly understood. In sum, the appeals of the market approaches are not "just that simple."

It may be objected that yet another explication of the complexity of it all is neither an original nor a useful contribution to policy analysis. It is impossible not to admire the parsimony of incentives disembodied from their organizational, institutional, and political contexts and spun out in an elegant causal web weaving together consumer calculations, organizational formation, interorganizational behavior, and a more efficient health care system. Yet, not all analytical simplifications useful for generating policy *ideas* are also useful for generating policy *strategies*. Especially in today's high tide of political enthusiasm for market approaches to cost containment, there may be some point in recalling the obvious: that some simplifications are simplistic and therefore possibly misleading to policy makers.

This paper will draw upon certain aspects of public policy experience with HMOs to raise its cautions and conjectures. HMOs are a useful focus for three reasons. First, most practical experience with market approaches derives from HMO development efforts. Second, some proposed market approaches depend heavily on HMO-like entities to embody the right incentives and to trigger the competition which revitalized markets are thought to demand. Third, some market advocates believe that HMOs are the best means of overcoming the many well-known deviations of health care markets from perfect or normal market behavior. For example, it does not matter that physician suppliers tend to define the degree and type of consumer demand or that consumers lack the information and interest to shop around for efficient suppliers of care if physicians, by going to work for an HMO, and consumers, by subscribing to one, can be led to "precommit" (Fuchs, 1979:170) themselves to efficiency.

The origins of the federal HMO development strategy need no more than a brief review here. Faced with the need to do something about rising health care costs, but unwilling to adopt extensive regulation, consumer cost-sharing, or national health insurance, the Nixon administration was persuaded in 1970 that an attempt to build health

maintenance organizations, entities which took the "skeleton" of famous prepaid group practices such as the Kaiser-Permanente Plans and implanted it in highly diverse and flexible organizational forms was an attractive market approach. In 1970 the administration asked Congress to create a new HMO option for Medicare recipients. In 1971 it began using discretionary funds to plan the development of about 100 HMOs around the country. In the same year it proposed that Congress create a special HMO development program. If this were done, the Department of Health, Education, and Welfare (HEW) argued, there might be 1700 HMOs within a few years with perhaps 40 million people enrolled (U.S. Department of Health, Education and Welfare, 1971:37). After long debate Congress passed an HMO development program in 1973; the program, amended in 1976 and 1978, remains in existence today. Results, however, have been relatively unimpressive: today there are about 230 HMOs, enrolling about 4 percent of the population (about 9 million people). Some believe that the federal government itself is largely to blame for these modest accomplishments: the 1973 law, it is said, was unworkable, and administration of the program was poor. Not until the amendments of 1976 and an administrative reorganization in 1977 did the program get a fair chance. This essay cannot evaluate this view in detail. An alternative explanation is worth considering however: that the policy analysis behind the HMO development effort was flawed in important ways, that a rapid growth in HMO numbers and enrollment was simply not an outcome the federal government was equipped to bring about.

Incentives and Institutions

Throughout the 1970s, federal policy makers dealing with HMOs cheerfully relied on two code words reiterated by policy analysts—incentives and competition—tied together conceptually by a third code term, market approach. To professional economists who use these terms regularly, they denote—at least sometimes—processes with rigorous definitions and concomitants. To many of the policy analysts and policy makers engaged in HMO-building, these terms had a host of vague and imprecise, but nevertheless ambitious and seductive, connotations. HMOs promised such all-American ends as pluralism, choice, efficiency, and reorganization achieved by such all-American

means as markets, incentives, and competition. The correct manipulation of conceptual elements produced a strategy that would yield both cost containment, attractive to all but especially to conservatives, and a challenge to fee-for-service (FFS) medicine, attractive to the innovation- and reform-minded. Equally important, it appeared to ensure that rarity—a solution that would satisfy both ideological camps. According to HMO proponents, the organizations would contain costs, improve access, and enhance quality of care, without tradeoffs among these goals and at little cost to the federal government. Policy makers seldom encounter so compact and glowing a package of policy assets, and it is no wonder that they rushed to embrace it.

HMO advocates extrapolated basic assumptions and relationships of economic theory to the health field and to HMOs in particular, promising that the combination of new incentives and reinvigorated competition would produce market conditions that would lead in turn to a better and more efficient health care system. This economic reasoning gained force from its close coincidence with the two major reformist strains of that school of thought within the health community that has long argued for a reorganization or restructuring of the health care system not by means of government rules but rather by means of changes in financial incentives.

The first school of reformers calls for "industrialization" of the health care system. In this view it is socially and economically absurd that a highly specialized, high-technology field like medicine should continue to be organized in small "cottage industry" units of solo practitioners integrated ad hoc with hospitals, payment mechanisms, medical centers, and other institutional fragments in need of coordination on behalf of care of the whole person. The reformers view a rearrangement and coordination of the fragments in larger-unit organizations, which would make the scale of production conform to the technology of the industry, as the logical solution. The HMO, an organization that combines in one setting doctors, clinics, hospitals, administrators, and consumers (or at any rate brings them together in one plan) and, under a central financial administration, assumes full responsibility for the comprehensive health care needs of members struck some as the ideal embodiment of this reorganization (Ellwood et al., 1971).

The second reformist strain calls for the replacement of FFS payment modes with thoroughgoing prepayment. The critique is straightforward: FFS reimbursement gives physicians an incentive to supply

excessive care to the consumer. Requiring doctors to provide care on a fixed budget set in advance and to share in the risk of exceeding that budget, as in an HMO, reverses the illogical incentive system of FFS. At the same time, the organizations' need to compete for customers assures not only that doctors will avoid giving too little care for economic reasons but that on the contrary they will treat patients early, indeed keep them well, in order to hold down costs.

The synthesis in one organization of comprehensive delivery and prepaid financing yielded a rational, self-regulating entity which, when set down in the larger system, would by the competitive pressures of its efficiency, force that system to change its ways: the result would be improved health care through the self-regulation of the market. This image, a fusion of reformist thinking popular among many progressive health professionals since the reports of the Committee on the Costs of Medical Care in the 1930s and of arguments widespread among health economists, generated the reasoning that the HMO proponents advanced and the politicians accepted.

To these analysts, to high-level Health, Education, and Welfare (HEW) officials in the Nixon administration, and to many legislators, the logic of the HMO initiatives seemed to be almost intuitively obvious. Clearly the incentives of the FFS, third-party system were illogical, the reverse of what they ought to be. Doctors were getting paid to treat the sick; and the more they treated them, the richer the providers grew. Obviously the federal government should attempt to "leverage" change to unite prepaid financing and group practice in responsible organizations that would reward doctors financially for keeping patients well and thereby embody correct and logical incentives. Once put in place, economic laws governing the HMO's internal incentive system would lead to competition in the larger system and, thereby, would produce high-quality, accessible care, efficiently delivered, in the system as a whole. Small federal sums to cover the start-up costs of HMOs might therefore go a long way.

The proponents were too ready to accept the assurances of the literal model of HMOs that economic processes would reconcile quality, access, and cost in the highly desirable ways predicted. But, even if one granted the proponents their predictions, the difficulty remained that they took for granted the most problematic element of the exercise, the organization-building process, those coordinated contributions needed to put an HMO together in the first place. In George

Homans' words, economic theory may have considerable success at explaining "behavior once the institutions are given," but "it is much more difficult to explain the institutional conditions themselves." Although economic theory may be, as Homans put it, "lucky in being able to take institutions pretty much for granted" (Homans, 1967), those who resort to economic theory for policy analyses may enjoy no such luck. The HMO episode demonstrates a central irony and limitation of economics-based policy analysis in the health care field, namely, that an orientation that takes so little direct account of the institution-building process generates so often and so enthusiastically recommendations that presuppose heroic institution-building efforts.

Under the spell of the model, policy makers failed carefully to consider the HMO as an organization, as a system of contributions. Instead they tended to view it as some unitary entity the existence of which was contingent mainly on the right amounts and composition of federal aid. In the eyes of the administration many HMOs—indeed 1700—could be launched with small federal sums because, so long as requirements were kept few and flexible, private sponsors would rush in with private capital. To Senator Edward M. Kennedy (D-Mass.) and other liberals, an indefinitely large number of HMOs could be started if only the federal government put up enough billions of dollars. Debate then turned to the problem of finding middle ground between these unacceptable extremes. What should be the relative importance of grants versus loans? What, if any, role should subsidies play in the program? What type of plan should be eligible for what type of aid, and so forth? Between the abstractions of the policy analysts and the details of the lawmakers, basic "middle-range" questions were largely overlooked—assuming the presence of federal funds, large or small, who would want to claim them? What would they do with them? What results could be expected?

Unfortunately, the plausibility of the HMO concept as a policy strategy depended heavily on answers to precisely such questions as these. Why would sponsors launch HMOs? Why would physicians go to work for them? Why would consumers subscribe to them? Why would hospitals cooperate with them? Even if one granted that the incentives of the ideal-typical HMO would work as intended *if* these contributors contributed, what incentives did the proposal offer them *to* contribute and to keep contributing in harmonious interaction over time?

This simple question had an equally simple answer: few. But except for some program specialists in the Social Security Administration and the Health Services and Mental Health Administration, whose advice on the HMO proposal was sought as a matter of politeness and then ignored, no one appears fully to have recognized the importance of these questions. The questions did not fit the analysts' model, which addressed the behavior, not the creation, of institutions; nor did they enter the early deliberations of politicians more accustomed to thinking expansively about the formidable leverage of federal grants than about their limits. As events soon showed, however, neglect of these questions proved to be a severe deficiency in the HMO strategy.

A little familiarity with the evolution of the United States health care system, or for that matter a little rumination, detached from the ideology of markets, incentives, and competition, might have shown not only that it was unlikely that key contributors would find themselves strongly induced to form and support HMOs but also that they faced strong disincentives to do so. Basic, bedrock trends in the health care system—not by-products of faulty incentives, but deeply-rooted elements of consumer psychology, professional culture, and organizational character—worked against the growth and development of HMOs. First, the tendency in the United States (and indeed in most of Europe) to entrust the financing and delivery of care to separate hands made it unlikely that *sponsors* (some of which, such as hospitals, dealt only with one of these functions, and others of which, such as industrial firms, dealt directly with neither) would attempt to integrate both functions in an HMO under their own auspices. Second, the growth of FFS group practices allows *physicians* to enjoy most of the advantages of prepaid group practices while accepting few of their constraints. Third, steady expansion of third-party payment health insurance plans, encompassing an ever-larger share of medical bills (including outpatient bills) and reducing the consumer's direct share of costs, undercuts the HMO's appeals to potential *subscribers*. Fourth, the tendency to perform more medical functions of an increasingly complex and costly technological character in *hospitals* sets hospitals that have based their organizational arrangements and budgetary expectations on this trend at odds with the decreases in inpatient use (and therefore in revenues) that an HMO's accustomed mode of operation entails. For these and other reasons, these contributors have

strong interests in keeping separated processes the HMO internalizes. In theory, industrialization—pulling together into one organization processes previously performed by interaction among several—is a highly rational and responsible approach to reforming the system. In practice, incorporating matters handled by interorganizational relations within an intraorganizational framework may raise levels of interdependence, problems of coordination and control, and therefore conflict to levels that potential participants find unacceptable and therefore face a strong incentive to avoid.

American policy makers might have made more realistic judgments about the prospects of the HMO strategy if they had considered European experience. In Europe, PGP arrangements were once widespread. Health care was provided under the auspices of unions, churches, fraternal groups, and other voluntary associations that contracted with doctors for fixed prepaid sums on behalf of their members (Glaser, 1970). But these arrangements rarely survived the introduction of national health insurance, with basic benefit entitlements and free choice of physician for most of the population.

One lesson of this experience is that, although much of the population will accept, indeed welcome, care provided by PGP-like arrangements in the absence of universal coverage, broad entitlements lead to a demand for freedom of choice of provider. Another is that the principle of free choice of providers—the precept that any qualified physician can treat any entitled beneficiary—is also very important to doctors. In Germany, "from 1892 on, these issues, the physicians' access to sickness fund practice and the patients' freedom-of-choice, dominated discussion between sickness funds and the medical profession" (Blanpain et al., 1978); and "freedom" steadily gained ground, as it has also in other European nations.

To be sure, the United States differs from Europe in an important way: the privatism and diversity of American health insurance policies permit extensive competition among insurers. By offering more value for the subscriber's dollar, it has been argued, HMOs might attract a sizable market share. Even so, comparative analysis suggests that it is unlikely that the United States population, increasingly well covered by third-party plans allowing freedom of choice of provider and financed in ever-larger degree by employer contributions, will foresake their freedom for closed panel plans. Comparison also shows the implausibility of the view that doctors, many of them resistant

to group practice of any sort, will move in large numbers to *prepaid* group practices, or that many of them will voluntarily foresake FFS reimbursement for salaries or capitation.

The moral—simple, unsubtle, but pertinent—is that incentive-based syllogisms that derive conclusions from a chain of highly problematic institution-building processes should not be taken for finished and plausible pieces of policy analysis. The fundamental weakness of the HMO proposal was that it rested on an uncritical application of the concept of incentives. This concept is, of course, one of the most useful and widely used in the social sciences and perhaps the most widely used in policy analysis, but it is not the all-purpose tool it is sometimes taken to be. That policy should "change the incentives" to bring behavior into line with what government seeks has the ring of unassailable insight, eternal truth, elegant simplicity. Not surprisingly, some policy analysts have apparently persuaded themselves that the merest flick of an incentive system can, like Sumner's mores, make anything right. The right incentives, one is assured, will lead businesses back into central cities (the "urbank" and "urban enterprise zone" proposals); make companies produce and consumers buy much less gasoline (decontrol of gas prices); lead polluting firms to pollute "optimally" (pollution taxes, fees, and "rights"); make lower-class persons behave like solid, hard-working middle-class citizens (improved "objective opportunities"); and lead doctors who, poor benighted souls, would otherwise treat patients only when they have become ill, to suddenly start keeping them well (HMOs). Very likely, incentives are capable of doing some of these things to some degree and others very little or not at all; however, the fact is that remarkably little is now known about what policy problems successfully lend themselves to what types of incentive-based solutions.

An incentive is simply a reward or penalty. It is, of course, an elementary and powerful psychosocial truth that people tend to respond to rewards and penalties. This truth, however, cannot be applied wholesale and unrefined to policy analysis and translated directly into useful practical advice. Individuals face incentives; systems have properties. Although system properties are not wholly distinct from individual incentives, they are not wholly reducible to them either. Incentives are embodied in sociopolitical and psychocultural contexts, embedded in institutions, in a word. In some cases, this fact may be disregarded without harm; in others, reliance on disembodied

incentives may render policy advice useless or worse. It is therefore highly apposite to seek principles that distinguish between these situations.

Of any proposal to manipulate incentives as a policy device, three questions should be asked at the outset. First, who must be made subject to the incentives if the desired outcome is to occur? Second, how do these individuals define rewards and penalties; that is, how do their values bear on the incentives under discussion? Third, how large must the inducement be to bring about the desired outcome? The first question is institutional: that is, it requires a canvass of the major participants in the delivery systems (or whatever) to be changed. The latter two are psychological and cultural: they require an analysis of values and norms. Unless the answers to these questions are relatively straightforward and favorable, the postulated play of incentives is likely to be hindered, and the incentive approach may not work.

In cases where it is reasonable at least for analytic purposes to picture the policy problem as one of bringing about the proper relationship between government and individual, the three questions may have direct and actionable answers. For instance James Q. Wilson has shown that in thinking about crime it can be useful to disengage from deep causal issues, look at the problem as one of the available measures government may take vis-à-vis criminals, and then ask what incentives (in this case, deterrents) government possesses. The "who" is the criminal, the "what" is the loss of freedom, and the "how great" involves deprivations of liberty of greater or lesser periods (Wilson, 1977).

Most relationships government attempts to influence by means of policy are more complex. Education, for example, is a policy area in which research has pointed out the presence and importance of previously unrecognized patterns of influence. This discovery led in turn to newly-perceived perplexities in policy-making. The findings of James Coleman and his associates (1966) on the correlates of educational achievement among elementary and secondary school students introduced into what had generally been regarded as a relationship among government, school, and student a fourth powerful variable—family background. Coleman (1972) threw new light on the relationship between government policy and educational achievement precisely because he refused to eschew causal analysis in favor of policy analysis, insisting instead on searching for the influence of hidden

forces behind accepted images. The be sure, the Coleman findings made the policy question appear far less actionable than it had seemed before. Had the researchers limited themselves to policy analysis in the narrow sense, however—to discussion of readily available "policy tools" for the "manipulation of objective conditions" (Wilson, 1977:159, 161)—they would have missed what may be the heart of the matter.

Failure to appreciate the nature and complexity of health care institutions and their implications for the HMO-building effort is the most important explanation for the disappointments of the HMO strategy. Eyes fixed on the theoretical virtues of the HMO as an institution, the analysts gave too little thought to the complexities of bringing these institutions into being. It was apparently thought sufficient that government dangle seed money (an incentive) before the eyes of entrepreneurs. But the organization-building process was far more complex than this: government must attract sponsors who must recruit and socialize providers (physicians and hospitals) and then attract and place under the (properly functioning) providers' care a sizable number of consumers. In a fair assessment of the plausibility of this strategy, the trio of questions mentioned above—who, what, and how large—was crucial but almost entirely neglected by the analysts' model. The dependence of the comprehensive, responsible HMO on four sets of actors—sponsors, doctors, subscribers, and hospitals; the complex interplay of economic, political, cultural, psychological, and organizational variables in forming the tastes of each group for what an HMO offered them; and the strong forces working against building and joining HMOs were central to assessing the proposal's promise.

HMOs, in short, should be viewed as complex organizational coalitions. Their formation and stability require not only that consumers demand them (whatever this means in practice) but also that this demand be felt strongly by sponsors, physicians, and hospitals, which may have strong preferences against building or participating in HMOs. Then consumers who demand HMOs in general must accept and select them in concrete choice situations—quite another matter. Had these factors been taken into account, the exercise would have disrupted the advocates' agenda. The contingent and high-risk nature of the strategy would have been exposed; goals and expectations would have been scaled down; a system-wide reorganization would have been

neither promised nor predicted; the "numbers game" would have appeared foolish; and politicians might have lost interest.

Competition and Complexity

Even if health maintenance organizations could be built effortlessly and in large numbers, it is unclear what policy impact they would have. HMO proponents generally took for granted that the competitive presence of HMOs in the larger system would create incentives that would actualize the theoretical virtues claimed on behalf of competition. Unfortunately, the outcome the analysts confidently predicted lies mainly in the realm of the deductive.

Although the analysts' theories relied on a bilateral image to deduce the benefits that the presence of cost conscious HMOs would bring about—the HMO versus its FFS competition—the process is in reality multiordered, highly complex, and only partially responsive to economic and competitive forces. To accomplish their postulated effects, HMOs must make their presence felt on each of five variables, each subject to a complicated mix of competitive and noncompetitive, monetary and nonmonetary forces of varying strengths. These variables are consumers, technology, physicians, hospitals, and third-party payers. In the health field, there is no single, personalized object—the benefit-cost-balancing criminal to be deterred, for example—at whom the government may beam its incentives. There are instead five loosely-linked elements each of which is driven by forces significantly distinct from those driving others and each of which is therefore differently susceptible to diverse types and strengths of governmental incentives. To understand the impact of an HMO or of other types of competition, one must explore the values each of these five variables assumes in the presence of the new competitor. Only in this way can one predict whether an input injected at the beginning of the complex chain of cause and effect may be expected to generate the predicted and desired output, or indeed any recognizable output at all. All five variables should be kept simultaneously in view. Insofar as they fail to set HMOs in their full institutional setting and thereby fail to keep interdependence and interaction constantly in view, analysts will fail to get an accurate reading of the efficacy of an HMO's competitive

incentives. Unfortunately, however, not enough is known about the values of these five variables to support confident policy analysis, much less the bold promises of the HMO advocates.

Put simply, health care expenditures reflect five forces: (1) the nature and extent of consumer expectations; (2) the nature and extent of medical technologies; (3) the number and behavior of physicians; (4) the number and organizational character of hospitals; and (5) the structure and scope of third-party payment mechanisms. These variables interact with one another in local delivery systems and therefore must be taken into account in formulating policies at the federal level designed to change these systems. Over time, all five variables have assumed values that call for more and better medical care. Larger numbers of consumers (some of whom find care newly accessible as a result of federal programs) bring ever-higher expectations to the system. The growth of medical knowledge and the diffusion of medical technologies generate an ever-larger number of more costly procedures which become part of popular and professional definitions of good care. A growing number of doctors, facing these expanding consumer expectations and technological opportunities, have a strong professional and economic interest in giving each patient the most and the best. Hospitals in search of organizational prestige and high-caliber medical staffs have expanded their beds, facilities, equipment, and services—and therewith their costs. The growth of third-party payment plans, in which insurers tend to reimburse providers with less than a sharply critical eye, has added fuel to all these expansive, expensive developments.

The number of variables and the complexity of their interactions place great obstacles in the way of policy analysis, that is, recommendations for governmental action based on some combination of theory and research. Sound analyses should neglect none of the five variables, but the variables embody processes very different from one another and therefore disrupt lines of disciplinary specialization. Physician behavior should be viewed not only from the standpoint of economics but also from those of the sociology of professions and even anthropology. Consumer expectations and behavior require the insights of psychology, sociology, and economics. Understanding medical technology demands these disciplines and an admixture of natural science. Hospital and insurance firm behavior is probably best illuminated by organizational analysis. Taking variables out of context

and examining them in the light of one discipline alone (say economics) guarantees distortion. But examining the full range of variables in the light of several pertinent disciplines mainly exposes the complexity of it all, induces humility and restraint in the student, and leads to cautious and circumscribed policy analyses or to none at all. Those who understand the system most fully tend therefore to be least entrepreneurial in their recommendations and tend least to seize or attract the ear of policy makers. Conversely, policy advocacy in the health field presupposes a capacity for gross simplifications.

Unfortunately, the simplifications of the policy analysts may lead to misunderstandings; for, if complexity may be willed away in the analytic world, it keeps breaking into the real world. A policy analytic input in the health field must make its way through five "black boxes"—consumers, technology, physicians, hospitals, and insurers—each with different institutional properties that skew and distort the input as surely as a prism skews and distorts a ray of light beamed through it.

The HMO strategy works insofar as it injects competitive pressures that break into and restructure the interinstitutional processes that uncritically favor more and "better"—and more costly—medical care. The problems, then, are to specify how and how far these processes are subject to competitive pressures and how and how likely HMOs are to exert such pressures. The question, in sum, is how might HMOs affect the market characteristics of the United States health care system?

Judging by the confidence with which HMO proponents and other advocates of competitive solutions to medical care inflation advance their various proposals, one might conclude that the market behavior of the medical care system is well understood. This is not the case. Indeed, in the cases of consumer and physician behavior, there does not exist even a well-developed vocabulary with which to name and describe processes, let alone a model that links processes to one another in patterns useful to policy makers. As a policy tool, however, competition presupposes consistent behavior and an ability to make refined predictions about it, and it works if, and only if, it affects the major variables in anticipated and desired directions. The literal theory of HMOs promises precisely this: HMOs, offering broader benefits at substantial savings over FFS competitors, will pressure third-party payers, physicians, and hospitals into curbing their own costs and

thereby altering both their uncritical uses of technology and the efficiency of the care they offer consumers. But it is doubtful that any of the five variables is highly susceptible to competition in the sense in which the term has traditionally been used in economics and in which the literal HMO theory used it.

For one thing, the proposal presupposes that HMO efficiencies can be brought to bear directly on the financial calculations of the consumer and that the consumer will respond primarily to these financial considerations. But as conventional third-party plans financed increasingly by employer contributions to employee health premiums have spread, the individual's share of the cost of his health coverage has declined, thereby reducing his incentive to choose the efficient plan. In 1977, employers contributed 100 percent of employee health insurance premiums in 57 percent of cases (Phelps, 1980:62). Second, although the HMO may be the efficient plan, it is in many places also the more expensive plan, often demanding a payroll deduction larger than that required to join the competition. Although the HMO may offer more coverage for each dollar, consumers may not value the additional coverage enough to be willing to incur the deduction. Third, consumers do not choose health insurance on financial grounds alone. Matters of style and taste—for one's present physician, against "clinic medicine," for freedom of choice in general, or against the HMO's hospital in particular, for example—also affect the decision. Little is known about these elements of consumer choice. It is therefore little more than guesswork to try to predict how a change in a financial incentive aimed at the consumer's pocketbook—in this case, introduction of an HMO—will affect his health care coverage decisions.

Nor is it clear that competition among plans will alter medical norms so as to make the technological imperative less powerful. In the quest for a competitive edge, HMOs may substitute less for more technically intensive care, but here too noneconomic variables intervene. Unless the plan offers the most and the best and gives physicians a reasonably free hand to practice good medicine as defined by their professional training and outlook, it will have difficulty attracting and retaining good physicians. Also pertinent are the consumer's expectations that membership in an HMO will not oblige him to forgo the advances of modern medicine, and physicians' risk of malpractice suits if they fail to do "all they could."

Moreover, unless the HMO owns or controls its own hospitals, it

will share in the costs of the acquisition and use of technology along with the hospital's other clients. In the quest for organizational prominence hospitals will, unless constrained by public regulation, seek to be the first in town with the latest medical gadget. If they acquire it, they will try to use it; and, to the degree that they succeed, HMOs relying on that hospital will partake of the costs. Perhaps sustained HMO competition could have some impact on the diffusion and use of technology by doctors, hospitals, and insurers in the larger system. How such competition works, and how large its effects might be under different circumstances are unclear, however.

If competition is to be felt and acted on, these feelings and responses must come from providers of medical care and coverage; namely, doctors, hospitals, and insurers. These providers display odd blends of competitive and noncompetitive processes, however, about which much remains to be learned. In most places, health insurance is a competitive business: the competition takes place mainly between nonprofit Blue Cross and Blue Shield plans and profit-making commercial plans seeking the business of large purchasers (notably employers and unions); and it is carried on in the economic media of premiums, costs, and benefits offered. Hospital costs, on the other hand, are usually driven by competition of a very different type—among predominantly nonprofit institutions that advance their organizational interests by competition not in the currency of price but of quality, or at any rate the technological and professional trappings of quality. The production functions of the quality- or image-competitive hospitals and the costs that ensue naturally complicate the economic logic of predicting the behavior of the price-competitive insurers called upon to pay hospital bills.

Physician behavior responds to still other forces; the degree to which the term competition accurately captures these forces has been little studied and is little understood. Physicians are often said to monopolize the provision of medical care services, and from this it is often thought to follow that new competition would be a good and efficient thing. This assessment of the problem, however, rests on an uncritical use of language. Throughout the United States economy, Lester Thurow (1980) writes, "it is becoming . . . less and less clear what a monopoly means." In the health care sector, "which in the main consists of a multitude of relatively small private service units" (Mott, 1977:238), the meaning of the term has never been clear.

The basic problem is not that physicians monopolize services in the traditional economic sense (indeed those who charge monopoly often acknowledge in the next breath that medicine in the United States is a cottage industry) but rather that physicians claim expertise over the proper application of medical care in general and over the amounts and types of care that particular consumers ought to demand and that physicians ought to supply. The problem, in Freidson's (1970) words, is "professional dominance" not "monopoly." Using the latter term enthrones lack of competition as the central cost problem by semantic fiat. If monopoly is the problem, then breaking the monopoly must be the corrective. Viewing the problem as one of the demand-defining capacities of professional suppliers places the question in a very different conceptual and practical light.

Physician behavior is a complex tapestry of professional (including personal, cognitive, peer-related, and ethical) and financial considerations about which abstract economic reasoning conceals at least as much as it clarifies. This complexity presumably explains the remarkable disagreement among policy-oriented economists on the effects of increasing the supply of physicians. Some argue that such a step would be a disastrous invitation to enormous increases in treatments and costs as physicians used their demand-defining powers to maintain "target incomes," that is, those incomes they believe they have a right to achieve as a consequence of years spent in acquiring expertise. Others contend that the competition engendered by an increased supply of physicians would drive charges down and thereby strike a blow for cost containment. The disagreement cannot be resolved because the nature and consequences of competition in physicians' behavior have not been well explored.

Despite the predominance of economists in the health policy literature, surprisingly little careful empirical attention has been given to exploring what such terms as "markets," "competition," and "well-functioning market competition" mean or might mean in health care services and what their actual or possible meanings mean in turn for public policy. Those accustomed to envying economists for analytical and empirical rigor can only marvel at their widespread disagreement over seemingly elementary descriptive matters in the health field.

One analyst will cite the private character of the United States health care system, apparently taking it for granted that nonpublic and market-based are synonymous. A second will compile long lists

of the ways in which health care services deviate from the assumptions that support classical market theory and take an agnostic or highly cautious position on policy solutions. A third analyst, looking at the very same list of deviations, will offer heated assurances that policy makers can solve their problems only by strengthening or introducing competition, market forces, cost consciousness, and the like. A fourth will declare firmly that markets and market forces do not and cannot work in a field with the peculiar properties of health care, while a fifth bitterly deplores the American tendency to treat health care as a commodity to be bought and sold.

It is far from clear what should be expected from increased competition in the health care field. Empirically, only two competitive effects stand forth clearly: first, in the largely nonprice-competitive hospital sector, organizational competition has fueled an "arm's race" for newer and better technology without much regard for costs; and second, in the reasonably price-competitive insurance sector, competition has made it difficult for poor risks, those with unfortunate actuarial attributes or an unfortunate health history, to get coverage—in short, it has promoted skimming and creaming. Competition with experience-rated commercial insurance plans forced Blue Cross to abandon most of its community rating long ago, thereby creating problems that made the case for government intervention by way of Medicare and Medicaid. Neither competitive effect is socially desirable, yet no others may be clearly attributed to competition in the health care field.

Given this institutional context, one should be skeptical of theoretical assertions that the introduction of an HMO into the larger system will produce all manner of reforms and improvements. A realistic assessment of the prospects requires answers to two questions. First, to what extent and how do HMOs compete? Second, to what extent and how do conventional plans respond to this competition? Answers come less easily than one might think.

The same factors that make HMOs difficult to build by blueprint also make it difficult to explain in general terms what makes them competitive. Competitiveness turns on highly particular and local aspects of a plan's setting: location, the attitudes of employers and employees, the generosity of employers' contributions to the health coverage of their workers, and others. It also turns on highly particular strategic choices of management: staffing decisions, the appearance

and design of facilities, utilization controls, marketing assessments and efforts, and others. The "correct" interaction and balance among these many variables define a plan that is *able* to compete. But the list of variables yields no general formula for competitiveness that applies equally to all plans. Some will be more competitive than others for reasons of time, place, and circumstance.

Obviously HMOs must in some sense compete; this truism means nothing more than that HMOs cannot be indifferent to how the price and contents of their product compare with those of other products. Fewer conclusions follow logically from this fact than is sometimes supposed, however. It takes at least two parties to create a competitive setting; and, if one or both of the potential competitors is substantially insulated from the ordeals of competition, competitive discipline relaxes for the other too. Ability, will, and need to compete are different matters. None follows directly from the others.

Competition may be expected to have its intended effects only if, first, both competitors must absorb their own true costs over time and, second, both can control their costs. Medical care markets frequently violate both assumptions, at least in the case of the HMO's major competitor which is usually, though not always, a Blue Cross plan and which will be designated here by the shorthand term "Blue Cross." Blue Cross plans convert increased costs into higher premiums passed mainly along to employers and then to workers in the form of smaller wage increases and to the public at large in the consumer price index. Not all—indeed sometimes not any—of the increases are borne directly by the individuals whose coverage the premium purchases. Nor are these plans well suited to control costs. Although they may monitor and investigate claims for payment submitted by enrollees and providers, too much fastidiousness and too many disallowances generate conflict and may be worse for business than premium increases. These important areas of competitive insulation in Blue Cross operations define in turn the competitive challenge faced by HMOs.

If the HMO's competitors are themselves inflationary and lax, the HMO can loosen up too and still remain competitive. So long as the HMO offers broader benefits for not a great deal more money, it will be, everything else being equal, competitive even if it does not maximize its savings, indeed even if it is almost as inefficient as the competition.

The literal theory of HMO competition assumes that HMOs will attempt to maximize savings—that is, exploit to the hilt the various efficiencies inherent in the HMO structure; but plans may often prefer, in Herbert Simon's term, to "satisfice." If a plan is attempting to reach the break-even enrollment point or to grow very rapidly, it does indeed face incentives to maximize, that is, to offer the broadest possible benefits for the smallest possible price. There are high organizational costs as a result of maximizing, however; and a plan that is running in the black and growing as fast as its facilities and preferences dictate will weigh these costs carefully. Two costs of maximizing are of special importance: first, the strict utilization controls required to ensure that care is allocated tightly and in accord with least-costs principles may alienate doctors and set them in conflict with the administration; second, strict economies and efficiencies might give members the impression that HMO care is a bargain basement brand with distinctively different norms from those prevailing in the mainstream. Plans with very well socialized physicians and members may be able to maximize savings without incurring these costs, but no economic laws ensure that these human elements will behave as they should. Moreover, even plans in urgent need of building enrollment in order to break even need not force costs and premiums to their lowest feasible levels in order to do so. Instead, they may mount an aggressive marketing campaign by expanding contacts with unions and employers or step up their advertising. These qualifications to the maximizing model—that stable plans need not maximize, that to maximize carries high organizational costs, and that alternatives to it exist—should be considered in estimates of the strength and nature of competitive pressures exerted by HMOs. The notion that HMOs may be satisficers has received little analytical attention. To the degree that they do satisfice, however, injecting HMOs into the larger system is unlikely to have the direct, sizable results foreseen by adherents of the maximizing model.

A reasonable assessment of the competitive impact of HMOs should, in short, take close account of the market positions and organizational characters of both HMOs and their competition. A priori, one might expect competition to be most vigorous between young HMOs in search of a break-even enrollment and well-disciplined, comparatively efficient Blue Cross operations, that is, those with the least slack. Conversely, one would expect competition to be least vigorous between

stable HMOs content with their market shares and growth rates and poorly disciplined, comparatively lax Blue Cross plans. Even as hypotheses, however, these generalizations are suggestive at best; organizational idiosyncracies and management philosophies in both HMOs and Blue Cross plans are of major, perhaps central, importance; and these factors lie outside the scope of economic laws. One assumes, for example, that the Kaiser plans are tough competitors not mainly because they fear going under if they run a somewhat less tight ship but primarily because of their long standing, deeply ingrained allegiance to practices of sound management.

It may be expected that the vigor of competition will depend too on the market share of the HMOs. It would be strange indeed if the Blue Cross plans of California did not feel strong competitive pressure from the two Kaiser plans in that state, both of which have been in business for more than thirty years and each of which has a membership of more than one million. It would be even stranger, however, if these strong competitive pressures automatically accompanied HMOs of whatever age and size around the country.

Although a recent study of the competitive effects of HMOs by the Federal Trade Commission (FTC) (1977) found evidence of competition between HMOs and Blue Cross in the western states, where Kaiser and some other plans are strong and long established, little evidence could be found of competition in other areas of the country. Some of the areas studied are the sites of old and comparatively large HMOs: Washington, D.C., for example, houses the Group Health Association (GHA), a forty-year-old plan of roughly 110,000 members; and New York City is the home of the Health Insurance Plan of Greater New York (HIP), a thirty-year-old plan with about 770,000 members. The FTC study shows that the usual maximizing assumption that any HMO able to survive over time must compete is simplistic. Plans like GHA and HIP survive but apparently do not compete, at least not aggressively, indeed, judging by the FTC findings, not even noticeably. On satisficing assumptions, this is perfectly natural behavior for settled plans which for reasons of facility size, managerial philosophy, or some other reason either are not eager to expand or conclude that the likelihood of significant expansion is too small to justify the organizational costs required to make savings as great, premiums as low, or benefits as broad as possible.

These considerations have led some HMO proponents to argue that

the benefits of competition will be best and perhaps only realized in areas where HMOs compete vigorously with each other. When this happens, it is argued, an HMO cannot use Blue Cross inefficiency as an excuse for laxity of its own; instead, efficiency will breed further pressure for efficiency. Recent experience in Minneapolis, where seven HMOs compete with one another, has received a wide press (Christianson and McClure, 1979); but the results of this competition are unclear. Harold Luft (1980) observed that, despite a doubling of HMO enrollment in Minneapolis-St. Paul between 1975 and 1977 and HMO hospital use averaging 42 percent below the Blue Cross group average, overall hospital use in the area "stayed constant or increased slightly"; whereas the HMO reductions should have produced an areawide decrease of 15 days per 1000, even *apart* from a competitive effect. The result, Luft remarks, might be explained in many ways but is "consistent with both the notions of no major competitive response and the selective enrollment of low utilizers in the HMOs."

Competition among HMOs may be expected to have its intended effects only if several conditions are met. First, the entrepreneurs and managers of HMOs must be willing to compete with each other. Unfortunately, there is no good reason why they would be. Most HMO executives want to succeed, not test academic notions about competition. They succeed by building strong, stable organizations, not by subjecting themselves to the risk of failing a fair market test. HMO administrators, like most other executives, tend to be highly averse to risks to their organization's stability and therewith to their own reputations and careers. Competition is a very salient risk.

For this reason, HMO founders and executives tend to analyze markets carefully before they plunge in and tend to be wary of fragmenting HMO markets of uncertain strength. If they do enter a market already populated by HMOs, they will often try to differentiate their product. One approach is to specialize by location. In Massachusetts, for example, the state insurance commissioner licensed the state's first open panel HMO only after requiring that its application be rewritten to insure that it and other HMOs would not "be like the Mafia, dividing the state into families." (Boston Evening Globe, 1978). Another strategy is to specialize by "taste," challenging an HMO not with another similarly structured HMO but with an IPA, for instance. In short, HMOs may deliberately choose not to challenge

each other's markets. This possibility poses obvious problems for the theory of competition. According to Walter McClure (1980), "the worst realistic scenario occurs if the first few health care plans in an area become content with their market share after they have acquired 20–30,000 enrollees or so to assure stability. Then, relatively few consumers, unions, and employers understand or demand fair market choice." This worst realistic scenario is also the most realistic scenario. As one HMO administrator put it in an interview, "many HMOs would be happy to get 25,000 and just leave it right there. It's easier to manage."

Second, if HMOs are to compete with one another, employers must be willing to offer more than one HMO and perhaps also to promote them to their employees. To the degree that HMOs specialize by area, this may be difficult. Employers are reluctant to bear the administrative costs of offering plans remote from work or convenient to the homes of only a few of their workers. Even if the plans are well located, employers may be diffident. Some resist the costs and inconvenience of reprogramming health offerings in any way. Others will do so to meet the legal requirement that they offer a federally qualified HMO if and when one exists in their area but will not offer another HMO before or afterward. Even employers willing to offer multiple HMOs may decline to promote them; many consider it prudent not to meddle in employees' health care decisions. In all these respects, Minneapolis appears to be quite distinctive if not unique: there several major employers have taken a lead not only in offering but also in promoting several HMOs (Iglehart, 1978).

Third, competitive HMOs presuppose that unions bargaining collectively on behalf of employees will welcome multiple HMOs and will leave the choice of particular plans to their individual members. Unions sometimes welcome an HMO option as a bargaining chip with conventional plans (the threat of taking their business elsewhere may thus become credible). Occasionally unions welcome a new HMO as a club to hold over an established HMO in which membership is heavily enrolled and dissatisfied. Usually, however, they prefer to commit their membership to and consolidate their influence with one plan, not fragment both among several.

Fourth, to be a durable policy solution competition among HMOs must in some sense be self-stabilizing. One requirement of a sound competitive system is that strong competitors be induced to compete

by the prospect of enjoying the fruits of superior performance, including the development of a commanding market share by beating the competition. Another requirement is that competitors be prevented from achieving monopoly power. Balancing these requirements is no simple matter, as FTC and other antitrust experience shows. If aggressively competitive HMOs rout their competition, will the weak HMOs be allowed to fail? Or will they be bailed out, sacrificing efficiency for a competition justified in the name of efficiency?

The analytical point of these reflections is that competition in health care should be treated not simply as an economic process, but also as a product (or casualty) of the interests of actors in formal organizations, especially HMO sponsors and managers, employers, unions, and those government agencies that oversee and regulate competition. The practical point is that the conditions required to support vigorous competition among HMOs are unlikely to be met for extended periods in many places.

Even if HMOs (one or several) came out seeking a knockout, so to speak, one should consider the separate questions of the ability, need, and will of Blue Cross to respond. If competition is an infallible road to lower costs, it may be asked, why has the persistent price-based competition between Blue Cross and commercial insurers not led to lower costs over time? Apparently competition per se is not enough. The usual answer to this puzzle is that third-party payers are irresponsible, that is, they lack control over and responsibility for the behavior of the doctors whose treatment decisions they largely ratify. Because third-party payers tolerate inefficient treatments, pay the bills, raise their premiums, and then market mainly to employers who pay much or most or all of these higher premiums and pass the costs along to the public and because both Blue Cross and its commercial competition are on an equal footing in this respect, neither has an incentive for efficiency. An HMO, by contrast, can control its providers and must absorb its own costs in responsible fashion and therefore does face incentives for efficiency. The presence of an HMO, therefore, will have effects on a third-party payer different from those of another third-party competitor.

This reasoning makes questionable assumptions about both the HMO's demand for competition and the ability of Blue Cross to supply it. As noted above, it may be argued that the same lack of internal discipline that HMO competition is expected to combat may

establish a ceiling or norm of maximum acceptable inflation which the HMO may find it more comfortable to hover around or just below than drastically to undercut. On the supply side, it is surely not evident—and to an organization theorist not even plausible—that the presence of an HMO with, say, 20,000 members will make a Blue Cross plan long accustomed to, and content with, permissiveness suddenly begin fighting with doctors, hospitals, and enrollees over appropriate treatment and unwarranted claims. It is quite likely that the fundamental dynamic here too is organizational, not merely financial; it is a question of the strength of leadership and the nature of management philosophy in the highly varied Blue Cross plans. Even if an HMO is highly efficient (that is, able to offer a wider set of benefits at a cost well below that of the competition), Blue Cross officials may find it less costly on the whole to lose some members (it would be remarkable if an HMO's penetration rate in many areas exceeded 20 percent, after all, and extraordinary indeed if it grew large enough to threaten a Blue Cross plan's survival) than to battle doctors, hospitals, and enrollees in an effort to drive costs and premiums sharply downward. Nothing follows automatically from the injection of competition, at least not from competition of the type and on the scale that HMOs now generally offer. If HMOs were set down amidst all 69 Blue Cross plans, the result would probably be 69 different competitive responses ranging from none at all to vigorous, with most falling somewhere in between but closer to none.

The argument offered here is not that Blue Cross plans will not respond competitively to the presence of an HMO, but rather that they need not and may not do so. The hypothesis that responses are a function not of economic laws but rather of organizational politics and managerial policies specific to each plan suggests the corollary that the most efficient Blue Cross plans may offer the most competitive responses. That is, one might expect the tough competitors, those Blue Cross plans well run by executives who pride themselves on achieving and maintaining a high penetration rate and on offering an attractive product, who "hate to lose one member" (in the words of an HMO official describing the attitudes of the tough Blue Cross competition he faced) and who are determined to run a tight ship, to be most willing to take on doctors and other claimants in the interests of sound management and HMOs in the interests of organizational maintenance.

If these hypotheses are sound, analysts should guard against spuriously attributing to competition behavior that derives mainly from managerial philosophy and organizational politics. In the United States health care system, plans everywhere compete to some degree. This competition takes no single form and has no determinate result, however, but rather many forms and results. Competitors may take one another carefully into account, as apparently happens in California where the two Kaiser plans are very large and achieve high penetration rates in the San Francisco and Los Angeles metropolitan areas; or they may largely ignore one another, as apparently happens in Washington, D.C., and in New York City. Some plans facing sharp competition appear to be efficient; others less so. Correlation should not be mistaken for causation: one should no more automatically attribute to the presence of an HMO the efficiencies of competitors than one should conclude that continued inefficiencies in conventional plans faced with HMO competition are caused by the presence of an HMO.

If competition is contingent on organizational politics, Blue Cross plans with similar market shares might react quite differently to the entry of an HMO into their service areas. This does seem to be the case. In example, the Blue Cross plans serving Rochester, New York; Providence, Rhode Island; and Cleveland, Ohio, all command a strong share of the local health insurance market. Yet, whereas Blue Cross of northwestern New York helped to establish HMOs in Rochester, Rhode Island's Blue Cross plan has been mildly supportive but not greatly enthusiastic about plans in Providence; and the Blue Cross plan serving Cleveland was described by one former HMO executive as uncooperative and hostile to HMOs. In short, Blue Cross responses vary with the managerial outlooks of their executives; to these executives, as to everyone else, HMOs are Rorschach tests into which one reads what one will. Some executives have resisted them strongly; some have welcomed them in hopes that they would fail and vindicate the *status quo;* some have become involved in them as means of cornering a share of the potential HMO market for themselves; some have participated in HMO development in the interests of product diversification; some have entered the field to demonstrate to the government and to the public the flexibility and open-mindedness of the insurance industry; and others have become involved, or have declined to get involved, for still other reasons. No abstract model describing the ideal-typical HMO locked in competition with the

ideal-typical Blue Cross firm to the greater efficiency of both begins to fit the facts. Useful models wait not upon the elaboration and refinement of economic laws of competition but rather upon careful qualitative research into organizational behavior in health insurance plans.

But, even if HMOs could be made to compete aggressively and Blue Cross plans could be made to respond with fear and trembling and efficiency, the effects of such competition would not be clear, and some of them might not be desirable. For one thing, competition can lead to underservice and abuse. This happened in California where the Reagan administration unleashed very vigorous competition among prepaid health plans (PHP) and between PHPs and FFS physicians for Medicaid recipients in the same area. Reagan "relied on the market place to develop competition, believing the good would drive the bad out. It just didn't work that way," Elizabeth Owen, director of a prepaid health project in the California Health Department, recently observed (Group Health News, 1980:3). Although the California PHP experience had several unusual properties, the facts remain that one major means of competing is to hold premiums down, that one major way to do this is to realize internal economies, that some ways to do this are to underserve and to ration or restrict access to care, and that these possibilities will never be entirely absent from the minds of physicians and executives whose main attachment to prepaid plans is money. Exclusively money-minded executives and the abuses they practice may be few. Even solid and decent plans may give rise to questions about the source and consequences of internal economies, however. For example, Harold Luft's (1978) finding that HMOs achieve savings by reducing hospital admissions for nondiscretionary as well as for discretionary procedures by no means convicts HMOs of underservice, but it does raise questions worthy of further research.

One should also consider what may be termed the "adaptive" costs of competition. HMO competition may, for example, lead Blue Cross to broaden its own benefits, thereby encouraging utilization. California may offer an instructive example. The FTC study (1977:77, n. 3) notes that Blue Cross of Northern California claims to have "the broadest outpatient benefits package of any Blue Cross plan," a development that the authors view as a "competitive step" to meet the appeal of the huge Northern California Kaiser plan. Luft (1980:304)

points out that, although California ranks forty-sixth among states in the share of its expenditures for hospital care, it nonetheless stood third in per capita health spending in 1969, the last year for which such data were available. The explanation, he writes, is that "perhaps as a result of the improved ambulatory care coverage by conventional insurers, California ranked second in the share of per capita expenditures for physicians' services." He concludes that "by some standards the mix of medical services bought by Californians may be more efficient, but there is no evidence that even massive HMO enrollment has resulted in overall cost containment."

Another possible cost of adaptation to competition is that hospitals "may raise rates to compensate for reduced utilization" brought on by the presence of an HMO (FTC, 1977:117, n. 1). Consider, for example, the case of Washington, D.C., a city with three HMOs in 1978, a forty-year-old giant of over 100,000 members, a rapidly growing plan of about 43,000 members, and a smaller HMO of about 15,000. In 1978 the *Washington Post* reported that the average cost of a day of care in Washington hospitals was rising 50 percent faster than the national average of 18.5 percent. (In Maryland, which has a strong rate-setting commission, the article noted, the increase had been held to 8.2 percent.) The reason appeared to be low occupancy and resulting "high unit costs, since many expenses remain the same even when some beds or wards are not being used."

It is doubtful that the presence of the HMOs affected this situation much one way or another. Yet, the workings of vigorous competition might be expected to reduce occupancy further. The interesting policy question is: What happens then? Will hospitals voluntarily redefine their services and facilities by means of cutbacks, mergers, and closures? Will they cling to their underused facilities and continue to cover rising unit costs in their per diem charges? Will competition by itself brake this tendency and induce a more efficient hospital sector? Or will the assistance of public regulation—rate-setting, decertification, and the like—be required, and perhaps more urgently and on a larger scale? The fact is that no one knows what effect HMO competition will have on costs, or even if it will be downward or upward. Likewise no one knows whether competition will prove to be an alternative to regulation or an invitation to further and more stringent regulation.

Insurance and Efficiency

In the 1970s the federal government launched in earnest the search for acceptable health care cost controls, beginning with decentralized approaches, both incentive-based and regulatory. In the 1980s there will be debate over more centralized measures toward which the efforts of the 1970s may prove to be transitional.

The debate over centralization grew intense in 1977 when the Carter administration proposed that Congress enact a health care cost containment plan that would impose federal revenue and capital caps on hospitals. Congress rejected the plan decisively in 1979. Meanwhile, pricked by the threat of this escalation of regulatory power, opponents of regulation have scrambled with new urgency to devise or revise incentive-based alternatives.

It is not surprising that these efforts have repeatedly returned to HMOs. As the 1970s closed, however, incentive theorists increasingly recognized the limits of a decentralized organization-building strategy. An effective HMO strategy would at the very least require changes in financial incentives initiated by the central government; these changes might reinforce, but would remain essentially independent of, the HMO strategy. This reconceptualization of the requisites of an effective incentive-based strategy is one of the more important products of the HMO experience of the 1970s. In the 1970s, policy logic took the form: "*If* HMOs are launched (with modest federal start-up aid), *then* consequences X, Y, and Z will follow." Increasingly today policy logic takes the form: "*If* the federal government makes changes A, B, and C in programs and laws D, E, and F, *then* HMOs may catch on in greater numbers, and *then* consequences X, Y, and Z, including the elimination of many of the obstacles to market competition, will follow." This belated acknowledgement that the HMO strategy is not free-standing and independent of painful change is an important step toward realism. What is realistic is not necessarily feasible or desirable, however.

The proposals to use federal law to encourage market approaches to cost containment are complex, diverse, and difficult to summarize. (In part this results from the tendency of the authors of these measures to rush to the hopper with their solutions, reflect afterward on the full complexity of what they have proposed, and then modify their proposals substantially.) Most, though not all, of these proposals build

on three basic elements. First, they would require that all employers who offer health benefits to a workforce above a certain size offer multiple choices, usually meaning two or three distinct plans. Second, so that employees have not only a choice but also an incentive to choose the inexpensive option, they would require that employers make equal contributions to the various offerings. Employees choosing more expensive options would pay for the extras out-of-pocket. Third, in order to sharpen the incentive to choose the inexpensive plan, the proposals would depart from present practice and treat employer contributions to employee health insurance premiums above a certain dollar limit as taxable income to the employee. Some versions would give a tax rebate to employees choosing cheaper plans. These measures, it is argued, will guarantee that consumers have both a choice among plans and an incentive to choose the more efficient plans. The result would be price competition among plans. (See U.S. Senate Finance Committee, 1980; Enthoven, 1980; but also Seidman, 1980, for a different approach.)

It will be very difficult to translate these principles into legislation for four major reasons. First, the approach is not likely to be highly popular with the electorate. One may assume that most people view their insurance purchases as acts of prudence, not extravagance; that they regard their present direct share of health expenses as an adequate or perhaps even excessive check on frivolous use; and that they will not be pleased to see the tax code manipulated to manipulate their coverage decisions while other tax cuts are promised. Moreover, these proposals would greatly disrupt established collective bargaining prerogatives and are strongly opposed by organized labor.

Second, the proposals raise many seemingly small questions that assume great significance when viewed through the eyes of major organizations affected by them. For example, what will be the minimum number of employees in firms before they become subject to the multiple choice requirement? How does the choice of one or another number affect administrative costs to employers and carriers, ability to experience rate, bargaining leverage, and other factors? What is to constitute a distinct offering? Can one carrier—for instance, Blue Cross—offer separate plans or must the plans be offered by separate carriers? Must one or more of the offerings be an HMO? Must one or all HMO offerings be federally qualified? Or state qualified? How is the precise dollar cap on employer contributions excluded

from federal tax to be derived? Can a national cap work, or must regional caps be installed to compensate for variations in costs?

Third, using the tax code for purposes of health cost containment may prove to be highly frustrating to government and citizen alike. In Herbert Kaufman's words (1977:84–85): "It does not take a vivid imagination to visualize the consequences of using taxation for purposes besides raising revenue. The multiplication of categories would itself necessitate a flood of instructions, which would be followed by more instructions as unanticipated ambiguities presented new problems." There would follow "requests for advisory opinions," "complaints about the length of time needed to get answers," appeals and court battles, and "a larger body of enforcement agents." Kaufman also notes that "taxation has already become one of the major sources of what people think of as red tape. The more purposes it is made to serve, the worse it is likely to get."

Finally, even assuming that agreement could be reached on all these details, there is a fourth element contained in some market approach proposals, notably, Alain Enthoven's consumer choice plan, but absent from others, that elicits strong controversy. This is the requirement that all of the multiple plans offered market a minimum, federally defined, benefit package and observe other federally imposed constraints on rate-setting and recruitment. This provision would protect HMOs and other comprehensive plans from the adverse selection likely to occur in a purely competitive setting. Under the market approach, offerings may be expected to run from very inexpensive indemnity-type plans with high deductibles and copayments and many exclusions and limitations to HMOs offering wide benefits with few deductibles, copayments, exclusions, or limitations, but charging a higher premium. Given a choice and financial incentives (a tax rebate and a loss of tax exclusion) tied to premium levels, healthier people with good health histories and little expected need for care may be expected to choose the cheap indemnity plans while sicker people expecting to use much care may opt for the HMO. Over time, indemnity costs will fall while HMO costs rise, eventually driving HMOs from the market. The only way to avoid this outcome is to define a minimum benefit package and require that all eligible plans offer it (Enthoven, 1980:78–82).

This proposal has created great dissension within the ranks of those who support market approaches and consumer choice in general. Pro-

ponents of cost-sharing argue in essence that, although HMOs have their uses and merits, there is no good reason to circumscribe the limits of free competition so sharply simply to protect them. The point of a market approach should be, in the words of Alfred Kahn, "to see the market free to offer consumers the widest range of choices they are willing to select" (U.S. Senate Finance Committee, 1980:192).

The prospect that cost-sharing will be the main outcome of free markets and wide choices has in turn evoked a long list of familiar objections. Cost-sharing, opponents contend, deters relatively inexpensive preventive and outpatient care and may actually raise costs over time by increasing the need for hospitalization, indiscriminately deters beneficial medical procedures along with ones of little expected benefit, inequitably imposes higher costs on those with the greatest needs, asks people to make complex benefit-cost calculations in moments of anxiety and stress, and invites privately purchased supplementary insurance plans to fill gaps in the primary policies. However, the Enthoven approach—multiple offerings, equal contributions, and a tax cap combined with minimum benefit packages and other regulatory measures designed to make the world safe for HMOs and other comprehensive, organized systems—seems to some market builders to put unacceptable limits on the free play of market competition.

Even if these various difficulties could be overcome, no one knows what effect a market approach would have if it were adopted. As Karen Davis explained, "there is little evidence to indicate that these efforts can provide substantial immediate relief from health care inflation or that competitive approaches can effect more than marginal changes in the health care system," for "we have little practical experience which shows how the majority of consumers would actually behave in such circumstances" (U.S. Senate Finance Committee, 1980:37).

Evidence from the Federal Employees Health Benefits Plan (FEHBP), sometimes cited as a rough prototype of a consumer choice plan, suggests that responses may be small. The federal plan offers workers a choice among Blue Cross, commercial plans, and HMOs (where available); requires that the plans meet certain minimum requirements; and pays 60 percent of the average of premiums of a sample of major plans but no more than 75 percent of the premium of any plan selected. HMOs have been offered since the program began in 1960,

and the number of HMOs offered jumped from 21 in 1960 to 64 in 1978. Yet, the number of program beneficiaries enrolled in HMOs has grown only slightly over time, from 5.8 percent in 1960 to 8.4 percent in 1978. Moreover, the Kaiser Plans have all along accounted for about half of this enrollment. There is no reason to assume that the general population will prove more Pavlovian in responding to FEHBP-like financial incentives than has the federal work force.

None of these incentive approaches is the answer their proponents sometimes take them to be. Indeed, no one has the slightest idea how any of them would work if put into practice. Their principal contribution is that when scrutinized closely they dispel the illusion that simple, painless, inoffensive federal strategies can be devised to improve the efficiency of the health care system by means of HMOs or otherwise. Modest sums of seed money and manipulation of financial incentives at the margin will not do. If the incentives are just incentives—that is, one more benefit or cost added at the margin of freely taken decisions—they may well turn out to be too small to accomplish their purpose. To meet its objectives, the federal government must be prepared to manipulate the particulars of the tax code and of financing programs strongly and unequivocally toward HMOs or toward other exemplars of efficiency. That is, it must award windfalls or impose burdens large enough reliably to constrain decisions on a large scale. But then it will no longer be benignly manipulating incentives; it will instead be authoritatively withdrawing familiar benefits such as tax exclusions or first dollar coverage and thereby imposing costs and disincentives to continue accustomed and widely accepted behavior. To some, this approach to efficiency is preferable to regulation. Be this as it may, calling it an incentive approach strains language severely. To put the point in the plain Benthamite language it deserves, both regulatory and market approaches work by means of governmental imposition of various types and degrees of pain. The policy choice lies, therefore, not between a libertarian, freespirited, incentive approach honoring consumer choice and an oppressive, coercive, regulatory approach forcing narrow options down the throats of a resistant populace, but rather between types and degrees of publicly imposed pain. Efforts to achieve efficiency and cost control by means of incentives, markets, and competition would not be, if taken seriously, an inconspicuous exercise in constructing new consumer choices. They would instead demand extensive social engi-

neering that would impose large changes on the structure of the American health care system. To work, these efforts must penalize significantly the vast majority of the population, which has given no indication whatever that it wishes to be forced to be free to choose between extensive cost-sharing that renders meaningless its accompanying freedom of choice of providers and comprehensive coverage in closed panel HMOs.

The current habit of describing the incentive approaches discussed above with the hallowed term markets confers an undeserved respectability on approaches that share little in common with markets as traditionally understood and obscures the enormous differences between new markets and old. Traditionally, a market approach has denoted social arrangements that facilitate the aggregation and channel the expression of decentralized, "atomized," individually taken preferences within broad and general public rules of conduct (contracts shall be upheld, fraud and violence are prohibited, and so forth). The so-called market approaches recommended to policy makers today as a means of employing private interests in the service of public ends have a very different character. These approaches invite the central government to design with care and specificity a set of top-down rewards and penalties which, when applied to the system from above, may be depended on to change millions of individual choices significantly in directions that government prefers and that the individuals affected hitherto rejected. The object of the old markets was to express preferences; that of the new markets is to shape them. Old markets facilitated expression of a range of choice limited mainly by individuals' willingness and ability to pay, with institutions held constant, so to speak. New markets construct a range of choices and then stack the deck, by manipulating incentives toward what government defines as the right choice, with the explicit intention of producing institutional change. If the new approach were described accurately—as, for example, "centrally planned social engineering by the federal government involving the manipulation of material rewards and penalties to trigger major behavioral changes"—instead of in code words with ancient and honored libertarian connotations, the nature of the enterprise and of the policy options would be much clearer.

It is logically possible that some market approach to cost containment that does not suffer from the drawbacks discussed here could be devised. This logical possibility is unlikely to come to pass in

practice, however, because at bottom these approaches, however ingenious or theoretically elegant, rest on questionable assumptions about the nature of the demand for health insurance. The usual image portrays consumers whose principal concern is the dollar cost to them of health insurance and whose overriding interest lies in achieving as much of a free ride as possible, that is, in acquiring for themselves as much coverage with as few limitations as possible at the lowest possible out-of-pocket costs, thereby removing financial deterrents to their consumption, and waste, of care. This problem, wherein consumers lose interest in restricting the amount of care they receive because third parties pay most of the bill, is called "moral hazard."

This image of the demand for health insurance and of the effects of moral hazard on the consumption of health care is open to question. For example, although the cost the consumer bears is certainly one relevant aspect of his choice among health insurance plans, it is not the only aspect. Matters of taste and style of care also enter in, especially when, as in the case of the choice between an HMO and a conventional competitor, choosing the health coverage offered by the HMO entails choosing its delivery system also. This has always been a major obstacle to HMO growth despite the tendency of HMOs to offer broad benefits and to impose lower out-of-pocket costs on consumers. For this reason, the propensity to join HMOs cannot be predicted or manipulated by financial incentives alone.

Nor are present health insurance patterns adequately pictured as a product of thoroughgoing moral hazard, of free riders run riot. One might begin by distinguishing between two types of free rider problems. The first describes a situation in which some ride free at the expense of others because the former class has somehow exempted or insulated itself from the costs of goods or services generally (collectively) enjoyed. Group A enjoys a benefit but pays little or nothing, allowing group B to bear all the costs of providing the benefit. In this situation there are two groups, one which rides free and one which is taken for a ride. The problem is that the nature of the collective good itself prevents group A from being excluded from its provision even though the group declines to contribute to the costs of its production.

Although the problems arising from widespread third-party payment of health care costs are sometimes described in similar terms, the description is misleading. The two classes that constitute the

classic collective-good free-rider problem do not exist in the case of health care services and costs. For no one is health care a "free collective good"; everyone pays for health care—in higher insurance premiums, higher taxes, higher out-of-pocket costs, higher prices, foregone wage increases, or in all of these and in other ways—and everyone knows it. And in one respect the problem is the reverse of the classic free rider problem: whereas the classic problem is that nonpayers cannot be excluded from collective benefits, in the health insurance case it sometimes happens that certain payers are excluded from the collective good—some unemployed or self-employed persons, for example, who bear health related increases in taxes, prices, and other ways but who have declined to purchase or have been denied health insurance.

Most analysts of moral hazard, however, have in mind a second, different version of the free rider problem. This problem is not that there exist two classes, one of exploiters and one of the exploited, but rather that under third-party payment each member of the single-payer-consumer class lacks a personal financial incentive to restrain the amount of care he consumes, if and when he consumes care, because abstinence on his part would not be emulated by others and would therefore make a merely imperceptible dent in the total social cost of medical care. In this sense, it is said, each rides free at the expense of all. The rational solution, it is argued, is to devise arrangements forcing more of the true costs of care directly onto consumers so as to require them to weigh possible costs of care against the likely benefit or value of care as measured by their own willingness to pay for it.

As critics of this economic reasoning have often pointed out, the analysis overlooks important elements in the interplay between individual decision-making and the peculiar properties of medical care. Concrete evaluations of the benefits and costs of particular services carrying particular costs "at the point of service delivery" are largely beside the point when the point is to achieve *insurance* against *risk*. Health care is not merely another valued product or consumer good. As Bruce Vladeck argues,

> the theoretical proposition that free goods tend to be overconsumed and that eliminating "moral hazard" will reduce consumption has considerable intuitive appeal, especially to those naturally sympathetic to economic models of human behavior. As applied to medical care, however, it is an insidious principle, imposing hardship on

> the healthy and sick alike, violating the very purposes of medical assistance programs, and perpetuating the linkage between access to care and ability to pay. If, as a society, we choose to treat health care as a merit good, then it is absurd to assume that its demand function resembles that for ice cream. (Vladeck, 1976:497–498)

One insures against risk precisely because one does not want to be confronted with such willingness-to-pay questions in the unhappy event of illness. People buy health insurance, first, because one never knows what objective conditions (illnesses) may strike; second, because one never knows exactly how one will feel about the value of alternative treatments for various objective conditions of various degrees of severity; and, third, because one does not feel capable of deciding and does not want to be forced to compute benefit-cost ratios attaching to various treatment-illness combinations when an illness poses these questions. Anxiety levels are apt to be too high and the professional expertise of the patient too low to permit rational decision-making at such a time.

The result is that all (or most) purchase generous insurance benefits so that all (or most) may ride free *if* something unfortunate happens. The favored political status of health spending lies here. In William Glaser's words (1982), "most other spending programs are transfers to other persons, but health spending is viewed as a potential benefit to one's self when it is urgently needed." To some critics this social behavior is the irrational, irresponsible log-rolling that defines moral hazard. From another point of view, however, it is a highly rational, or at any rate entirely understandable, form of collective risk spreading and sharing. To be sure, consumers ride free when they partake of the most and best care available because they do not bear a burdensome share of the costs. On the other hand, consumers buy the right to enjoy such care with awareness of the aggregate costs of their (collective) decisions—everyone knows that health care is expensive and that it is wrong to waste it—and in the expectation and hope that they will never be forced to exercise their right. Although there are no doubt some Scrooges fully convinced that third-party payment of health services leads consumers to seek care recklessly and for the sheer perverse fun of it, in this respect, too, medical insurance departs from the usual free rider problem, wherein the consumers' incentive to consume varies positively and directly with the scope of third-party coverage. Thus, in its second sense too the free rider diagnosis misses

the mark. Analyses of health insurance that see in it only or mainly the perversities of heedlessness and waste-shifting set policy discussion off in misleading directions.

The usual analyses of health insurance today offer neither useful policy advice nor convincing explanations of prevailing patterns. These analyses either over- or underexplain present arrangements. If moral hazard is indeed the central dynamic and the universe of consumers is peopled with crafty, wasteful free riders, it is difficult to explain why this universe, acting in the political marketplace, did not bring about in its self-interest some cradle-to-grave program of national health insurance (NHI) some time ago. This would be the logical outcome of the moral hazard, free rider diagnosis; but it is one the United States has resisted. Instead the United States relies on a mix of public and private arrangements that generally offer less than comprehensive benefits and less than first-dollar coverage for care and that generally incorporate some cost-sharing features, of which the market theorists would like to see more.

There is no obvious explanation for this electoral self-restraint, but a reasonable hypothesis is that the electorate fears that the enactment of comprehensive NHI might lead most or many citizens to start acting as economic theory says they now act and that it fears the collective costs of this. But if consumer-voters show this much cost consciousness and self-restraint, why do they not show more? That is, why does the same willingness to avoid the temptations of NHI not generate a cost-containing, efficiency-favoring set of arrangements, including truly deterrent cost-sharing provisions, such as many economists recommend? Reasonable hypotheses are that, although the electorate wants something less than comprehensive services at very high costs, it wants very full coverage for the most intensive and costly services, notably inpatient and surgical services, and that, although it does not demand full first-dollar coverage (at least not by way of public financing), it wants enough coverage to insure that out-of-pocket costs do not become truly burdensome. The result of these preferences would be a middle ground between the two logical extremes to which the theoretical assumptions of the moral hazard theorists lead. And it is this illogical middle ground that United States coverage patterns occupy.

Several derivative hypotheses follow. First, consumers may make a distinction between consumer-initiated and physician-initiated treat-

ments; and whereas they tend to be willing to bear a sizable share of the cost of the former (as a check on extravagance), they wish to bear few of the costs of the latter (as a check on anxiety and inexpertise). Second, this distinction will correspond very roughly to that between outpatient care (consumer-initiated) and inpatient care (physician-initiated). Consumers may prefer to see the two treated differently in insurance arrangements. Although they may be willing to continue to bear some share of the cost of the former, they may strongly resist schemes that impose large costs of the latter on them. If so, schemes that merge the two modes and entitle the consumer to government aid after he has incurred from his own pocket costs (for whichever purpose) established by a sliding income-related scale may prove to be highly unpopular.

As for HMOs, consumers may in general prefer good coverage for inpatient procedures combined with some risk of incurring out-of-pocket costs for outpatient procedures to the comprehensive bargain offered by an HMO, especially when HMO care restricts the consumer to the staff and facilities of the plan itself. Finally, consumers are likely to resist strongly any scheme that obliges them to incur large out-of-pocket costs for either outpatient or inpatient care.

It is a mistake to assume that the patterns described here can only be explained by the absence of consumer choice, meaning the consumer's ability to choose coverage from sources more efficient than FFS, third-party-payment-based plans like Blue Cross. In the United States consumers exercise choice in many ways—notably, through their choice of health plans in the workplace or in the market, through collective bargaining, and through the political process. An efficient system of cost-sharing provisions or incentives encouraging HMOs could be widely in place within a few months—if consumer-voters wanted it and were willing so to instruct insurance agents, employers, union representatives, and politicians. The same may be said of comprehensive NHI. The problem is not that consumers cannot choose among alternative modes of care but that they have chosen, for good and sufficient if little understood reasons of their own, alternatives of which some analysts disapprove and that they have exercised those choices by means of nonmarket decision mechanisms which these analysts distrust.

It should be emphasized that the arguments advanced here are crude

hypotheses and that, unfortunately, very little is known about consumer attitudes and preferences on any of these matters. Policy analysts have become so entangled in the counterfactual logic of trying to devise ways in which consumers would convey what they might be willing to pay for health care services, if battered, creaky health care markets could be made to resemble the handsome creature in the texts, that they have devoted almost no attention to studying—by means of interviews, surveys, and other empirical research techniques—what people do in fact want from a health insurance system and how they prefer to pay for it.

Conclusion

Much of the policy analysis behind market approaches to health cost containment has suffered from confusion over the differences among fact, hypothesis, and evidence. This confusion has (to recall Bain's words) made the analysts' assessments of the workability of competition in the health field even more provisional and personal than they must unavoidably be.

When Paul Ellwood devised and top HEW officials decided to promote an HMO strategy, they knew of the experiences of a few PGPs, notably the Kaiser plans. They knew, in short, a few facts. That the essence of the Kaiser accomplishment lay in the union of prepaid financing and group practice and that these accomplishments could be duplicated wherever prepayment and group practice were conjoined were hypotheses. Hypotheses of at least equal plausibility were that various idiosyncracies in the history, location, staffing, structure, and other circumstances of these plans were important to their success and that these peculiarities could not easily be duplicated on a large scale elsewhere. Instead of attempting patiently to develop evidence that might help one choose among these competing hypotheses, the policy advocates moved adroitly into the realm of metaphor by speaking confidently of the "skeleton" of PGP and of "prototypes." The central question remained, however: is it true that any combination of prepayment and group practice, from the largely self-contained Kaiser system to the jerrybuilt IPA, could replicate the

Kaiser achievements? After a decade of federal encouragement to HMOs, the answer is still unclear. Everyone knows what everyone knew before the HMO strategy was launched: HMOs have impressively low rates of hospital use. But the extent of savings by IPAs is disputed, the degree to which HMO inpatient economies are explained by self-selection or offset by other costs is debated, and little is known about the quality of care in these younger plans.

Nevertheless, HMOs are now trotted out as a "prototype" of the possibilities of comprehensive and organized health care systems in a greatly rearranged, competitive health insurance system. Consumers who resist such rearrangements because they believe that good care is expensive are said to be mistaken: organized systems such as Kaiser show that it is possible to cut cost without cutting the quality of care (Enthoven, 1980:xix). However, the *fact* that good care can be inexpensive implies neither that good care is always or usually inexpensive nor that inexpensive care is always or usually good. That care is good and inexpensive at Kaiser does not even mean that it is good and inexpensive also at the 230-odd other HMOs and IPAs; these organizations, after all, are very different from Kaiser. In Rashi Fein's words (1980:362), "We lack accepted norms of what is and what is not appropriate." Despite the extreme recklessness with which the term efficiency is tossed about in such discussions, the fact is that the correlates of physician (or other provider) efficency are not well understood. In short, a judgment on whether or not the relationship between quality and cost in the Kaiser Plans is an interesting datum or a prototype ripe for generalization depends on amassing and analyzing much more evidence.

Competitive proposals exhibit the same conceptual problems. That competition appears to work in Minneapolis-St. Paul, Hawaii, and Clackamas County, Oregon (Enthoven, in Senate Finance Committee, 1980:59) is an interesting fact. That these situations contain basic principles that may be generalized nationwide is a hypothesis. A hypothesis of at least equal plausibility is that these situations are idiosyncratic, highly dependent on local community, medical, and organizational leadership and coalitions and on other supportive social structures to be found in few other places. At this stage in the development of market approaches in the health field, policy *advocacy* should take a distant back seat to policy *analysis:* that is, to the

patient and dispassionate search for empirical evidence that bears clearly on hypotheses founded on a mere handful of interesting facts.

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