

Paying the Price: Medical Care, Minorities, and the Newly Competitive Health Care System

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I took one Draught of Life —
I'll tell you what I paid —
Precisely an existence —
The market price, they say.

Emily Dickinson, poem no. 1725

THERE HAS LONG BEEN A TENSION IN AMERICAN policy making between reliance on government and reliance on the market to allocate socially valued services such as health care, education, and social services. Nowhere has this tension been more pronounced than for those services used by racial and ethnic minorities.

The market has been portrayed by its advocates as preserving free choice, safeguarding minorities from the oft-times insensitive will of the majority (Friedman 1962). But these safeguards clearly have their limits. Minorities who lack financial resources will have little voice in the market. With a poverty rate for black families that is three times that of white households, much of the black community is economically disenfranchised (Jones and Rice 1987). Nor are all choices in the market freely made. Those who face discrimination lose much of their free choice. Under some circumstances, discrimination based

on race is not only possible, but virtually inevitable in a market system (Spence 1974).

If the market only imperfectly reflects minority interests, the same is certainly true for government. When a representative government inadequately represents blacks, it will not be fully responsive to their concerns. And despite two decades of voting-rights legislation and registration campaigns, blacks continue to be underrepresented, particularly in Congress and most state legislatures (Persons 1987).

For those who would promote minority interests, there are, therefore, no obvious choices between public and private sectors, between markets and the political process. Equally thoughtful observers reach diametrically opposed conclusions, some favoring the market (Sowell 1981), others government action (Winn 1987).

American medicine of the 1980s, though, has seemingly neared a consensus favoring a greater role for market forces and private enterprise (Goldsmith 1984; Schlesinger et al. 1987). These views have strongly shaped the health policies pursued by the Reagan administration (Dobson et al. 1986). They have been encouraged by large employers and other private purchasers of health services. Virtually all observers agree that the United States health care system of the 1990s will be far more "competitive" than at any period in recent history (Arthur Anderson & Co. 1984).

But those who advocate these changes often do so on the basis of very broad generalizations, arguing that the "average" purchaser of health care services is almost certain to benefit (Kindig, Sidel, and Birnbaum 1977). Relatively little attention has been paid to the fate of individuals and groups that are in some manner not "typical," either because of their health care needs or the options open to them as consumers of health care (Anderson and Fox 1987; Schlesinger 1986, 1987). Receiving perhaps the least attention are the racial minorities of this country, who are likely to face some important disadvantages in the newly competitive markets for health services (Winn 1987).

This article assesses the effects of competition on the health care of black Americans. Because there has been relatively little empirical research on this topic, the evidence presented below is often fragmented and incomplete, drawn in large part from research intended for other purposes. In some instances, no data are available at all, and it becomes necessary to reason by analogy. Though the inadequacy of this data

makes clear the need for additional research, it does not in my assessment undermine the basic conclusions of the article—that while some black Americans will benefit from a more competitive health care system, the least advantaged will likely be made even worse off.

The article is divided into four sections. The first describes in detail the various changes in American medicine that are often grouped together under the label of “increasing competition.” The second identifies subsets of the black population that may fare more or less well under competition. The third section reviews recent evidence on the actual costs and benefits of competition to black communities, evidence used in the final section to discuss the appropriate future role of public policy in this area.

Competition in the Health Care System

American medicine, like the rest of our society, has always contained a strong element of competition (Vladeck 1985). Labeling ongoing changes in the health care system as “increased competition” is thus to some degree a misnomer. What is changing is the nature, as well as the extent, of competition among health care providers.

Historically, health care providers competed to attract patients—in particular, to attract patients with the resources or insurance to pay for their health care. Following the post-World War II expansion of hospital facilities, the most aggressive competition occurred in the market for hospital services. To attract patients, hospital administrators believed that they had to attract physicians. Hospitals could do this by offering physicians more supportive environments for their practices, with a larger nursing staff as well as more elaborate and accessible technologies. Consequently, competition during this period tended to increase costs. Studies of hospital markets during the 1970s found that the more competitive the local market for hospital services, the higher the hospitals’ operating costs (Noether 1987; Robinson and Luft 1985; D. Farley 1985). Increased competition and higher costs were associated with more full-time-equivalent staff per bed and a broader range of diagnostic and therapeutic services (Noether 1987; D. Farley 1985).

Sharp declines in hospital use over the past few years—occupancy rates fell from 76 percent in 1981 to 65 percent in 1985—have

increased pressures for hospitals to find additional patients. Their methods for doing this, though, have changed from the strategies of the 1970s.

The nature of the relation between hospitals and physicians has changed. The expansion of medical schools in the 1960s and 1970s has led to what many perceive to be a "glut" of physicians (Harris 1986). Consequently, hospitals have become less concerned with attracting medical staff, and have increasingly sought to market directly to potential patients (Seay et al. 1986). At the same time, private practitioners have become more entrepreneurial, establishing a host of free-standing facilities such as ambulatory surgery centers and emergency medical centers (Ermann and Gabel 1985). These directly compete with hospitals, and many observers believe that this competition will intensify in the future (Seay et al. 1986; Arthur Anderson & Co. 1984).

In addition, purchasers of health care have become far more sensitive to the price of services. Faced with the rapidly rising costs of health care benefits, private employers and public agencies have developed purchasing systems that encourage or require enrollees to seek lower-cost providers. In the private sector, these have most often taken the form of "preferred provider arrangements" (PPAs). In a PPA, enrollees pay lower copayments if they obtain health care from providers who have established reduced-price contracts with the employer or insurer (Lissovoy et al. 1986). In the public sector, these innovative arrangements are generally termed "competitive bidding" systems. In a number of Medicaid programs, for example, providers bid for the right to treat Medicaid enrollees, and the state selects the low-cost bidder or bidders in each region (Anderson and Fox 1987; Freund and Neuschler 1986).

These changes in the market for health services can significantly alter the behavior of providers, and thus the accessibility and quality of health care. How these changes will affect blacks is discussed in some detail below. But changes in market conditions are not the only potentially important consequences of the new competitiveness in health care. Market conditions are to some extent a reflection of, and to some extent reflected by, what could be termed a new "competitive ethos," a shift in popular perceptions about the appropriate roles of health providers in the community and public policy in the health care system.

For hospitals and other institutional providers, this ethos represents

a change in expectations. Increasingly, health care facilities are being perceived and portrayed as commercial enterprises, rather than as institutions with a fiduciary responsibility to the community in which they are located. This changes the expectations of and incentives for the administrators of the facility.

Any hospital administrator who doesn't do all he can to fend off as many general assistance patients as he can . . . just isn't being "businesslike" and will be so judged by his board of trustees. The word "businesslike" poses the problem in a larger context. The chorus of criticism of the not-for-profit hospital now coming from business leaders and government alike and much abetted by the present editorial content of many hospital journals is that they need to be "better managed." Not surprisingly, many CEOs are taking this to mean that you shouldn't treat many patients who represent bad debts, free care, or oversized "contractual allowances" (Kinzer 1984, 8).

These changes undoubtedly go beyond admissions policies. The more health care facilities are viewed as commercial operations, the more their governing structure is likely to become like that of any other business. One would thus expect the board of directors to include fewer "members of the community" and more representatives of the professionals with which the facility does business—physicians, large employers, and officers of local financial institutions.

The growing competitive ethos in health care is also shaping public policy. Most evident have been policies promoting "deregulation," allowing market forces to work unfettered (Winn 1987; Davis and Millman 1983). A dozen states, for example, have discontinued their certificate-of-need programs to encourage the entry of new health care facilities (Polchow 1986). Less obvious, but potentially more significant, have been changes in public subsidies to health care agencies. Proponents of competition typically call for "a level playing field," that is, for the elimination of subsidies that are available only to some providers. Their rationale is that "fair play" in the market requires that all competitors begin on an even footing.

Whatever the merits of this argument on ethical grounds, it can have important consequences for the delivery of health services. Preferential subsidies, including tax exemption, are made available primarily to public and private nonprofit agencies (Clark 1980). But with subsidies

there comes an expectation of community service. The Hill-Burton program, for instance, subsidized the construction of a number of public and nonprofit hospitals (Lave and Lave 1974). In return, hospitals receiving funds were required to make services available to the medically indigent.

Not all subsidies explicitly require community service, and those that do may not be effectively enforced (Silver 1974). Nonetheless, subsidies have provided both a legal and, to some extent, a moral basis for encouraging private providers to take actions in the public interest (Blumstein 1986). Eliminating subsidies would inhibit the extent to which policy makers and public advocates can influence the delivery system in this manner. Making subsidies available to all providers would diffuse their effectiveness, since it is the public and larger private nonprofit facilities that are disproportionately located in the most disadvantaged communities of our country (Vladeck 1985; Davis and Millman 1983).

As this discussion suggests, the changes wrought by competition will be reflected in both the market and public policy. Competition will alter access to care, but it will also change the nature and extent of public influence on private health care providers. The consequences for blacks, and other groups, will thus involve their role as members of the community as well as consumers of health care. Before assessing whether these changes will be for good or ill, it is useful to review briefly some of the important factors that have historically affected blacks' use of health services.

Black Americans as Consumers of Health Care Services

The benefits of competitive health care markets depend to a large extent on the potential for patients to purchase treatment suited to their health needs, choosing among alternative sources of care. Two important hindrances exist for many black Americans.

First, many lack the purchasing power to voice effectively their preferences in the market. A disproportionate number of blacks live in low-income households. A third of all black households have incomes below the poverty line, and almost half of all black children live in these families (Jones and Rice 1987; U.S. Congressional Budget Office 1985). With such limited resources, many blacks cannot afford to

purchase private health insurance. Only 50 percent of all black respondents under the age of 65 reported on the 1984 National Health Interview Survey that they had private insurance coverage (Andersen et al. 1987). Respondents without private coverage were divided evenly between those enrolled in Medicaid and those with no insurance coverage. Blacks are thus 50 percent more likely than whites to have no health insurance and 5 times as likely to be covered by Medicaid.

These financial factors have a number of important consequences for use of health care. Blacks will be disproportionately affected by experiments that introduce competitive bidding to the Medicaid program—40 percent of all Medicaid enrollees are black. Many other black Americans face significant financial barriers when seeking needed health care. Nine percent reported in 1986 that they did not receive health care for “economic reasons” (Freeman et al. 1987). Blacks who reported themselves to be in “poor or fair health” had one-third fewer visits to a doctor than did whites with comparable health status; a quarter of all blacks with chronic illnesses did not see a physician at all in the previous year (Freeman et al. 1987).

Black Americans thus are often less “connected” than are whites to the health care system. Twenty percent reported that they had no “regular source of care” in 1986; for many of the others, their regular source of care was a hospital emergency room or outpatient department, where they had only limited continuity of contact with a particular provider (Leon 1987; Okada and Sparer 1976). This limited contact affects the options and choices available to blacks as patients.

The second important consideration for blacks as consumers of health services is that, apart from differences in income, they have fewer alternative sources of health care. This is true for several reasons. Black communities are much more likely to have a limited number of health care providers. This includes both inner cities and rural areas in relatively poor states (Foley and Johnson 1987; Ruiz and Herbert 1984). As of 1985, for example, one-third of the 750 American counties with the highest proportion of black population had been designated by the federal government as “critical shortage areas” for primary care physicians; this is half again as common as for all other counties in the country. Consequently, a disproportionate number of blacks rely on hospitals and community health centers to provide primary care (Davis et al. 1987; Hanft 1977). Black overall health

care utilization in these communities is lower than that of whites with comparable incomes (Okada and Sparer 1976).

Even when services are geographically accessible, blacks may face racial discrimination that makes it difficult for them to obtain care or limits their choices among health care providers (Jones and Rice 1987; Holliman 1983; Windle 1980). This discrimination may simply be the result of irrational racial prejudice, but may also reflect a more calculated judgment that black patients will be more difficult or expensive to treat. The origins of this expectation are discussed in detail later in this article.

Lack of information prevents many blacks from becoming effective consumers of health care. Surveys have shown that minority Americans are less informed than are whites about both the services available in their community and the provisions of their health insurance policies (Holmes, Teresi, and Holmes 1983; Marquis 1983). There are several possible explanations for these differences. As noted above, blacks tend to be less closely tied to a particular health care provider and thus are less likely to have a physician who fully understands their health needs and can adequately advise them. And communication between provider and patient may be further impeded by barriers of culture and language (Foley and Johnson 1987). The episodic employment history of many black workers makes it less likely that they will have contact with benefits managers at the companies that employ them (Jones and Rice 1987). All these problems are compounded by lack of education—minority Americans are three times as likely to have less than five years of formal education (Rudov and Santangelo 1979).

For many blacks the changes in competition among health care providers discussed above will have much the same costs and benefits as they do for the rest of the country. Assessing the consequences of competition for this broader population is an important task, but it is one that has been discussed extensively elsewhere (Meyer 1983; Luft 1985; Willis 1986). The remainder of this article will focus instead on those black communities—urban and rural—that in the past have lacked the financial and medical resources for adequate access to health care. The critical question is thus whether the changing nature of health care competition will ameliorate or exacerbate these problems.

Disadvantaged Minorities and Competition in American Medicine

As discussed above, a number of shifts in health care and health policy are often associated with increasing health care competition. For simplicity, these will be combined here into three general categories. The first set of changes are reflected in the private market for health care, affecting blacks in their role as consumers. The second involves reforms designed to introduce competitive bidding to the Medicaid program, affecting the 5 million blacks enrolled in that program. The third involves the set of changes in public expectations and public policy associated with the growth of a competitive ethos in health care, affecting blacks by reducing the influence that they, and the general body politic, have over the delivery of health care.

Competition in Private Markets for Health Services

Two ongoing trends have altered competition among health providers: first, the apparently growing excess supply of both hospital beds and physicians; and second, the increased price sensitivity of private insurers and employers. One would expect that these trends would work in offsetting directions, the first enhancing, the second reducing, the accessibility of health care in low-income black communities.

The more empty hospital beds and physicians' waiting rooms, the greater the financial incentive for health care providers to treat patients they would previously have viewed as undesirable (Vladeck 1985). These conditions may induce providers to overlook racial prejudice. It may encourage them to locate practices in areas that they would otherwise have considered unsuitable (Lewis 1976).

The effects of increased price competition are likely to be more problematic. On the positive side, if price-based competition causes providers to become more efficient, they will profitably be able to treat more patients with limited insurance or financial resources. Disadvantaged black communities would clearly benefit (P Farley 1985). On the other hand, competitive pressures are likely to lead to larger reductions in prices than in operating costs (Schlesinger, Blumenthal, and Schlesinger 1986). This reduces the profits generated by treating privately insured patients, and providers become less able to cross-subsidize care of the uninsured or provide services that do not yield

sufficient revenues to cover costs (Schlesinger et al. 1987; Shortell et al. 1986). Low-income communities, which have disproportionately black populations, will bear the brunt of these cutbacks.

The net effect on access depends on the relative magnitudes of these various changes. Unfortunately, there has been too little research in this area to identify conclusively the effects of competition on access in general, let alone for specific racial groups. The expanding supply of physicians does appear to have had some positive effects. In 1980, 41 percent of the counties in the highest quartile for the proportion of inhabitants who were black had been designated critical shortage areas for primary care physicians. By 1985 this had declined to 34 percent.

This greater availability of providers, however, seems to have been offset by other changes. Prior to 1980 racial differences in health care use had been steadily declining over time (Leon 1987). Since 1980, as competitive pressures in health care have been building, black overall access to health care has clearly declined. Studies have found that financially motivated transfers of patients from private to public hospitals—up to 90 percent involving minority patients in some cities—increased significantly during this period (Schiff et al. 1986). Between 1982 and 1986 the gap in physician use between blacks and whites in poor or fair health grew by more than a quarter (Freeman et al. 1987). The proportion of blacks without a regular source of care rose from 13 to 20 percent (Leon 1987).

Competition alone did not cause these outcomes. Other important changes in the health care system have occurred during this period that also may have hindered black access to care, including state cutbacks in Medicaid eligibility and benefits as well as changes in the coverage and practices of private insurers (Goldsmith 1984; Munnell 1985). Without further research, it is impossible to identify the separate effects of competition. It seems very likely, however, that the blacks who benefit from increasing competition are those with at least limited insurance coverage, making them marginally profitable to treat. Those lacking any insurance are likely to find it increasingly difficult to find private health providers who are willing or able to provide them with care.

Competition in Public Programs: Competitive Bidding in Medicaid

Corresponding to the growing emphasis on competition for the privately insured, there has been greater interest in competitive reforms for public programs like Medicare and Medicaid (Willis 1986). This interest has been embodied in a series of demonstration projects and several more permanent program changes. As noted above, because one in five black Americans is enrolled in Medicaid, representing 40 percent of the program's recipients, changes in Medicaid have a particularly pronounced effect on low-income black communities.

The specific nature of these Medicaid experiments varies from state to state. Some have focused on reducing charges paid to hospitals, others on enhancing the role of primary care physicians (Anderson and Fox 1987; Freund and Neuschler 1986). Because many of these programs involve a fixed annual payment to an HMO or other prepaid health provider, I will focus here on this approach.

Most of these programs have several common features. Providers wishing to treat Medicaid enrollees must submit a "bid," stating the price at which they are willing to provide services. State officials (or an organization acting at their behest) select one or more of the bidders to be the designated Medicaid provider in each community. These are typically chosen on the basis of cost, though other criteria may also affect the selection (Christianson et al. 1983). If there are several designated providers in an area, Medicaid recipients are generally given the option of selecting their preferred provider—those who do not make a choice within a specified period are assigned to a provider. Most programs periodically permit beneficiaries who are dissatisfied with a provider to switch to another in the area.

The potential advantages and disadvantages of these competitive models reflect in part the competitive bidding process, in part the requirement that providers be prepaid for the care they provide. Competitive bidding arrangements reduce program costs, at least in the short run (Christianson et al. 1983; Freund and Neuschler 1987). They do so by restricting enrollee choices to a limited number of lower-cost providers. This would seem to reduce access to care and potentially to threaten quality, since it restricts the alternatives for enrollees if they are dissatisfied with the care that they receive.

In practice, however, these may be small liabilities. Historically,

many states have had difficulty convincing providers, particularly physicians, to participate in their traditional Medicaid programs, because they are paid relatively little for medical services (Sloan, Mitchell, and Cromwell 1978; Davidson et al. 1983). As a result, Medicaid recipients often had few real choices for obtaining treatment, so that being limited in the future to choosing among a small number of participating HMOs may not seriously restrict their options, though it may reduce somewhat their access to minority physicians (Foley and Johnson 1987; Kindig et al. 1977; McDaniel 1985). In fact, accessibility and quality of care may be enhanced because patients are formally linked to a particular provider or group of providers. If significant numbers of enrollees go without needed treatment, it becomes easier to assign responsibility to those providers.

It is often argued that this sense of responsibility is augmented when providers are prepaid for the care that they provide. To the extent that prepayment places providers at financial risk for illness, it creates an inducement for them to identify illness at an early stage when it is less expensive to treat. This is thought to be a particularly important consideration for minorities from low-income communities, who often lack a regular source of care and may thus require outreach to bring them into the health care system (Wolfe 1977).

Not all the consequences of competitive bidding, however, are likely to be favorable. Although competitive bidding systems increase the probability that Medicaid recipients will be formally tied to a particular provider, they do not guarantee that the recipients will actually receive treatment. Prepaid plans must operate within a fixed budget. The more effective the competitive bidding system is in cutting costs, the smaller this budget will be. To keep within budget, prepaid plans have adopted a variety of administrative procedures for rationing care (Luft 1982).

It remains a matter of considerable debate whether enrollees with lower incomes and less education are able to negotiate effectively these administrative requirements and obtain needed health care (Foley and Johnson 1987; Luft 1981). Studies of HMOs operating in predominantly black, low-income communities have also reached somewhat mixed results, but generally suggest that access and quality of care in prepaid plans is at least as high as, and often higher than, that for solo practitioners (Dutton and Silber 1980; Gaus, Cooper, and Hirschman 1976).

Less recognized, however, is the extent to which operating under limited budgets may encourage a form of economic discrimination against black enrollees. HMOs participating in competitive bidding programs receive a fixed payment for each member. Plans that enroll relatively healthy Medicaid recipients will prosper under this system; those with unusually sick and therefore expensive enrollees will face financial difficulties. Race serves as an effective predictor of future health care costs. In part as a legacy of past restrictions on access, blacks are 50 percent more likely than whites to be in fair and poor health (Freeman et al. 1987). As a result, when given greater access to care, they tend to have longer stays in the hospital and higher overall health care costs (Andersen et al. 1987; Heyssel 1981). Providers concerned with limiting their expenditures can thus be expected to discourage enrollment by black Medicaid recipients and perhaps to focus their cost-containment efforts on this group.

Because Medicaid competitive bidding programs are new, we have relatively little hard evidence to determine the consequences for black participants. Preliminary evidence suggests that in urban areas, at least, the programs have been reasonably successful at attracting a number of participating plans and satisfying Medicaid recipients (Anderson and Fox 1987). In Arizona, for example, 79 percent of black enrollees reported that they found health care more accessible under the competitive bidding program than under previous arrangements (Flinn Foundation 1986). Over two-thirds preferred the care they received under the program to that available previously (Flinn Foundation 1986). (It should be remembered, however, that prior to adopting the competitive bidding system Arizona was the only state without a Medicaid program and thus represented a rather low standard of comparison.)

Several caveats, however, should be added to this basically positive assessment. First, competitive bidding systems are likely to be less effective in rural areas, in which the number of bidders is fewer and geographic barriers to access greater (Turner 1985; Christianson, Hillman, and Smith 1983; Martin 1977). It is, therefore, not surprising that the native American population in Arizona was significantly less satisfied with the competitive bidding program than was the more urban black population (Flinn Foundation 1986). Second, these programs generally offer less choice than is initially apparent. Even in areas in which there are a significant number of participating providers, the

most popular typically reach their enrollment capacity fairly quickly, leaving few attractive options for many Medicaid recipients (Rowland and Lyons 1987). Third, few if any of the existing competitive bidding programs have developed the administrative capacity to monitor effectively provision of services, and thus to hold providers responsible if health needs are going unmet (Anderson and Fox 1987). This is perhaps natural in new programs, but it is unclear how long it will take for their administrative capabilities to improve.

Finally, whatever the impact of competitive bidding on Medicaid recipients, it is likely to have a decidedly adverse effect on health care for the uninsured living in the same community. Providers who treat substantial numbers of Medicaid recipients also often have many uninsured patients. Consequently, as competitive bidding cuts payments for Medicaid enrollees, it further reduces provider ability to cross-subsidize unprofitable patients. Under these conditions, providers become less willing to treat the uninsured (Schlesinger et al. 1987). In addition, competitive bidding programs induce providers to join HMOs, few of which encourage their medical staff to treat uninsured patients (Anderson and Fox 1987).

Evidence from Arizona documents the loss of access for the non-Medicaid poor after a competitive bidding program has been established. The proportion of low-income blacks who did not have a regular source of care increased by over 60 percent (Flinn Foundation 1986). The proportion of low-income families not in Medicaid who were refused care for financial reasons also increased; the proportion unable to obtain care for a sick child more than doubled (Kirkman-Liff 1986).

The Competitive Ethos and Control over the Health Care System

Although most discussions of competition focus on the market for health care, more significant consequences for black communities may lie outside the direct delivery of services. With the growth of a competitive ethos, and the corresponding perception of health facilities as commercial enterprises, have come changes in popular expectations of providers and the extent of public influence over their performance. These changes can be seen in both the internal governance of health care organizations and the public policies that shape their behavior.

Competition and the Governance of Health Care Facilities. One potentially

important influence on the services provided at a health care facility is its sense of commitment to the local community and the influence of community members on its governance (Dorwart and Meyers 1981). Although nonprofit organizations are generally expected to encourage community participation, actual practices have been highly variable (Middleton 1987). In general, representation of minority interests appears to be weakest in larger institutions, such as general hospitals, in which boards of directors tend to be dominated by community elites (Kindig et al. 1977; McDaniel 1985). Minorities seem to have greater influence in facilities such as community health and mental health centers, which operate under more explicit federal guidelines governing participation on boards of directors (Dorwart and Meyers 1981). As one review of these organizations observed:

The ability of some minority community groups to build leadership and power via the federally funded community health center program served to defuse conflict over health services as well as to bring services into congruence with community perceptions of need (Davis and Millman 1983, 75).

To the extent that health facilities are seen as commercial enterprises, however, they are less likely to be required or pressured to maintain this community participation in governance. There are, as yet, no studies of this outgrowth of competition. Comparisons between for-profit and nonprofit hospitals, however, seem analogous, since the public generally perceives the former as more commercially oriented than their private nonprofit counterparts (Jackson and Jensen 1984).

Surveys of hospital boards of directors indicate that there is less potential for broad community representation on the boards of for-profit facilities. In part, this is simply because these boards are significantly smaller than those of comparable-sized nonprofit hospitals (Sloan 1980). The composition of the boards is also rather different. In the average private nonprofit hospital, just over half of the board is composed of physicians and representatives of the business community. In the average for-profit hospital, these groups represent between 80 and 85 percent of the board (Sloan 1980). It is, therefore, likely that the governance of these more commercial facilities is shaped to a greater extent by professional concerns (Alexander, Morrissey, and Shortell 1986). Broader community interests may be given less attention.

Competition and Community Influence over Health Care Facilities. The practices of health care providers are also shaped by political pressures and government regulation. These can work to the benefit of otherwise disadvantaged communities, particularly in those public programs that explicitly require participation by members of the community. Provider behavior may be changed by either formal regulatory requirements or more informal moral suasion.

The certificate-of-need (CON) program represents a good example of these benefits. In many states, health care institutions intent on substantial new capital acquisitions or construction projects are required to seek approval from a local health systems agency (HSA). In 27 of the 39 states with CON programs, approval of a CON request is contingent on the willingness of the facility to provide care to the medically indigent. In 22 of these states this is required by law or administrative regulation, in 5 states it has emerged as a practice of the committees reviewing CON applications (Polchow 1986).

To the extent that a competitive ethos is associated with deregulation of the health care system, this source of leverage over facility behavior will be lost. The consequences of this loss for disadvantaged black communities are difficult to assess accurately. On one hand, blacks have been well represented in the health planning and regulatory system (Altman, Greene, and Sapolsky 1981). Nationwide, 15 percent of the board members of local HSAs have been black (Institute of Medicine 1981).

On the other hand, many observers have questioned whether participants in these public programs actually represent the interests of the less advantaged members of their communities (Morone 1981; Lewis 1976). Those on HSA boards were rarely from low-income households. In communities in which blacks were most likely to face racial discrimination when seeking health care, they were also least likely to participate in the CON program (Checkoway 1981). Even these critics acknowledge, however, that HSAs have often provided effective political leverage to encourage providers to treat more low-income patients (Checkoway 1981).

It therefore seems likely that the growing competitive ethos in American medicine will be associated with a decline in black influence over the performance of health care facilities. More generally, it will reduce public pressures for private facilities to act in the interests of disadvantaged communities. The consequences of these changes, being

indirect, are more difficult to quantify and document than are some of the market-based changes discussed earlier. It would be a mistake, however, to equate quantifiability with importance. It seems very likely that the long-term responsiveness of the health care system to the needs of black communities will depend at least as much on the ability of community members to participate and influence the governance of medical institutions as on the willingness of providers to see black patients as profitable customers.

Conclusion: Competitive Markets and Competing Health Policies

Owing to the recency of competitive pressures in health and the dearth of research on their implications for minorities, much of the foregoing discussion was necessarily speculative. Nonetheless, it seems clear that a more competitive health care system will have mixed, but predominantly negative, effects on less-advantaged black Americans. Competition does offer some benefits to the partially insured who should gain in access because a larger number of providers become willing to offer them care. Since somewhere between 18 and 25 percent of the black population can be classified in this group, this is not an insignificant benefit (P. Farley 1985). But it is likely to be overshadowed by questions about the care of blacks enrolled in competitive bidding programs under Medicaid and by the almost certainly large losses of access for the 5 million blacks who have no health insurance. Perhaps more important in the long term will be the accompanying reduction in influence over the governance and performance of health facilities located in black communities.

This assessment assumes a continued incremental expansion of price-based competition and a competitive ethos in American medicine. Were policy makers to adopt some of the more comprehensive proposals for competitive reform, though, the implications for minorities might be quite different. Proponents of these competitive plans generally acknowledge most of the problems discussed above. To overcome these liabilities, they propose large-scale redistributions of income to increase the ability of low-income households to purchase adequate health care. For example, Enthoven's proposed "Consumer Choice Health Plan" (CCHP) would provide low-income families with a voucher worth

\$1,350 in 1978 dollars (\$2,250 in 1985 dollars) toward the purchase of prepaid health care:

One of the goals of any national health insurance proposal is to redistribute resources so that the poor will have access to good care. The most effective way to redistribute income is to do it directly, i.e., to take the money from the well-to-do and pay it in cash or vouchers to the poor. . . . Purchasing power is the most effective way to command resources. A low-income family with a voucher worth \$1350 to shop around in a competitive market is much more likely to receive good quality services willingly provided than in any other system (Enthoven 1977, 5).

Faced by discrimination and limited geographic access to health care providers, disadvantaged black families may not fare as well as the average low-income household. Nonetheless, these concerns should be addressable, and a proposal such as Enthoven's clearly holds appeal for many black families with limited financial resources. Of course, so would any proposal that redistributes income to this extent—in 1985 dollars, CCHP would entail a payment of well over \$15 billion annually to low-income black families. The advantages and disadvantages of competition, relative to other resource allocation systems, are trivial compared to the consequences of payments this size.

Unfortunately, the redistributive aspects of the program are likely to be the weak political link in the proposal. Historical experience with policy making in this country suggests that the redistributive provisions of public policies tend to be lost somewhere between the initial program conception and its eventual implementation (Ripley and Franklin 1982). The risk seems particularly great in this case. Not only would many blacks receive large vouchers as a result of their limited incomes, but their vouchers would have to be additionally augmented to compensate providers for agreeing to treat a population with below-average health status (and thus above-average future health care expenses) (Winn 1987). A second rather bitter lesson of history is that programs or provisions targeted explicitly to blacks in this manner rarely have the political support to assure their continued survival (Jones and Rice 1987; Kieser 1987). Realistically then, the rather ambiguous benefits of procompetition provisions are far more likely to survive to become law than are the certainly beneficial redistributive aspects of the proposal.

But if a comprehensive plan that promotes competition and redistributes income is beyond the reach of contemporary policy makers, how then should they respond to concerns about the consequences of competition for disadvantaged black communities? To address this question, it is helpful to introduce a simple conceptual framework for considering policy interventions of this type.

Generally speaking, policy makers have available three strategies for addressing the needs of groups who are adversely affected by broad societal changes: separation, adaptation, or compensation. Under the first approach, policies could be designed to isolate, or shield, disadvantaged communities from competitive pressures. Under the second strategy, competitive models could be adapted to meet the special needs of black participants. Finally, competitive influences could be allowed to fully evolve in the health care system, but compensation would be provided to those made worse off by competition.

A complete and detailed assessment of these strategies is beyond the scope of this article. Political circumstances and historical experience suggest, however, that some of these strategies can be more fruitfully pursued than can others. First, the history of racial tensions and segregation in this country makes it difficult to initiate and maintain a program that differentiates, even in a positive sense, one racial group from another. This limits the extent to which compensatory programs can be explicitly targeted to black families. For example, a recent review of programs designed to reduce the disparity between black and white infant mortality questioned the value of racially targeted programs on the grounds that they would be perceived as either "labelling the beneficiaries as different in a negative sense" or would polarize other racial groups who "might perceive their needs to be just as great" (Howze 1987, 131–2). For similar reasons, it may prove difficult, or even impossible, to shield minority groups from society-wide competitive pressures that policy makers wish to encourage in order to limit the growth of health care costs.

Anyone who believes that rich white people are prepared to absorb increased costs of medicine for black people is living in a fool's paradise. . . . It is necessary, therefore, for blacks to be in the forefront of alternative methods for managing medicine. . . . They must recognize the inevitable fact that medical expenditures will be managed and must seek strategies that minimize the impact on the black community (McDaniel 1985, 110).

Whether or not racial polarization in policy making is in fact this extreme, concerns of this sort will certainly limit the range of politically feasible responses to the adverse by-products of competition. These considerations suggest that a conversion or adaptation strategy may be more effective than separation or compensation strategies, which carry greater overtones of racial discrimination.

This approach could take several forms. Several seemingly promising reforms involve better adapting competitive bidding systems to fit the needs of black communities. For example, these programs could be made more suitable for potentially high-cost patients by incorporating health status adjustments into provider payments or by offering publicly funded reinsurance to providers to pay for very high-cost cases. Modifications of this type would reduce the incentive for participating plans to discriminate against black patients on economic grounds. Competitive bidding systems could also adopt provisions to mitigate the adverse effects for the uninsured of expanding the role of HMOs in low-income communities. Participating plans could, for example, be required to provide a minimum amount of care to the medically indigent living in the area.

It may not, however, prove necessary to abandon completely the compensation strategy. Although it may prove politically difficult to tie compensatory programs to particular racial groups, it may be feasible to link these programs to geographic areas or communities in which there are a disproportionate number of disadvantaged black residents. Congressional precedents exist for this approach. Programs that "forgive" medical school loans for physicians who practice in medically underserved areas work on this principle. More recently, to cope with some of the consequences of Medicare's shift to prospective payment for hospital care, Congress authorized the Health Care Financing Administration to develop more generous provisions for so-called "disproportionate share" hospitals. These are facilities located in areas with an unusually large number of low-income patients. Indirectly, such provisions disproportionately benefit disadvantaged minority groups.

The two greatest problems created by increased competition in many black communities are the reduced ability of providers to treat the uninsured and the reduced influence of the community over facility performance. These could be simultaneously addressed with a single compensating program. By authorizing a program that provided a pool of funds to pay for uncompensated care in particularly disadvantaged

communities, policy makers could reduce the incentive to avoid treating the uninsured (Lewin and Lewin 1987; Rice and Payne 1981). By channeling these funds through a local board composed of community representatives, the program could restore some of the community's leverage over the health care institutions located within their boundaries.

These proposed strategies for public policy are simply meant to be suggestive. Defining effective and politically resilient reforms clearly requires far more detailed analysis. The overall strategy or particular proposals offered here can be further refined as we gain a better understanding of how system-wide changes in competition among health care providers affect particular groups of patients and communities. But it is important that policy makers begin to consider these issues. They must develop ways of constructively addressing the growing variations in health system performance that are related to race. Political action and public policy in this area will obviously raise some sensitive questions. But continued inaction will only guarantee that groups that have in the past lacked adequate access to health care will in the future face even greater barriers and threats to their well-being.

References

- Alexander, J., M. Morrissey, and S. Shortell. 1986. Physician Participation in the Administration and Governance of System and Freestanding Hospitals: A Comparison by Type of Ownership. In *For-Profit Enterprise in Health Care*, ed. B.H. Gray, 402–21. Washington: National Academy Press.
- Altman, D., R. Greene, and H. Sapolsky. 1981. *Health Planning and Regulation: The Decision-Making Process*. Washington: AUPHA Press.
- Andersen, R., M. Chen, L. Aday, and L. Cornelius. 1987. Health Status and Medical Care Utilization. *Health Affairs* 6(1):136–56.
- Anderson, M., and Fox, P. 1987. Lessons Learned from Medicaid Managed Care Approaches. *Health Affairs* 6(1):71–86.
- Arthur Anderson & Co. 1984. *Health Care in the 1990s: Trends and Strategies*. Chicago.
- Blumstein, J. 1986. Providing Hospital Care to Indigent Patients: Hill-Burton as a Case Study and a Paradigm. In *Uncompensated Hospital Care, Rights and Responsibilities*, ed. F. Sloan, J. Blumstein, and J. Perrin, 94–107. Baltimore: Johns Hopkins Press.
- Checkoway, B. 1981. Consumer Movements in Health Planning. In *Health Planning in the United States: Selected Policy Issues*, ed. Committee

- on Health Planning Goals and Standards, Institute of Medicine, vol. 1, 184–203. Washington: National Academy Press.
- Christianson, J., D. Hillman, and K. Smith. 1983. The Arizona Experiment: Competitive Bidding for Indigent Medical Care. *Health Affairs* 2(3):88–102.
- Clark, R. 1980. Does the Nonprofit Form Fit the Hospital Industry? *Harvard Law Review* 93:1416–89.
- Davidson, S., J. Perloff, P. Kletke, D. Schiff, and J. Connelly. 1983. Full and Limited Medicaid Participation among Pediatricians. *Pediatrics* 72(4):552–59.
- Davis, K., M. Lillie–Blanton, B. Lyons, F. Mullan, N. Powe, and D. Rowland. 1987. Health Care for Black Americans: The Public Sector Role. *Milbank Quarterly* 65(Suppl. 1):213–47.
- Davis, E., and M. Millman. 1983. *Health Care for the Urban Poor: Directions for Policy*, Totowa, N.J.: Rowman and Allanheld.
- Dobson, A., J. Langenbrunner, S. Pelovitz, and J. Willis. 1986. The Future of Medicare Policy Reform: Priorities for Research and Demonstrations. *Health Care Financing Review* 1986 annual supplement: 1–7.
- Dorwart, R., and W. Meyers. 1981. *Citizen Participation in Mental Health*. Springfield, Ill.: Charles C. Thomas.
- Dutton, D., and R. Silber. 1980. Children's Health Outcomes in Six Different Ambulatory Care Delivery Systems. *Medical Care* 18:693–714.
- Enthoven, A. 1977. The Consumer Choice Approach to National Health Insurance: Equity, the Market Place, and the Legitimacy of the Decision-making Process. In *Effects of the Payment Mechanism on the Health Care Delivery System*, ed. W. Roy, 4–10. DHEW pub. no. (PHS) 78–3227. Washington.
- Ermann, D., and J. Gabel. 1985. The Changing Face of American Health Care: Multihospital Systems, Emergency Centers, and Surgery Centers. *Medical Care* 23(5):401–20.
- Farley, D. 1985. *Competition among Hospitals: Market Structure and Its Relation to Utilization, Costs and Financial Position*. DHHS pub. no. (PHS) 85–3353. Washington.
- Farley, P. 1985. Who are the Uninsured? *Milbank Memorial Fund Quarterly/Health and Society* 63(3):476–503.
- Flinn Foundation. 1986. *Health Care for Arizona's Poor, 1982–1984*. Phoenix.
- Foley, M., and G. Johnson. 1987. Health Care of Blacks in American Inner Cities. In *Health Care Issues in Black America*, ed. W. Jones, Jr., and M.F. Rice, 211–32. New York: Greenwood Press.
- Freeman, H., R. Blendon, L. Aiken, S. Sudman, C. Mullinix, and

- C. Corey. 1987. Americans Report Their Access to Health Care. *Health Affairs* 6(1):6–18.
- Freund, D., and E. Neuschler. 1986. Overview of Medicaid Capitation and Case-management Initiatives. *Health Care Financing Review* annual supplement:21–30.
- Friedman, M. 1962. *Capitalism and Freedom*, Chicago: University of Chicago Press.
- Gaus, C., B. Cooper, and C. Hirschman. 1976. Contrasts in HMO and Fee-For-Service Performance. *Social Security Bulletin* 39(5):3–14.
- Goldsmith, J. 1984. Death of a Paradigm: The Challenge of Competition. *Health Affairs* 3:5–19.
- Hanft, R. 1977. Problems and Issues in the Financing of Health Care. Paper presented at a National Conference on Health Policy, Planning, and Financing the Future of Health Care for Blacks in America, Washington, October 28–29.
- Harris, J. 1986. How Many Doctors Are Enough? *Health Affairs* 5(4):73–83.
- Heyssel, R. 1981. Competition and the Marketplace for Health Care—It Won't Be Problem Free. *Hospitals* 55(22):107–14.
- Holliman, J. 1983. Access to Health Care. In *Securing Access to Health Care: Ethical Implications of Differences in the Availability of Health Services*, President's Commission for the Study of Ethical Problems in Medicine, 79–106. Washington.
- Holmes, D., J. Teresi, and M. Holmes. 1983. Differences among Black, Hispanic and White People in Knowledge about Long-term Care Services. *Health Care Financing Review* 5:51–65.
- Howze, D. 1987. Closing the Gap between Black and White Infant Mortality Rates: An Analysis of Policy Options. In *Health Care Issues in Black America*, ed. W. Jones, Jr., and M.F. Rice, 119–39. New York: Greenwood Press.
- Institute of Medicine. 1981. *Health Planning in the United States: Selected Policy Issues*. Vol. 1. Washington: National Academy Press.
- Jackson, B., and Jensen, J. 1984. Consumers See Chain Ownership as Minus for Hospitals: Survey. *Modern Healthcare* 14:176–78.
- Johns, L. 1983. Selective Contracting in California: Early Effects and Policy Implications. *Inquiry* 22:24–32.
- Jones, W., and M. Rice. 1987. Black Health Care: An Overview. In *Health Care Issues in Black America*, ed. W. Jones, Jr., and M.F. Rice, 1–20. New York: Greenwood Press.
- Kieser, K. 1987. Congress and Black Health: Dynamics and Strategies. In *Health Care Issues in Black America*, ed. W. Jones, Jr., and M.F. Rice, 59–77. New York: Greenwood Press.
- Kindig, D., V. Sidel, and I. Birnbaum. 1977. National Health

- Insurance for Inner City Underserved Areas: General Criteria and Analysis of a Proposed Administrative Mechanism. In *Effects of the Payment Mechanism on the Health Care Delivery System*, ed. W. Roy, 60–75. DHEW pub. no. (PHS) 78–3227. Washington.
- Kinzer, D. 1984. Care of the Poor Revisited. *Inquiry* 21:5–16.
- Kirkmann-Liff, B. 1986. Refusal of Care: Evidence from Arizona. *Health Affairs* 5(4):15–24.
- Lave, J., and L. Lave. 1974. *The Hospital Construction Act*. Washington: American Enterprise Institute.
- Leon, M. 1987. *Access to Health Care in the United States: Results of a 1986 Survey*. Robert Wood Johnson Foundation Special Report no. 2. Princeton: Robert Wood Johnson Foundation.
- Lewin, L., and Lewin, M. 1987. Financing Charity Care in an Era of Competition. *Health Affairs* (6)1:47–60.
- Lewis, C. 1976. Efforts to Increase the Number of Physicians: Impact on Access to Medical Care. In *A Right to Health: The Problem of Access to Primary Medical Care*, ed. C. Lewis, R. Fein, and D. Mechanic, 92–110. New York: John Wiley.
- Lissovoy, G., T. Rice, D. Ermann, and J. Gabel. 1986. Preferred Provider Organizations: Today's Models and Tomorrow's Prospects. *Inquiry* 23(1):7–15.
- Luft, H. 1981. *Health Maintenance Organizations: Dimensions of Performance*. New York: John Wiley.
- . 1982. Health Maintenance Organizations and the Rationing of Medical Care. *Milbank Memorial Fund Quarterly/Health and Society* 60:268–306.
- . 1985. Competition and Regulation. *Medical Care* 23(5):383–400.
- Marquis, M. 1983. Consumers' Knowledge about Their Health Insurance Coverage. *Health Care Financing Review* 5(1):65–80.
- Martin, E. 1977. Consumer Choice Health Plan Impact on Rural America. In *Effects of the Payment Mechanism on the Health Care Delivery System*, ed. W. Roy, 45–50. DHEW pub. no. (PHS) 78–3227. Washington.
- McDaniel, R. 1985. Management and Medicine, Never the Twain Shall Meet. *Journal of the National Medical Association* 77(2):107–12.
- Meyer, J.A. 1983. Introduction. In *Market Reforms in Health Care*, ed. J. Meyer, 1–11. Washington: Enterprise Institute for Public Policy Research.
- Middleton, M. 1987. Nonprofit Board of Directors: Beyond the Governance Function. In *The Nonprofit Sector*, ed. W. Powell, 141–53. New Haven: Yale University Press.
- Morone, J. 1981. The Real World of Representation and the HSAs.

- In *Health Planning in the United States: Selected Policy Issues*, ed. Committee on Health Planning Goals and Standards, Institute of Medicine, vol. 2, 257–89. Washington: National Academy Press.
- Munnell, A. 1985. Ensuring Entitlement to Health Care Services. *New England Economic Review* November/December:30–40.
- Noether, M. 1987. *Competition among Hospitals*. Staff Report of the Bureau of Economics, Federal Trade Commission. Washington.
- Okada, L., and G. Sparer. 1976. Access to Usual Source of Care by Race and Income in Ten Urban Areas. *Journal of Community Health* 1(3):163–75.
- Persons, G. 1987. Blacks in State and Local Government: Progress and Constraints. In *The State of Black America*, ed. Janet Dewart, 167–92. New York: National Urban League.
- Polchow, M. 1986. *State Efforts at Health Cost Containment: 1986 Update*. Washington: National Conference of State Legislatures.
- Rice, H., and L. Payne. 1981. Health Issues for the Eighties. In *The State of Black America*, ed. National Urban League, 119–51. New York: National Urban League.
- Ripley, R., and G. Franklin. 1982. *Bureaucracy and Policy Implementation*. Homewood, Ill.: Dorsey.
- Robinson, J., and Luft, H. 1985. The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care. *Journal of Health Economics* 4:333–56.
- Rowland, D., and B. Lyons. 1987. Mandatory HMO Care for Milwaukee's Poor. *Health Affairs* 6(1):87–100.
- Rudov, M., and N. Santangelo. 1979. Health Status of Minorities and Low-income Groups. DHEW pub. no. (HRA) 79–627. Washington.
- Ruiz, D., and Herbert, T. 1984. The Economics of Health Care for Elderly Blacks. *Journal of the National Medical Association* 76(9):849–53.
- Schiff, R., D. Ansell, J. Schlosser, A. Idris, A. Morrison, and S. Whitman. 1986. Transfers to a Public Hospital: A Prospective of 467 Patients. *New England Journal of Medicine* 314(9):552–57.
- Schlesinger, M. 1986. On the Limits of Expanding Health Care Reform: Chronic Care in Prepaid Settings. *Milbank Quarterly* 64(2):189–215.
- . 1987. Children's Health Services and the Changing Organization of the Health Care System. In *Children in a Changing Health Care System: Prospects and Proposals for Reform*, ed. M. Schlesinger and L. Eisenberg. Baltimore: Johns Hopkins University Press. (Forthcoming.)
- Schlesinger, M., J. Bentkover, D. Blumenthal, R. Musacchio, and

- J. Willer. 1987. The Privatization of Health Care and Physicians' Perceptions of Access to Hospital Services. *Milbank Quarterly* 65(2):1-33.
- Schlesinger, M., D. Blumenthal, and E. Schlesinger. 1986. Profits under Pressure: The Economic Performance of Investor-owned and Nonprofit Health Maintenance Organizations. *Medical Care* 24(7):615-27.
- Seay, J., B. Vladeck, P. Kramer, D. Gould, and J. McCormack. 1986. Holding Fast to the Good: The Future of the Voluntary Hospital. *Inquiry* 23(3):253-60.
- Shortell, S., E. Morrison, S. Hughes, B. Friedman, J. Coverdill, and L. Berg. 1986. The Effects of Hospital Ownership on Nontraditional Services. *Health Affairs* 5(4):97-111.
- Silver, L. 1974. The Legal Accountability of Nonprofit Hospitals. In *Regulating Health Facilities Construction*, ed. C. Havighurst, 76-89. Washington: American Enterprise Institute.
- Sloan, F. 1980. The Internal Organization of Hospitals: A Descriptive Study. *Health Services Research* 15(3):203-30.
- Sloan, F., J. Mitchell, and J. Cromwell. 1978. Physician Participation in State Medicaid Programs. *Journal of Human Resources* 13:211-45.
- Sloan, F., J. Valvano, and R. Mullner. 1986. Identifying the Issues: A Statistical Profile. In *Uncompensated Hospital Care, Rights and Responsibilities*, ed. F. Sloan, J. Blumstein, and J. Perrin. Baltimore: Johns Hopkins Press.
- Sowell, T. 1981. *Markets and Minorities*. New York: Basic Books.
- Spence, A.M. 1974. *Market Signaling: Informational Transfer in Hiring and Related Screening Processes*. Cambridge: Harvard University Press.
- Turner, T. 1985. Health Care Issues in Southern Rural Black America. *Urban League Review* 9(2):47-51.
- U.S. Congressional Budget Office. 1985. *Reducing Poverty among Children*. Washington.
- Vladeck, B. 1985. The Dilemma between Competition and Community Service. *Inquiry* 22:115-21.
- Willis, J. 1986. Preface. *Health Care Financing Review* 1986 annual supplement. 1-2.
- Windle, C. 1980. Correlates of Community Mental Health Centers' Underservice to Non-Whites. *Journal of Community Psychology* 8:140-46,
- Winn, M. 1987. Competitive Health Care: Assessing an Alternative Solution for Health Care Problems. In *Health Care Issues in America*, ed. W. Jones, Jr., and M.F. Rice, 233-44. New York: Greenwood Press.

Wolfe, S. 1977. Problems and Issues in the Financing of Health Care. Paper presented at the National Conference on Health Policy, Planning and Financing the Future of Health Care for Blacks in America, Washington, October 28–29.

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