

Competition—Regulation and the HMO:  
Impact on Hospitals and Physicians

*Proceedings of the Twenty-third Annual  
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The Graduate Program in Hospital Administration and  
Center for Health Administration Studies  
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The Twenty-third Annual George Bugbee Symposium on Hospital Affairs conducted by the Graduate Program in Hospital Administration and Center for Health Administration Studies of the Graduate School of Business, University of Chicago, was held at the Center for Continuing Education on the University of Chicago's campus on June 4-5, 1981. These symposia are a reflection of the strong concern of the Graduate Program in Hospital Administration with complex current issues in health care management.

The topic for this, the Twenty-third Symposium, was chosen by a committee of the Alumni Association because of its relevance in this period of changing environment for health care institutions. These proceedings are published and distributed in the hope that they will prove useful to both practitioners and students of health care management.

Special thanks are due Mrs. June Veenstra, who staffed the symposium, Ms. Roberta Arnold who edited these proceedings, and Ms. Joyce VanGrondelle who typed the manuscript.

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## INTRODUCTORY REMARKS

Ronald M. Andersen, Chairman

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The first session of the Twenty-third Annual George Bugbee Symposium on Hospital Affairs, sponsored by the Center for Health Administration Studies and the Graduate Program in Hospital Administration, Graduate School of Business, University of Chicago, convened at 8:40 A.M. Thursday, June 4, 1981, in the Assembly Room of the Center for Continuing Education, with Ronald Andersen, director of the Graduate Program in Hospital Administration and Center for Health Administration Studies, University of Chicago, presiding as chairman.

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CHAIRMAN RONALD M. ANDERSEN: I would like to welcome you to the Twenty-third Annual George Bugbee Symposium on Hospital Affairs. Our symposium is directed toward alumni of the Chicago program in Hospital Administration and friends and colleagues of the Center for Health Administration Studies. Its purpose is to review and examine critically a significant issue in health services management.

It is, indeed, a pleasure to see so many familiar faces and to have an opportunity to renew old acquaintances. Although we have many distinguished guests, I would like to acknowledge in particular the presence of George Bugbee. Prior to the twenty-second symposium last year and on the recommendation of the Alumni Council of the Hospital Administration Program, the symposium was named in George's honor.

In this brief introduction I cannot elaborate on George's long, distinguished career, his many honors and achievements as a hospital administrator, as executive director of the American Hospital Association, director of the Health Information Foundation in New York, and director of the Center for Health Administration Studies and the Graduate Program in Hospital Administration at Chicago. Let me just say that to the extent that our symposium is at all successful in carefully examining and reviewing important issues in the field and shedding any new light or perhaps bringing new ideas to bear on these topics, we are only following an example which George has long provided us.

The symposium is developed by a committee including the Alumni Council of the Program in Hospital Administration and the faculty. The lion's share of organizing and implementing the program has fallen to Odin Anderson, professor of sociology in the Graduate School of Business, University of Chicago; professor in the sociology department at the University of Wisconsin--Madison; and former director of CHAS. Odin has done a very good job organizing this

year's program, and we have asked him to set the stage by indicating the issues involved in examining competition and regulation in the health care field.

REMARKS ON THE CURRENT STATUS OF THE COMPETITION-REGULATION ISSUE

Odin W. Anderson

ODIN W. ANDERSON: I regard my introductory remarks as a warm-up for two very serious papers that will follow.

I learned in an introductory course in psychology years ago that a major characteristic of human beings is ambivalence--a propensity to find it very difficult to make clear choices because of conflicting desires and values.

American society appears to value private ownership and competition and some sort of regulation to facilitate competition in the production and distribution of goods and services generally, such as radios, automobiles, houses, dry cleaners, groceries, and fast-food restaurants. Paralleling these are a wide variety of public goods such as education, roads, and sanitary-environment controls. The body politic has been a great deal more ambivalent, however, when it has come to deciding whether personal health services, in contrast to traditional public health services, are private goods, public goods, or a combination of the two. This ambivalence is not true of other parliamentary democracies in the Western world, not to mention the Communist systems east of the Berlin Wall. The financing and delivery of personal health services are quite unambiguously regarded as public and governmental responsibilities, and the existence of a private sector is an anomaly which apparently indicates dissatisfaction with the public system on the part of a small minority of citizens.

Early in this country's history, as personal health services became increasingly effective and in demand, the American compromise was the creation of nonprofit and voluntary hospitals whose characteristics I need not describe for this audience. Public hospitals became a residual of the essentially nonprofit system for the poor as spillover from the voluntary hospitals. The voluntary hospitals and the privately practicing physicians were able to survive and even flourish on charges to the emerging broad middle class in this country as early as 1880. However, hospitals received a great deal of free capital for hospital construction and equipment from philanthropic and community sources.

American society then skirted the issue of exclusively public versus exclusively private and for-profit market methods by creating the nonprofit, tax-exempt, and charity image: personal health services should not be soiled by a crass profit motive. Even well-paid physicians in private practice who own or rent their own offices and equipment and are completely self-capitalized also

draw over themselves the mantle of altruism. The notion still lingers that physicians scale their fees according to the patient's income, or at least that their professional ethics permit such sliding scales, but, in fact, physicians no longer provide free care in any visible magnitude. Many physicians, of course, feel that they are subsidizing Medicare and Medicaid patients.

One of our symposium speakers, Burton Weisbrod, has a theory that the non-profit sector of our economy exists because of the failure of both the pure market and the pure public approaches to produce certain goods and services. This is an intriguing insight, but it may be, for my taste, too rational, at least for the personal health services. I speculate that Americans are reluctant to turn all personal health services over to government funding, ownership, and control for fear of losing their ability to determine the time and nature of their access to the services. This desire for personal control is, of course, a very middle-class value, but this is a middle-class country, with a tradition of choice and amount of discretionary income unlike any place in the world. The Swedes, the Swiss, and the Canadians reportedly have as high a standard of living as we, but their tradition of discretionary prerogatives does not have as long a history as ours in the United States. However, the American ambivalence I mentioned previously is evident in that we do not want the personal health services thrown into the marketplace as just another commodity.

Despite the great changes in family structure in recent decades, personal health services are extensions of the nurturing functions of the family. Kith and kin continue to exist in networks of obligation even though they do not live in large, single households as extended families. Personal health services, in my view, are regarded as extensions of the family, and thus access to them should not be the subject of undue bargaining and quibbling. I am reminded of a line in Robert Frost's poem "Death of the Hired Man" in which home was described as a place to which one must be permitted access. This is the public image of the personal health services and one which the health services do not deny in principle. Given this image, the American public feels uncomfortable with the pure market concept, even if the government would provide vouchers for the poor in such a market.

Americans also regard regulation with ambivalence, for it can interfere with the prerogatives of choice and nature of the access, though it is recognized that regulation is necessary to establish and maintain competition.

The American adaptation to the polarities of pure market and pure public is the nonprofit approach. In fact, even the for-profit health insurance companies

are sensitive to charges of profiteering, such as, "Sick people are being exploited; if profit-making organizations are to have any profits at all, they should be made from well people."

Enter the concept of "competition," which is associated with the money changers. Can Americans accept the concept of competition between delivery options? There is increasing evidence that they may well do so under the lash of rising costs in a system which purportedly lacks incentives to contain costs and in a system where we are loath to have any direct and intensive regulation.

The compromise here may be competitive options which are, in the main, chartered as nonprofit agencies, eliminating the need to satisfy stockholders. As usual, a mixture of nonprofit/for-profit options are emerging and in operation, but it is likely that the nonprofit type will be the dominant one for the reasons mentioned.

In any case, this is the only developed country in the world which still has the possibility to test the concept of competition (and regulation to promote competition) to contain costs and increase efficiency. Perhaps we can contain ambivalence as well.

THE PROMISE OF COMPETITION: A SANGUINE VIEW

Walter McClure

CHAIRMAN RONALD M. ANDERSEN: Our first speaker today is Walter McClure, vice-president and director of the Health Policy Group of InterStudy in Excelsior, Minnesota. Walt has long been recognized as an architect and advocate of a competitive strategy for medical care and a leading expert on health maintenance organizations (HMOs).

WALTER McCLURE: Thank you, Ron. It is a pleasure to be here. In fact, it is both a privilege and a bit intimidating to be in the same room with two of my intellectual grandfathers, Odin Anderson and Herb Klarman. Although they would not necessarily want to be associated with everything I say, a great deal of what I first learned in this field, I owe to them.

A competition strategy consists of two parts: (1) a structurally sound market model for the future medical care system and (2) an implementation strategy to move from the present system, in severe market failure, to this future model. My analysis will address only the first part, the future market model. The problem of implementation has been addressed elsewhere [1-6].

The need for and nature of a structurally competitive medical care system has been addressed by several authors [1-12]. These authors have shown that the problems of the present medical care system and its failure to achieve desired goals stem basically from severe market failure. If the medical care system cannot be restructured to establish a sound market, there appears to be little recourse to solve the problems and meet the goals save through strong direct economic regulation, in effect converting the medical care system into a more or less public utility. The point of my discussion is to demonstrate by analysis and evidence that technically feasible market models for the medical care system appear to exist which would have a major positive impact on desired medical care system goals.

The competition strategy should be understood as a means, not an end. The purpose of establishing a structurally sound medical care market is to achieve desired policy goals. The major goals may be roughly summarized as:

- (1) financial protection--no one should suffer undue financial harm because of the cost of adequate medical care;
- (2) equitable access--no one should be denied adequate medical care because of financial, availability, or other undue barriers or circumstances;

- (3) effectiveness and efficiency--within the resources that the nation is willing to spend, medical care should produce the maximum health and patient satisfaction possible for the population and constantly innovate to improve health and patient satisfaction per medical dollar spent (also referred to as the "quality" goal); and
- (4) expenditure restraint--medical care expenditures should not escalate unduly relative to expenditures for other goods and services necessary for the nation's health and well-being.

If the competition strategy fails substantially on one or more of these goals, it should be supplemented or supplanted by other policy strategies.

The term "competition" is used here in its technical economic sense and never in its popular sense of simple rivalry. By competition is meant that producers must compete on both price and nonprice (service, quality, availability, etc.) factors under the conditions of a structurally sound market. Thus a structurally sound market consists not only of viable competitors but certain structural market conditions, including a price mechanism seen by both consumers and producers, freedom of entry and exit by competitors to and from the field, noncollusive competitors (no cartel or monopoly behavior), and adequate consumer information on producers and products. I refer to a market that meets these conditions as a structurally sound market; a market that fails to meet these conditions is said to be in market failure. Both economic theory and experience strongly suggest that any proposed future market model for the medical care system that does not meet these conditions, at least to a sufficient approximation, is likely to fail to meet the desired goals. (From these conditions, it is evident that the models proposed below seek only workable rather than perfect competition.)

#### A MARKET MODEL FOR THE FUTURE MEDICAL CARE SYSTEM

In fact at least two distinct market models for a structurally sound medical market have been articulated. The models satisfy the market requirements above in rather different ways and have different implications and consequences for the future medical care system. The first model, employing large front-end deductibles and co-insurance in all or most insurance plans, has been described by Feldstein [1] and Pauly [9]. The price mechanism in this model is service prices (e.g., physician fees and hospital charges), and competition is between individual providers. The second model, employing competition between

health care plans and conventional insurance/provider plans, has been described by several authors [2-8,10,11]. The price mechanism for provider competition is premiums, and competition is between groupings of providers. A third possible model has received some study [12]. Provider price competition in this model would occur primarily in a secondary market between insurers and providers, and the primary market would be between consumers and insurers; it is not yet clear that this model can stand alone. The model presented below seeks to combine all three of these models in a consistent way.

The essential characteristics of the market model proposed here may be summarized as follows.

- (1) Competing insurance and health care plans: In the great majority of communities, the market would consist of a diversity of health care plans (HMOs, Individual Practice Associations [IPAs], Health Alliances, etc.) competing with each other and a diversity of traditional provider and insurer plans (heavily cost-shared insurance plans, preferred provider insurance plans, conventional comprehensive insurance plans, etc.).
- (2) Fair market choice: Consumers would be offered, at least annually, a multiple choice of plans, and any employer or government contribution in behalf of a given consumer would be fixed, with the consumer paying or being rebated any balance of the premium for the plan of his choice.

The purpose of the diversity of plans is to introduce price as well as nonprice competition. (The present system is in severe market failure largely because there is no effective price mechanism, so that competition is solely over cost-generating, nonprice factors.) The health care plans create provider groupings that can compete on premiums. The strongly cost-shared plans introduce service price competition to traditional providers. The preferred provider insurance plans (defined below) create a secondary market between insurers and traditional providers. Fair market choice in benefit programs creates freedom of entry (and exit) for plans to consumers through multiple choice and establishes premiums (more precisely, marginal premiums) as a primary price mechanism for provider competition. The market model above, more fully elaborated below, could be implemented in many ways. It could be done as part of a national health insurance (NHI) plan [5,10] or as a precursor to an NHI plan, or on its own merits without an NHI plan (in the latter case, Medicare and Medicaid modifications would be necessary for low-income persons). Incremental approaches short of NHI could be accomplished by coercive legislation [4] or by



leadership approaches with minimal legislation [6]. Alternative sociopolitical strategies to implement the model are beyond the scope of this paper. The point is simply that there are many possible ways to implement a market model; massive immediate legislation is one way, but there are also more flexible incremental ways entailing rather minimal enabling legislation.

The characteristics of the future medical care delivery and financing system that might emerge from this model may be described somewhat more fully in terms of administration, delivery, financing, and regulation. (The description below should be thought of as probable and approximate rather than rigid or precise.)

### Administration

Assume that, at some future time, 40 to 70 percent of the covered population is enrolled in competitive health care plans and major risk or other cost-shared insurance plans, with the remainder in comprehensive health insurance plans. (Call all of these arrangements "plans" for brevity.) Administrative arrangements can be viewed before and after NHI. Prior to NHI, it is assumed that the covered population remains at its present level (about 80 percent of the population) or is perhaps expanded by gap-filling public financing programs. Fair market choice arrangements are available to nearly all covered persons. Employees are offered multiple choice through their employer, and Medicare and Medicaid recipients through these public programs; other individuals deal directly with the plan of their choice. It is further assumed that most plans in an area are available to each covered person, though there may be some small variation; for instance, one group may be offered one set of plans while another group is offered a highly overlapping but slightly different set of plans. After NHI (assuming that NHI is desired) it can be assumed that all persons are covered. The NHI may choose to have fair market choice administered by a single public agency in each geographical area along the lines of the Federal Employees Health Benefit Program (FEHBP). Assume for simplicity that each plan may offer one benefit package and one premium in each area. (Before NHI, different plans might offer different benefits and premiums to different groups.)

### Delivery

The major new element in the medical delivery system is a wide variety of

health care plans, diverse in sponsorship and organization and mostly under private ownership. Major urban areas may have fifteen or twenty such health care plans competing with each other and more traditional physicians and hospitals. Rural areas may have a branch office of a health care plan or none at all, remaining entirely served by traditional providers. Traditional providers are reimbursed by major risk plans and comprehensive insurance plans and also may have limited contracts with several health care plans. Perhaps 30 percent or more of physicians are affiliated exclusively with health care plans, and many more physicians are affiliated on a part-time basis. Perhaps 30 percent of hospitals are exclusively affiliated with a health care plan, and most of the remainder have some affiliation with one or more health care plans. As now, public general hospitals and special programs provide service to transients, illegal aliens, and other vulnerable persons unable to participate in a fair market choice situation; at the same time, some public hospitals and clinics also participate in health care plans.

#### Financing

Financing may be usefully viewed before and after NHI. Before NHI, employees would be permitted to apply any bargained contribution from their employer toward any plan in their multiple-choice offering. Similarly, Medicare and Medicaid would be amended to allow recipients to apply a fixed public contribution toward any plan permitted to participate in these programs. As now, self-employed and other individuals would have no financial help until NHI is enacted. After NHI, all persons presumably would be entitled to an income-related (i.e., larger for lower incomes) public contribution to apply toward any plan permitted to participate in NHI. This contribution could be administered through tax credits, grants, or vouchers as desired. The contribution probably would be related to area cost and health risk factors as well. The difference between the contribution and the premium of the chosen plan would be paid out of pocket by the consumer (or rebated to the consumer if the contribution exceeded the premium). For simplicity it is assumed that no other tax deductions are allowed beyond this contribution.

#### Supportive Regulation

In the extreme form of the proposed market strategy, cost control

regulation presumably would be superfluous; therefore rate controls, fee controls, capital controls, and Certificate of Need (CON) would not be present. Rather, regulation would focus on assuring that effective competition was maintained; consumer information and antitrust would be emphasized. Planners would concentrate on cooperative, educational, and persuasive efforts. Quality regulation would be applied to both health care plan provider and traditional providers alike; to accommodate pluralistic styles of medical practice, such regulation would focus as much as possible on patient outcomes as well as medical procedure audits [13].

The description above leaves many details open but is sufficient to predict most of the performance of the medical care system under the market strategy. Many of the details omitted are addressed in subsequent discussion of issues relating to the philosophical appropriateness, practicality, and performance characteristics of the hypothesized competitive model.

#### PHILOSOPHICAL OBJECTIONS: IS A MARKET STRATEGY APPROPRIATE?

Interestingly, philosophical disagreement with the market reform strategy tends to be found in two disparate groups. One group consists of what might be termed "traditional liberals" concerned with the application of "private enterprise" principles and rhetoric to the medical care delivery system. The second group consists of two overlapping sets of individuals--"traditional conservatives" and traditional providers of medical care. Both (referred to jointly as conservatives) are concerned with any policy proposals which threaten the status quo in medical care delivery. The concerns of both liberals and conservatives are examined in greater detail below.

#### Liberal Concerns

Liberal critics of market reform prize equity above many other goals. They believe a society should be judged in large part by the way it treats its unfortunate and disadvantaged members. Some liberals distrust that any market strategy can achieve equity in the delivery of medical care. They suspect it will simply enrich, intentionally or unintentionally, the already advantaged at the expense of the disadvantaged. They point out that the medical care market has performed poorly to date. Furthermore, they believe that other areas of the economy, where private markets have failed to help the poor, provide

evidence that a reformed market in medical care will not work. Often this general distrust of private enterprise is accompanied by support of strong government regulation as a means of countering the power of advantaged providers.

While the concern for reasonable equity in medical care is certainly appropriate, it is not clear that (1) a restructured market cannot promote equity but (2) a strong regulatory system will better serve the disadvantaged. Equity can be accorded a high priority in the proposed market strategy by subsidizing low-income people in their choice among health care plans and insurance plans. Private markets do not produce equity in many sectors of the economy only because government has not felt equity to be a sufficiently high priority to subsidize specifically the purchasing power of low-income people for those goods or services. In those areas where it has (e.g., food stamps), such subsidies have not worked perfectly but they have resulted in substantial improvement in the positions of low-income groups. Furthermore, subsidies under a reformed market system would be a wholly controllable and budgetable public expense, unlike present Medicare and Medicaid. Regarding the second contention, an extremely common finding of research on industries with price, quantity, or entry regulations is that such regulations protect the interests of producers more often than consumers [4-16]. Thus in practice, extensive economic regulation may be a relatively poor tool for promoting equity.

Furthermore, one likely consequence of a centrally regulated system probably would be to remove economic choices from consumers and place them in the hands of regulators. This assumes that most consumers are unable to make their own medical care decisions as well as regulators can make them. In any society there are a few vulnerable people for whom this is true; these people need and should have such public protection, not only in medical care but with respect to many aspects of living. However, the vast majority of people are quite as competent as regulators. Medical care is no more complicated than many other products equally dangerous to health and well-being that consumers purchase with acceptable competence in markets. While some fraud and abuse, resulting from the ignorance of consumers and the unscrupulous actions of some producers, does occur in predominantly private markets, it can occur with equal frequency in heavily regulated industries or in totally public industries. Private markets have no corner on fraud and abuse. Effective performance of private markets does not require that every consumer make wise choices every time, only that enough consumers make wise choices enough of the time to shape

overall producer behavior. Also, the market strategy does not require the removal of existing quality controls, such as licensure and peer review. Private markets have not worked well in the delivery of medical care heretofore because medical care providers and consumers have not been faced with appropriate incentives. The proposed market strategy seeks to restructure the system to establish such incentives and is not to be confused with the status quo or laissez-faire.

It also should be noted that the crucial feature of the market approach is expanded consumer choice, not producer profit. More accurately, it is consumers making choices on the basis of "value for money." Producer profit is useful in drawing producers off to new, but risky, areas of potentially unfulfilled consumer demand. However, in a truly competitive market "abnormal" profits for producers could not be sustained.

Some opposition to market reform from "traditional liberals" springs from self-interest as well as public interest considerations. Private markets are dominated by business-minded people, while regulation enhances the prestige, power, and job security of the intellectuals and bureaucrats who dominate government agencies and academic centers. To some extent, intellectuals and bureaucrats may underrate the "high-mindedness" of private-sector people and overrate their own; consequently, they may resent approaches which elevate such people over themselves. If this is true, subtle social prejudice may be an important factor in understanding opposition to private market reform strategies.

#### Conservative Concerns

Conservative critics of the market strategy distrust sweeping change that assumes the perfectability of man and his institutions. They prefer incremental improvements that conceivably could be reversed if they fail. They believe that, for every beneficial innovation, there are many others that are harmful. And unlike paper "grand designs," real human institutions are not easily scrapped and started over again once altered. If disrupted by ill-conceived change, they may take years to recover their original level of performance, with adverse effects on perhaps millions of people. In particular, conservatives believe that the high standards of performance of the American medical care system depend critically on the fragile forces of tradition, professional ethics, and trust. Competitive reforms could imperil these

standards and impose constraint on the freedom of physicians to do the best for their patients. Providers fear that the proposed strategy may force them to abandon everything in which they have some confidence to engage in a new, untried, "theoretical" scheme. They also feel it unfair that one kind of health care organization be promoted over another, particularly if the other is traditional practice. Finally, some conservatives argue that even if the medical care system at its present excessive level does not have much impact on health, it at least provides employment to many people and adds to GNP.

In general, these are important arguments which must not be ignored, but conservatives must recognize that the issue in the delivery of medical care is no longer between change and no change. Spiraling medical expenditures are not only unbalancing budgets in both government and industry; they are also threatening our nation's ability to finance other pressing priorities. These expenditures will force change, and the only real issue now is the nature of that change, who will lead it, and the eventual outcome. Although providers should not be blamed for the existing problems of the medical care system (since the system is behaving exactly as society has structured and rewarded it to behave), they will have to live with any reform attempts. Unless providers come forward with credible private approaches, cost pressure will force government to proceed without them. Providers then will have little voice in the future of their own system.

In supporting changes, providers must accept that in a future cost-contained system they will not have the same unfettered freedom they enjoy today. If adequate, high-quality medical care and financial protection are to be provided to all Americans at a cost the nation can afford, physicians will not be free to do everything they know how to do. The best conceivable medical care is no more justifiable nor affordable than the best conceivable military defense or the best conceivable educational system. Similarly to these, medical care will have to be limited to balance with other national needs. Accepting that there will be some constraint on professional freedom, it makes a great deal of difference for professional freedom whether that constraint will be exercised mainly by professional peers competing to satisfy patients in a structurally sound private market or whether it will be exercised mainly through government regulatory decisions.

The proposed market strategy is an evolutionary approach that does not force change at a disruptive pace. At any point it can be modified or discontinued with little chance that permanent harm has been done. The strategy

does not aim to eliminate traditional practice but, rather, to build a more pluralistic, competitive private system in which traditional practice remains an important element. It does so by attempting to reorganize existing practice into new competitive arrangements which eventually place competitive pressure on traditional providers as well. Thus the strategy promotes choice and competition, not one type of practice over another. While initially the new alternatives will have to be promoted, eventually they will have to stand on their own. Traditional practice needs no initial promotion because it already dominates and has no competitors in our perversely reimbursed system. Providers committed to traditional practice may remain there, but they should support freedom of choice for their innovative colleagues, as well as patients, to participate in the new arrangements.

The employment argument cited above does not survive close scrutiny. The employment of people in proliferating medical care jobs unproductive of improved health no more justifies an excessive medical care system than do proliferating unproductive public jobs justify excessive government bureaucracy. The nation needs to move people into productive areas that meet pressing priorities and improve its real level of well-being.

Some opposition to market reforms from some conservatives springs from self-interest as well as public interest considerations. Some providers fear loss of professional prerogatives (and there will be some loss in any effective competitive system). However, the experience of other countries suggests that there will be little loss in the professional status of physicians or their relative income positions whether market or regulatory approaches to cost containment are taken. Since mounting expenditure-containment pressures imply that change can only be delayed and not stopped, the issue is less the well-being of providers (who will do well in either case) than the choice of a reform approach that is consistent with the best practice of medicine.

#### PRACTICAL CONSIDERATIONS: WILL A MARKET STRATEGY WORK?

A second potential concern of policymakers and providers focuses on the practicality of the market reform strategy. Specifically, there is concern on the part of some that health care plans cannot be established, that they will not be attractive to consumers, that they will not compete with each other and with traditional providers, and that traditional providers will not respond competitively to them. In other words, while market reform may be attractive as

a theoretical construct, its practicality is regarded as questionable. Clearly there is no completely satisfactory evidence which can be drawn on to address these concerns in the absence of widespread experience with competitive markets. The market strategy attempts to create incentives in the delivery of medical care which have not existed previously. Therefore concerns with its practicality have been addressed in the past primarily with speculative reasoning supported by limited empirical evidence. However, markets displaying competitive characteristics recently have been growing in number and now are supplying new information concerning the practical feasibility of the market reform strategy [17-27].

### Is the Market Strategy Technically Feasible?

Health care plans have operated successfully with as few as 5,000 enrollees, but 20,000 enrollees or more provide better strength and stability. Thus each urban area of over a million population (which areas in aggregate encompass 40 percent of Americans) could support ten to twenty moderate to large plans. Each urban area of 100,000 to 1 million population (which areas encompass another 27 percent of Americans) could support two to ten moderate-sized plans. Since the problems of escalating cost, excessive specialists, and overelaborate hospitals are concentrated in the larger urban areas, which set the style of medical practice, competition appears most feasible exactly where it is needed.

Even in areas with less than 100,000 population, some competition may be feasible between a single health care plan and traditional providers. In rural areas, branches of larger health care plans could compete, or these areas could solicit bids for a health care plan or other organization to manage all of their medical care facilities. However, in rural areas the primary issue is usually availability of services rather than their cost, making competition in these areas somewhat less essential. They may benefit indirectly from competition in the cities if it pushes surplus physicians into underserved areas.

Fair market choice also appears feasible on a large scale. The FEHBP has operated fair market choice for over 8 million federal employees throughout the nation for almost twenty years. Compared with Medicare, with its constantly expanding regulations and legislative amendments, the federal employees program operates with relative simplicity and has required very little corrective



legislation.

A big obstacle to the development of competition on a broader scale probably has been the lack of consumers with fair market choice. Few employers offer multiple choice, and federal employees do not constitute a large enough enrollment pool in most areas to support even one strong health care plan, let alone several. The proposed market strategy seeks to widen the availability of fair market choice.

#### Can Health Care Plans Be Established?

Establishment of the numbers of health care plans required for nationwide implementation of the market strategy would be very difficult and probably would require a considerable length of time. In most areas, providers currently lack strong economic incentives to participate in health care plans. Furthermore, until enough plans are formed to stimulate competition, this circumstance will persist. While it is true that initial plans in communities occasionally are the serendipitous brainchilds of providers searching for better ways to practice medicine, a nationwide market strategy cannot be based on these somewhat random occurrences. It seems more likely that motivation for initial plan formation must be provided by educational efforts, support, and pressure directed toward providers by business, labor, government, or other concerned groups. Once a strong health care plan is established in a community, the obstacles to formation of succeeding plans are much reduced. Initial plans stimulate competitive pressures which beget new plans.

The experience in Minneapolis-St. Paul demonstrated that promotional efforts can be successful in the development of health care plans [26]. Six new plans were organized in that community between 1972 and 1977. The total enrollment in health care plans there now has reached about 20 percent of the metropolitan population [20]. Formation of these plans was accomplished by local private initiatives on the part of employers, insurers, and providers; federal, state, and local public planning efforts played only a marginal role. There seems nothing so unique about the Minneapolis-St. Paul area to suggest that similar private stimulative efforts could not succeed elsewhere. That area's success could be aided by more appropriate, well-targeted state and federal efforts.

## Will Competitive Plans Grow?

Health care plans have existed for a number of years in various forms, but their growth in numbers and enrollment has been slow. If health care plans cannot attract relatively large numbers of enrollees, the potential impact of the market strategy is quite limited. There are several reasons why extrapolation of the historical growth trend in health care plan enrollment into the future would not be appropriate, even were new stimulative efforts on the part of government not undertaken. Before these reasons are indicated, it is useful to discuss the history behind the slow development of health care plans to this point. (See Weller [28] for a complete discussion of the points raised below.)

Any historical discussion of impediments to health care plan development ultimately must focus on the 1929 "Baylor plan" to which the present Blue Cross traces its origin. This plan was organized around the medical staff of Baylor Hospital. The Blue Cross 1979 Fact Book blandly acknowledges that "plans began forming across the country (in 1930), each associated with a single hospital. By 1932 community-wide plans emerged, offering a choice of hospitals. In 1933 the American Hospital Association began to encourage (community-wide) plans and took steps to regulate and approve them." Some understanding of what happened between 1929 and 1932 that caused the shift from competing, hospital-based plans to a single, community-wide plan embracing all hospitals can be gleaned from statements of contemporary medical and Blue Cross leaders, such as Dr. A. A. Jenkins, president of the Cleveland Academy of Medicine, and C. Rufus Rorem, the early leader of the Blue Cross movement [28]. Said Jenkins: "By joining together, the hospitals unitedly serve the community and obviate the adoption in Cleveland of small parallel competing insurance plans which bring about price-cutting and service-cutting chaos." Said Rorem: "In this way, the administrators and trustees of the member hospitals are able to throw their influence behind one hospital service plan rather than to dissipate their energies in competition." As Weller observes, medical societies and hospital associations were thus quick to condemn competing plans and to enshrine monopoly plans in their ethical canons, where they have remained for almost fifty years. These early leaders should not be condemned for their anticompetitive actions since society apparently agreed with them, as evidenced by numerous supportive state laws and court rulings.

When employment-related health insurance became widespread after the

Second World War, it followed the accepted Blue Cross pattern of including all providers. Competing plans, opposed by providers as unethical, were not considered. The same pattern was adopted by Medicare and Medicaid; indeed, any alternative approach might have antagonized organized medicine sufficiently to defeat the new programs. The only major break in this pattern was the FEHBP in 1959. Because many federal agencies had their own insurance plan which they were reluctant to give up, as a compromise FEHBP permitted employees a multiple choice among their existing plans and the new government-wide Blue Cross and Aetna plans. A few early HMOs also were included in this fair market choice arrangement. Over the next ten years, HMOs generally were quite successful under such fair market choice, enrolling as many as 40 percent of federal employees in some areas. However, there were too few federal employees in any one town to support one HMO, let alone several. With very few exceptions, other employers did not offer fair market choice, since there was no pressure from employees, most of whom had little knowledge of HMOs (i.e., there were too few HMOs under the limited market access to create consumer awareness), and change was opposed by providers.

It is only in the last ten years that these historical factors have been altered measurably by new developments. First, insurance benefits have become more comprehensive; earlier, when insurance benefits were weak, consumers had to pay substantial additional premiums for comprehensive HMO benefits. Second, a "crossover" effect is occurring, where cost escalation of traditional health care is making insurance premiums more expensive than competitive health care plans, despite the more comprehensive benefits of health care plans. For example, the majority of health care plans in the federal employees program offer greater benefits for lower premiums than the conventional insurance. Finally, the attitudes of business and labor, as well as the incentives they face regarding medical care, seem to be changing. Heretofore, employers regarded health benefits as a cheap (tax-subsidized) way to attract a better work force, and unions have seen these benefits as bargaining prizes for their members. Now that most large employers offer extensive benefits, this perspective is becoming outmoded. Employers can attract a better work force by containing the costs of existing benefits, thereby releasing funds for employee pay increases and the expansion of other fringe benefits. Therefore these groups now have stronger incentives to support measures with the potential to restrain increases in the cost of health care benefits. This could lead them to promote competitive health care plans through the use of fair market choice

arrangements.

Health care plans must be able to attract additional providers in order to support enrollment growth. There appear to be factors which promise to make providers increasingly receptive to participation in health care plans. First, organized medicine is becoming more tolerant and supportive of freedom of choice for physicians to participate in competitive plans as well as traditional practice. One sign of the new tolerance is the AMA Cost Commission Report, approved by the House of Delegates and supportive of competitive plans [29]. But it will take time for this more tolerant attitude to trickle down to local physicians. Second, new operational health care plans have developed which require only modest change from existing professional arrangements. The original prototype for a competitive plan, the prepaid group practice, while generally excellent in performance, was not acceptable to enough physicians, required substantial change and organizational effort to initiate, had high start-up cost and risk, and demanded skilled management and long lead time. The IPAs, Health Alliances, and other health care plan arrangements can be implemented with much more feasible lead time, effort, and expense. Third, the growing surplus of physicians [30], which raises cost in the present system, also promotes participation in health care plans. New physicians are more willing to participate in health care plans to acquire a practice, and established physicians sometimes start plans to enroll their patients, protecting them from other physicians.

The empirical studies cited above suggest that a typical "growth cycle" exists for health care plans in any community. The first plans in an area encounter the most physician resistance. Along with the concept of fair market choice, they are unfamiliar to consumers and employers. The first plans may not be attractive to some consumers and sometimes are located inconveniently. This creates only weak competitive pressure for the first plans to grow or for providers to participate or organize new plans. However, if these plans gradually gain enrollment and physicians and precipitate new competitive plans, pluralistic styles of practice become more professionally acceptable. Consumer understanding increases, plan locations become widespread, and fair market choice becomes commonplace. This results in even more vigorous plan marketing and growth.

Some health care plans may have less incentive to grow than others. For example, some physician group plans, once they have sufficient enrollees to occupy all their physicians, may have little reason to expand further; adding

more physicians in order to grow may be perceived by existing participating physicians as a potential source of organizational stress. Or, a consumer-sponsored plan may become less growth-minded once it has sufficient enrollees for stability; enrollees may not be willing to pay higher premiums to support the capital expenditures necessary to increase the plan's availability to other consumers. However, it is not necessary for all existing plans to grow if new plans are forming to enroll new consumers. The best incentive for all plans to grow and new plans to organize is the presence (or threat of entry) of one or two growth-minded plans. (For-profit plans tend to be growth-minded, but so do many other plans.) Then all plans must market vigorously or even expand, and traditional practitioners must compete to retain their patients. The market strategy will have to encourage private and public payers to maintain stimulative efforts until there are sufficient growth-minded plans in the area for competition to become firmly entrenched. A diversity of plan sponsors and organizational arrangements will encourage such competition.

#### Will Providers Really Compete and Not Collude?

One commonly voiced concern about the market approach is that providers will not really engage in economic competition. Instead, health care plans and traditional providers will tacitly divide up the market. The health care plans will price themselves just enough below traditional insurance to maintain their market share. Traditional providers, not having to fear loss of patients, will not change their behavior, and conventional insurance premiums will continue to rise. The health care plans thus will pocket excessive earnings by allowing their premiums to rise with traditional insurance premiums.

There is nothing unique to medical care about this scenario; it is a standard problem in all markets. However, modern market economies have developed the tools to minimize such occurrences and to break them up when they do occur. It appears to be a manageable problem once basic competitive conditions have been established. The case for potential collusion is strongest before these basic conditions are in place. 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 enough enrollees to assure financial stability (say, 20,000 to 30,000). At this point, relatively few consumers, unions, and employers may understand or demand fair market choice. Without sufficient existing pluralism for more economic styles of practice to gain professional

acceptance, traditional physicians can ostracize colleagues who are considering participation in new plans. Growth and competitive incentives become severely restricted.

The market strategy will have to counter this initial hazard by maintaining stimulative efforts until enough plans are established in an area for competition to take hold. As more areas establish effective market forces, and mainstream employers and physicians become involved, competitive plans and styles of practice will become legitimized, and it will be easier to overcome these hazards in other areas. In addition to promotional efforts, the same tools that help maintain effective competition in established markets will also help in establishing those markets.

Once fair market choice is understood and demanded by most employers, unions, and consumers, and once competitive plans and styles of practice are legitimized to enough providers, competitive conditions and the incentives they create should be self-sustaining. The ability of new plans to enter the market should force all plans to keep premiums competitive and eventually drive premiums down to the point that new plans stop entering the market.

#### A COMPETITIVE SCENARIO: THREE PHASES IN THE DEVELOPMENT OF A COMPETITIVE MARKET

If effective competition among health care plans and between health care plans and traditional providers can be created, it seems likely to develop in a three-phase sequence. Initially competition would be most keen among the health care plans themselves. The proportion of community residents enrolled in health care plans would be small. Traditional providers would ignore the loss of patients to health care plans, and, in fact, individual physicians might be unaware that they were losing patients. Competition at this stage would have no measurable impact on community-wide medical care utilization and cost statistics. The only evidence of developing competition would be the competitive actions of the health care plans.

In phase 2, health care plan enrollment would reach the point where it could no longer be ignored by traditional providers. This threshold market share would vary from community to community, depending on conditions in the medical care delivery system and the marketing aggressiveness of health care plans. At this point, traditional providers might react to health care plan growth by raising their service prices or providing more services to remaining

patients. If fair market choice was not yet widespread, so that many consumers lacked the option of enrolling in health care plans, such actions on the part of providers could succeed temporarily in protecting their incomes. These actions would increase the premiums of traditional insurance plans and make the premiums of health care plans more attractive. But lacking fair market choice, substantial numbers of consumers could or would not switch plans; their employers and Medicare and Medicaid would simply have to eat the cost increase. Thus during phase 2 there could be a measurable increase in community-wide utilization and cost statistics, if the cost-increasing behavior of traditional providers overwhelmed any cost reductions generated by the health care plans.

In phase 3, fair market choice would become widespread. Facing the marginal increase in insurance premiums, consumers would now increasingly shift to more efficient health care plans. Eventually, some traditional providers would not be able to find a sufficient number of patients to maintain desired incomes. Consequently, they would be forced to organize their own health care plans to compete for patients, accept stringent controls by traditional insurance plans, cut prices, and/or move to less competitive areas (increasing the possibilities for competitive plans there). Phase 3 would begin when competitive health care plans substantially altered traditional provider behavior in this manner. Probably 60 to 80 percent of the population would have to have fair market choice, and between 20 and 40 percent of an area's population would have to be health care plan members before this would occur, but the actual percentages again would vary from community to community depending on market factors. As the competition intensified in phase 3, measurable reductions in community utilization, excess capacity, and costs could be expected. This would be particularly true if Medicare and Medicaid eligibles were offered a fair market choice among health care plans, so that providers were not able to resist competitive pressures by providing excessive services to these groups.

There are a number of key factors in assuring that this competitive scenario progresses to phase 3. As described above, they include (1) ease of entry by new plans, (2) diversity of plan sponsorship and organizational form (making the emergence of growth-minded plans more likely and collusion less likely), (3) several plans competing for the same consumers, and (4) widespread fair market choice. It can be anticipated that both traditional providers and existing health care plans would urge employers and government to place all kinds of restrictive conditions on new health care plans before they may

participate in multiple choice. This would be justified on the grounds of keeping out unsound plans, but, of course, a strong motivation is to keep out new competitors. While employers and government must evaluate the medical and financial soundness of health care plans, new plans should be allowed to participate in multiple-choice offerings unless there are compelling reasons to the contrary. The emphasis should not be to restrict the offering of new plans unless they prove themselves beyond the shadow of a doubt. Two additional conditions can facilitate competition: (5) prohibiting health care plans and health insurance plans from subsidizing premiums in one area from premiums in another area, and (6) eliminating tax deductions favoring more expensive plans. Finally, (7) judicious antitrust surveillance would help police the market. The market strategy attempts to implement all these conditions as well as to encourage strong promotional efforts by the private and public sectors to legitimize and organize competitive plans.

To succeed, these promotional efforts would have to sustain growth and competition in each area past phase 2, where developing competition is the most vulnerable. In this phase, traditional providers may attempt to organize to limit competitive developments. Since community costs may be increasing, promoters of competition may not be able to identify cost savings to justify their support. Therefore it may prove difficult for competitive developments to sustain the momentum necessary to move into phase 3 of market reform.

In summary, the market strategy appears feasible if enough health care plans can be organized and fair market conditions can be established. Perfect competition should not be expected in every community (in medical care, or in any other market). However, with judicious antitrust surveillance, reasonable ease of entry for a variety of plans, and sustained promotional efforts, competition among health care plans and traditional providers should be possible. Furthermore, it should initially emerge most strongly in high-income areas with surplus numbers of physicians. This has many advantages. It identifies health care plans as acceptable "mainstream" medicine, helping legitimize pluralistic styles of medicine in other areas. It focuses competition exactly where the gains are potentially the greatest. Finally, it results in competition for the enrollment of relatively knowledgeable consumers who are the most likely to identify and reject substandard plans.



PERFORMANCE EXPECTATIONS: CAN A MARKET STRATEGY CONTRIBUTE TO THE ACHIEVEMENT OF MEDICAL CARE DELIVERY SYSTEM GOALS?

Assuming that the market approach can be implemented to phase 3, where effective competition conditions are established and maintained, will increased levels of achievement of medical care delivery system goals result? This question is addressed by analyzing the likely impact of the proposed market reform on each of the medical care policy goals set out at the beginning of this discussion.

Will the Market Strategy Contain Medical Care Expenditures?

It is assumed that the restructured medical care system would behave essentially the same as other sectors of the economy which possess structurally sound markets. In all effective markets, there are incentives for cost-conscious behavior. In a reformed medical care market, existing or new plans would have to contain premiums in order to attract enrollees. This restraint on premiums would result in an equilibrium condition in which premiums are just sufficient to provide a normal return to the plans after they provided the services and benefits necessary to attract consumers. An efficient plan would not be able to reduce its premium further, since then it would no longer be financially viable or it would provide inadequate services to its members, presumably causing them to disenroll. Inefficient plans and providers would be forced to change their methods in order to meet the competition from efficient plans.

Along with this theoretical argument, there is substantial research evidence that efficient health care plans facing competitive pressure can provide care at lower cost than the traditional medical care system. These existing plans (largely group practice HMOs) on average use less than two-thirds of the physicians and hospital days required by the traditional system for the same patient populations, using fewer specialists and less expensive technology in the process [31]. There is no evidence that the quality of the care provided by existing plans is inferior to the care offered by traditional providers (see below).

These present economies are only indicative of the savings which might accrue in a fully implemented market system. At present, health care plans must exist in an environment dominated by conventional cost-ineffective practice

standards and with the cost of medical inputs dictated by this behavior. Under the incentives created by structurally sound competition, cost-effective styles of practice would become increasingly acceptable within the medical profession, and cost-ineffective styles would be deemphasized. Unneeded personnel and technology would find no demand for their services in an effective, reformed market, and their prices would fall commensurately. This is in marked contrast to the present system where, in the absence of price competition, surplus providers can create considerable demand.

The potential impact of health care plans on hospitals is illustrative of the cost-effective changes which would result from the market approach. Competition would gradually force hospital utilization down to the rates that obtain in the most efficient plans. A health care plan or insurance plan that had excessive hospitalization would not be able to maintain a competitive premium. Adjusted to a typical U.S. population, efficient plans utilize 600 to 800 hospital days per 1,000 enrollees, compared with 1,200 days per 1,000 persons for the United States at present. Hospital use, therefore, would gradually fall as health care plan enrollment grew, and hospitals would have difficulty maintaining existing revenues. Health care plans would try to concentrate their patients at the most efficient hospitals. Traditional hospitals that refused to negotiate competitive rates, or that raised rates to increase revenue, would drive up the premium of insurance plans, causing more consumers to enroll in efficient plans. Eventually surplus hospitals would be forced to consolidate or go out of business [32]. Also, health care plans probably would attempt to concentrate their highly technological tertiary-care needs at a few efficiently utilized regional centers. For example, even the large HMOs have found it more efficient to purchase open-heart surgery from medical centers rather than provide it at their own hospitals. The eventual result should be reduction of hospital and technological capacity to more appropriate and efficient levels and concentration of specialized care in fewer, more efficient regional centers.

As a result of their existing efficiencies, the premiums of health care plans generally have risen more slowly than conventional insurance in the past few years. Under the more intense competition of several health care plans in an area, premium increases should moderate even further. Employers, unions, and government also might become unwilling to raise their contributions toward health premiums so rapidly. This would mean that consumers who chose an inflationary plan would be forced to pay most of the premium increase out of

their own resources. Thus any plan that attempted to raise its premium faster than competing plans would meet strong consumer resistance and lose enrollees to the less inflationary plans.

As premium competition among health care plans and between health care plans and conventional insurance plans intensified, the conventional plans would be under increased pressure to take actions which would contain their premium increases. Although insurers historically have been relatively weak agents for cost containment, there are effective actions which they could take to create cost-conscious incentives for providers [4,12]. The strongest cost-containment tool of private insurers is the "provider participation contract," used by Blue Cross/Blue Shield and other "service" insurance plans (as distinguished from indemnity insurance plans, which do not use participation contracts). In essence, participating providers agree to accept the insurance plan's reimbursement as payment in full. Nonparticipating providers may charge higher rates, but the insurer will pay only a fixed amount toward such rates; usually this amount is approximately 90 percent of their maximum allowable reimbursement to participating providers. The nonparticipating provider must recover the remainder from the patient. Since recovering bills from patients takes effort and expense, and reimbursement from the Blues and other service insurers has traditionally been generous, most providers elect to sign participation contracts.

Service insurers could attempt to contain costs by reducing the maximum allowable reimbursement for participating providers. The most effective reduction would be to condition maximum reimbursement on total claims experience, so that providers could not maintain incomes by increasing utilization. The insurer also could do stringent utilization review of subscriber care, refusing reimbursement for unnecessary services to participating providers and refusing participation to providers of consistently excessive services. Such strong measures might lead many providers to stop participating. To make participation more attractive than nonparticipation, the insurer could cut reimbursement to nonparticipating providers to, say, only 60 to 50 percent of maximum allowable reimbursement to participating providers. This arrangement is termed a "preferred provider insurance plan." Some subscribers might decide to find another insurance company. However, it seems equally plausible that most subscribers would begin to shift from nonparticipating providers to participating providers to avoid high out-of-pocket payments. With this type of consumer response, loss of participating providers

would be minimal.

An even more acceptable arrangement is possible under fair market choice. The insurer could offer two comprehensive insurance plans, one the customary plan and the second the preferred provider plan outlined above. Subscribers could choose either the preferred provider plan, knowing that they would face high out-of-pocket charges when using a nonparticipating provider, or they could choose the conventional plan, knowing that they would have to pay a higher premium.

The preferred provider plan is much like a halfway house between a conventional insurance plan and a health care plan. Under the conventional plan, consumers may go to any nonparticipating provider and services will be reimbursed almost in full. Under a health care plan consumers receive no reimbursement if they use an unapproved nonparticipating provider service. Under the preferred provider insurance plan consumers receive some, but limited, reimbursement for using a nonparticipating provider service. As long as consumers have a choice of plans, the preferred provider plan appears quite acceptable.

The preferred provider plan allows the insurer to act as a guardian for all subscribers of that plan. In effect, the insurer takes the position that it has identified a set of efficient, high-quality participating providers whose services will be reimbursed in full; a subscriber is free to go to other providers but the insurer, acting as agent for the other subscribers, will not subsidize this decision by paying the full cost. The preferred provider insurance plan thus begins to redirect subscribers from presumably less efficient providers to presumably more efficient providers. If it does not, its premium will rise to uncompetitive levels.

While the Blues probably are in the most advantageous position to develop competitive preferred provider insurance plans, in principle Medicare, which also uses provider participation contracts, could take the same actions. However, Medicare is a public program subject to political pressures. If Medicare cut reimbursement to nonparticipating providers, there would be strong political reaction, not only from physicians and hospitals but from the elderly who have to pay the high out-of-pocket costs and face potential discrimination from providers. This situation might be avoided if Medicare instituted fair market choice and offered the preferred provider plan as an option. However, it is still doubtful that this action could survive politically.

Private indemnity insurers also have less leverage than service insurers

because they do not use participation contracts. In essence, indemnity insurers deal only with the subscriber. The subscriber pays the provider, and the indemnity insurer reimburses the subscriber up to a scheduled maximum for each service. Thus the commercial insurers now have little direct leverage on providers. However, indemnity insurers can limit reimbursement for certain services to efficient providers, a cost-containment tool available to service insurers as well. For example, an insurance plan might provide an alcoholism benefit but only if the service is obtained from a particular alcoholism treatment center. Such a benefit would have to be negotiated with each employed group to avoid subscriber dissatisfaction. A variety of other actions also are possible, including bulk purchasing of drugs and other supplies for subscribers, second surgical opinion benefits, and peer review, but these actions are of limited value unless the incentives on providers are altered [32].

By far the most potent tool available to indemnity insurance plans is strong front-end co-insurance and deductibles (i.e., the marketing of major risk insurance). Fair market choice may make heavily cost-shared plans more acceptable to consumers. Moreover, if both service and indemnity insurers did introduce greater consumer cost sharing, they could strengthen competition by providing consumers with effective price and expenditure data on providers. Consumers facing high front-end out-of-pocket costs would have incentives to utilize comparative information on provider prices and expenditures for common episodes. Such information would guide them to the more efficient providers, and other providers might have to become more efficient to compete for patients.

The examples above indicate that lack of insurer effectiveness in cost containment cannot be attributed entirely to an absence of effective alternatives. Instead, a more likely explanation is the existence of powerful negative incentives to take such actions. In the present medical care system, most truly effective insurer actions would antagonize either providers or consumers and thereby weaken the competitive position of insurers. The establishment of effective competitive health care plans would change these negative incentives facing insurers. If competitive health care plans were to erode substantially the patient base of traditional physicians by enrolling a large fraction of an area's population, as hypothesized in phase 3 of market development, then traditional physicians would begin to accept, perhaps even welcome, effective insurer action to make the traditional system more competitive. In the absence of such competition or other pressure on physicians, the insurer actions discussed above are unlikely to be undertaken.

## Will the Market Strategy Financially Protect People?

By themselves, competitive plans and fair market choice do not assure that lower-income people have the means to purchase services offered by the system; this must come from public subsidies. However, if the market approach is successfully implemented and government chooses to subsidize lower-income people through fair market choice with an income-related fixed contribution toward the premium of any plan of the consumer's choice, then that subsidy need not be inflationary. Indeed it appears that with a structurally sound market, medical care would be sufficiently efficient eventually to extend adequate coverage to all Americans for no more than existing national expenditures. In contrast, it has been argued that the present subsidy, provided through open-ended Medicare and Medicaid third-party reimbursement, contributes significantly to medical care inflation. Implementation of the market approach thus may enhance the political feasibility of universal protection. Providing such income-related subsidies under fair market choice to low-income persons must eventually be part of any comprehensive market strategy.

## Will the Market Strategy Make Medical Care More Equitably and Appropriately Accessible?

Assuming that competition reaches phase 3, it should gradually (over a decade) distribute medical care resources in ways that make medical services more efficient and more equitably available across the nation. This conclusion is based on the fact that a competitive system can "saturate" its market more easily than a system in market failure.

Present inequities in the distribution of medical care services among different population groups stem from at least two factors: financial barriers and resource availability factors. Unsubsidized lower-income people receive fewer services because they cannot pay; this could be corrected by universal subsidies. However, even if people have the means to pay, they cannot buy the services if the medical resources--for example, physicians and hospitals--are not available. Thus Medicare and Medicaid have substantially (but not perfectly) equalized the distribution of services among income groups, but there is no evidence that they have shifted the distribution of physicians and hospital resources out of professionally attractive, overserved areas into professionally less attractive, underserved areas.

It is difficult for the present medical care system to move resources from overserved to underserved areas because there are only weak "saturation" forces in overserved areas. Physicians and hospitals can congregate in attractive areas and maintain their incomes, within limits, by raising prices, providing more services, and increasing the elaborateness of the services, all of which will be paid by third parties. There is thus little pressure for these resources to move from areas of surplus to areas of shortage, until the surplus reaches extreme levels.

A structurally sound market would introduce saturation forces. If a health care plan were to escalate services to a fixed enrollment, its premium would rise rapidly to uncompetitive levels and it would lose enrollees. Instead, health care plans wishing to increase income must hold premiums low and enroll more consumers. Since a health care plan needs fewer physicians and hospital resources than would be utilized to serve a similar population in the traditional system, the more people it enrolls, the fewer patients that are left to support the excess traditional providers. If traditional providers attempt to raise prices and service rates to these fewer patients, the cost of traditional insurance rises, causing more of the patients to enroll with health care plans. If the insurance plans are not allowed to subsidize their premiums in this location from premiums in a less well-served area, this premium escalation would become even sharper. Eventually, some traditional providers would be forced out of business in a competitive area, owing to a lack of patients, until only a nonexcessive number of traditional providers would be left. Excess traditional providers either would have become participants in a health care plan or moved to a less well-served area where saturation had not occurred.

In the case of physicians, the potential for the market approach to result in geographical redistribution of resources seems real. Adjusted to a typical U.S. population, efficient health care plans use about 1.3 physicians per 1,000 persons, about 60 percent in primary care and 40 percent in specialty care [33]. This compares with 1.8 physicians per 1,000 population for the nation as a whole, of whom roughly 40 percent are primary physicians and 60 percent secondary specialists [34]. Many affluent urban areas have well over two physicians per 1,000 population, while many underserved inner-city and rural areas have less than one physician per 1,000. Thus it could be argued that physicians in the present system are in excess and maldistributed by both location and specialty. The market strategy has the potential to improve the

existing physician distribution by making overserved areas less attractive and underserved areas more attractive.

After competitive plans were initiated in affluent urban areas, competition presumably would force down physician-to-population ratios among both health care plans and traditional physicians toward the ratios that obtain in the most efficient plans (i.e., the saturation effect). Thus excess physicians would have to move out to less well-served areas in order to obtain sufficient patients. If all persons received income-related subsidies, physicians would have no financial reason to shun even low-income areas. Furthermore, the more organized health care plans seeking a wider market could establish branches in underserved areas, minimizing peer group isolation and making those areas more professionally attractive. This combination, in which competition forces physicians out of overserved areas and adequate patient financing and better organization draw them toward underserved areas, might contribute to a more even physician distribution geographically across the country. However, while competition should limit the number of excess physicians in urban areas, somewhat less than adequate physician numbers may be drawn to rural areas. No country, including the Soviet Union, has been totally successful in moving physicians to isolated regions. Constant public efforts seem necessary to maintain adequate physician numbers in such areas, but urban saturation incentives should help greatly.

The saturation forces of competition would operate most strongly on the overcrowded specialties. As competition forced specialist-to-population ratios down to the levels in the most efficient plans, many specialists would find themselves with relatively few patients. Health care plans which maintain their own specialists would hire relatively few of them. The health care plans which purchase specialty care from traditional providers likely would contract with a few efficient specialists. Under such market forces (in contrast to the present system), the price of specialty care would gradually fall, reducing the incentive for medical students to enter specialties. In contrast, expanding health care plans would have high demand for primary physicians and their status and income should increase, drawing physicians to primary care. The result should be a gradual shift to a more appropriate and efficient distribution among specialties.

One further, less vital factor also should be mentioned: The more organized health care plans (particularly prepaid group practices) tend to even out the provision of services within their own enrollments [33,35]. High



utilizers are brought down and low utilizers brought up. Initially, the more organized health care plans would be less common because they are difficult and expensive to start. Eventually, as health care plan practice becomes more customary, the more loosely organized health care plans might begin to tighten their organization to gain competitive advantage. This might also encourage a more appropriate distribution of health services among population groups.

#### Will the Market Strategy Improve Medical Care Quality?

Some skeptics of the market approach are concerned that competitive health care plans would deliberately skimp on quality. It seems certain that some deliberate skimping and underservice by unscrupulous providers would occur, just as deliberate and potentially dangerous overservice by a few unscrupulous providers occurs in conventional practice. Neither the market system nor traditional practice provides wholly adequate safeguards against this type of abuse. However, the actions of an unscrupulous few no more condemn all health care plans than they condemn all conventional providers.

Despite the media attention inevitably accorded instances of fraud and abuse, the vast majority of health professionals are highly honorable and would not deliberately abuse their patients. In fact they would leave any health care plan that attempted to force them to underserve their patients. The high level of excess expense, use, and capacity immaterial to health in the traditional system is not due to fraud and abuse; it is due to the absence of incentives for efficiency. The market approach would appear to introduce incentives to improve medical care effectiveness, increasing the amount of health which could be purchased per medical care dollar expended. Perhaps the greatest single improvement in medical care effectiveness would occur if health care resources were more appropriately allocated. The incentives for reallocation in a competitive system already have been described.

One could argue that the essence of quality in the practice of medicine is physicians consulting with their peers to reach the best clinical judgment. Health care plans facilitate and legitimize such peer consultation and review. Unlike the present system in which peer review is an onerous policing duty that may alienate a source of referrals, in a health care plan participating physicians presumably would want to assure that their colleagues are practicing efficient, high-quality care that would not discredit the plan to consumers. They would evaluate physicians thoroughly before allowing them to participate.

With their medical records available to other participating colleagues, physicians likely would be more conscientious. Furthermore, the highly organized plans would make consultation among physicians easier and more likely.

Another important factor in enhancing quality in the delivery of medical care is accountability. Health care plans establish the accountability of providers for a defined set of consumers, not just for some patients in particular episodes, as in traditional practice. For example, in the traditional system if low rates of child immunization occur in a population, no provider is accountable for this failure or has the responsibility to correct it. In a health care plan enrolled population, accountability for detection and therapy is clearly fixed on the plan providers. Furthermore, the best quality-assurance systems require longitudinal statistical data on large samples of patients; health care plans make such quality-assurance systems far more feasible than the traditional system because of the enrolled nature of the populations.

Finally, the market approach results in consumers choosing their providers in advance of being sick (if they select a health care plan) and could provide them with better information about their choices. Multiple choice may cause plans to give consumers more complete information as part of their marketing efforts. Because health care plans serve several thousand enrollees, it would be easier for consumers to find several people to talk to who use the plan. Under these circumstances, a health care plan which acquired a reputation for poor quality probably would lose enrollment rapidly. Also, a health care plan serving private enrollees necessarily would have to pass the scrutiny of employers and unions. It is unlikely that either of these groups would offer the plan to employees if there were doubts about its clinical or financial soundness. Thus quality and responsive service should become strong selling points in a competitive market.

Beyond these analytical arguments, there is some empirical evidence. Cunningham and Williamson provide an excellent review of the research literature on quality of care in HMOs [36]. The HMOs studied generally have acquitted themselves on quality about as well or better than the traditional practice control groups with whom they were compared. At least at present, it would appear that variations in quality among HMOs or among conventional providers separately are at least as great as any detectable quality difference between the two modes generically. However, this evidence is not strictly appropriate for inferences about quality in a competitive system since these

HMOs have not been subject to the competitive pressures anticipated in the market approach.

The potential for delivery of high-quality medical care through competing health care plans has been questioned by some on the basis of the California Medicaid experience, in which prepaid health plans were organized exclusively for Medicaid recipients [37,38]. It is clear that this California program was initially ill-conceived, poorly designed, and poorly supervised. Virtually any plan that came forward was permitted to enroll recipients. By limiting the plans to Medicaid enrollees, the program focused initial competition on the most vulnerable consumers. (Had California required that these plans first enroll at least an equal number of private enrollees, these better informed consumers--and their employers and unions--probably would have protected Medicaid enrollees by avoiding poor plans.) Some of the California plans performed well, and others were well intentioned but did not have the requisite management skills. However, some plans did practice deception and fraud and delivered poor services. In fact, Medicaid recipients apparently disenrolled in large numbers from these plans even faster than the state was able to disqualify the plans.

This may indicate that underservice in health care plans is more visible to consumers than overservice abuse in conventional practice. Poor-quality health care plans come to public notice exactly because they get into visible troubles and suffer disenrollment, whereas poor-quality conventional providers often escape public notice because their shortcomings are less visible. The visibility of poor-quality care delivered by health care plans can help state regulators close offending plans, as occurred in California. (Unfortunately, the offending providers can often return to conventional practice and escape further notice.) Thus the market approach offers a quality incentive missing in the present system.

In summary, the seriousness of any fraud and abuse should not be minimized. However, when fraud and abuse have been discovered in traditional practice "Medicaid mills," no one has suggested (nor should they) that traditional practice be abandoned as a consequence. The fraud and abuse involving Medicaid health care plans in California apparently was the result of improper program design and public oversight. This conclusion is supported by the Minneapolis-St. Paul experience where seven HMOs, all privately initiated and serving largely private enrollees, compete vigorously with no hint of scandal, abuse, or second-rate quality [27].

The larger point is that in virtually every other industry with

structurally sound competition, such competition produces constant innovation improving both quality and productivity. Few goods and services from such industries are not superior in either quality or cost (measured in how long a person must work to buy them) or both to their counterparts (assuming they even existed) of twenty years ago. On this score a competitive market appears superior to any known alternative in practice. There seems no reason from the analysis and evidence above that a competitive medical care system would be any exception. While episodes of fraud and abuse may exist at the margins, as occurs in other competitive industries (and regulated ones as well), over the long term a structurally sound market tends to keep them few and short lived. And if the market cannot be made sufficiently sound to acceptably minimize all consistent abuse, existing quality regulation can be continued and improved to minimize it. In short, a structurally sound competitive medical care system with adequate public oversight should produce quality at least equal if not superior to either the present system or an economically regulated system.

#### SUMMARY

A structurally sound market model for the future medical care system has been presented. In addition to competition on nonprice factors (quality, service, availability, etc.), the proposed model should introduce provider price competition on service prices and premiums and establish other structural requirements for a sound market. Analysis of the technical feasibility of this market model suggests that the model is sufficiently feasible in most areas to create workable competition. As for the impact of the market model of major medical care policy goals, the analysis here suggests that the proposed competitive model should appropriately restrain medical expenditures and improve efficiency, improve the distribution of medical care services and resources, and improve quality and innovation. Equity for low-income persons is assured if their purchasing power is appropriately subsidized through market-oriented Medicaid modifications or NHI. Thus if a structurally sound medical care market can be sufficiently well implemented, it appears that the new intrinsic incentives will drive the medical care system toward the desired policy goals largely on its own with only minimal additional intervention and oversight required from public policy.

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THE LIMITATIONS OF COMPETITION: A SKEPTICAL VIEW

Burton A. Weisbrod

CHAIRMAN RONALD M. ANDERSEN: Our next speaker is Burton Weisbrod, professor of economics at the University of Wisconsin. Burton's numerous books and articles deal with a wide range of economic and social issues. We are pleased to have him here to give us a little different perspective on the issues involved in competition.

BURTON A. WEISBROD: I think it must take some courage or foolhardiness on my part to come before you to talk against competition, the lifeblood of economists, and even more courage or foolhardiness to do this at the University of Chicago. But when Odin asked me to speak, I could not say no.

Much of what I am going to say relative to what Walter McClure has said boils down to whether one views the glass as half filled or half empty.

If Adam Smith were here today, he would probably say something such as this: You can fool all of the people some of the time, and you can fool some of the people all of the time, but competition prevents you from fooling all of the people all of the time. And that is in many ways a caricature, but not a bad caricature, of what economists think about competition. Economists' confidence in competition is not entirely boundless, but it is surely considerable, and so I have had to ask myself, What am I doing here arguing seriously that perhaps increased competition may not be desirable--in fact, may even be inefficient?

One of the things that will become clear as I proceed is that the definition of competition is by no means unambiguous; I hope that I can make clear what I mean by competition and how my definition of the term and my attitude toward it differs from that of Walter McClure.

In markets for ordinary commodities, competition is generally thought of as an unmitigated blessing. Indeed, noncompetitive markets normally imply market failures. What does competition do? For consumers it increases options, and for producers, it leads them as if by the well-known invisible hand to minimize production costs and to maximize economic efficiency--all, of course, in the process of the pursuit of profit.

The result (at least in equilibrium, after the adjustment period of which Walter spoke) is that individual self-interest which means utility maximization for consumers and profit maximization for producers coincides with social welfare



maximization. Thus everyone seeks their own self-interest, and out of this seeming chaos comes some excellent results for society as a whole.

Is the market for health care different from other markets? If it is, what is the role of competition in the health care market?

Without arguing that health care is unique (and I do not want to argue that), I maintain that some basic assumptions underlying economists' confidence in competition do not help in much of the health care industry. As a result, our confidence in competition to optimize price, quantity, and quality may not hold in health care.

There are three attributes of markets that I want to suggest distinguish some markets from others and distinguish health care markets, in particular, from a number of but not all other markets. These three conditions or assumptions that lie behind our traditional confidence in competition are (1) that there are well-informed consumers, (2) that prices reflect real social costs, and (3) that firms are profit maximizers. I question these assumptions. First, how reasonable is it to assume that consumers are well informed? Obviously, being informed is not an either/or matter but a matter of degree, and the question is, To what extent is the assumption of well-informed consumers appropriate?

Walter McClure spent quite a bit of time on the second issue. If you have well-informed consumers, and they are confronted by the right prices ("right" meaning, I suggest, that the prices reflect real social costs), then you can expect efficient results. People know what they are doing, they are responding in their own self-interest, and they are confronted by prices that reflect the costs of doing various things.

The third point has to do with the nature of the motivations behind the production side of the process. If we assume profit maximization as a motivation, we can without much trouble predict what producers are going to do in response to a tax, a subsidy, or a regulation of one sort or another. All we have to do is ask, What is this tax or subsidy or regulation going to do to the profit incentives of the firm? And then we can proceed forthwith to predict how the firm will react.

To return to the first issue of information and its relationship to competition in health care, the standard competitive model of the economist assumes that consumers are well informed or that they can and do learn quickly and at low cost. Consider the case of chocolate chip cookies. A consumer typically purchases cookies frequently enough to learn from experience which

variety or brand of cookie he or she prefers. The point is, cookies are bought frequently; they are quite inexpensive relative to our incomes, and therefore we get a lot of experience by purchasing them.

For medical care, the situation is typically rather different. Such care is obtained rather infrequently by most people and in a wide variety of forms for a wide variety of symptoms, which makes it difficult for the consumer to judge quality. In other words, the consumer of medical care is with rare exceptions not buying the equivalent of chocolate chip cookies every week or month. While we may say that the person is buying medical care, it is not a standardized thing that is purchased from one time to another. Even if I have the same symptoms today that I had two months or two years ago, and even if my physician did what I think is the right thing for me two months or two years ago, that does not mean that going back today will give the same results, because my symptoms may in fact be signs of a different problem. Thus the consumer of medical care typically is not purchasing a standardized commodity, and as a result, learning from experience is much more complex.

Another aspect of the full-information assumption is that the consumer is able to judge the effect of a particular purchase, that is, is able to compare his or her utility level with and without the specific purchase of it. It is this comparison that determines the consumer's economic demand or willingness to pay. When cookies are involved, the consumer has little difficulty determining his or her utility with and without them. The situation with medical care is quite different; what would happen if the consumer did not obtain the care may be dramatically different from what would happen if he or she did obtain it. The main factor is the ability of the human body to correct problems without external intervention. Many physicians seem to have little doubt, for example, that at least 90 percent of all patient visits are unnecessary, unnecessary in the sense that the patient would have recovered fully without seeing the physician. Moreover, answering the question of how one's welfare will be affected by the consumption of a particular good or service is more difficult for medical care than for most goods and services not only because body mechanisms are fighting disease independent of medical interventions, but also because evidence of the side effects of the medical intervention is frequently delayed for days, weeks, or even decades. An example of the latter is the recent discovery of an abnormal frequency of cervical cancer among women whose mothers ingested a particular drug during pregnancy.

Thus it is very difficult to disentangle these forces in order to identify the incremental effect of a medical input. Health care, remember, is the field that made the term "quackery" famous. This is the economic sector that gave us the "Violeta," a high-voltage generator that allegedly could treat eighty-six ailments, ranging from abscesses to writer's cramp; the sector that brought forth a hand-held vibrator that promised to remove cobwebs from the brain; and the field that brought us the "Spectrochrome," which treated heart disease with red and purple lights while the patient faced north standing in the nude.

Consumers are generally aware of their inability to judge the effectiveness of medical care. This leads us to another sense in which medical care is special, though by no means unique. Aware of their lack of ability to judge quality, consumers are likely to turn to agents for advice. Perhaps nowhere is the use of agents more widespread than in medical care, for physicians are in many cases delegated the full decision-making authority, not merely an advisory role, for patients.

The use of an agent generally carries the risk that the agent may have a conflict of interest, possibly serving his or her own self-interest rather than the interest of the consumer for whom he or she is agent. When a physician recommends return office visits, hospitalization in a hospital of which he or she is part owner, or use of a costly diagnostic technology that has been installed in the office, the consumer-patient may find it difficult to know whether the physician is serving the patient's best interest.

Such problems of principle involving agents are associated with what has come to be called in economics jargon "informational asymmetry," situations in which buyers and sellers are unequally informed. Similar situations in which the consumer relies on the agent who may or may not act in the consumer's best interest are found in industries such as legal services, education, and child care and, in varying degree, throughout the business world (e.g., with respect to the honesty and completeness of information in corporate reports to stockholders).

Once again the point is not that medical care is a completely unique industry, but it does have characteristics that make it inappropriate to assume that there are well-informed consumers. Since competition assumes the latter, doubts must be raised about the economic consequences of increased competition. Thirty years ago the economist Tibor Scitovsky wrote an influential article entitled "Ignorance as a Source of Oligopoly Power." According to Scitovsky, when consumers find it costly to judge quality, their ignorance restricts the

effectiveness of competition and enhances monopoly power. Just a few years ago another economist, Mark Satterwaite, analyzed the physician market in the context of the consumer's lack of information. He showed that an increase in the supply of physicians--more competition--could actually increase the cost to consumers of searching for an appropriate physician. By raising search costs, the increased supply would have the effect of making the demand for each physician's services more inelastic, thereby augmenting the physician's monopoly power. The result, increased supply, leads to higher prices, not to lower prices as a conventional model would imply. A greater supply of physicians, or, in other words, more competition, can lead to increased prices in the medical care market.

The health care market is unusual not only in the degree to which its consumers are well informed but also in the nature of its pricing practices. The economist's idealized model of competition assumes that prices reflect marginal social costs of production. Consumers who face these prices will purchase the commodity if, and only if, its marginal value to them exceeds its cost of production. But the economist's model of pricing is at best caricatured in the health care industry. With some 90 percent of the population having health insurance, we see the undeniable validity of what Walter McClure was pointing out: that the price to the patient of additional medical care is often very low, frequently even zero, even though the social cost is far higher. Moreover, employer-financed health insurance is not subject to income taxation, and thus the purchase of health insurance is further subsidized. Finally, the health care coverage under governmental Medicare and Medicaid acts further to drive a wedge between the real cost of medical care and the cost or price as seen by the consumer.

But whenever consumers of any good confront a price that is below social cost, excessive consumption is likely. Add to this effect a pricing system in which hospitals and often physicians are paid by governmental and private insurers on the basis of actual costs so that there is little incentive for holding down costs. Thus we have a pricing system that at every point fails to confront decision makers with the true social costs of their decisions. This is far from the economist's model in which increased competition promotes allocated efficiency.

When McClure referred to the need for more competition, he was clearly not talking simply about more competitors or about more options available to consumers. He was talking about those things, plus a substantial change in the whole pricing system, and all of those things were being lumped together under

the name of changing competition. I am not trying to say that his perspective is right or wrong and mine is wrong or right. I want to make clear that, when I am talking about competition, I am talking about changing numbers of producers and changing varieties of options on the supply side, but in the context of our existing pricing mechanisms, mechanisms which provide not very salutary incentives for both producers and consumers. Furthermore, it is important to recognize that all of these things are interrelated. Changing one part of the system when the other parts are problematic in some fundamental sense does not lead generally to desirable results.

Thus given our current pricing arrangements, involving government reimbursement, it is not clear that simply increasing competition will promote allocative efficiency.

With virtually every hospital wanting a CAT scanner costing well over a million dollars, one cannot help but register a doubt about the consequences of increasing the supply of hospitals. Unless the entire health insurance and medical care pricing structure is altered, it is by no means clear that increasing the supply of medical resources will cut costs.

Moreover, given the prevailing institutional structure in which only certain physicians may treat patients in any particular hospital and only a physician, not the patient, can admit a patient to a hospital, the results of increased competition associated, say, with greater freedom of entry into the hospital industry are unclear. It is likely, however, that the situation would bear an analytic similarity to results of unrestricted entry into a number of other industries such as ocean fisheries, oil drilling, national parks, and other common property-type resources. That is, the consequences of unrestricted entry into this type of industry frequently lead to excessive entry which leads to excess capacity among producers and commensurately higher average costs, rather than the lower costs we expect in competitive markets.

All of these problems limit our conventional reliance on competition among producers to allocate medical care resources efficiently.

By establishing the physician as the linchpin of the system, our current medical care system relies on the physician to determine the appropriate level and variety of medical care to be provided, including whether hospitalization is required, for what period, with which level of service, and with which specialists. What seems to have been overlooked is that our current system places physicians in a position of dual and conflicting responsibility. On the one hand, the physician acts as agent for the poorly informed patient, doing what

the patient would do if he or she possessed the medical expertise of the physician. On the other hand, and simultaneously, the physician is an agent for the government, taking into account the fact that patients will sometimes seek to use more medical service than they really need (e.g., a physician may admit an elderly patient into a hospital so as to reduce the care burden on the family).

The physician's ethical code, a code that is frequently seen by economists as anticompetitive, seems to be oriented toward the physician-patient relationship rather than the physician-government relationship. This situation in which the physician is the agent for the patient, for government, and for insurers has put physicians in an increasingly difficult position when these agent roles conflict. Moreover, an individual consumer-patient is often unable to judge whether the agent-physician is doing a good job.

This is not the place to delve into the consequences of this ethical code, but we do need to understand much better than we do now how it affects the behavior of physicians, hospitals, and patients. To the extent that the ethical code restricts competition in the physician's sphere of influence, the effects of increase competition in another part of the medical care industry--for example, in the markets for nurses, psychiatric social workers, or health care insurers--are not self-evident.

So far I have tried to show that the medical care market violates two fundamental assumptions of the economic model in which more competition is better: well-informed consumers and prices that reflect the real marginal costs of production. There is a third important dimension in which the medical care market is unusual, though once again I say not unique. It is unusual in deviating from the model in which competition contributes to efficiency, and this is the substantial role of nonproprietary producers, governmental and private, nonprofit.

In the hospital industry a few years ago, 32 percent of the beds were in governmental hospitals (city, county, state, federal); 63 percent were in private, nonprofit hospitals; and about 5 or 6 percent were in proprietary hospitals. Similarly, about 10 percent of the beds in the nursing home industry were run by governments, typically county governments; about 17 percent were in private, nonprofit homes; and about 73 percent were in proprietary facilities.

The significance of this mixed-industry character of the medical care sector may well be profound. In a market comprised of only profit-maximizing firms, increased competition may tend to promote efficiency, production, and low prices. But will the same be true of markets dominated by nonproprietary firms? The

answer is not at all clear. Our present ability to understand and predict how governmental and private nonprofit firms respond to increased competition is limited indeed.

The federal government, increasingly concerned about the explosion of medical care costs, has tried out a wide variety of mechanisms for dealing with those increased costs. (Actually, that is a misnomer; they are increased expenditures. Whether there are increased costs is a somewhat separate matter.) Several devices have been used, including HMOs, PSROs, and perspective reimbursement. To the best of my knowledge, in the analyses of what the consequences of any of these measures is likely to be, no attention has been given to the fact that the firms being influenced by these various mechanisms are firms in mixed industries. That is, only a portion--and in the case of the hospital industry, not even anywhere near the majority--are firms that act as profit maximizers.

If you know that a firm is trying to maximize profits, it is not difficult to deduce how it will respond to any particular constraint imposed on it. But what can you expect a nonprofit firm to do in response to a particular incentive? I think that it is impossible to answer this unless we know what nonprofit organizations are up to and what they are trying to do. The situation with respect to governmental organizations is similar: Is there any reason to believe that a government-run hospital will respond to some kind of price incentive in the same way that a for-profit hospital will?

The answer is by no means obvious yet. So the point is this: If one talks about the effects of increased competition in the health care sector, one implies that it makes little or no difference whether the increased number of suppliers is comprised of proprietary firms; church-owned nonprofit or other nonprofit facilities; community, county, state, or federal government institutions; or some other form of institution. However, the assumption that all of these institutions behave in essentially the same way is not suggested by either prevailing economic theory or empirical evidence.

For example, there is some reason to believe that nonprofit hospitals concentrate on high-quality service to a greater extent than do proprietary hospitals. If this is so, an increase in the number of nonprofit hospitals might well lead to increased costs associated with the higher quality. In contrast, an increase in the number of proprietary hospitals would be more likely to bring about decreased costs and, perhaps, decreased quality.

Public policy measures affect not only the level of competition in health

care but also its institutional forms. Entry of nonprofit organizations depends significantly on congressional legislation regarding nonprofit organizations and also on Internal Revenue Service administration of tax laws. Entry of governmental organizations is determined explicitly by legislatures, and the entry of proprietary firms depends similarly on governmental policies such as those affecting production costs, minimum service quality, and prices.

We lack satisfactory theoretical models for predicting behavior of governmental and private, nonprofit organizations, models that specify objectives analogous to profit maximization in the proprietary sector and constraints such as market demands. More specifically, we know little about the manner in which various types of organizations respond to such stimuli as taxes, subsidies, expenditure ceilings, regulatory constraints, and increased or decreased competition. While formal theory may be weak, however, there are a great many opinions about the comparative behavior of proprietary, nonprofit, and governmental organizations.

One careful study in the child care industry, for example, concluded the following: There appears to be near consensus among persons who write about day care that a private, for-profit enterprise in the market is an unsatisfactory way of organizing this activity. They went on to say that there is a deep suspicion of for-profit nursing homes and hospitals. Clearly, profit is being mentally associated with exploitation rather than responsible service. In a similar vein, a New York State regulatory commission recently recommended that "the government gradually phase out proprietary nursing facilities in New York and substitute voluntary, nonprofit institutions as the mainstay of this industry."

The point is that at the theoretical level we have very little knowledge of the comparative behavior of for-profit, nonprofit, and governmental institutions, while at the empirical level we have very little evidence but many opinions. The bottom line is, talking about increasing competition without specifying whether that competition is going to come about through more proprietary organizations, more nonprofit organizations, or more public organizations is sweeping under the rug a great deal of our ignorance about the comparative behavior of these different types of institutions.

Some evidence suggests that caution is appropriate before we apply models that assume well-informed consumers, profit-maximizing producers, and efficient prices to the health care sector, which is characterized by poorly informed consumers, substantial elements of governmental or private nonprofit production, and prices that do not reflect social costs.



From 1960 through 1980, the ratio of physicians to U.S. population increased, as did the consumer price index for physician services. Although this simple correlation does not prove anything, it does suggest that an increase in physician-suppliers did not bring down prices of physician services. Another statistic concerns the number of hospital beds per 100,000 population: This number has risen substantially, from somewhat over 600 in 1960 to over 1,000 in 1980. At the same time as the supply of hospital beds has risen, we know that the powerful force of competition has not brought down the prices of hospital beds. On the contrary, the consumer price index for hospital rooms has increased substantially. Thus the simple notion that increase in supply is going to bring down price is not easily borne out by data in the hospital industry.

Another item. In a study of the nursing home industry in Wisconsin, which I am now completing in collaboration with Schlesinger, we are examining two dimensions of nursing home behavior. Our study of 600 homes seeks to shed light on the question of whether institutional form in health care makes a difference, that is, does it make a difference whether a nursing home is owned by a proprietary firm; a church-run, nonprofit organization; a non-church-affiliated organization; or a government? In particular, we asked, Are these different institutional forms associated with certain frequencies of regulatory violations, and are they associated with certain frequencies of formal complaints leveled against them?

Controlling for the size of the organization and for a number of quality and locational variables, we have found two things. First, proprietary homes have significantly fewer violations of regulatory codes. This finding seems to fly in the face of some prevalent views, including some I mentioned from the day-care study and from the Moreland Commission study in New York State, where there is great skepticism of proprietary organizations. The second finding had to do with the frequency with which people complained in some official manner to some state agency. The church-run nonprofits received significantly fewer complaints than did the proprietary, the governmental, or the other nonprofits.

In short, in the case of nursing homes, various ownership types appear to behave differently, and consumers appear to perceive differences among them. I think this is some indication that we cannot disregard the institutional form that competition takes as we try to project the consequences of changes in the degree of competition.

One more item. The virtual absence of advertising in the health care area is noteworthy. It suggests not that competition is absent but that the industry

is an unusual one, so that conventional models of organization behavior may have limited applicability. What is the significance of the fact that medical societies have been able to prevent price advertising by physicians? What is the importance of the fact that one does not find hospitals advertising their high quality or low price, of the fact that hospitals do not have sales during the year, do not offer bargain prices on surgery during off-peak hours, do not offer special family rates? What is the significance of all of this? I am not sure.

The health care industry is quite unusual. I have focused on three important dimensions of its atypical behavior: the limited information available to consumers, the prevalence of prices that bear little relationship to real costs of services, and the prominence of governmental and private nonprofit firms in competition with proprietary firms.

Economists' confidence in competitive markets grows largely, as I said before, from a model in which consumers are well informed, prices reflect real marginal social costs, and firms are profit maximizers.

Thus the consequences and the virtues of increased competition in the health care sector are not self-evident. An important notion in economic theory holds that in general, when some conditions required for efficiency do not exist, it is nonefficient to fulfill other conditions for efficiency.

A coherent health care policy remains a distant vision in the United States. Given the system we now have (some term it a nonsystem), I would be extremely cautious about relying on competition, on an increase in the supply of health care providers and facilities to optimize the level of distribution of health care resources.

I have not even touched on a number of other characteristics of the health care market that make it unusual with regard to competition: the fact that life itself is sometimes, though not often, at stake; the fact that innovation in the market often grows out of governmentally supported research, especially through NIH, and has profound effects on the markets for provision of medical care; and the fact that the industry is now heavily regulated and that much of the regulation (and here I am referring especially to FDA regulation) ignores prices and costs.

I do not wish to close, however, by unduly dramatizing the uniqueness of health care. In many ways, this industry is similar to the legal services and education markets, in which output is also difficult to monitor, consumers are often poorly informed, prices are also inefficient, and professional suppliers and their organizations are powerful. Stated more broadly, the health care market

is not immune to the pressures and tensions that characterize interactions between buyers and sellers in all markets.

The point on which I will close is this: We cannot construct wise public policy on health care by applying elementary economic analysis. Health care and chocolate chip cookies really are different.

#### DISCUSSION

Ronald M. Andersen, Chairman

RONALD M. ANDERSEN: Are there any questions from the audience?

HERBERT E. KLARMAN: I would like to point up a very sharp difference between what Walter McClure said and what Burton Weisbrod said. According to Walter, you can improve competition to the extent that you fulfill more of the underlying requirements; in other words, three is better than two, and four is better than three. Burt, on the other hand, clearly stated that if you are missing some of the requirements, do not be so sure that you will improve economic efficiency by correcting one or more of the others. I wonder whether we could get them to discuss this very important difference.

WALTER McCLURE: I will take a crack at the nonprofit one. I happen to favor having nonprofits competing with for-profit organizations in this industry. I do not think we are so ignorant about nonprofit behavior. The room is full of people who run nonprofit hospitals. And there is one common motivation for profits and nonprofits--the desire to survive.

I think economists have been too narrow about this profit-maximization behavior. I welcome the entry of for-profit organizations into this field, and, in fact, if the nonprofit sector does not get in gear, there is going to be nothing but proprietaries in the for-profit game, in the competitive game, because the investor-owned hospitals can get their hands on capital. They can get into this competitive plan game, so we may not have to worry about the behavior of nonprofits ten years down the road.

I do not think that is desirable. I think that the more diversity you have among the competing plans, the better. I do not want to see traditional practice disappear. Competition between the two modes is good, but I would like to see for-profits competing with nonprofits, and group practices competing with individual-practice plans, and consumer-run plans competing with physician-run plans, and so forth. The more diversity in the market, the less likelihood of collusion.

In addition, I think the for-profits will bring an important business discipline to the nonprofits. There is a nonprofit syndrome which says that it is all right to lose money if you are doing good work. You have to do away with that. Most of the big nonprofits have long since given that up, and they are very sound business operations in the market system. They are maximizing their growth, potential, and revenues in an unsteady market system and doing it very well. For-profits maximize business discipline, and the nonprofits will have to match that business discipline to survive, which they will. If there is a for-profit growing in their market, they will compete to survive. However, I think the nonprofits introduce a certain polyeleemosynary consideration. Beyond maximizing profits, there are certain other considerations and ideals, and you can see them when you compare the motivations and concerns of Blue Cross with those of the commercials.

I think the competition between the two of them is good for both, and so I do not want to see nonprofits disappear, I do not think the introduction of profits will destroy this market; on the contrary, it will improve it.

CHAIRMAN ANDERSEN: Burt, do you want to respond to that?

BURTON WEISBROD: There are things that we believe and there are things that we, in some sense, know. That is, there are things that we believe are the case, and there are things which we know and can convey to others by rational argument, evidence, theory, and so forth.

I think we know far too little about the behavior of organizations to say, even if it is true, that all organizations put survival first. Even if it is true, that is a long way from concluding anything about behavior. That is, presumably it is only at the point of the organization's dying that the motivation for survival becomes relevant. Since the decisions that any organization makes are rarely life and death decisions, I do not find it at all helpful in understanding an organization's behavior to say that survival is the number one motivation. In short, I still believe that the consequences of increased competition depend on the institutional forms.

I am not advocating either more or less nonprofit activity. What I am trying to say is that there is some reason to believe the form of the competition makes a difference, and the knowledge we have about the significance of the form is extremely limited.

## VIEWS FROM ORGANIZATIONS

Samuel H. Howard, James Isbister, Howard Berman, Lynn E. Jensen, James F. Doherty, and Richard J. Mellman

CHAIRMAN RONALD M. ANDERSEN: We have asked a very distinguished group of people from key health organizations in the country to give us their views on regulation and competition. Although they may be speaking from perspectives within their organizations, that does not necessarily mean that they are representing the views of their organizations. They might wish to address this as they present their remarks.

Sam Howard, vice-president and treasurer of Hospital Affiliates International in Nashville, has asked if he could set the stage for us with respect to the organizations.

SAMUEL H. HOWARD: I bring you greetings from the Federation of American Hospitals and the National Association of Investor-owned Hospitals. It is quite an honor to be invited to participate in this Twenty-third Annual George Bugbee Symposium on Hospital Affairs; it is also a humbling experience to participate on a panel with such distinguished and nationally recognized speakers.

This is a personal honor for me to speak on behalf of the more than 1,000 investor-owned hospitals and hospital management companies in the United States on this timely and very appropriate subject of competition in health care. As treasurer of the Federation of American Hospitals and chairman of the Legislative Committee for the past two years of this association, I have monitored very closely many events directly concerning competition in health care in our industry. In addition, my personal participation in various health care forums and in the production of various studies has provided me with an interesting and unique insight into this subject.

One of the biggest criticisms of trade organizations and the public policy positions they take is that trade associations generally speak from the lowest common denominator of their membership--or take positions involving the least amount of risk to the smallest segment of their membership. This leads me to think that they "don't want to work the board." I am convinced that much of the federation's success can be directly attributed to the fact that we have not fallen into this general mode. Instead, we have advocated change and new directions in health care policies. We have done this for a number of reasons, some of them related to our own "special interests" or, more accurately, to our

projections or speculations about how we might fare economically under a reformed health system.

Perhaps the single most persuasive argument which led us to adopt a position calling for change was the feeling that the alternative was not the status quo but, rather, a public utility model under which our opportunities would be severely limited. Thus we have been vigorous advocates of an approach to health care policies which would lead, we hope, to a complete restructuring of our reimbursement, insurance, and tax systems to promote greater competition in every facet of the health care delivery system.

Let me state first that the health care system in the United States is fundamentally sound. Its strength is derived from its firm base in the private sector and from the incentives for excellence and efficiency inherent in a free market system. There is, however, a weakness which has resulted from the elimination of some of the natural free-market forces. One consequence of this weakness is the rapid increase in health care spending we have witnessed during the past decade.

As many of you know, there is general agreement that the principal weakness in our health care process is a third-party payment system which shields consumers from the true cost of receiving care. In the private sector, the system of medical insurance coverage has desensitized health care consumers to its costs via the use of low deductibles and co-insurance. Medicare and Medicaid have also contributed significantly to the increased demand for health care by eliminating cost consciousness among their recipients. This situation is greatly aggravated by a cost-reimbursement system which provides incentives for excessive spending by health care providers and insures lack of competition or marketplace restraints on the prices of health services.

I believe, as the federation does, that without a doubt the most effective way to address this weakness in the health care system is to build on its strengths. Instead of more government regulation or involvement, with services of hospitals and other providers arbitrarily rationing health care or adversely affecting the quality of care, we recommend a healthy dose of competition to our health care delivery system.

When we use the term "competition," we mean restoring price to a more prominent position in the individual's health care decisions. Cost consciousness on behalf of health care consumers is intrinsic to any solution to rising health care costs. Without price awareness--and you have heard this already today--demand is infinite. This is particularly true of our public health care

programs of Medicare and Medicaid. Without price awareness, demand under these programs inevitably expands. Without corresponding adjustments in the supply of services, rationing of care among competing public patients must occur by some means. For example, the British system demonstrates that when price is removed, time becomes a rationing device, as evidenced by the delays in the delivery process.

Furthermore, another matter of concern is that of freedom of choice in medical care decisions. Health care decisions are personal decisions--or, at least, they have always been personal decisions. Government policy that fosters cost controls through rationing of health services threatens to limit personal medical decisions by restricting the availability of options--particularly high-cost options and new technology. If government succeeds in its efforts to save dollars by closing hospitals, limiting access to new equipment and services, and targeting specific providers as beneficiaries of government health care funds, then the individual's right to pursue every medical means of saving his life (even with his own money) is effectively annulled.

Thus our "competitive thrust" is designed to put price back into health care decision making as the rationing device and, most important, to maintain and enhance individual freedom of choice in medical care decisions.

Question: How do we infuse our health care system with a healthy dose of competition?

There are two plans offered by Republican Senators David Durenberger of Minnesota and Orrin Hatch of Utah. These two proposals have certain basic features in common. Both require employers to offer their employees a choice of more than one type of insurance coverage. They require employers to contribute the same amount for each employee, regardless of the type of insurance coverage the employees choose. Employees who choose plans which cost less than the basic contribution would get a cash rebate from their employer.

Another plan is the Gephardt-Stockman Health Care Reform Act. This far-reaching legislation would unleash the marketplace on health insurers and providers while deregulating the industry from forces such as the certificate of need (CON) and rate setting. It should be emphasized that these two young men, Gephardt and Stockman, are very strong believers in the free market. For example, former-Congressman Stockman from Michigan opposed the federal loan guarantee to Chrysler on the basis of his philosophy on marketplace issues. The point is that you cannot have a real marketplace without the risk of bankruptcy. In a free-market environment, there would be some higher risks for hospitals:

(1) Greater patient cost sharing would result in higher hospital bad debts. (2) The abolition of federal CON would void the current franchise value of hospitals. (3) HMO and other prepaid health plan development would result in a lower hospital inpatient census. (4) Teaching/research hospitals would have to justify their higher rates. (5) Investor-owned hospitals would lose their guaranteed return on equity reimbursement if Medicare and Medicaid ceased to exist. (6) Finally, bankruptcy and closing of some of our beloved hospitals and other health care institutions would occur.

There is the broader concern about labor pressure for high-option plans, federal government regulation of health insurance plans, and numerous other issues, but those six points are the ones that concern hospitals.

It is my opinion that these concerns should be aired and answered, but nervous voices in the industry are begging the real question, and that is, Should we preserve the status quo? Let's face it--our industry has passed the point of successfully defending the status quo. The defeat of the Carter Control Bill in 1979 emphasized the fact that Congress wants to find other reforms to meet the health care cost problem--reforms which address the underlying causes of inflation, reforms which do not rely on government bureaucracy and regulation.

As always, the health care industry should stand ready to provide constructive input into this legislative agenda. In my opinion, the only alternative to the status quo that is viable and would continue to provide for good quality health care in this country is competition.

When we raise our voices for a competitive industry, however, we should also recognize that there are some trade-offs, trade-offs to the risks that I alluded to earlier. First, hospital bad debts might increase as a result of the increase of deductibles and copayments in a competitive system. While this is probably true, the trade-off is less government regulation and reduced compliance costs to hospitals. In addition, bad debts would be more than offset by a transfer of some Medicare cost-based reimbursement to private insurance paying negotiated charges for Medicare services.

Second, health planning does provide a franchise-type protection for hospitals which would be jeopardized by repeal of the federal law. This is probably true but to a small degree. Repeal of the federal law would not repeal the state CON laws. It would result in lack of funding of HSAs and the 10,000 people now employed in the planning process. Planners would probably be forced to concentrate on large projects and stop the costly and inflationary interference in routine management decisions ranging from the replacement of



equipment to the purchase of carpets or parking lot repairs.

Third, there is concern that HMO development would accelerate, threatening hospital occupancy. This fear is based on the false premise that unnecessary admissions are essential to profits. Our hospitals have proved that a well-managed facility can show profits with low occupancy. In addition, HMOs require hospital subcontractors, and in most communities, investor-owned hospitals would be competitive because they are small. Routine cases would more likely be admitted to smaller hospitals than to more comprehensive tertiary-care teaching hospitals.

The challenge to teaching hospitals in justifying their rates is real. I have worked in a teaching hospital. Their costs are understandably higher--research components, "sicker" patients with longer stays, residence programs, and other academic overhead all contribute, and legitimately so. The challenge for the teaching hospitals, it seems to me, is, first, to analyze their patient costs, then price competitively. Second, they must separate their teaching and research costs so they can be funded separately. There is no question that the public appreciates the need for both teaching and research and for a predictable base to fund them. Moreover, I think you will find that business and government will find a way to finance these programs of vital importance to the health care of our people. The problem occurs when these costs are recouped in part by including them in the patient's bill for relatively routine medical services.

Thus teaching institutions must distinguish their contribution to medical research and education from other health care costs. This separation will help clarify our thinking about the economics of health care and ease our adjusting to the changes certain to come.

It is true that the investor-owned hospitals would lose their guaranteed return on equity if Medicare and Medicaid ceased to exist. Consistency has never been a virtue of politics, but in this case, we cannot say we are for competition and then oppose certain risk taking. The well-managed hospital will do well in a competitive environment because it can be flexible where necessary and can respond quickly. Furthermore, this lack of return on equity would be offset by more reasonable reimbursement for Medicare and Medicaid beneficiaries based on price rather than costs.

One comment on Dr. Weisbrod's concern about the investor-owned industry: I have been in investor-owned industry for four years and in the nonprofit industry for five years. I have found that there is no significant difference in the

quality of care provided by these institutions. As a matter of fact, I think they could be somewhat higher.

I am a member of a company that manages 150 nonprofit hospitals, owns fifty, has eight HMOs in the United States, and also has eighteen nursing homes. We will be presenting quality-assurance awards to the senior officials in those institutions. This competition in terms of quality of care provided has been going on for eight years in our own company and is based on patient surveys, physician surveys, and an annual joint commission survey.

Even though none of us likes to talk about it, bankruptcy does represent a real possibility in a competitive environment. The society has to have some way of ridding itself of the inefficient in a more impersonal manner. The constant striving to maintain leadership will bring about new ways and means of accomplishing more efficiency. Thus bankruptcy represents that cleansing of the inefficient associated with our industry.

The question is, Where do we start? How far do we go in the initial stages of injecting competition into our industry? I believe that there are two steps we need to take to inject competition into our industry. The first is close the open-ended tax-law treatment of health benefits purchased by employers as tax-free benefits for employees. The second is to allow Medicare and Medicaid beneficiaries the right to select health insurance coverage from private insurance plans based on a specific dollar contribution from the federal government similar to the Federal Employees Health Benefits Program.

The Gephardt-Stockman legislation proposes such a Medicare/Medicaid option, and such a recommendation has been made by other Reagan health advisers. We at the federation believe this concept should be seriously considered as a method to contain federal health care costs without rationing. At the same time, we recommend caution with respect to the enactment of legislation mandating employers to offer three alternative plans with fixed contributions. Opening the door to public policy manipulation of health care benefit provisions for the achievement of micro-economic policy goals is a dangerous precedent. The administrative costs to some businesses and the risk of ultimate equalization of health care benefit plans could be understandably unproductive and counterproductive. Furthermore, there is reason to believe that if legislation is enacted that would close the open-ended tax treatment of health benefit plans, large employers will voluntarily offer multiple-choice arrangements.

We believe very strongly in the Medicare/Medicaid opt-out proposal. I might add here that my own firm financed and produced a study last year which indicated

that if we were to allow the Medicare and Medicaid beneficiaries to opt out of the program and all of them purchased private insurance plans, the federal government would save \$2.5 billion (in 1980 dollars) in their health care budgets. This assumed that the federal government paid 100 percent of the premium for all of those plans, but all of those plans had some type of co-insurance provisions in them. Price is very important if you are going to have a competitive environment.

I think that we can look forward with somewhat cautious optimism to what is going to happen within the next three to four years. We have an administration that is committed to the competitive approach. We have a secretary of Health and Human Services who understands the health care industry and also believes in competition. We have a director of the Office of Management and Budget, David Stockman, who has introduced the most far-reaching health care reform proposal ever known.

We must take advantage of this opportunity and restructure our health care system, and in the words of Jack Anderson, the chairman of the board of Hospital Affiliates, "We must take every opportunity which presents itself to put our hospitals and the health care system back on the road to recovery." I would say that now is the time.

CHAIRMAN ANDERSEN: Our next speaker is James Isbister, executive representative of the National Association of Blue Cross/Blue Shield Plans.

JAMES ISBISTER: As Ron indicated, our charge is to discuss the competition proposals from the perspective of the organizations within which we work. In my own case this is a very easy task because the Blue Cross and Blue Shield Associations have not taken a position on any of the bills.

But I would like to start with a story, the tale of the blind man who was walking across the street with a seeing-eye dog. He got halfway across the street and the dog stopped, lifted his leg, and proceeded to urinate on the blind man. The man continued on to the other side of the intersection where he stopped, reached in his pocket, pulled out a dog cookie, and handed it to the dog. A person standing there in a state of absolute disbelief said, "How can you reward the dog for such despicable behavior?" To which the blind man replied, "Reward him, hell, I am trying to find his mouth so I can kick him in the rear."

This is what has become known in the associations as my competition story because I think that we are talking about a concept which takes a variety of

forms. Each of our speakers has seen a different part of the competition model and so has understood the whole somewhat differently than the others have. I think that is something we need to keep in mind.

Would the model in general, in terms of the major features described, achieve the proponents' objectives, which I perceive to be cost containment and greater productivity in the provision of health care? That is the critical question, and the plan fact--demonstrated by the discussion this morning--is that it cannot be answered authoritatively. The model has not been tested in all of its dimensions, nor are there many empirical studies which can illuminate the debate.

The theory starts with an activated, knowledgeable, informed consumer making rational decisions in economic terms. We heard that issue debated this morning. One side says consumers are likely to become more knowledgeable, assertive, aggressive, and cost conscious. The other side says that will not happen, that health care is not a normal commodity, and that individuals faced with illness and survival are not going to shop as they might for other commodities. But let us assume for purposes of this discussion that consumers do become activated. What then?

I would like to repeat a bit of what Walter McClure said in terms of the main paths through which proponents of this competition model see change occurring.

They all start with the consumer. In the first instance, some believe that consumers will buy low-cost insurance plans with high co-insurance and deductibles which will cause them to feel the bite of health care costs and thereby reduce their demands for services.

In the second instance, consumers are seen as demanding alternative delivery systems such as HMOs, health plans, and other forms of provider organizations which are able to deliver health care at lower costs. In the third situation, insurers of fee-for-service health care are seen as facing greater competition and being forced to lean hard on providers to be more cost effective, ultimately forcing the least efficient to go out of business.

The final results will not be known for a long time, perhaps up to ten years, if such comprehensive legislation passes. I think the effects will vary substantially geographically, particularly if one starts from the assumption, as Walter McClure did this morning, that alternative delivery systems will be the principal foil for stimulating change. This is because of substantial variation in local markets around the country in the availability of and the interest in

alternative health care delivery systems.

I would argue that the real outcomes will depend heavily on the rules set for the competition by law and regulation. The procompetition model, as we all understand it, while antiregulatory in intent, paradoxically is also a vehicle through which the government can powerfully shape the insurance and prepaid health care markets. If a law were to set a low limit on the tax-free employer contribution and require only minimum benefits to be offered under a multiple-choice option, incentives will be set to move the market in one direction, toward greater cost sharing, co-insurance, and deductibles. If the government were to set a high limit on the tax-free contribution and mandate generous or more liberal benefit coverage, the incentives will be set to move the market in a different direction. Finding the correct balance is going to be the major task facing the legislative draftsmen over the next several months. It is highly complicated by the fact that the proponents of these proposals see change coming from two essentially different directions: one, more cost sharing; the other, more alternative delivery systems.

In the brief time available, let me say that there are all kinds of technical problems involved in the drafting of this legislation, many of which go beyond being merely technical for the reasons I have just described. They have set the incentives and we will ultimately shape the outcome.

I would like to dwell on just two issues from an insurance perspective; one, how insurers might be forced to compete under the model, and two, the problem of adverse selection.

First, insurer competition. What is the theory, and what is the reality? Some of the proponents believe the model will force greater competition and thereby force insurers to make, through a variety of arrangements, providers behave in different ways. These arrangements could include changed reimbursement mechanisms, perhaps contracting with only selective providers, or setting up the insurers' own health care delivery organizations.

We and some of the commercial insurers have already established alternative delivery systems of various types. In our own case we now have about seventy of them serving about 1.3 million members, so there is evidence that insurers will move into alternative delivery systems.

With regard to the impact of the model on traditional insurance coverage, there is reason to question the theory. Depending on how the competition is structured, it may very well be that insurers will choose to compete by every possible means short of the intended result of the model, namely, tough

negotiations or different arrangements to change provider behavior. There are a variety of means by which this competition can take place, involving risk selection, co-insurance and deductibles, tailoring benefits to an increasingly segmented market, perhaps reducing administrative costs by cutting back on medical necessity and other quality-assurance activities. In an individual-choice market there will be a very strong incentive to keep the consumer happy, and that could possibly translate into a desire to pay claims promptly and, perhaps, uncritically.

The other problem I want to discuss briefly is that of adverse selection. If the insurance market becomes highly segmented into high- and low-cost options, as is likely, one must be concerned about what happens to the concept of insurance and the spreading of risk over a broad population base.

The periodic availability to employees of a range of health benefit choices during open season would probably trigger what is known in the business as "adverse selection." That is to say, people who are sick or who have reason to anticipate high health care costs in their families will tend to choose the most comprehensive, higher-priced coverage available to them, while those who regard themselves as relatively unlikely to incur heavy health expenses will opt for less expensive health insurance coverage. In public policy terms, the problem with this is that it raises the cost of insurance to those who need it most, even to the point of making it unaffordable. Adverse selection has been documented and can be seen in a number of the multiple-choice options, high-low options which have already been offered in this country.

The Federal Employees Health Benefits Program is often cited as a model by some of the proponents of competition. Let me just tell you what has happened there with respect to our own high-option benefits package.

Our high-option package was considerably less than double the low-option's actuarial value, but as a result of the movement of higher-risk people into the option and the experience rating for it, the premium is now considerably more than double that of the low option. If you look at the enrollees who move in and out during the open seasons, the people who move into the high options turn out to have 145 percent of the average claims experience; those who leave during open season had 65 percent. The effect of this through time is to create a substantial variation in the premium structure and to have the people at higher risk, those who need the service the most, in the higher-cost option with an escalating premium cost.

We have seen this phenomenon in several other insurance plans written for

public employee groups around the country, in farm bureaus of the Midwest, and in some of the competition which is going on between conventional insurance and prepayment plans with HMOs. Thus our experience seems to demonstrate that open enrollment and multiple options can eventually defeat the advantage of the law of large numbers.

Of course, the intensity of adverse selection would depend heavily on how the rules of the competition are set; namely, the statutory or regulatory manipulation of some of the features of the competitive model. The figure at which the employee's contribution is set, the frequency of and rules for open seasons during which employees can shift benefits, and the scope and level of coverage mandate it. These problems and others can be ameliorated by careful drafting of laws and regulations which establish the rules of the competition.

This, of course, flies in the face of the antiregulatory beliefs of many of the supporters of the competition, consumer-choice bills. Alain Enthoven, one of the leading proponents of such legislation, recently published an article in the New England Journal of Medicine which describes this dilemma well. He rather optimistically predicts that a compromise can be worked out. It remains to be seen whether that can be done. The obvious focus of the competition proponents and bill drafters over the next several months will be on this issue, the fine tuning of the bills in search of that compromise.

We in the associations have been studying these proposals carefully and have commissioned a number of papers. For example, John Newman, who is here in the audience, has just done an excellent review of what the literature tells us about the effect of deductibles and co-insurance on utilization, a key issue, and we are looking at other aspects of the subject as well, particularly what can be learned from the natural experiments which have already occurred.

Let me conclude by stating a few principles which are likely to guide, and I emphasize likely, the Blue Cross and Blue Shield Association's input to the debate.

One, we obviously will resist the alternative which Walter McClure described, namely, public utility regulation as an approach. We believe that the solution of these problems ought to be sought in the private sector and that innovation, testing, and so forth ought to be sought there.

We will be supportive of competition, but competition that is not based on high segmentation of the market by risk. We will observe, as some of the speakers have done, that many things contribute to the rise in health care costs, among them, higher personal incomes, higher general inflation in the economy,

technological innovation, and continued strong consumer demand for the best service.

We will also observe that the supply side of the equation is an important determinant of cost. Largely for that reason, we (and we have fewer and fewer allies in this regard) will support the continuation of some form of community-based health planning as a means of restraining unnecessary health facilities' construction and renovation.

We will argue that if the competition model is to be followed, it must be carefully structured in order to overcome some of the problems which I described earlier: preferred risk selection, adverse selection, free riding as consumers would move back and forth among plans, and avoidance of the selection of skimpy options by low-income people who would ultimately resort to public facilities for care.

We will argue for the continuation of comprehensive coverage as one of the options, as consumer preference for that option remains strong in a number of markets.

Finally, we will argue that everything should be done to keep employer-based group insurance on the theory that if you do not do that, you are going to lose the ultimate clout and authority and interest, and therefore the clout and the authority of the employer in influencing health care cost containment.

CHAIRMAN ANDERSEN: Our next speaker is Howard Berman, vice-president of the American Hospital Association (AHA) and a teacher in the program on hospital administration at the University of Chicago.

HOWARD BERMAN: Recently I was at a board retreat, and one of the speakers was talking about oxymorons. Oxymorons are misfits of the English language. They are contradictory words that have come to be used together even though they are in conflict; for example, "jumbo shrimp," "perpetual planning," "postal service," "painless dentistry," and (my own favorite) "military justice." Let me suggest that for purposes of today's discussion, we might be able to add another oxymoron, and that is "health services competition."

No one can deny that competitive theory and philosophy has had a profound effect on shaping our economic development and our economic thought. Similarly, I do not think that anyone can deny that the theoretical conditions necessary for the effect of the workings of competition do not exist operationally, so when we talk about competition, we are talking about something that is different from



an intellectually pure concept. Now, how far one believes one can stray from the purity of a concept and still garner the benefits of competition is an interesting intellectual warm-up exercise.

The newly discovered Right, the supply-side economists, argue that an industry can be competitive even if it consists of only one firm. This argument rests on the notion that competition is produced as a result of the one firm competing against the threat of future rivals. The theory argues that the firm's monopoly can be maintained only as long as it keeps its prices low enough to exclude others from entering the market. I think that is an interesting argument, and I consider it a monument to the creative mind of the economist. Moreover, in enterprises that require low levels of capital investment, it may even have some validity.

On the other side of the coin, however, is a vast body of legislation, a vast body of case law, which leads one to at least stop and think again about the idea that there is a perfect fit between a single-firm market structure and competition.

In juxtaposition to the advocates of competition are those social economists who doubt that the health services industry can be safely left to a pure free-market approach. They argue, and again I do not think that anyone can deny their argument's essential validity, that many hospital markets depart substantially from the requisites of competitive restraints and that these departures are inevitable.

In most towns and moderate-sized cities, the market is too small to support enough hospitals to fulfill the requirements of free-market competition. It would thus be an uneconomical set of circumstances to require numerous competitive hospitals, except perhaps in large, dense markets. The costliness of interinstitutional competition does not mean, however, that competition has no role. In fact, just the opposite may be true.

This suggests to me, and probably to you also, that "competition" has become a shorthand term which means a variety of things to different people.

The notion of competition is not new to the hospital field. We have all heard the classical economist's analysis of hospital behavior which concludes that hospitals not only compete but compete aggressively. To the chagrin of the classical economist, however, hospital competition has historically taken nonclassical forms.

Hospitals have essentially competed for patients. Given this structure, given the operating dynamics of the health care marketplace, competition for

patients is actually competition for physicians, and the way a hospital competes for physicians is through offerings of facilities and services. Thus hospitals have actually competed on the basis of facilities and services instead of on the theoretically expected basis of price competition.

On a more profound level, however, hospitals have also traditionally competed in another manner: they have competed against a standard of excellence. Over time that standard has changed, reflecting a change in the knowledge base, reflecting increased public expectation. But it is against that standard, as opposed to against one another, that hospitals have competed.

Still, we all know that there is at least a bit of truth in the classical economist's conclusions, and it is understandable how the implicit, and in some cases the explicit, incentives of the payment system result in nonprice competition.

Thus it would be inappropriate to characterize hospital behavior as being noncompetitive. It has been competitive, but competition has not taken the form of a price competition.

Even so, that does not mean that the health field has been completely devoid of price competition. Ask any health insurance company's chief marketing officer, and he will tell you about the problems and pressures of his day-to-day struggle to compete successfully in the market. He will emphasize to you that price and service are the pivotal factors and that the market is tough because it is a market characterized by well-informed buyers, by buyers and sellers acting independently, and by free entry of new buyers and sellers into the market. What I have described are the conditions for classical free-market price competition.

It is at that point, the point of carrier competition for population groups, that price competition has traditionally taken place in the health field. Typically, this level of competition has not been translated into interinstitutional price competition. The reasons for this lack of translation are both historical and practical. They reflect the conventional wisdom of the times. They reflect the public attitudes and expectations. They reflect the importance placed on access and on freedom of choice. And they reflect our understanding and our reliance on other devices for assuring efficiency.

Price competition at the point of selecting a health benefit plan has shown that it can be a beneficial point of competition.

The current interest in consumer choice reflects a natural evolution of this long-standing history of marketplace competition for population groups. Here again, however, it is important to avoid the shorthand trap and to be precise about

what we mean. "Consumer choice" and "competition" are often used interchangeably. Consumer choice, however, is an idea that is distinct from price competition in the marketplace. Essentially, consumer choice as viewed by the AHA is a promising method both for moderating the demand for health care and for giving consumers a bigger role in deciding how much they want to spend on health care. From our perspective, consumer choice consists of basically two ideas. First, consumers have to have a financial stake in the decisions to purchase health benefits and services; second, consumers should have a variety of choices of health plans.

In its basic form, consumer choice is not a concept which encompasses interinstitutional competition as a fundamental element. Interinstitutional price competition may result as a by-product, as a ripple effect of consumer choice. It is not, however, intrinsic to the basic concept.

In February, the AHA House of Delegates gave consideration to how consumer choice could be used for the employed population, and three necessary features were identified. First, employers must offer a choice of plans to employees; second, the employer's share of the premium cost must be fixed and equal regardless of the plan selected by the employee; and third, a limit must be placed on the tax-free status of employer contributions for health benefits.

Though the AHA has endorsed the principles of consumer choice, it is treading very cautiously with respect to the mechanics. The concept is seductively simple. Its operational effects, its implications, its ripples with respect to such issues as the impact on hospitals (particularly teaching hospitals and, more important, public general hospitals), the needed safeguards against consumer underinsurance, and questions of administration are all issues that still have to be sorted out before it can be determined if consumer choice is good public policy.

Let me make a self-serving assumption that I have laid out a common ground and you understand the AHA's position, and against that background, let me make a final point.

Certainly there are many issues that still must be worked out, and certainly there are all sorts of answers that have to be found before we should proceed with consumer choice or any other competitive approach. However, even in the fact of those unknowns, of those kinds of uncertainties, the AHA has endorsed the concept of consumer choice. The reasons for that decision are several. The most important, however, is probably the lessons of the past fifteen years. Simply put, we have learned since the beginning of Medicare that regardless of what the

conventional wisdom might have been, financing is not a neutral factor. Financing will affect demand and actually will have to increase demand. Supply-side controls, that is, controls that are narrowly focused, that focus only on the hospital production function, can produce only temporary, short-run shifts in expense patterns; supply-side controls in and of themselves cannot produce stable, long-run solutions--stable in the sense that they are consistent with the demands and expectations of the American public. Finally, we have learned that to establish stable, long-run solutions, supply-and-demand initiatives have to be pursued in tandem. This last lesson makes consumer-choice approaches of interest to us.

Consumer choice is an approach that activates the demand side, that brings into play the demand side of the cost-containment equation. Moreover, this approach represents the means of bringing the force of competitive pressure into the health care transaction at that point where it can have a beneficial effect. If we do not involve demand-side approaches, then we are left with only production function controls, with supply-side pressures. That does not mean that we replace the historical myopia of supply-side controls with demand myopia. Rather, it means that we stop viewing the solution in compartments and we bring these two approaches together into a synchronized whole. We begin to use both supply- and demand-side strategies.

Obviously, it is a long way from here to there, and we have just begun.

CHAIRMAN ANDERSEN: Our next speaker is Lynn E. Jensen, director of the Center of Research at the American Medical Association.

LYNN E. JENSEN: It is an honor to participate in this Twenty-third Annual George Bugbee Symposium on Hospital Affairs and to have an opportunity to discuss with you the American Medical Association's position or positions on HMOs and on competition in general.

My remarks will be divided into three categories. First, I want to take a look at what AMA policy is on the topic of competition, and since not many of the other speakers have focused on HMOs, I will have something to say on those. Next, I will take a look at national legislative initiatives that are being discussed at this time and relate those to the AMA's current policy. Finally, since I am the director of the AMA Research Center, I could not pass up an opportunity to discuss the research we are doing at the association and the directions that we will be taking during the decade of the 1980s. Before turning

to the AMA policy, I would like to begin with a brief historical sketch of how the association's policy on competition, regulation, and HMOs has evolved, at least in the recent past. The AMA has long grappled with these issues of competition.

Beginning about 1974, the association was quite concerned about escalating health care costs and wanted to find an innovative way to come to grips with these problems. Therefore, in 1975, the AMA Board of Trustees and House of Delegates authorized the establishment of an independent AMA-sponsored Commission on the Cost of Medical Care. John Mannix and a number of other distinguished individuals who are familiar with the health care sector served on that commission. After eighteen months of deliberation, the commission produced a three-volume final report and a short summary or executive summary of the report, containing forty-eight recommendations and an outline of the issues that the association should consider. The association worked on that agenda for much of the last half of the 1970s, and some of the business is still under review by our House of Delegates and other policymaking bodies.

In the first section of those recommendations there were eight that related to injecting competition into the health care sector; these were not vastly different from the proposals that have been put forth by Clark Havighurst, Alain Enthoven, and Walter McClure. The bulk of those eight recommendations was accepted by our House of Delegates as policy. At that point, they were dealing essentially with concepts, and the reality of the implications of some of those concept may not have been fully comprehended. As I will indicate later in my remarks, we are going to begin to see some of the implications of the policy that the association adopted.

The features that Walter McClure talked about in terms of fixed contribution from employers, multiple choice, and information to consumers were all part and parcel of what the AMA accepted as policy as early as June of 1978 when the House of Delegates discussed the commission report. One part of that first set of eight recommendations gave the association some trouble, namely, the role of HMOs within this sector and how they relate to the traditional delivery modes. Recommendation 3 stated that HMOs do have the potential to strengthen consumer and provider price consciousness by competing on the basis of services delivered and price. The AMA policies should be neutral regarding HMOs and fee-for-service practices, and there should be fair market competition between HMOs and other provider and insurance systems.

The AMA House of Delegates approved that recommendation in concept or in

principle, but because there was concern that there had not been enough evaluation of HMO performance at that point, the matter was referred back to the Board of Trustees and to AMA staff for further studies on competition in general and HMOs in particular.

The Board of Trustees passed the baton on to one of the association's eight standing councils, the Council on Medical Service, and, beginning in September 1978, the council initiated a fairly lengthy evaluation of the performance of HMOs in their various forms. (As you know, "HMO" is a term that requires a fair amount of definition because HMOs can take a variety of forms.) The Council on Medical Service and the staff of the AMA assigned to that project engaged in a fairly extensive literature review and performed on-site visits to fifteen HMOs. At the end of their review they reported back to our House of Delegates in July 1980 at the annual meeting, and that report resulted once again in a reaffirmation of the association's policy and concept and laid the groundwork for the association's current policy.

I will now turn to the basic elements of that policy. First of all, the association recognized the desirability of and need for a pluralistic health care delivery system. Next, the association reaffirmed that there should be neutral public policy among forms of delivery, and there should be fair market competition. The basic policy restated concern with respect to the quality of care that might be delivered and suggested that attention should be directed to this item with particular emphasis on maintaining continuity of service so that any form of delivery, any mode of delivery, should provide the patient with the appropriate continuity of service. The association has seen that HMOs and other forms of group practice have been growing in importance in recent years, and thus it was instructed to serve as a clearinghouse of information for physicians and medical societies on HMOs. Furthermore, the House of Delegates indicated that all physicians should become better informed on HMOs and should review that form of delivery as opposed to other forms of delivery for possible advantages in the coming decade. Finally, the House of Delegates mandated that the AMA and its staff should continue to evaluate performance of all forms of delivery and continue monitoring developments with respect to competition.

In testimony before the U.S. Senate Subcommittee on Health and Scientific Research on May 1, 1981, the AMA representatives once again reiterated the basic principles that I have just indicated to you. They did call for a termination of the HMO Act in the form that it had taken since 1973 and for an end to government preferential treatment of HMOs, and in this they are in accord with the present

administration. But if Congress is not of a mind to terminate the previous HMO Act and to allow HMOs to compete with other types of other modes of delivery in unsubsidized manner, the association called for requiring that HMOs comply with the provisions that are in the earlier 1973 act and its amendments.

However, in addition to the HMO legislation itself, as earlier speakers have indicated, there are a number of procompetition bills that are currently under consideration. This is really the second generation of the procompetition bills, and currently we have proposals from Senator Hatch, Senator Durenberger, and Representative Gephardt. As you may have gathered from my earlier remarks, the association policy contains many elements that would be found in any of these bills.

As Howard Berman indicated in his remarks with respect to the AHA, the AMA is also concerned about how these provisions would get implemented, how we would move from concept to fact. So while we have not reached a position where we are able to wholeheartedly endorse any specific piece of legislation, there are broad areas of agreement. Those parts of the Hatch and Durenberger bill that call for reforming tax incentives, mandating a fixed contribution toward the health care plan of employees on the part of employers, do not pose any difficulty for us. The Gephardt bill is under further consideration by association lawyers and accountants to determine exactly how far reaching its principles are. Some of the language in that bill suggests that there would be a fairly substantial dismantling of current federal, state, and other laws and regulations, and we do not feel completely comfortable in our knowledge of what that implies. I think that in all of these pieces of legislation, at least in this wave of bills, the HMO is not specifically a cornerstone for achieving competition, but it is clearly one of the mechanisms that can be used to promote competition, and we need to take a look at what that role will be.

That brings me to the topic of AMA research activities, the area with which I am most familiar. Before I get into specific research and policy analysis activities, I must say that I believe that we have a great deal of work to do on the crucial stage of implementation. It has been easier to outline the concepts than it has been to determine how we will get from where we are today to where we would like to be.

There are certain forces that are going to move us considerably upscale, to use Walter McClure's reference, from the small-scale models with which we have been dealing. First, we should not underestimate the budget-cutting activities in government and in the private sector. These are going to force a certain

amount of cost consciousness in both for-profit and not-for-profit organizations. In addition, other speakers have alluded to some activity on the supply side; sharper focus needs to be brought to bear on those items. The increasing supply of physicians will promote competition and speed up the development of competitive forces in the health care sector. One mechanism through which this can occur is that, as physicians are graduated in increasing numbers and have difficulty establishing their first practice (because of increased debt as they get out of school or an increased number of potential competitors out there in a small area), they will turn to HMOs, group practice, or some other form for at least the first part of their establishment of practice. Thus the association is mindful that we need to have a policy which allows us to represent this growing segment of the physician population.

I think that these two forces--the budget-cutting activities as well as the increase in the supply of physicians--are going to in and of themselves move us considerably toward a situation of more competition.

Let me turn now to some specific research and policy analysis that the association will be doing over the next decade as these forces come into play. As I indicated earlier, our House of Delegates has mandated that the association and the staff will continue monitoring of and research on the topic of competition in HMOs. Indeed, the Council of Medical Service has a good part of its annual agenda devoted to this topic. There are reports which our House of Delegates will be examining and taking action on at our coming meetings.

In addition to what the Council on Medical Service will be doing, the AMA Research Center has a significant volume of research in this area. First, center staff member Fredric Wolinsky has done an analytic literature review. This review of HMO performance evaluations was published a few months ago in Milbank Memorial Fund Quarterly. We will continue to do that kind of basic review of the developments in this area.

We are also doing some primary research. The AMA Research Center has had an annual economic survey of physicians for the last decade and a half. The survey that we are just finishing now, and building research files on, has an HMO oversample built into it, so we can look at HMOs as opposed to other forms and look at some of the economic implications of the organization structure. We also will be doing a feasibility study of the impact of competition, with particular attention focused on physician utilization patterns in small areas and their use of hospitals.

In addition to the annual economic survey, the association has just



completed its group-practice census which it conducts every four to five years; that should prove to be a rich source of information on physicians. We will also continue some attitudinal research work we have done in the past to try to measure both the public and physicians' acceptance or resistance to changes in the health care delivery system.

In summary, the association advocates a pluralistic health care system, a system based on government neutrality and open competition in the marketplace. But the association takes a position that corresponds with the view of the current administration and recommends that federal funding of HMOs should cease. In the final analysis, the AMA believes that the public and physicians will be best served by fair competition in the health care delivery system. If HMOs can succeed in this environment, the AMA welcomes their participation and their membership.

CHAIRMAN ANDERSEN: Our next speaker is James F. Doherty, executive director of the Group Health Association of America.

JAMES F. DOHERTY: The Group Health Association of America is the major trade association for HMOs, particularly the group and staff models.

I do not intend to speak to you today about competitive theory; rather, I will look at competition in terms of the political process and how I think it is going to evolve, what will happen in the meantime, and where the hospital industry should be going at this time. I do this because my father once told me that whenever a new concept comes along, the first thing you do is look at its viability; second, you look at the politics of the thing to see how practical its adoption will be.

In 1979, the Carter administration submitted a budget to the Congress which called for substantial reductions in Medicare and Medicaid spending, and these reductions would result from mandatory cost controls that were going to be enacted. Having heard from Sam Howard and the Federation of American Hospitals in 1980, Carter submitted a similar budget, but this time he said that the reduced costs were going to come from the voluntary effort. Now, in 1981, President Reagan has submitted a budget, and that budget also mentions reduced costs of Medicare and Medicaid; this time the reason costs are going to be reduced is that we are going to set up a competitive proposal.

I do not know if any of you have read the T. R. Williams biography of Huey Long, but when Huey was selling snake oil, he had two kinds: there was high

popylorum and low popylorum, and the former was a little more expensive than the latter. When they asked Huey what was the difference between the two, he said, "On the high popylorum, you skin the bark from the bottom up, and on the low popylorum, you skin it down."

So the question is, Is competition high or low popylorum, or is it just another expression by another administration of its frustration that it cannot get spiraling health care cost inflation under control?

Just the other day I talked with one of the principal health advisers to David Stockman. According to him, the administration is now in the process of drafting a competition bill. He said, "I cannot tell you what it will look like because we haven't made up our mind yet. However, I can tell you that it will not be the Gephardt approach," whatever that means. And he went on to say, "I also can tell you that it will not be this kind of competitive world that many people envision where we have many HMOs, all of the world will be HMOs and they will be dueling for the health care dollar. I don't think we are going to have that kind of thing." So things are a little bit uncertain right now in Washington. I think that when you consider the fact that it took over thirty years to pass a Medicare law, which was less than perfect, it becomes clear that these competition proposals will not be actualized instantly.

Many people view the HMO experience, with which I am somewhat familiar, as a guide. Some people consider it the genesis and the basis of the competitive approach. Let's take a look at the HMOs' experience.

Some data indicate that HMOs are a competitive form of health care delivery and that there is a tendency for HMOs to have this ripple effect of reducing health care costs in the communities where they have made some high penetration. There is also some evidence that they do not have this ripple effect. I think that the HMO experience is a little bit too sparse right now to warrant any definite conclusions.

When the HMO concept first showed up on Capitol Hill in 1971 in a series of Medicare amendment proposals, it sought to have an equity price compared with the rest of the health care sector: give the HMOs the full economic advantage of their vaunted efficiency, their lower hospitalization rate, and so forth. In 1981 we are still trying to get that proposal enacted into law. Equalizing payments or trying to instill some kind of competitive system into the health care field in this country is indeed a long and slow process.

In 1973 the original HMO Act, which was sold as a marketplace alternative fostering competition and having a beneficial impact on health care costs, was

introduced in the law. Senator Kennedy tried to fit it within the Health Security Act. President Nixon signed the law in San Clemente, California, in 1973.

It turns out that an impossible piece of legislation was passed. There was no way that an HMO could provide the mandated benefits, could do the quality assurance systems, could in any way even subject itself to the federal activity that the 1973 act provided. In 1975, we were able to bring the Congress to its senses, and we amended the law, making the impossible HMO Act merely a bad law.

There were two features of the HMO Act that I think are worthy of note and have had some contribution to the growth and development of the competition theory. First, it did crack open the health care purchasing market, an employer-based market; it mandated that that market be opened, and it required employers to offer the alternative system. That to me was the most significant feature of the act, and, frankly, it is why many of the prepaid group practices that I represented hung around and tried to work with it. Second, the HMO Act contained the concept of mandating benefit packages. The only problem was that the packages were just totally esoteric and noncompetitive. But it was these two concepts of mandating a uniformity of packages and then mandating on the price side (in other words, payment equity by requiring employers to pay the same amount of money to the HMO and to their current health plans) that really made that act worthwhile and make its history worth examining.

In 1978, when Joseph Califano took over HEW, he said two things: We all have to quit smoking, and we have to promote HMOs. So we were able in 1978 to pass some amendments to the law which made it easier for HMOs to operate in a competitive marketplace and raised the level of national awareness of HMOs.

Now in 1981 we have some further amendments to the act, which present some magnificent opportunities for all of us and mean that many of the federal restrictions will go by the wayside. We are a little bit fearful that if all restrictions are eliminated, if these entities are permitted to go totally unregulated, we may open ourselves up to fraud and abuse. For a new industry, this is very difficult. Many of you are familiar with the prepaid health plan experience in California in the early 1970s where there was much fraud and abuse. We felt that in the marketplace, and today many employers still question our validity and viability because of that experience.

However, a number of encouraging things have happened. The Blue Cross/Blue Shield organization entered the HMO field and has plans totaling about a million members in HMOs nationwide. The entry into the field of the Insurance Company of

North American, which has supplied the necessary capital and management expertise, is one of the most exciting things that has happened. And just recently here in Chicago, the Prudential Insurance Company has bought a small plan and intends to expand that plan throughout the Chicago area. Thus I see HMO membership increasing and a transition from federal support to private sector support.

In 1971, when we were trying to get that law passed, there were less than thirty HMOs in the country, and their total membership was somewhere around 3.5 million. If you eliminated the Kaiser organization, I think the total HMO membership in the country could have met in a phone booth. But according to Dr. Ellwood's latest census, there are around 240 HMOs of various forms and types in the country, and there are over 10 million members. That is not tremendous growth, but the key thing is that the access has been provided, and so I predict that there will be a substantial HMO growth in the country.

In 1981 we still do not have a decent HMO law with sensible federal regulation; HMOs are overregulated. We have been unsuccessful in getting that law, even though Sam Howard and INA and others are now supporting the idea of a competitive approach to Medicare. Even with the favorable climate in the administration and on Capitol Hill, the likelihood of our getting that law is somewhere around fifty-fifty. So if we are talking about competition, and people are looking at HMOs as a guide, we have a long way to go from here to there.

Any competitive approach to health care offends the status quo, because you are changing things, asking employers to give up their tax exemptions, and raising a question in their mind about whether the costs of health care are simply going to be added to current cost of production, which they feel are unbearable now. The labor movement, which has traditionally felt that comprehensive mandated packages should be part and parcel of the health scene, is apoplectic (even though they may not have the votes on the Hill) about any kind of competition proposal. Then you have the eighty-nine health groups, or the eighty-nine interest groups in the health field, who are either lobbying for or have a piece of the pie, and you are asking them to give up their piece of the health care pie.

Now, having offended so many powerful political institutions, you have to talk about how you are going to restructure a health care market that is 40 percent federally subsidized, 40 percent employer subsidized, and 20 percent consumer paid for.

If we have not made up our mind about how we are going to get from here to

there, where are we now?

A competition proposal is now being developed. When Congress gets through working its heavy hand on it, it is going to be a little bit different from the one first proposed. I hope that they will avoid what happened to us in the HMO Act and not pass another monstrosity, but I do not think my hope is very well founded. In any event, I do not see any meaningful, national competition legislation in this country for about the next ten years, and the only reason I shorten it to ten years is simply that the government is out of money, and the government cannot come in and make some gigantic proposal which will involve the huge expenditure of taxpayer dollars in order to restructure the U.S. health care system. Such problems as inflation and the Social Security Fund just about preclude any further government expenditures. Yet, there is a health care cost inflation, and whether or not voluntary efforts work, the inflation will continue. It will run between 10 and 15 percent a year and ahead of general inflation indices. Therefore something must be done; this state of affairs cannot be permitted to continue. The HMOs indicate that maybe a competitive approach is an answer, but what do you do between now and then?

I have always been rather disappointed in the American hospital industry. It was only when the Federation of American Hospitals and Hospital Affiliates and groups like that began to take a look at HMOs that the AHA upgraded its ambulatory care facilities activities. A hospital is a natural for a competitive system. It is the major medical center of any community. It has its liaisons with providers, equipment, and whatever is needed. Yet it seems to me that when it comes to innovation in health care delivery and systems, the hospitals are always the last. I am glad that Sam Howard gave the lie to this idea that a competitive system will somehow adversely affect the hospital because it will lower utilization. Where HMOs have entered the market and done so substantially, it has been proved that underutilization is not the case. As a matter of fact, HMOs lend an element of certainty to a hospital's life in terms of its budgeting process and that sort of thing.

So it seems to me that hospitals ought to sit down and talk about not just HMO sponsorship but also other kinds of innovative delivery systems. Somehow or other providers ought to be brought together in an organized system and various kinds of packages and payment systems ought to be marketed so that as the competition idea ripens (which it must do over the next ten years), the hospitals will have a key role in the development of the new system.

CHAIRMAN ANDERSEN: Our final speaker will be Richard J. Mellman, vice-president, Prudential Insurance Company of America.

RICHARD J. MELLMAN: I am speaking on behalf of the Health Insurance Association of America, the trade association of virtually all of the insurance companies that write health insurance. The HIAA is intrigued with the procompetition concept and issue and with the marketing-force issue. However, we are concerned that it is moving from phase 1 to phase 3 a little too rapidly.

Let me explain that just a bit. Phase 1, I think, is epitomized by the brilliant, incisive remarks of Walter McClure, who set the challenge before us, as have many economists and health policy theorists. Phase 3 might be described as bills in the Congress, and these bills have so much political appeal to so many people that I think we are very much afraid that they are going to move too fast before the nuts and bolts have been thought through, analyzed, and researched.

For example, the idea of putting a flat cap of, for example, \$125 a month on the amount which an employer can contribute to the health insurance benefits of his employees would affect very seriously the people who happen to work in places like Los Angeles, Chicago, New York, Philadelphia, and Detroit, but it has great appeal as a revenue-raising, budget-balancing measure to congressmen who happen to represent South Carolina, Arkansas, or Wyoming. There are many things like that in these bills.

I would characterize phase 2 as the research analysis, policy formulation, and thinking through to the modifications that the technicians in the health care and health financing industries feel would be advisable. We have a lot of work to do on that area, and this symposium is a very healthy development in stimulating that work required in phase 2.

Here are just some of the concerns which we in the insurance industry have about the bills now before the Congress.

First, Walter McClure was talking about competition among providers, but somehow that concept has been confused in a number of these bills with competition among insurance carriers or competition among insurance plans. I would submit that for an employer to say that he is going to offer employees a choice of Prudential, Aetna, or Blue Cross is not going to do much to change physician or hospital behavior.

The high and low options also contain certain perils. For example, an insurance policy is not like a loaf of bread which can be bought from a store

shelf at thirty-five cents. It is more analogous to guaranteeing someone unlimited access to all the bread he might want in the next year; before you can put a price on that, you have to know how many people are in the family, whether they like sandwiches, if they're on diets, and so on. So the difference in dollars and cents between the high- and low-cost options depends very much on the risk.

Jim talked about the difference in price between the high- and the low-cost Blue Cross, federal employees option, and the same thing, I am told, is true of the insurance indemnity option which Aetna offers. Let me illustrate with a few hypothetical numbers. The actuarial value of the difference in the benefits between the Aetna high- and low-cost option is only 9 percent. Let us say that the plans would be worth \$100 a month and \$110 a month, if everybody had signed up for one or the other. However, the low-risk people sign up for the low-cost plan and the high-risk people sign up for the high-risk plan, with the result that the actual difference in the benefit cost between those two is 70 percent.

Now, the federal employees plan does not contain a full rebate. Assume that the procompetition bill became law and we gave the 70 percent back in cash to the people who elected the low-cost option. That would accentuate this whole process. It would be a windfall to those folks; now who pays for that windfall?

Where the employer agrees to pay the high cost of the high-cost option or some percentage of it, which is generally the case today (particularly in collectively bargained cases), the employer in effect would be paying the high-risk cost for everybody. In my \$100 and \$110 example, let us say it comes out to be \$80 and \$130. The employer would be paying \$130 for everybody because he would be giving the \$50 between the \$80 and the \$130 back to the low-cost people in cash. In discussing this with some of the sponsors of the bills, we hear them say, "We don't contemplate that the employer will pay for the cost of the high-cost option. He will pay some sort of average cost of the two." The average cost is still the same as it was before the difference widened, so in that case, the employees will have a higher contribution to make for the high-cost option, and that additional money they pay will be refunded in cash to the people who elect the low-cost option. So in effect, we have moved away from a spreading of the risk.

At the present time, the young, healthy people are subsidizing the older people, and that subsidy would be lost.

In the federal employees plan, two of the principal differences between the high- and the low-cost option are that there is considerably more psychiatric

counseling in the high-option plan and there is also well-baby care.

Many of the advocates think that by signing up for the low-cost option, the consumer has been made more cost aware and more cost effective in seeking medical care when he needs it. I made the argument to Professor Goldshall of Harvard that I thought that was not true at all: what was happening was that families which included members who were pregnant or needed psychiatric counseling would sign up for the high-option plan in anticipation of getting those two. The professor respectfully disagreed and said, "Suppose the difference were life insurance? Don't you agree that, if we offered a dollar a month cash rebate per thousand back to everybody who didn't take the life insurance, the people who elected that might tend to be twenty to twenty-five years old, and their improved claim experience would not really be due to their becoming less accident prone?"

Somewhere between these two things is fact. Nobody knows how much is due to greater cost-aware behavior, nobody knows how much is due to risk. I suggest that the full rebate is a wrong idea, and somehow the rebate should be shared between the employer and employee so as to eliminate the windfall.

In talking about the multiple choice of insurance plans, some have suggested to us that rather than rely on high- and low-cost option plans, the procompetition legislation would put increased pressure on insurance carriers to form the type of health care alliances which Walter McClure talked about earlier. Prudential has been very bullish about HMOs: we have organized and operate a number of them. It has been our observation that this is a tremendously time- and money-consuming process; it takes a lot of talent, time, and money to line up an HMO. It does mean that the patient is forgoing free choice of physician and hospital if he or she opts for that plan. While about 3.5 percent of the population is covered under such plans at the present time, I think that it is going to take many, many years before the bulk of the population signs up for such a plan. I think it is also fairly obvious that limiting choice of physicians and hospitals would pose particularly difficult problems for my friend from Blue Cross/Blue Shield.

Let me conclude on this note. The Health Insurance Association has done a considerable amount of research and analysis on this. After such research, you have to spread the knowledge and educate your own membership. Only after you get to that point are you ready to consider the question, What changes would we suggest be made in this thing in order to make it workable? We hope that the administration bill to which Jim Doherty referred will not be voted on by the Congress before this all comes to pass.



If we have learned one thing from listening to the six of us, it is that each of us speaks from a different point of view, and if we all proceed to set our own policy positions in cement, the hearings before Congress on this subject are likely to be confused. I suggest that these six organizations and others who are interested (e.g., the business community) should get together at a retreat somewhere and pursue this subject further through research and discussion of research. We could determine our areas of agreement and disagreement.

CHAIRMAN ANDERSEN: I would like to thank the panelists who are remaining and those who have left for their participation. It was indeed a pleasure and an honor to have you all with us at one table and one setting.

HOSPITALS AND PHYSICIANS: VERTICAL AND HORIZONTAL REORGANIZATION TO MANAGE  
COMPETITION-REGULATION

James D. Campbell

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The second session of the Twenty-third Annual George Bugbee Symposium on Hospital Affairs convened at 2:00 P.M. with Richard W. Foster presiding.

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CHAIRMAN RICHARD W. FOSTER: It is very difficult to summarize the message in the tea leaves from this morning, but I will make a brief attempt.

There is some consensus that we have some theoretical ideas to suggest what a competitive world might look like, but we also have some reservations: competition might not work out as planned; or, even if a fully competitive system could work well, implementation of only certain requirements for a competitive system might not move us closer to the desired outcome. There has been partial testing of this competitive model but no complete test, no example of what Walter McClure called a "mature market"; so we are faced with some ambiguity on both the theoretical and empirical sides.

The two conclusions appear to be that (1) there is the likelihood of some kind of competitive reform, and a lot of organizations are spending a great deal of time trying to figure out what the effects of such a program might be; and (2) those organizations have not been able to reach consensus on what those effects might be. Thus it is an interesting time for institutions in the health care field to be planning for the future.

The focus of this afternoon's session is an attempt to determine what kinds of strategies might be appropriate for institutions in the face of this kind of uncertainty. We heard some suggestion this morning that hospitals were not as innovative as they could be. Whatever the validity of that proposition, I think we have a few exceptions to it on the program this afternoon.

Our first speaker is well known for his direction of one of the most innovative health care systems in the country. After studying at Knox College at the University of Chicago, James Campbell completed his M.D. degree at Harvard Medical School. He completed his internship and residency at Boston City Hospital, returning to Chicago to the practice of medicine in internal medicine as a member of the faculty of the University of Illinois and on the staff at Presbyterian Hospital.

After a brief stint as the dean of Albany Medical College, he returned to Chicago and to the faculty of the University of Illinois and staff of Presbyterian Hospital, this time as chairman of the Department of Medicine. He

continued to hold that position after the merger which created Presbyterian-St. Luke's Hospital, of which he became president in 1964.

There subsequently came the resurrection of Rush Medical College and the formation of Rush-Presbyterian-St. Luke's Medical Center, of which he became president in 1969. In addition to Rush Medical College, the Rush University of the Health Sciences now includes a number of other programs, and the Rush-Presbyterian-St. Luke's Medical System includes not only those educational programs and the original hospitals but also a number of other institutions, including long-term care institutions and a host of other services too numerous to mention here.

It is a tremendous pleasure and honor to have James Campbell with us.

JAMES A. CAMPBELL: I want to express my pleasure at being here and having a chance to meet so many of you.

I, too, had a couple of summary thoughts from this morning. I was particularly interested in Mr. Doherty's comment, which I summarized thus: "Time wounds all heals." And I also want to add that, as you were kind enough to suggest that our system had grown, I think you must allow for some shrinkage to occur if it seems wise and desirable. In addition, as we talked about competition this morning, I noted that we ought to recognize that regulation of providers could follow just as rapidly as competition among providers. Finally, this morning I was delighted to learn why we have been doing so many of the things that we have been doing!

We heard from several of our distinguished speakers that the essence of competition in the health care enterprise entails maximum freedom of choice, and I would say that that is not only freedom for the consumers but also freedom of choice for providers, including the paying agents. The essential element is a legal framework within which competition will work as beneficially as possible. Such a framework does not currently exist, and again, according to Mr. Doherty, may not exist for at least another ten years. That may be a boon or a disaster.

Neither regulation nor competition is a new concept in our industry. Physicians have been and for the most part still are entrepreneurs and are almost as independent as farmers. To the extent allowed by regulation, that spirit of entrepreneurship is reflected in the actions of other providers, including hospitals, medical schools, surgicenters, and emergicenters.

The government appears to be at a crossroad of increasing current regulations or deregulating the industry to facilitate some of the elements of

competition. We are not sure which path the government will take; we are only sure that there will be a change.

At Rush-Presbyterian-St. Luke's Medical Center (RPSLMC) we have tried to make it our responsibility to get out ahead of change when we can and manage ourselves in whatever changes take place in order to improve the position of our patients, our professional manpower, and our health delivery effort. Regardless of the regulatory environment, we feel that it is our responsibility to be a good competitor. Despite some of the statements this morning, being a good competitor does not mean focusing solely on price. It is our observation that successful competitors, whether they be institutions or physicians or other providers, focus on consumer satisfaction, and that will continue to be our aim as we move through the current uncertainties. While we may need to shift strategies during these periods of change, we believe we are in a strong and flexible position to compete within a variety of possible environments, including those of severe reductions in resources and increasing regulation.

Our solution we call ambitiously the "Rush System for Health." The substance of what I say may neither interest nor intrigue you, and surely it will be promptly forgotten. I am given to enthusiasm and exhortation and frequently express myself in that fashion to cover strong doubts. As is also my usual custom, I would like to give you a few (unoriginal) aphorisms or platitudes, which might be worth recalling later and which, if kept in mind, could possibly serve as my summary statements. (1) Governments have a way of getting what they want. (2) One man's meat is another man's poison. (3) There is safety in numbers. (4) Everything has been thought of before; the difficulty is to think of it again.

The inferences from those aphorisms are clear. Nevertheless, I will try to review some of our own experiences and expectations that might be relevant to the theme of physicians and institutional orientation during the current period of competition, regulation, and so forth. I will share an amplified Rush experience with you in a case-method fashion and let you draw your own interpretations, and I will try to stick to specifics so that you can make the generalizations.

The Rush system is a concept developed on a stratified and integrated system of care and appropriate manpower production or academic effort. It is voluntary and, therefore, must compete. It uses the corporate model for its organizational prototype, from its board through its top management.

The size of the system is based on the health and care requirements of a population of about 1 to 1.5 million people, which is the minimum base necessary

to assure the critical mass required for safe and effective patient care of high complexity, for example, veno transplantations or cardiovascular surgery, and the size sufficient to support a quality and efficient academic effort for its manpower production. The size is also the key to economies of scale, and most of the benefits of that have been clearly demonstrated in horizontal systems.

By definition, services available within the Rush system must be comprehensive, representing multiple levels of care if they are sufficient to meet the spectrum of diseases in a population base that large. Therefore, it is a vertical system. Comprehensiveness assures availability of service appropriate to patient needs, but it is the manpower component which is the key to assuring access and continuity.

Manpower in sufficient supply and with proper distribution--that is, of physicians, nurses, and related health professionals--must be linked or integrated throughout the various levels within the system. Although linkages are best created by the commonality of a single organized professional staff group so that patients may be taken, not sent, from one level to the next as is conventional in Western European models, our goal steps toward this ideal, but it does require understanding and tolerance--virtues sometimes found in short supply in medical staffs, even in academic medical centers.

In addition to its delivery base, RPSLMC and its related institutions, through the academic component, can produce the manpower necessary to staff a system and to devote certain resources to discovering application of new technologies. The numbers and types of manpower which are produced are based on the care requirements of the population base. In that way we are assured that specialties of graduates, in both nursing and medicine, are in balance with the system and broad community needs.

The design of RPSLMC was created in the late 1960s and early 1970s, at which time it was committed to assuming leadership for establishing a single system of care for people, regardless of the socioeconomic or ethnic status of patients seeking services. Incidentally, we were quite consistent with the governmental policies of the time, which were emphasizing access and equity. Therefore, our system was committed to proportional and equitable access for the various populations for which the system, through its related institutions and staffs, proposed to care. We call it a fair share concept: Care for a fair share of urban and rural medically underserved people.

For example, in the late 1960s and early 1970s we established, with assistance from the Office of Economic Opportunity, the Mile Square Neighborhood

Health Center serving 25,000 inner-city residents on Chicago's West Side. In case you have any misconceptions regarding that neighborhood, that is where the Black Panthers were shot. It had the highest crime rate against both persons and property and the lowest per capita income. It was an interesting area and an interesting time. It was also during this period that RPSLMC established affiliations with several inner-city hospitals in addition to suburban and rural hospitals to assist those institutions, for manpower recruitment, and to provide broad patient bases, linkage and referral, and educational services.

Providing options to patients is essential to the Rush system. Pluralism in delivery and organization of practice has been deliberately and visibly incorporated into the system. Patients may gain access to the system through private, solo, and group practices, which are the predominant forms used at RPSLMC within the system. They may also gain access through ANCHOR, our prepaid HMO, our family practice centers, through neighborhood health centers and multiple geographic locations throughout Chicago and the suburbs, and through nurse practitioners in selected settings, particularly the adolescent family center.

A word about our prepaid group-practice plan, ANCHOR, a new comprehensive health organization. It was established in 1971 around our own union employees, who asked for a fringe benefit health package. We indicated that we would be happy to provide one for them. It now has over 40,000 members in six locations with two more locations being planned or under construction, and our last new addition to our ANCHOR network was built across from Grant Hospital, one of our network hospitals.

Our HMO now has a few Medicare and some Medicaid enrollees. We have recently obtained approval for the participation of the Illinois Department of Public Aid in our HMO. The current capitation for ANCHOR for Medicaid enrollees is about 85 percent of those of nonenrolled recipients of the Department of Public Aid expenditures in Cook County.

All ANCHOR physicians obviously have appointments to the staff and the members of the faculty to insure linkage and quality, peer review, continuing education, and so on. Secondary hospital care is provided primarily at neighborhood network hospitals, and tertiary referrals are made at RPSLMC to assure quality, cost-effective care through stratification and linkage.

Incidentally, about 14 percent of the total days of care provided at the center to ANCHOR enrollees are from a referred branch location. It is interesting to note that 90 percent of the employers' groups which offer ANCHOR

select a supplemental benefit option, which is consistent with the findings that you heard about this morning that when given a choice, consumers will usually select a more comprehensive and often a more costly benefit package. Price is perhaps the least important yardstick of competition used by some consumers, and we are interested in that.

A major step toward establishing more cost-effective delivery and a single standard of care was taken in 1977 by our institution when we transferred the old, central, free dispensary clinics which were established in 1847 into a variety of private group-practice settings. The medical care group, Doc's Corner, health specialist, Mile Square, adolescent family center, and more were practices established as replacement for the clinics. Studies by Campbell and Hudson (a different Campbell) showed that 90 percent of the former clinic patients were still followed in the private-practice settings. There is increased patient satisfaction and compliance with physician treatment protocols. The cost per visit is less even in fee-for-service private practice than in the clinics. It dropped from \$58.50 in 1977 dollars to \$30.00 in the private-practice settings. This is where we can certainly recall the fourth aphorism I mentioned earlier: The old central free dispensary was actually founded in Dr. Blaney's office, it just grew from a clinic, and it is now back where it belongs.

Utilization of nurse practitioners in these practices is not uncommon. That includes nurse midwives in the adolescent family medical center, and they can participate in deliveries if the patient so desires.

In brief, as it stands today, the Rush system for health comprises a network of community hospitals and ambulatory care practice settings linked to the academic medical center, Rush-Presbyterian-St. Luke's, through a variety of contractual relationships ranging from affiliation to direct ownership and easing arrangements. The current total bed complement in the system is 5,546. The metropolitan component represents approximately 14 percent of total hospital beds in the metropolitan Chicago area. The system spans 180 miles and transcends four health systems agencies, five counties, and nine municipalities. The core of the system is the academic medical center organized, as I mentioned, under one corporate structure.

While the primary mission is clearly to provide patient services, the academic activities are perhaps worth noting in passing. The university or the academic component is ten years old and has four colleges: medicine, nursing, health sciences, and the graduate college, with a total enrollment of over 1,500 students. It focuses on upper-level health professions education. For example,

the enrollment in the nursing college is greater in the Master's degree programs than in the Bachelor's degree program. Furthermore, the Baccalaureate programs accept only students beyond their third and fourth years of undergraduate school, and one-third of the graduates have prior Baccalaureate degrees. The track record in graduate medical education suggests successful competition.

Back to patient care. The corporation owns three clinical facilities for inpatient service: Presbyterian-St. Luke's, Johnson R. Bowman Health Center for the Elderly, and Sheridan Road Pavilion. Approximately two-thirds of the medical-surgical bed capacity at Presbyterian-St. Luke's Hospital, the main 870 inpatient facility, is devoted to the care of patients with selected illnesses, to tertiary services. Sheridan Road Pavilion, located fifteen miles north of the main campus on Sheridan Road, is primarily a secondary medical-surgical hospital. These core facilities are further integrated through a common faculty and medical staff with carefully defined practice activities to form the basis for a system of stratified inpatient care. As with most regionalized systems, the goal is to provide an appropriate level of continuous care based on a patient's clinical needs and the volume of services demanded.

There are other institutions, that is, the network institutions, which relate to the center through agreements of affiliation and association with independent staffs and ownership, many of whose members, however, have appointments to the faculties of the Rush Medical College, College of Nursing, and other health science staffs. Patient flow from these institutions is less structured, of course, and highly dependent on informal relationships among the separate staffs. Support services, continuing education, and common relationships have engendered strong collegial feelings and have enhanced patient referrals.

The question is, Is this successful competition for physicians, and is this successful competition for patients? It does seem to result in more physician satisfaction and greater patient satisfaction.

Our experience has demonstrated that the more closely integrated the system is, the greater the benefits. We would like to think that someone, sometime would like to merge with us rather than to have us acquire them, but that has not, I am sorry to say, occurred. Institutions which do join the network must subscribe to the principles in which we believe and hope to foster in the next decade.

Emphasis is on patient care, fortified through an academic mission for manpower. We also emphasize vertical organization and integration and the



pluralistic approach to health care delivery and financing. In general, we feel that providers, whether or not they are members of our network, do a better job if they are part of a vertically integrated system.

Perhaps some of the investor-owner institutions and religious orders which are predominantly horizontal systems could develop an academic medical center or two for their systems and have a vertical component. It seems to me as appropriate to build from that base as it is to move from the academic medical centers outward.

Part of the glue which helps hold the physician-institution relationship together is based on the old idea of Lindsey Beaton's that a physician should never graduate from medical school but should be part of one through all his active days in what should be a learned profession. This concept of Beaton's, of course, was based on an ancient Talmudic idea: From my teachers I learned a lot. From my peers I learned more. But from my students, I learned the most.

Translating this truism into reality suggests that the best way to guarantee learning is to make someone not a student but a member of the faculty. I must admit that as yet, we have not been able to put this totally into practice, but even so, this is primarily a patient care and not just an academic problem.

Current government regulation does not focus on issues of consumer satisfaction, access, or quality--it focuses almost exclusively on expenditures. It is apparent that legislators did not understand the health industry when they mandated maximum entitlement for Medicare and Medicaid beneficiaries in the 1960s. They underestimated the potential demand for services as well as the rapidly expanding technology. They continued to underestimate that. As a result, the emphasis was to increase demand through increased access, limitless options, and virtually a blank, uncashable check. If reduction in federal expenditure is now government's primary consideration, the health care system to be rational must allow and encourage some more defined benefit package, and I will not repeat the hazards of the differentiation.

It has become increasingly difficult at the tertiary level to grade or even suggest differences in quality of levels of service unless technology for treatment is completely withheld. Can an egalitarian society accept the responsibility of withholding services? Can society accept a double standard of care for those services which can be graded? On the other hand, can we deny the value Americans place on the ability to get more if they are willing to pay more?

We cannot continue to focus on raising the lowest level of care at the expense of the optimal. We are suggesting that sooner or later, the government

will want to try to answer some of these questions, the government will get what it wants at any given time, and we are prepared to try to respond. We feel that our pluralistic philosophy is consistent with our planning and our action.

Of course, the legal framework within which competition will work must provide the maximum freedom of choice.

If we look at the Gephardt proposal, embracing many of Enthoven's philosophies, there has been considerable concern that these proposals may have a negative impact on academic medical centers and teaching hospitals. We have reviewed and discussed some of these concerns with a few of the staff at the AAMC. We are not quite as apprehensive as they, though we do, of course, have some concerns. We believe that our system has given us an advantage to compete in the current environment, and examination of several issues tends to support this relative optimism.

Take undergraduate, graduate, and related health professions education. The central issue here is whether teaching institutions with direct and indirect cost of education and training can be competitive. Will the result of competition be disaffiliation of community hospitals, adding a greater burden to academic medical centers? We believe that the impact of teaching on patient care costs may have been exaggerated. Our own data show that the cost of graduate medical education and nursing education in our own shop is \$11.37 a day, which adds less than 4 percent to the daily basic charge. This amount is obviously less than the 4 percent of the total per diem room charge, which is consistent with the findings in AAMC's recent study and is modest in comparison with the benefits that many people perceive in the teaching hospital.

If, however, society or the government decides that the cost of health professions education should be shared differently, we would support that proposition, and I think that is in the Gephardt bill. To review the results of an earlier study of house officer activity: approximately 35 to 50 percent of a house officer's time is devoted to providing patient care, 25 to 30 percent is devoted to their own education, and 10 to 30 percent is devoted to teaching undergraduate medical students. Rather than charge, for example, the sick pool for house officer education, the cost could be borne by some who profited more directly--the student, maybe society in general. This would mean that medical school tuition costs would go up. It might also mean that a separate funding mechanism might need to be established to spread society's share of costs more equitably. This, of course, we would support.

A comment on tertiary care and case mix. Concern has been expressed that

the teaching hospitals, including ours, have a high component of tertiary care which is obviously costly and must be spread to the cost of secondary care provided by the same institution. If multiple levels of care are increasingly organized, the secondary-care base will shrink in the medical center hospital, but if systems are organized, it could be expanded far more broadly into the community base. If the secondary-care base must be used to spread the cost of an institution's tertiary care, I believe the system's development would make academic medical centers less vulnerable to this potential.

We believe physicians will refer patients to institutions giving the best care and the most patient and physician satisfaction. A common medical staff, of course, is desirable and would be ideal, but in the meantime, we will make do.

As for ambulatory care: It was noted earlier that our per visit cost of hospital-based ambulatory care is significantly higher than the cost of office visits to physicians. It is feared that some ambulatory care programs and primary-care training sponsored by teaching hospitals and medical schools may suffer if unreasonable caps are placed on reimbursement for this outpatient service.

As I mentioned earlier, we transformed our clinics into private-practice models in 1977. Education and training takes place in these settings at less cost to the medical center and certainly less cost to the payer.

We have also recently included in the ANCHOR HMO physician contracts the requirement that each of these faculty members provide at least four hours of instruction per week without additional monetary compensation, and this has been found most acceptable. Specifically, their contracts indicate that they are paid thirty-three hours for outpatient care and eleven hours for inpatient care and other activities; there are four hours of required academic effort for which they receive no remuneration.

Many medical schools are also dependent on fees generated from their faculties' clinical services via various medical practice plans or service plans. We do not have such a system and do not rely on revenue from these sources.

We have some concerns presented by the AAMC and others, as well as concerns about various congressional proposals. Regardless, we believe that the emphasis on patient care through a vertically organized system has prepared us for changes. The future remains a challenge. I believe that governments will get what they want. We also believe that people who have been given an opportunity to make selections based on consumer satisfaction as well as price may opt for something more costly rather than less, because their satisfaction may justify

the greater expense.

We expect that the governmental pendulum will swing in a more moderate fashion from the blank and uncashable check of the 1960s to a more rational entitlement package for the 1980s. I think the apparent meat of price competition to nonacademic health units and apparent poison to the academic health centers will be tempered by the regulation of benefit package coverage to most appropriate settings. This may actually result in enfranchising certain centers in a most desirable fashion, not only from cost containment but, even more important, for patient safety. In any event, it will require difficult, but not impossible, readjustment by both groups. So we at RPSLMC are on the way.

The case of the idealistic, growing, and imperfect Rush vertical system certainly seems to suggest that a "safety in numbers" notion prevails with us, for the sake not only of our patients but also of us as providers. It seems to offer the plurality and options suggested by competition and yet enables a reasoned cooperation toward rational programs, which has been the alleged goal of the planning and regulatory governmental agencies.

If other systems develop, and I hope they do, clearly we would then be faced with intersystem competition. And if that happens, we should know that regulation might be a jurisdictional dispute between HHS and the Federal Trade Commission.

I close by indicating our agreement with the following quote from one of last year's issues of the New England Journal of Medicine: "The challenge for the future is for the private sector to help decide what role the government should have in private-public partnership in which both sides show good will and occasional rascality, and neither side has a monopoly on virtues or vices. The partnership between big medicine, big business and big government [and I would personally add big labor] is still undefined. For the moment the ball appears to be in our court."

As we have heard in other contexts, "The system is the solution."

CHAIRMAN FOSTER: Thank you very much for that excellent talk, particularly those interesting remarks on academic medical centers, remarks which differed quite a bit from what we heard this morning and on earlier occasions.

HOSPITALS AND PHYSICIANS: INTERNAL ORGANIZATION TO MANAGE COMPETITION-REGULATION  
Ronald G. Spaeth

CHAIRMAN RICHARD W. FOSTER: It is a great pleasure for me to introduce the next speaker, Ronald Spaeth, senior executive vice-president of the Evanston Hospital Corporation. He received his B.A. from Case Western Reserve and his M.B.A. from the University of Chicago in the Program in Hospital Administration. From Chicago he went to Ohio State University (1967 to 1972) where he progressed from administrative resident through administrative assistant, assistant administrator, and administrator, and also served on the faculty of the Health Administration Program at Ohio State.

He returned to the Chicago area as vice-president for Administration Services of the Evanston Hospital Corporation and continued as vice-president of Corporate Services until his recent appointment as senior executive vice-president. He also serves as a member of the faculty of the Program in Hospital Administration here at Chicago, and he has been a tremendous asset to us.

It is a great pleasure to have Ron with us to speak with particular attention to the issue of relationships between hospitals and physicians in a competitive environment.

RONALD G. SPAETH: I have attended these symposia for the past seven or eight years, and I find that I derive the greatest value from them if I pick the salient points, mull over what they mean, see if they are at all appropriate to my organization, and, if so, use them in my organization.

The overall topic for this Twenty-third Annual George Bugbee Symposium is competition, regulation, and the impact on hospitals and physicians. I hope that there will be much information we can use when we go back to our respective institutions because the salient features of competition and regulation in one way, shape, or form are affecting all of us--no matter where our institutions are, no matter how big, no matter how small.

There is a sign in an Evanston gymnasium which says, "Running is healthy for some and dangerous to the health status of others." Running in certain directions may be very healthy for some hospitals and very unhealthy for those who start to run but suffer internal damage or just have an inability to run very well. I think you can see the analogy.

I would like to address the issue of internal organization by looking into

four important sectors: (1) the environment, (2) the boards of our corporations, (3) physicians and who they are, and (4) management and who we really are and should be.

## OVERVIEW

### The Environment

One-third of the hospital beds in this country today are in multiinstitutional arrangements or situations or shared-service programs, or are owned and operated by a flagship corporation. There was a stir in the health care field over the recent acquisition of Hospital Affiliates by Hospital Corporation of America (HCA) which predominates in the California, Texas, and Florida markets. With this merging, HCA controls more than 5 percent of the beds in this country--over 30,000 beds.

Mergers and acquisitions are becoming the bywords of the hospital field. There are at least four hospitals in the Chicagoland area today that are for sale and are in the process of being bought. Hospitals are buying other hospitals and are merging with other hospitals. Management contracts are common in the field. Investment bankers are keys to the field, and brokers are selling. In fact, in the last few months, I have received three calls from hospital brokers advising me that they have exclusive rights for the sale of certain institutions.

Our environment is changing. In the American Hospital Association (AHA) look to the 1980s, we have identified the importance of ambulatory care, outreach programs, clinic programs, fee-for-service medicine, group practice, surgicenters, and free-standing emergicenters. In one suburb northwest of Chicago, there are four different hospitals which have put millions of dollars into free-standing emergency centers in a community of 25,000 people.

"Outreach." "Growth." "Market share." Perhaps new words and new concepts for the health care field. And still, there is the continued concern of our public, the government, business, and the consumer--most often, concern with the cost of care. What does this mean to the internal and external plans of hospitals? The cost-containment efforts? Cost containment versus quality of care? The voluntary effort? The February percentile increase over the prior February was an unadjusted 19 percent increase--adjusted to 14 percent after inflation. It's too high. The public asks, What are we doing about it?

Reimbursement worries. There were reimbursement cutbacks as recently as May in the State of Illinois, and a look at "capping" Medicaid per diem reimbursement. The effect is millions of dollars. At some institutions in the Chicagoland area, the effect is measured in the range of \$10 to \$20 to \$30 million of reimbursement cuts.

Our environment is changing, as well, in recruitment of personnel. There is a nursing shortage and a physician glut, a reverse of problems in prior years. There is difficulty in recruiting technologists and technicians into the field. All of these issues are having an impact on us, an impact on the internal operations of our institutions along with tough competition and never-ending regulation.

Examine the competition model under review by the AHA. What does it mean and how will it affect us? What will it do for pricing strategy or for our philosophy of rate of return on investment? These are business terms, perhaps brand new to the corporate offices of health care management, boards, to medical staffs, and to hospital administrators. Some are difficult to understand--difficult to equate with community image, social desires, and the social and community responsibility of the board.

Add to all of this the desires of the Reagan administration. Add tax cuts and defense spending versus concern about the health care field. Consider factors such as lessening of regulations in the health care field, a greater desire for free-market forces to work, a greater desire to spend less at the federal level on health care, the demise of the Health Systems Agency, block grants to the states for Medicaid programs, some mechanism to reduce the cost of Medicare in this country in the fact of a massive aging population. Professional Standards Review Organizations (PSRO) are gone or going. Utilization review is too expensive to administer. Planning for federal or state funding is absent.

Where does this take the individual corporate entity known as a "hospital"? We are all in it together. How are we going to progress, direct, approach the future? What kinds of models do we need? Where are we weakest, and how do we improve?

The Board

When we look at internal organization, the board must be first. How effective is your board in addressing the environment and strategic issues? How does it evaluate its performance and the performance of the corporation? What

are its obligations and its role? How timely is the decision-making process of the Board? How clearly defined is the chairman's role in your organization? How many times can you identify a "rubber-stamp syndrome" in hospital board policy activities? This makes it tough to set a direction for the future, to deal with your competition and changing regulation. Methods of communication are important, and board organization even more so. How do individuals get on the board? What is this board? Does it play a leadership role in the organization and in the community?

There is no reward for board membership in the not-for-profit sector. There is no paid directorship and no inuring of the profit to the corporation stockholders. Both regulation and competition suggest swift, effective, and efficient operation in many instances--bottom-line management. Where is the incentive for your board to remove its public accountability and local community representation role and put on this new role--the business role--a role that may require saying no to the community or physician staff?

It is said that industry board membership requires approximately fifty to 100 hours per year in meeting time, while hospital board membership requires 400 to 1,000 hours per year of board member time. Are agendas so difficult for board members to understand that it takes countless meetings to communicate the operation for which you are responsible or your plans? Of course, hospital governance must include financial, legal, and educational issues, as well as issues of patient care quality. Decisions are required often. However, the formula in the for-profit sector includes smaller boards, paid boards, stock availability, a different environment, and perhaps a clearer mission. Is this compatible with the not-for-profit sector?

### The Physician

Let us address the subject of the physician. Who are your physicians? What do they really know about your hospital? How do you communicate with them? We deal most often with the fee-for-service practitioner of medicine and at times with the salaried-employee physician. They are vastly different. How do they fit on the same campus? Look at the delicate balance of the hospital assisting the salaried physician onsite while he competes with the fee-for-service physician practicing in his office. What about physician groups gaining a greater power base? Groups of physicians may be able to guarantee you admissions and patient days. Compare this to the HMO movement. The HMO guarantees



admissions and patient days. Do you give them a discount? We do to Medicare, Medicaid, and sometimes Blue Cross. Is this not operating in the free market? What impact will we feel internally as IPAs, HMOs, and others mandate rate discounts in return for their business? Evaluate the impact on operations and pricing strategy.

The kinds of physicians you are recruiting may differ from those that work in the for-profit sector. Are they the HMO physician or the IPA physician? Are you their primary facility or do you compete for the physician?

What about regulations on physicians, reimbursement regulations, malpractice insurance issues, competition for physicians? Competing for a physician's patients while trying to assure quality care and yet being asked to keep the volume and price down--these things are not compatible. How do we control cost if we cannot affect demand? How often do you include MDs in your management decision-making process regarding these issues? These are all environmental issues related to us and the physician.

#### The Management

And with all of this, what about the management? The constant pressures of the internal operations of a major medical complex include management of supplies and salaries, people and grievances, facilities and the community, recruitment and quality assurance--whether it be cleanliness and food service, nursing care, and the number of nurse anesthetists you have in your operating room, or what you have that is sellable and what isn't. What can you market and what do you demarket?

What kind of an organization structure do you have that allows you the management flexibility to do both the internal operational functions clearly and efficiently while identifying the needs that are required to keep your institution viable outside--competitive, marketed, and in the eyes of the community? How do you strategize for the future? These are major issues for management in the 1980s.

What kind of management are you--reactive or proactive? Have you got the key talents? Where are you going in the world of the generalist versus the specialist? Perhaps a look outside our field is important. Specialists are recruited often. Financial talent is important. Controllers are becoming company presidents. Boards, physicians, management--what's the key to our internal progress?

With that overview, I give you the following.

## MANAGING COMPETITION-REGULATION

### The Board

I do not believe that we can deal effectively in an environment of competition, regulation, and future planning with large boards. Boards of corporations that move swiftly usually have no more than twenty to twenty-five members. Similarly, the board member who serves because of his financial giving but has no experience on a board may not help the organization. In the 1980s, boards should include physicians, but board members who represent a constituency may be a drawback, so physicians might come from other than your hospital staff. Board meetings should have agendas that are pertinent to the total operation and direction of the corporation, and we must decrease the time spent in meetings to equate with industry's figures.

Perhaps it is time to review our board committee structure. Many of us follow the Joint Commission's suggestions for committees whether they be joint conferences, education or financial committees, and so forth. When did you last look at committees and their reasons for being? Is it not time to recognize board committee organization on a functional basis overseeing operations versus overseeing finance? I suggest fewer committees and combining functions. As an example, a personnel committee to deal with all aspects of the human resources (but not dollars), including fringes, market share, and recruitment. This wage expenditure is clearly in the budget/finance realm. There are many other examples. Another look at committees is warranted.

All board members must be oriented toward their environment. They should feel comfortable with the expenses incurred by the corporation, the gross revenue, the pricing philosophy, the profit philosophy, and the growth philosophy. They must understand the relationship with the physicians and recognize where to draw the line between board responsibility, management responsibility, and clinical care. While not giving up a role in fund raising and community interface, boards of the 1980s must be more involved in the business aspects of hospitals and more involved in such complex issues as multihospital systems, shared services with other institutions, and the reality of merger or acquisition. The board must demand and continue to update an appropriate long-range corporate plan.

It would be of value for hospital corporations to look at "what works" in other industries at the board level and, in some instances, pattern board organization, structure, and bylaws after those of businesses. In fact, recent reports suggest the prospect of paid hospital board members in the future. What that will do to hospital boards will be interesting and something to measure very carefully.

However, we must be careful to understand not-for-profit versus for-profit sectors from a board standpoint, and paid directors begin the understanding. Furthermore, recognize that both sectors can and do borrow money, can and do make a profit, can and do get philanthropy; but only the for-profit sector has the ability to get capital through sale of stock--a key capital formation difference and a key point in comparing our worlds.

The CEO, with complete knowledge of the product, must take a leadership role in educating his board in the health care business while assuring its public accountability. While the role of the hospital in the community is defined, a board that does not understand growth potential or closure potential cannot react to either. It is, therefore, imperative that board members be aware of the feasible directions of the corporation.

### The Physician

We plan, we manage, we direct our corporations in a competitive world, and yet, without the doctor. What do we really know about our medical staffs? Who are these clients--these revenue-generating units? What are the prospects of finally involving our professional staffs in the operation and planning of our corporation?

Some hospitals involve their professional staff in budgeting, patient-day projections, and in identifying capital equipment and staffing needs of the institutions. Some do not even do that.

We must have a medical staff organized so that it can deal with management and board. In the educational setting, some organization is present--paid department chairmen, deans, medical school relationships. But in the nonteaching arena, what is the organization? Many hospitals have no paid medical directors. Other hospitals use the traditional, elected president of the professional staff to plan with--an individual with perhaps less than the desired allegiance to the corporation, an individual more interested in his own practice and revenue sources than those of the institution.

I would submit to you that the involvement of the medical staff in the operation of your institution is a key to effectively managing in the 1980s. In order to market any of your product, you need to know more about it. You need to market a service only after involving the physician. Using physicians on board committees, board members on physician committees, and management on both will help.

How do patients really get into your institution? How are they referred to your physicians? Are physicians strategically located in your service area? Can hospitals really locate physicians in areas selected by the hospital?

What is your market share of selected services? With whom do your MDs compete? Do your specialists get referrals because of an academic base, a reputation, an expertise? Are they referred to because they are the only game in town? How many beds are filled because of expertise, reputation, referral? What can we do to enhance our physicians--market, ads, assist with equipment, staff, and so forth? What kinds of patients are your physicians bringing in, cost-based reimbursement losers? Physicians' practices must be analyzed to assure our future; keys to this are patient payment or insurance company availability.

Management needs to create systems with medical staffs to assure an understanding of the patient, the revenue base, the third-party reimbursement associated with that patient, and that physician's practice. Every time we deal with cost and reimbursement, we leave the physician out. Every time we set rates, we leave the physician out. Every time we start to talk about merging or buying or making a deal, we leave the physician out. He is the key to the length of stay, the patient days, and the volume of X-ray, laboratory, and pharmacy work being generated. He can note for you the trends of his medical practice if given a chance and your interest. The data available from your physicians' practices is invaluable and must be obtained.

As we look into the 1980s, the basic ties between physicians and hospitals must be made tighter. Yes, I think we are in competition for physicians who will admit patients and allow us to generate a bottom line.

We need a profile of our medical staffs. Johns Hopkins University Medical Center is asking their patients how they got to their physician--whether it was by referral, by reputation, or direct. This is beginning to give Hopkins an understanding of their impact into a service area and whether their physicians are attracting patients into their center.

Relationships with physicians are changing. Some hospitals in this country are giving discounts to physician groups to assure that their beds will be

filled. Other hospitals are doing ambulatory testing at incremental volume pricing levels to create alternate sources of revenue, such as laboratory work for office buildings. Guaranteed volume for a guaranteed price. We must be flexible but also recognize the impact on our financial statements as these approaches are developed. If your medical staff forms an IPA, they are going to come to you for a rate--just as the HMO will, just as Blue Cross does, and as Medicare and Medicaid mandate.

Reimbursement, cost, cost containment, and volume relationships are all key issues in dealing with medical staffs in the 1980s, and only when we have appropriate internal organization that allows physician involvement in hospital affairs can we progress.

#### Management and the Internal Organization of the Hospital

In order for us to deal with our environment, internal operations must be well managed. We must understand our product and control our costs and operations. I cannot imagine that we would move through the 1980s without productivity measures whether they be HSA-type statistics or others generated from within. Somehow, some way, we must create an operation with an end product that is measurable.

Our foresight must allow data by subspecialty, identifying net income by service (net by contractual allowances) and by physician. We should identify those areas where we want loss leaders, where we can attract a segment of the population to stimulate other parts of our business. It all gets back to the issues of organization and competence. Our major goal has to be operation success, fiscal viability, and a proactive management staff. To wait to be reactive may put us in the same column as those looking to merge or be bought. I am an advocate of the corporate organization model. Hospitals are big business and should organize as such.

We have countless legal entanglements related to patient care, landownership, contracts with purveyors or physicians, research grants, employee guarantees, and so on. Where is the legal resource in your organization?

We have so many financial implications that without special talents, we may not close. Who handles buying versus leasing, return on investment, pricing, and other such decisions for you? Purchasing is an art and a science. We must recognize that ever-increasing technology in our field and the inflationary spiral of cost of goods. Purchasing and materials management have never been

more important. Key control is necessary today through proper bidding, long-term contracts, guaranteed prices, economic reorder quantity, inventory controls, and so on.

What about marketing--promoting hospitals in order to assure progress in a competitive environment? The AHA identifies market share, market mix, and marketing as concepts important for the 1980s. Marketing is an organized effort to identify needs and then develop a product to satisfy those needs, and in a hospital, it is an integrated effort. The entire hospital must be participating in this need satisfaction. Again, you must assure appropriate communication mechanisms.

Marketing is not hiring a marketing director and a staff to promote something while the institution continues to do the same thing it does now for its existing clients. So you may see by this terse definition, you are not selling unnecessary surgeries or CAT scans. In a very appropriate way, you are identifying the needs of your community, exploring your ability to satisfy those needs, and then marketing them.

From a practical standpoint, before marketing anything, specific steps must be taken. For this, I quote what I believe to be excellent background material from the American College of Hospital Administrators' course on marketing: "A marketing plan must include a budget objective, a service area analysis, identification of problems and opportunities, a marketing objective, the strategies, the action plan, then the marketing budget, and any further information necessary." Marketing is here to stay. It is a key component of business organization and should similarly be bolstered in hospitals.

And what about people, our major resource? The days of three clerks running a personnel office will soon be over. People management is the key to our survival. We need resources to assure training, recruitment, career paths, and the ability to retain people through benefit and wage programs that are no longer traditional. We must recognize our labor pool and pattern our remuneration to them. If our personnel need money to live, why do we continue to enhance our retirement benefits for members of a mobile work force whose median age may be twenty-five? We are not the parent and may not have a "forever" responsibility for our workers.

Key talents must be available to our corporation to assure progress in these areas. We need planners, legal specialists, architects, public relations, and marketing experts--all important pieces to today's hospital business. And as external worlds open to us, we must assure that what we do is well communicated

internally.

We must create data from operations so that our medical staff and board can strategize along with us. The do's and don'ts of competition must be known. We should know what our neighbors are doing, who they are, who their competition is, and the direction in which they are going.

You all know that the long-range plans of every corporation in your area must be on file with your local HSA. How many of you read them? How many of you have identified the strategic plans of your competitors? How many of you recognize them as competitors? Industry does this all the time.

While assuring day-to-day operations and maintaining the integrity of the corporation, a strategy is required for the future. Both growth or no-growth strategies have implications, both must be understood. If it is status quo you seek, assure effective internal management, fiscal viability, and a service-area niche. Service-area studies are important and must include the medical staff. Your consumer must be identified and the population growth around you defined. In the 1980s, you must look at what you want to market and demarket while you review pricing philosophies and cost-containment programs.

In the status quo model, you may no longer be able to be all things to all people as you have been in the past. That being the case, there may be a real need to understand the implications of closing an OB service, a pediatric service, a psychiatry service, or an ambulatory care facility. These decisions can be measured, and data must be available to understand the decision by all parties involved.

If it is a growth model you seek, there is a need for external involvement and perhaps an organization with operational management separate from fiscal, marketing, and planning specialists who will view the competition, define the service area, and explore the expansion process. A goal must be identified as to what segment of the population you will serve and in what capacity. Will you assure yourself of medical/surgical beds filled through primary care physician admissions, or will you seek a cardiovascular surgery program that may make you predominant in that area? What services are needed by your community and how will you render them, and all this at what cost?

The Evanston Hospital Corporation is a three-hospital corporation with operating personnel at each of three sites fully responsible for the day-to-day working at those facilities. A centralized corporate staff is involved with finance, planning, law, construction, merger and acquisition discussions while it attempts to protect all existing assets. This organization allows time for

planning and corporate strategy for discussions with neighboring institutions, bankers, consultants, and brokers who have information about other hospitals.

In conclusion, the patient today is an interested party. This, in itself, may change the management world. If price is going to be more important, and health care is going to be price sensitive, our decisions may be different. We are in need of corporate organization to advance our operations in a more sophisticated business world.

Hospital Corporation of America and other for-profits may move into our markets. How can we compete with them? Commercial laboratories consistently compete with our laboratories for the market in ambulatory care. There is a changing insurance world and a changing regulatory world. We will do things differently as these externalities change. The key to our management organization must be talent and flexibility to react in a timely fashion.

I believe that regulation will continue to be a burden. Present Reagan administration "free-market" philosophies are only temporary. Let us not be misled. Similarly, competition is a real part of our present and future. To flourish in this environment, we must all look at our internal philosophies, organizations, and goals and recognize that we may want to plan some changes in the coming years.

CHAIRMAN FOSTER: Thank you, Ron. Although we have a full schedule this afternoon, there is time for questions that any of you might have for either or both of the previous speakers. Both speakers have alluded to being prepared for contraction in the system. Campbell raised some questions about whether teaching institutions and/or tertiary-care institutions would be special victims of this contraction. Much of what Spaeth said could be interpreted as elaborating on the theme of which institutions will die: the poorly managed institutions are the ones that go. I would like to know if he or Campbell could suggest other criteria for particularly vulnerable institutions.

DR. CAMPBELL: I think I would pick your two apparently vulnerable services, obstetrics and pediatrics. If those are retained in some academic medical centers, it is conceivable that they would be retained there because of "teaching necessities."

Part of the point of elaborating a system is to indicate that some of the conventional academic as well as some of the conventional patient-care biases must be destroyed. I think that there is no particular magic in having a



university defined as a cluster of buildings or a teaching hospital defined as a single building. I think decentralized education is not only possible but in many instances absolutely desirable, and I think such decentralization will become increasingly essential. Those things which must be taught should be taught in the most appropriate setting at the least discomfort to the patient. That speaks for itself. I hope that the days of the 1950s, when I first came to Chicago, are long gone in which it was felt by some institutions (not only in Chicago but everywhere in this nation) that it was essential to have poor people for teaching material.

MR. SPAETH: I would suggest that there is a prospect that the ambulatory care programs that acute-care facilities have gone into or are going into may be the ones that get demarketed. I concur with Campbell on the pediatric, OB market, maybe even psychiatry, and on the dilemmas of the teaching hospitals.

I note also a massive movement, at least in the Chicago suburbs, in the free-standing emergency centers that are being fostered and run by nonhospital entities, that do not have the overhead, that do not have the specific rules and regulations that we all have.

MARKETING STRATEGIES AND COMPETITION-REGULATION

Jeff C. Goldsmith

CHAIRMAN RICHARD W. FOSTER: It is a pleasure to introduce our next speaker, Jeff Goldsmith, director of Health Planning and Regulatory Affairs at the University of Chicago Hospitals and Clinics. Jeff received his B.A. from Reed College in classics and came to the University of Chicago where he earned an M.A. in social psychology and a Ph.D. in sociology before he went to the Illinois Bureau of the Budget as special assistant to the director. Jeff subsequently returned to the campus as special assistant to the vice-president for the University of Chicago Medical Center and the dean of the Division of Biological Sciences before he assumed his current position. As a faculty member in the Graduate School of Business, Jeff teaches a course in marketing for nonprofit organizations. He also coteaches a course in public policy and health care with Odin Anderson, and, fortunately for me, he has been willing to assist me in a course I teach on regulation in health care.

JEFF C. GOLDSMITH: It is a pleasure to be here and a privilege to have followed to this podium two distinguished managers and innovators in the health care field who have produced extraordinary institutions and are helping move them forward into an increasingly uncertain world.

I hope to do three things today. I would like to talk about the market for health care and the transformation that the use of increased economic competition, of increased medical purchasing power, is going to work on that market. I am going to talk about the response of some other industries in the U.S. economy to situations of maturing or declining markets for their services and what kinds of things hospitals and hospital managers can learn from that pattern of adaptation. Finally, I intend to discuss some of the marketing imperatives for individual firms and systems in a changing industry.

You heard much this morning about the policy debate over how to restructure the rules under which health insurance and health care is reimbursed and the set of circumstances under which health plans compete. I believe that that debate is the tip of an iceberg, and the larger debate is over how the changing set of economic incentives embodied in the various competitive plans and alternatives will affect the behavior of managers, particularly the managers of hospitals.

I will not assume a particular approach to the development of the competitive system. I believe that we are already in an intensely competitive

system, and I hope to document some of that belief later in my talk. Rather, I am going to assume that over a period of the next several years, as a result of tightening economic conditions, there will be selective withdrawal of government funding from various kinds of health care and the gradual evolution, through congressional legislation and other developments, of increased competition among health plans. What we are really talking about here is the increased use of medical purchasing power.

In a competitive system, we are talking about the interposition of brokers into the allocation of health resources and a change in the role of the third party in the payment of care from that of a relatively passive keeper, a relatively medically neutral actor to an active, brokering, rationing function.

Paul Ellwood and his colleagues have compared the HMO to a prime contractor in arranging the care for the populations of enrolled patients. Whether we are talking about HMOs performing that prime contractor role or an increasingly aggressive use by third-party payers and government agencies of the enormous power that they have in purchasing health care, I believe that the third party will become more active, in fact, will have no choice but to play an active role in forcing economic trade-offs within the health care industry.

Under this type of evolution, I think it is inevitable that hospitals will move away from a reimbursement system in which they are paid their costs for rendering care, toward a system in which they are paid what they can get for rendering care. That movement and evolution is going to produce an uncertainty and a set of risks and opportunities that frame the setting within which managers are going to have to respond to a changing health care environment.

It seems to me that hospitals are the most vulnerable segment of the health care industry in an environment of increased economic competition and increased scarcity. The hospital is a little like an urban department store which is under intense pressure from alternative retailing modes, from discount houses, drug stores, specialty shops, and so forth. This proliferation of alternative ways of purchasing retail goods has left the urban department store stranded in a declining market, and that particular mode of retailing may no longer be viable in the consumer market into which we are heading, as evidenced by the increasing economic difficulty of many of the department store chains in this country. The hospital is in a similar position: The market for its services is being consumed by a variety of alternative methods of delivering health care, all of which have in common the following elements: They are cheaper, more flexible, more convenient to the consumer than the services provided in the hospital setting,

and, even in advance of procompetitive legislation, I think there is some fairly convincing evidence that the demand for inpatient hospital services, the core product of this entity we call the hospital, has leveled off in the last five years and may indeed have peaked. That is a controversial position because many people believe that the increased aging population will inevitably mean an increased demand for inpatient services. Yet I believe that while there will unquestionably be an increase in the demand for health care for the aged, that demand may not translate into a demand for inpatient hospital services.

Utilization trends indicate that total inpatient days of nonfederal, short-term, and other special hospitals in the country, the community hospitals, grew sharply from the postwar period until the early 1970s. Significantly enough, the first leveling off in that demand took place more or less coincidental with President Nixon's stabilization program, and there was an actual decline in inpatient hospital days in community hospitals during the freeze and phase 2 of the Nixon stabilization program.

There was then a period of about three years coincident with the lifting of those controls when inpatient activity in the community hospitals in the country increased. In the last five years for which we can get data, up to 1979, the demand for inpatient services has virtually leveled off. It grew by only about 2.6 percent during the last five years, and during that period the number of elderly in the country increased by 10 percent.

If you dig behind the data and look at the per capita rates of consumption of inpatient hospital services in the country, you see a somewhat more dramatic trend. Inpatient per capita consumption of hospital services decreased in the last four years by about 3 percent, and among the population aged fifteen to forty-four (the largest population segment in the country, the segment that includes the postwar baby boom, that enormous bulge of people who are moving through our society and creating all sorts of problems and opportunities), from 1975 to 1978 the per capita consumption of inpatient days among that population declined by 7 percent. That is the population that in twenty or thirty years is going to produce this enormous bulge in the elderly population that conventional wisdom suggests is going to be consuming a lot more hospital care. The trend over the period from the enactment of Medicare is even more dramatic. From 1965 to 1978, the per capita consumption of hospital care among this age cohort, fifteen to forty-four, declined by 21 percent.

This is the population that is caught up in the changing life-styles of the country--an increased emphasis on health care and exercise, and increased damage

from drinking and smoking--and that has benefited by the postwar boom in medical technology and science. If people are assuming that the elderly of tomorrow are going to be consuming the same volume of inpatient hospital care that today's elderly are consuming, I think there is the beginning of evidence to suggest that perhaps that is not so.

There are some disturbing signs, at least in this aggregate data, that we are no longer in a boom phase in the hospital industry. The costs may continue to rise and the complexity of what we do may continue to increase, but the volume of what we are doing is not increasing at anywhere near the rate it was in the first twenty or so years of the postwar era. The demand for services in the core market for inpatient days has roughly leveled off, and there are some signs that, at least on a per capita basis, people are consuming less hospital care now than they were four or five years ago; in my judgment, this trend is likely to continue.

There are three broad segments of the health care industry, all of which have in common the fact that they are growing more rapidly than the core inpatient market for care, that I believe have contributed to this leveling off, that represent a significant competitive threat to the conventionally organized free-standing hospital in an increasingly price competitive market. These three sectors include (1) the ambulatory care sector, the sector controlled largely by the private physician; (2) the sector of alternative delivery systems; and (3) the market for aftercare, or care for the elderly and chronically ill.

1. Enormous changes are taking place in the ambulatory care market. It is an even more intensely competitive market than the market for inpatient hospital services owing in large measure to an enormous increase in the supply of physicians pouring into the system, a 30 percent increase in the last ten years. Probably the two most significant potential elements in this ambulatory care segment are in ambulatory surgery and in the multispecialty group practices' capacity for rendering ancillary service outside of the hospital.

In the ambulatory services sector we have explosive growth around the country, not only in hospital-based organizations but increasingly in free-standing surgicenters. There is a belief in the surgical community that between 30 and 50 percent of all surgical procedures can be performed on an ambulatory basis without lowering the quality of patient care or in any way harming the patient. Surgical services represent 42 percent of that core market, and to the extent that surgeons (who are going to be in increasing supply over the next five to ten years) respond to the competitive pressures within the

physicians' marketplace, they will try to capture an increasing amount of the profits associated with performing that surgery in settings that they control and to share less of those profits with the hospital.

To the extent that payers force the trade-off between ambulatory surgery and inpatient surgery, the potential for growth in this sector of the health care industry is explosive. If 42 percent of the industry days are surgical days and there is an increasing capacity for rendering surgery outside of the hospital, it is fairly obvious that a major portion of that remaining core market is vulnerable to economic substitution, which is potentially of increasing convenience and consumer preference as well.

The urgent care centers represent a significant threat to one of the principal feeder systems of hospitals. Emergency rooms typically account for 15 to 30 percent of a hospital's inpatient volume, and yet it has now become clear that a significant percentage of what those emergency rooms do can be done outside of a hospital setting. Emergency care that is rendered in a free-standing setting deprives the hospital of the control of the flow of patients into the hospital.

There is a great deal of concern over the dialysis issue. The Reagan administration appears to have moved in the direction of backing a unified, single rate for an outpatient dialysis. I believe this will render a hospital-based dialysis program virtually nonviable economically and will force the dialysis business into the free-standing setting. To the extent that the hospital is not controlling the provision of dialysis, economic incentives will begin to dry up. The flow of patients from dialysis into transplant surgery programs and the economic disincentives of referring a patient into surgery are obvious, and the problems associated with it obvious.

In the ancillary services, multispecialty group practices have increasing access to capital; they are able to acquire CAT scanners and ultrasound equipment and to duplicate many of the hospital's profitable ancillary services in a lower-overhead setting, in a setting that the physician controls. They produce profits that go to the physician who owns those services.

Given the pressures on the physician that are going to be created by the continuing flow of doctors into this ambulatory sector, it is understandable that, in order to preserve their income and economic position, physicians are going to compete increasingly with the hospital in its most profitable services. If the hospital cannot determine a way to relate to those physicians constructively, the physician has the potential for pulling away the profit

centers from the hospital and leaving the hospital an unprofitable bundle of services that are not going to generate sufficient revenue to pay for the losers--and that, I think, is a very significant threat.

2. Alternative delivery systems: It is clear that however they do it, the principal economic benefit that these systems convey to the patient and the society is the rationing influence of inpatient care.

The typical HMO population uses only about 410 or 420 inpatient days of care a year. I am not going to become entangled in the issue whether that is because they are serving populations that would not have used them in the first place or because they are capable of exerting the kind of control and drafting function that cause people to use less services. But I firmly believe that if the enrollment of alternative delivery systems increases, the pressure on hospital utilization will increase as well, and there will be imposed between the hospital and the patient a system of care that says, Let's try and use less of the hospital services if it makes economic sense and patient care sense.

There is much dispute over how rapidly the alternative delivery systems enrollments are going to continue to grow and much debate over what impact withdrawal of economic subsidies from the government might have on the continued rate of growth. I believe that the HMOs are going to have difficulty reaching a 10 percent penetration of the market in the country. I do not think that they are going to get much beyond 25 million in enrollment by the end of the decade, but even at that conservative level, I am talking about almost tripling enrollment. That means the interposition of a significant force that is going to look on utilization of inpatient service as something to be rationed and systematically avoided if medically possible.

3. The final area, aftercare, is the area of most explosive growth in this entire model. Nursing home expenditures in this country rose at a nearly 20 percent compound rate during the 1970s compared with a compound rate for hospital expenditures of about 12.6 percent. The rates have increased in expenditures for home health care, which is a market that is now estimated at about \$2.5 billion and growing very rapidly. The rate of growth in that sector has been even more rapid.

While there is an enormous and growing debate inside this intensely competitive sector of the health care market about whether home health care is more economically viable than skilled nursing care or whether geriatric day care is more economically viable or sensitive than skilled nursing care, there is very little dispute about the fact that there is discretion in the system. All of

those types of care are more economically viable and probably more humane in responsible ways of caring for a patient who is elderly or chronically ill than is care in an inpatient setting. And to the extent that economic brokers are going to force trade-offs between inpatient care and aftercare, there is an enormous potential bonus to the system as a whole from shrinking inpatient care to this group by increasingly using and funding services in that penumbra.

Thus it seems to me that hospitals, for the reasons which I have suggested, are in a terribly vulnerable position economically, and the more brokering of health care that takes place within this market, the more pressure there is going to be, even given the increase in the elderly, on the core market for inpatient services.

Having looked at this somewhat gloomy scenario, can we as an industry learn anything from what other industries in the country have experienced under certain economic conditions?

Many of the manufacturing industries of this country went through a profound shakeout at the end of the Industrial Revolution in the 1880s and 1890s. As they moved into the first two decades of the twentieth century, these industries exhibited certain generic patterns of adaptation to the changes in their markets. Alfred D. Chandler, Jr., an eminent historian of business, in his Strategy and Structure: Chapters in the History of American Industrial Enterprise, studied the evolution of four very large firms in different sectors of the economy that survived that period, namely, Sears, General Motors, Du Pont, and Jersey Standard. In those four very different kinds of businesses Chandler found a common path of evolution as the market for the goods that those firms provided began to level off and, in some cases, contract. The very same changes that Chandler saw in the manufacturing sectors of this country about sixty to 100 years ago are taking place right now in our own industry.

Chandler detected that, in response to increased economic competition, the industries concentrated rapidly through mergers, acquisitions, holding companies, trusts, and so on. Campbell's adage that there is strength in numbers was certainly borne out in these contexts as firms used their economic power to either buy out or co-opt competitors within the same industry. In the health care industry, we are witnessing an unprecedented pace of consolidation or horizontal integration of the hospital systems; 30 percent of the hospitals in this country are parts of multihospital systems. The Hospital Corporation of America controls over 300 hospitals with aggregate revenues that will be estimated at \$2.4 billion in 1981.



The second pattern of adaptation that Chandler detected was vertical integration within the firm, both integration backward toward the supply of goods necessary to manufacture products and integration forward into marketing, into the creation of distribution systems that brought the manufactured product to the customers.

An example of backward integration would be U.S. Steel buying up ore-containing lands in northern Minnesota and the fleets of ore boats and rail cars that transported that ore to the plant. By controlling the acquisition and distribution of ore, U.S. Steel was able to lower its unit cost. In the hospital industry we have the example in Campbell's own institution of the creation of mechanisms for generating the supply of health manpower, the most scarce resource in the system.

In forward integration, firms like General Motors created networks of franchised dealers to distribute their products in local markets, to finance separately the carrying of inventories and the conduct of the retail level of trade. In this setting, industries bought out their intermediaries, the distributors and wholesalers, and replaced them in many cases with salaried employees; thus they captured the profits that would have accrued to the middlemen in that system.

One of the principal structural changes that has taken place in the last fifteen to twenty years in the hospital industry is an enormous increase in the number of pathways into the hospital. These include not only the hospital outpatient department, which is a creature of an earlier era, but also hospital emergency rooms, physicians' office buildings, free-standing satellite ambulatory facilities, HMOs, and community health centers.

This horizontal growth and vertical integration created enormous management problems for firms like GM, problems of coordination, production flow, distribution, financial control, accumulation of capital, and efficient use of resources. In response to tightening market conditions, firms created control systems and centralized management in order to get a handle on the flow of resources. In our own industry, particularly in the proprietary sector, we have the evolution of highly sophisticated management control and financial control systems that have the potential to lower the unit cost of care and provide management and financial control at the top and a sufficient amount of information to run a multi-unit system.

An important aside: Financial control is one of the toughest problems that hospitals will face in a tightening market. If you do not know what your

products and services cost, you are not going to have a very successful time selling them to increasingly sophisticated economic brokers.

Having at least provisionally solved the problem of assuring adequate management and financial control, these large firms then moved on and diversified into a variety of related businesses. Unlike some conglomerates in the 1960s, they did not just buy other organizations; rather, they tried to convert their existing productive capacity into mechanisms for delivering other kinds of goods to the market. Oil companies, for example, began selling motor oil as well as gasoline and fuel oil, and GM created a parts unit called Delco that sold parts on the open market. Swift and Company created units to manufacture and sell glue from the by-products of slaughtered animals.

The hospital industry has some excess capacity in certain areas and shortages in other areas. Nursing departments and social service departments are capable of delivering other forms of health care through visiting nurse programs and geriatric day care. Hospitals are increasingly trying to use their resources to deliver other kinds of products in inpatient care, in many cases products that relate to the use of inpatient care in the form of a feeder. One of the reasons that the federal government has been reluctant to fund home health care services is that health services professionals have noted that there is a "discovery effect." For example, when a visiting nurse goes to a home on a follow-up visit, she is likely to find another medical problem that requires hospitalization or medical intervention. Thus related health services can generate business for the hospital that would not have been there otherwise.

The firms Chandler studied also expanded into foreign markets. Hospital management firms are also moving abroad. If market conditions become tighter in this country, one can expect that hospital management firms will try to control more and more of foreign health care markets that are less regulated and potentially more profitable than are services in this country.

Finally, these very large firms were compelled to reorganize and rigorously divide direct line management from corporate staff functioning and guidance. There was a differentiation between the strategic guidance that a corporate executive office would provide and the kinds of line management, accountability, and decision making that would be provided in operating divisions. Firms segmented their own corporate structures into product lines and left the managers of those lines free to generate the resources and to control the process of production and distribution to the point where they were held accountable only through systems rather than through the day-to-day interactions of the chief

executive officer.

To the extent that there is going to be increased economic competition in the hospital industry, it is not necessarily going to be competition among isolated units but among systems because ultimately only those systems are going to be able to control and organize health resources in an efficient manner consistent with the economic pressures that are going to be brought to bear by the purchasers of care.

What does this mean for the individual hospital or the individual system? I think that the advent of economic competition has been greeted with what I would characterize as detached, diffused enthusiasm. People are so tired of current regulatory constraints that if they are given what they perceive to be an alternative system, they will flock to it. With the election of Ronald Reagan, I think that much of our industry began to feel a lifting of the burden of the Health Systems Agency, the PSRO, and the increasingly restrictive and constraining Medicare and Medicaid reimbursement systems, and they envisioned a new era of freedom and an ability to innovate. Uwe Reinhardt compared the euphoria over Reagan's election as president and the onset of competition with the sentiment in Europe at the beginning of World War I when everyone was convinced that the war would be over in three weeks, "we" were going to win it, and everyone was convinced that it was the other guy's blood that was going to be shed.

Large portions of this industry, particularly the free-standing portions, are about as well prepared for the kinds of economic and managerial pressures they will face under competition as the French army was before World War I. The industry has become accustomed to the reassurance of the system of cost reimbursement, the relative stability of cost reimbursement, and the relative protection of franchises afforded by health planning. Managers have shrunk from the task of articulating their systems and services beyond the walls of their hospital and developing approaches that will function when those safety nets are removed. Economic competition will impose pressures on health care institutions that were organized in a different, less competitive environment and are thus incapable of withstanding those pressures.

I think that one of the changes that is imperative if people are to adapt to this competitive environment involves a change in values. Cost reimbursement and the franchising of health planning made it possible to be relatively comfortable and to operate and manage in a risk-averse mode. Part of the conceptual and philosophical change that will be required by these circumstances is a

legitimation of entrepreneurship. Entrepreneurship is the essential element of institutional responses to the type of environment we are facing. In this environment, people must learn to take risks in the same way that businessmen do, by taking calculated risks with the use of data and a way of assessing opportunities and relating risks to benefits that permits institutions to make program decisions and commitments in investments that will pay off.

The concept and practice of marketing as it has evolved in the corporate world will be appropriate to the health care industry in the new, competitive environment. People in our industry think about marketing in terms of what you do when the utilization of your obstetrics unit falls off. In some of the proprietary firms, marketing is almost synonymous with acquisitions--going out and competing for hospitals and adding them to the system. However, according to Peter Drucker, marketing is one of the two core functions of a successful firm (the other being innovation). In a hospital setting, "marketing" is that set of activities designed to move the organization--not merely its administrators but its medical staff and trustees and all of its resources--toward meeting changing social needs. Evanston Hospital is an example of a premier marketing organization. It has adopted that philosophy of reexamining what the organization does and trying to move as an institution, not merely as an administration, to meet changing needs.

If organizations do not adapt to current social and economic changes, both philosophically and managerially, they are going to be left behind. I think the hospital industry is in the same spot now that the U.S. automobile industry was in the early 1960s when the handwriting was on the wall, when there were increasing developmental alternatives and increasing economic changes which suggested that the product of that industry might not be the kind of product that people would be purchasing in twenty years. The automobile industry is now suffering the consequences of its unwillingness to listen to what the market was telling it, to look at the changing needs of the society, and to allocate resources in a way that made it possible for its services and goods to remain relevant to people's needs.

The core activity of a marketer involves mobilizing the medical staff. In our own organization I began the development of a marketing data base by interviewing the principal admitters to our institution. I learned their practice patterns, where they trained, who their colleagues were, what their aspirations and interests were, what their clinical skills were, and what they were looking for from our institution and in their own careers. I became a

lobbyist in my organization in an attempt to get the institution's resources to the people who were producing, the people who were getting us referrals and building the clinical programs that were going to make us a great institution in the 1980s as we had been in the 1970s. If a marketer is unable to understand the economic interest of the physician and his interest in excellence in clinical practice, all of the elegant market research and airtight marketing plans are not worth much.

As a result of current economic pressures and because, in the relationship between the physician and the hospital, the physician really does hold the cards, hospital administrators will be forced to rethink the relationship between the physician and the hospital. Successful hospitals have developed a way to accommodate themselves to the private practice of medicine. Hospital-planned, hospital-based, and hospital-delivered ambulatory services are simply not in the same league, in terms of quality of cost, with services that are delivered in settings controlled by the physician.

I suggest that hospital planning should not focus on the creation of these large units, trying to hire people, put them on staff, and strip them of that sense of control over their work; instead, hospitals should move more in the direction of joint ventures with the physician, trying to create and identify practice opportunities for the physician.

The hospital has a powerful economic stake in the success of the private practices of its physicians. To the extent that a hospital can figure out a way to bridge that gap between the large, threatening hospital administration and the independent, somewhat concerned, free-standing entrepreneur and get the institution and the physician moving in the same direction, it will be able to harness the resources to compete in this kind of environment. On the other hand, trying to compete with the doctor will be an unproductive strategy in the kind of market that will prevail in the future.

In addition to this rethinking of the relationship of the hospital to the physician, organizations will have to rethink their corporate structures and relationships to other health care providers. They will have to determine ways to protect the price-sensitive components of their mix of services from unreasonable regulation, high overhead costs, and CON constraints imposed by what remains of the regulatory system.

A hospital in Chicago was thinking about building a free-standing emergency room, and it decided that it wanted to make the ER a hospital structure on hospital land. The hospital put in a CON application, struggled for the better

part of a year against the hospitals and physicians that control the Health Systems Agency in that area, expended hundreds of thousands of dollars, and then withdrew from the process. The alternative was simply to sell the land to the physician group that would provide the services, let them put up the facility, help them get it financed, and rely on the cooperative nature of that arrangement to assure that the patients generated by that free-standing facility would ultimately come to the core hospital.

Physicians have had the economic and political power to evade much of the regulation that the hospital has been unable to evade, and that flexibility and ability to move quickly and as an entrepreneur can work to the hospital's advantage if the hospital can figure out a way, philosophically and managerially, to put its resources at the disposal of its physicians. Every hospital has a core of physicians who are committed to it. The hospital should commit resources to those people, people who are going to consider it their hospital and are going to work with it in a cooperative framework. That kind of collaboration, it seems to me, is going to make it possible for institutions to survive.

Thus there are changes in both philosophy and management that are going to be essential if institutions are going to make it in a competitive environment. I have an enormous amount of faith and optimism that the entrepreneurial energy and potential of the hospital industry and of the physicians that work in it and provide its services can be harnessed, and with the appropriate approach, I think people can work together to survive in this market.

CHAIRMAN FOSTER: Thank you, Jeff. I would like to open the floor to questions at this time.

RICHARD L. JOHNSON: Something that has not been made explicit in all this is the fact that hospital administrators have been managers and not leaders. How are we going to make them leaders when they are caught in traps, with swinging doors, with medical staffs, lack of contracts, all these kinds of things, and what are the graduate programs doing to make the distinction between leadership and management?

DR. GOLDSMITH: I am not sure that I am capable of answering that question, but I think that the philosophic change we are talking about is important. If you are operating in an environment where you do not have a choice, leadership qualities emerge; if you are operating in a setting where the institutional rewards come to people who are willing to step out of that ministerial role and

begin taking risks, if you are in a situation where risk taking is actually rewarded, then I think the kind of leadership you are talking about will emerge.

MR. JOHNSON: The problem with risk taking is that the word "trustee" means you are holding in trust, and trustees consider themselves to be holding a public trust and do not want risk.

DR. GOLDSMITH: George Caldwell's response to that is that hospital trustees have been guilty of a dissipation of trust by virtue of that very attitude. They permitted the hospital to continue to function within a cost-reimbursed framework that is literally eating it alive. If you can impress upon people the fact that, while hospitals deliver a very different kind of product, as organizations they respond to the same kinds of incentives that businesses do, then perhaps you can get them to keep the businessman's hat on when they come to board meetings.

I think the problem is that this will not happen in a lot of organizations; some people are going to want to hang back, and their institutions may well be the organizations that simply go under.

BRUCE STEINWALD: You said earlier that effective hospital marketing means mobilizing medical staff. I am not going to disagree with you, but I ask you to think ahead toward a more competitive health care system, and I will give you a proposition that more cooperative systems will mean large-scale cooperation of individual physicians if not the medical profession as a whole. Can you elaborate on that proposition? How do you see physicians? What do you think the physicians' role will be in a competitive health system, and do you see it within the HMO context? Do you see many other options and alternatives to HMOs?

DR. GOLDSMITH: I think there are two paths: physicians are either going to accommodate themselves to become salaried employees of other organizations or they are going to try to develop free-standing, entrepreneurial kinds of settings to deliver services that people need.

I have a bias: I feel that entrepreneurship is a healthy motivation. And I think that many physicians will seek out the small-scale corporate framework and remain independent and try to deliver care in settings that they control.

Some people in the hospital industry believe that the increasing supply of physicians will place enough income pressure on physicians so that the hospital can go out into the market and hire people and put them on its staff. Frankly that is a dreadful misconception. Much more energy can be harnessed if the physician believes he is working for himself, if you can accommodate yourself organizationally to that independence.

The economic evidence accumulated by the AMA is that the greatest return to

scale and also the greatest income comes from small groups. I am not necessarily talking about people moving off into solo practice. Some people will continue to do that. What I think you will see is small-scale aggregations. I do not agree with Uwe Reinhardt's notion of the evolution of massive group practices outside of the prepaid context.

LAD F. GRAPSKI: I would like to make two comments. First, I would suggest that instead of selling the land to the physicians, you obtain a ground rent lease through which you control not only the land but the practice, and that will be much more beneficial to your entrepreneurship.

Second, I suggest that within your corporate organization, you could develop a profit corporation working with physicians in groups. Then they can share in the profits, and you share in them. That gives you a joint opportunity to work with good physicians and with the hospital to permit them to have the independence and also to share in the profits.

DR. GOLDSMITH: I think those are both excellent comments.

WILLIAM H. THOMPSON: I was fascinated by the analogies you were drawing between the hospital industry today and the manufacturing industry about eighty years ago. But some of the application would run into problems in the eyes of the public, which looks at the nonprofit hospital and has some expectations not only because of the tradition of a board of trustees in a quasi-public responsibility, but also because of the now great infusion of public dollars.

The example that comes to mind is really Ron Spaeth's example. When Evanston acquired the Community Hospital in Evanston a few months ago, a lot of citizens wanted Evanston Hospital to tell them right then and there what they were going to use that facility for.

Now, nobody asked Du Pont or General Motors eighty years ago as they made very creative managerial decisions, "What are you going to do as you make these decisions?" And yet today there is a public expectation for that. You cannot do business in quite the same way in our nonprofit hospitals.

DR. GOLDSMITH: I think there has been a profound change in our moral and social climate in the last 100 years, and I think that set of expectations is part of that change. Those expectations are applied to investor-owned hospitals too, so I don't think those expectations relate only to nonprofit institutions but to for-profit organizations as well.

I do not think that the expectations are going to go away, but I think that to the extent that you can harness those expectations and try to involve the community's own aspirations in what you are doing, you are going to be able to



preserve the legitimacy of your operation.

MR. THOMPSON: It does present some restraints. From a marketing standpoint you probably have a better atmosphere in which to do creative planning. The people around the table are not everybody, and yet in a sense, the public wants to be at that table, and it is very awkward.

DR. GOLDSMITH: I agree.

DEVELOPMENTS IN HEALTH MAINTENANCE ORGANIZATIONS IN THE TWIN CITIES AND  
COMPETITION-REGULATION

Lu Ann Aday

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The third session of the Twenty-third Annual Symposium on Hospital Affairs convened at 8:30 A.M. with Reed L. Morton presiding.

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CHAIRMAN REED L. MORTON: Good morning and welcome to the second day of the Twenty-third Annual George Bugbee Symposium on Hospital Affairs. I am Reed Morton, associate director of the Program in Hospital Administration. This morning the symposium continues its exploration of competition and regulation, with even more emphasis on the implications for hospitals and physicians.

As you may recall, Jeff Goldsmith exhorted us to be open to the marketing challenge of identifying needs, developing a service or product which satisfies them, and being willing to be entrepreneurial in facilitating the social and profitable consumption of those services and products. He also suggested that we should be willing to assume risks. Dick Johnson immediately asked what the graduate programs are doing to develop risk-taking leaders rather than risk-averse administrators of the status quo.

I can answer in part that the Chicago program has taken the approach of accepting a good-sized pool of talented students and then collecting a hefty chunk of tuition to give them a high motivation to graduate, get jobs, and advance quickly in order to recoup the income they have forgone during their two years in the program.

But joking aside, we take this responsibility seriously, and we attempt to give them an edge in the competitive world that they face, so one way of profiting, as in the stock market, is to buy low and sell high. However, the days of easily made markets in health care graduate study, as in the market for stocks and other equities, have passed. We have had to rely on another approach, that is, providing them (and you who are in attendance here today) with what we consider to be some of the best insider information. That is produced through CHAS, the Center for Health Administration Studies, which deals with many topics on the cutting edge of change. Those students who are exposed to the findings of our center's investigators are usually in a position to anticipate the opportunities, some would say problems, which will be waiting for them in the very near future and which are confronting all of us at present.

One of the principal strengths of CHAS is Lu Ann Aday, who has been associated with the center since 1973 when she arrived from Lafayette, Indiana,

maintaining the Purdue connection. Lu Ann has her doctorate from Purdue in sociology and is an associate director for research at the Center for Health Administration Studies.

Among many accomplishments at the center, Lu Ann has been a director for several studies: the National Study of Access in 1973, the Analyses of National Survey Data on Access to Medical Care from 1976 to 1980, and, at present, the Evaluation of Community Hospital Programs sponsored by the Robert Wood Johnson Foundation. She is also a co-principal investigator on the Twin Cities HMO Study, which has been supported by the Kaiser Family Foundation. Her topic today is related to the impact of HMOs in competition on hospitals in the Twin Cities.

LU ANN ADAY: Actually, my topic is broader than that; it includes discussion of the impact that the supposedly competitive milieu within the Twin Cities is having on the range of actors in the system there: hospitals, physicians, consumers, HMOs, and industry.

National attention has been increasingly directed in recent years to the emergence of alternative models for delivering care in that area. Interest has focused in particular on the evidence that the Twin Cities is one of the truly competitive health care markets in the United States. The emergence of a variety of alternative delivery systems, particularly HMOs, is credited with contributing to this perception of a competitive milieu.

The factors that have given rise to the development of a variety of delivery models there and the argument that the Twin Cities is a relatively mature competitive market are still researchable questions requiring more systematic study and documentation. In today's presentation, I would like to provide an overview of the major evidence that exists to date concerning the presence of a competitive health care environment, with particular reference to how the various actors in the health care marketplace have been affected by these developments.

The definitions of what precisely constitutes a competitive health care market have varied, as evidenced by the range of definitions which were offered in yesterday's discussions. Elements which have been suggested include free choice on the part of consumers among multiple third-party options, the structuring of these options so that the consumer is sensitive to the variant prices of the respective plans, and the diversity and variety of competing provider arrangements. There is evidence that each of these conditions is present in the Minneapolis-St. Paul marketplace.

A number of factors are credited with encouraging the growth and development

of alternative delivery systems, some of which are characteristics of the populations in the proposed market areas and others which are more descriptive of the health care system or the legal-political environment in which it operates. Characteristics of the population which are said to predispose to the growth of alternative models of care include a young and mobile population, a relatively small aged population, few segmented ethnic groups, and low unemployment rates.

The development of HMOs also appears to be encouraged in areas such as Minneapolis-St. Paul where there is an oversupply of physicians and, therefore, providers are concerned about maintaining their patient base; where there is a history, as there is in the Twin Cities, of receptivity to health care innovations such as medical care group-practice arrangements; or, as has been particularly the case in the Twin Cities, the employers are concerned with the possibilities offered by competitive options in containing the skyrocketing costs of medical care.

A number of aspects of the HMO legislation for the state of Minnesota have also undoubtedly contributed to the growth of that form of service delivery in the area. Only one of the seven Twin Cities' HMOs is federally qualified at present. The state law is, in general, somewhat more supportive of flexible and competitive arrangements than are the federal HMO statutes. For example, the federal law mandates a more comprehensive and expensive basic package of services than does the Minnesota state law. Also, the federal law requires that rates be fixed on the basis of a community rating system and be available at the same amount for individual and group enrollees, whereas in Minnesota the plans' charges can be based on experience rating of their respective groups' or individuals' costs. This means that there can be much more competitive rate setting across the respective plans. The federal law requires that HMO physicians in medical group arrangements practice their profession principally as providers of the HMO, whereas in Minnesota there is no such restriction. Physicians affiliated with HMOs may practice under a variety of delivery models, and they do. The mandatory dual-choice option is present in both the federal and the state laws. It requires all employers with more than twenty-five employees in terms of the federal law or 100 employees under the Minnesota statutes, which have been approached by HMO, to offer both a conventional plan and at least one prepaid plan if it is in the immediate area. This provision, too, has served to encourage the development of innovative, alternative delivery system models.

The HMOs can be classified into three basic generic organizational types: the staff, the group, and the individual-practice model. In the staff model the

physicians are salaried employees of the HMO. The group-practice model is characterized by groups of physicians who contract with the HMO to render services. In the individual-practice model the physician contracts with the HMO directly.

The HMOs in the Twin Cities represent both pure forms and combinations of these generic types of HMOs. Group Health Plan is the only HMO to be characterized as a pure staff model. All physicians rendering services for Group Health Plan are salaried employees of the plan. SHARE Health Plan and Coordinated Health Care are hybrid models which are composed of physicians who are salaried employees of the plan and other physicians who are members of fee-for-service medical groups rendering prepaid services to the plans under the contract. Nicollet/Eitel Health Plan and MedCenter Health Plan represent group-practice models. HMO Minnesota, a Blue Cross/Blue Shield Minnesota affiliate, represents a combination of the group-practice model and the individual-practice association model. Physicians' Health Plan is a pure individual-practice model that contracts with individual physicians.

The emergence of the variety of organizational arrangements reflected in the seven Twin Cities HMOs may itself be seen as evidence of the competitive response on the part of providers to capture a share of the consumer market through the unique sets of benefits that they provide and through the prices that they charge for those services.

Researchers at InterStudy argue that there is evidence of a great deal of price competition on the part of area HMOs. There is considerable variation in the premiums that HMOs quote to various employer groups.

Many companies in the Twin Cities also offer more than one HMO as an alternative to their traditional insurance plans. This leads HMOs to compete with one another as well as with the traditional insurers for enrollees through the prices that they charge for their plans. A number of Twin Cities employers contribute a fixed dollar amount of whichever health benefit an employee chooses, with the employee paying the difference. This, in particular, of course, serves to increase the salience to the consumer of the price he or she actually pays for coverage.

The premiums paid for HMOs in the Twin Cities are, in general, quite competitive with the traditional offerings, and, in fact, are somewhat lower on average than the traditional Blue Cross/Blue Shield plans.

The HMOs also compete on the basis of the benefit packages offered under the respective plans. The HMO benefit package for general hospital services and

physician services is standardized among plans as a result of services mandated by the Minnesota statutes. For other benefits considerable variability exists among HMOs.

The benefit packages for HMOs tend to be more comprehensive than those of the traditional insurers, particularly in the area of ambulatory care. However, there is evidence that traditional third-party payers are beginning to provide more benefits of this kind to remain competitive. Blue Cross/Blue Shield, in fact, has become very directly involved in the HMO business through its HMO affiliate, HMO Minnesota.

Twin Cities HMOs competitively market their services on bases other than price and benefit structures. The independent-practice models emphasize the consumer's ability to choose from a variety of providers through their networks of physicians. The group-practice HMOs emphasize the integrated nature and the high quality which can presumably be attained through a multispecialty group. Other HMOs have sought to expand their competitive advantage through the addition of satellite facilities or provider groups, which are more conveniently located for some potential consumers.

At the end of 1980, it was estimated that 21.1 percent of the Minneapolis-St. Paul metropolitan area population was enrolled in one of the seven HMOs. The HMO enrollment in the Twin Cities is apparently growing at an average rate of around 30 percent.

In 1980 Group Health Plan, the oldest and largest HMO in terms of enrollment, ranked first with 36 percent of the total HMO enrollment in the Twin Cities. This was a somewhat smaller share than its 42 percent share of the market in 1979. Physicians' Health Plan and HMO Minnesota--both individual-practice models and new entrants to the HMO market, comparatively speaking--increased their market share over this period. These fluctuations may, to some extent, reflect competition for a share of the HMO market among the older, well-established plans versus the newer plans.

Traditionally there have been very small proportions of the elderly and indigent populations enrolled in HMOs because of their being higher-risk individuals and the fact that the cost-based modes of reimbursement available through the main public financing systems for these groups--Medicare and Medicaid--have not been readily adapted to the prepaid capitation mode of coverage. Medicare beneficiaries who are enrolled in the federal hospital insurance or medical insurance options may elect to obtain a health care program to supplement Medicare benefits.

The proportion of total Medicare-eligible individuals enrolled in Twin Cities HMOs is quite small. In 1979, for example, only 1.6 percent of the total eligible population was enrolled in HMOs. Medicare beneficiaries do represent a very large potential market for HMO enrollees. The prepaid mode of financing care would also seem to offer an alternative to containing the skyrocketing costs of care for this group. At present, four of the Twin Cities HMOs are, in fact, involved in an HMO Medicare Capitation Demonstration Project funded by the Health Care Financing Administration: HMO Minnesota, MedCenter Health Plan, SHARE, and Nicollet/Eitel. This demonstration represents an effort to expand the availability of alternative delivery systems to the elderly--an important and relatively untapped share of the health care consumer market in the Twin Cities at the present time.

Another actor in the system is the physician. Physician behavior in the Twin Cities has also been affected by the availability of a variety of alternative delivery systems and the development of what appears to be an increasingly competitive health care environment.

One of the most notable developments in recent years is the formation of Physicians' Health Plan, an individual-practice model, initiated by the Hennepin County Medical Society in 1974. The growth of PHP was seen as a direct response to the growing competition offered by area HMOs to unaffiliated providers. At present, some 1,200 physicians are practicing with PHP. In addition, the Ramsey County Medical Society was quite instrumental in the development of the IPAs serving HMO Minnesota.

Another identifiable response on the part of the physician community to the growth of HMOs in the area was the organization by metropolitan physicians in 1971 of the Foundation for Health Care Evaluation. The foundation essentially serves as the PSRO for the Twin Cities. The foundation thus may be seen as an effort on the part of providers in a competitive environment to exercise more control over the cost and quality of care rendered by themselves and their peers.

The Twin Cities HMOs appear to experience little difficulty in attracting new physicians. In 1980 there were approximately 2,000 physicians directly affiliated with the seven Twin Cities HMOs. This represents more than half of the physicians rendering care in the metropolitan area. Of the 2,000 physicians, the vast majority, 88 percent, were affiliated with only one HMO. Twelve percent, however, were affiliated with one or more plans.

Physicians' Health Plan has the largest number of participating metropolitan area physicians, followed by HMO Minnesota. Group Health Plan has the largest

percentage of physicians who are exclusively affiliated with that plan, largely owing to the fact that the GHP physicians are, in fact, as I mentioned, salaried employees of the plan. MedCenter also has a large proportion of physicians who render care for the MedCenter Health Plan only. This is primarily because of the large complement of St. Louis Medical Park Center physicians--the founding multispecialty group for this particular HMO. Among physicians who participate in more than one plan, the greatest overlap appears to be between the individual-practice model physicians in HMO Minnesota and PHP.

The diversity of organizational arrangements available to physicians in the Twin Cities and the flexibility that exists for practicing within more than one plan serves to nurture the competition among providers to optimize their share of the health care consumer market.

The tendency on the part of HMOs to incorporate existing individual and group practices as a part of their delivery networks has resulted in Twin Cities' physicians rendering care to both fee-for-service and prepaid patients. Physicians affiliated with HMOs in Minneapolis-St. Paul may have from very small percentages to as much as 100 percent of their patient load as prepaid. In the Twin Cities, then, a unique situation is represented by the fact that the traditional fee-for-service market and, more particularly, the practices of individual physicians are being increasingly penetrated by prepaid patients as well. There is evidence that the organization and styles of practice of Twin Cities physicians are increasingly affected by the growing prepaid share of the health care market in the area. This represents an important area for further research in investigating the probable impact of alternative provider incentives on the fundamental ways in which patient care is organized and delivered.

Another important dynamic of the Twin Cities marketplace is the developing profile of contractual arrangements between HMOs and area hospitals. Though most Twin Cities hospitals have some affiliations with HMOs which provide for services to enrollees at normal full-billed charges, twenty of the thirty Minneapolis-St. Paul hospitals have contractual arrangements which provide that HMOs reimburse hospitals for the inpatient care of their enrollees on a basis other than charges. These arrangements may take the form of discounts on charges, controlled bill charges, negotiated per diem rates by type of service based on projected utilization rates, or a variety of other complex arrangements.

A study conducted by Kralewski and Countryman of Twin Cities HMO hospital affiliations indicated that twice as many contracts were initiated by hospitals as were initiated by the HMOs. The main reasons cited by hospitals in initiating



such affiliations were incentives to expand the population they serve, to gain new patients, or to maintain current levels of occupancy.

Group Health Plan, the largest Twin Cities' HMO, has executed the most contracts (six) with hospitals on the basis of a rate negotiated on other than full-billed charges. It is followed closely by Physicians' Health Plan with five contracts. Physicians' Health Plan is an individual-practice model which emphasizes its extensive service delivery network in its marketing effort.

Evidence that is consistently cited for the competitive effects of HMOs in the Twin Cities marketplace include the reduced rates and cost of hospitalization in the area, especially among HMO enrollees. The average number of hospital admissions, patient days per 1,000, and average length of stay tend to be higher in Minneapolis-St. Paul than for the nation as a whole. However, these rates are considerably lower for HMO enrollees in the Twin Cities metropolitan area. The fact that hospital-use rates are lower for the HMOs may, however, be due to who selects themselves into HMOs: Those who do tend to be younger and healthier. Rates may also be lower because outpatient services may be substituted for inpatient care among HMO enrollees. Much work needs to be done to sort out these effects.

There appears to have been somewhat of a decline in hospital admission rates and total patient days in the Minneapolis-St. Paul area since 1974, compared with an increasing or steadier rate on the part of the national average. This decrease is to some extent attributed to the competitive effects of HMOs in the area. Such a generalization should be made with caution, however, since these changes could also be due to utilization review controls instituted by the PSRO, HSA, or individual hospitals.

Other evidence cited for the system-wide effects of HMO competition in the Twin Cities are differences in total hospital and per capita expenditure rates of increase in the Twin Cities compared with the national average. Hospital expenditures in the Twin Cities, for example, rose about 9 percent in 1978, compared with about 12 percent for the nation as a whole during that period. Since 1976 the annual percentage change in the Consumer Price Index in the Twin Cities for all items has been somewhat greater than the rate of increase in other cities. However, the percentage increase in the medical care component of the Consumer Price Index in Minneapolis-St. Paul tends to be lower than that of other cities.

More intensive research is required to understand the extent to which HMOs per se have brought about system-wide changes in overall hospital use and

expenditure patterns. Preliminary data provide signals that such changes may be taking place. Subsequent research should focus on the extent to which noncompetitive factors such as utilization review, preexisting trends, or the selection effects operating with respect to who is enrolled in HMO may be accounting for some of the recent findings concerning hospital costs and use in the Twin Cities.

Employers have been one of the major catalysts for HMO development in the Twin Cities. During November and December of 1980 the Center for Health Administration Studies conducted telephone interviews with business firms in the Twin Cities metropolitan area regarding the types of health plans offered to their employees. Sixty-four companies employing 1,000 or more employees were contacted. Of the major types of health plans offered by these firms, a considerable proportion, 87 percent, offered one or more HMOs; 59 percent offered a conventional indemnity plan; 39 percent offered their own self-insured area health plan; and 14 percent offered Blue Cross/Blue Shield. Thus these data suggest a significant penetration of the employee market by area HMOs.

Several of the procompetition proposals give employers an important role in fostering competition by encouraging them to offer multiple health insurance plans and to contribute the same amount toward the total health insurance premium across all plans. Our survey results indicate that the major employers in the Twin Cities generally offer a choice of health insurance coverage. The amount of employer contributions toward an employee's total health insurance premium was analyzed from a subsample of the employers that we surveyed. According to our survey, about one out of five, 22 percent, contributed the same amount toward their single-person health plan options. For family coverage, about 29 percent contributed the same amount across all health plans, which suggests an interest on the part of these employers in fostering price competition among the plans.

The proportion of large firms we surveyed which offered HMOs grew from 6.2 percent in 1972 to 87.5 percent in 1981. From 1972 to 1975 relatively few firms offered an HMO. But in 1976, eleven firms started to offer an HMO; and in 1977, the number of firms starting to offer an HMO peaked at fifteen. From 1978 through 1981, the number of large firms starting to offer an HMO has declined significantly, suggesting some saturation of the large employer market by HMOs over time.

Since 1979, new HMOs offered by employers are being added to existing HMOs offered by those employers. The HMOs are beginning to compete even more significantly among themselves within employer groups offering such options.

Thus employers continue to play an important role in the development of HMOs in the Twin Cities by providing these alternatives.

In summary, then, the Minneapolis-St. Paul health care market is an interesting and important context in which to understand the emergence of competitive models for the purchase and delivery of medical care. The data available on the Twin Cities market provide some evidence of the extent to which the behavior of consumers, hospitals, the HMOs, physicians, and industry have both catalyzed and responded to these developments.

Over 21 percent of the Twin Cities residents are currently enrolled in HMOs. A variety of organizational and service delivery arrangements exist, and the seven HMOs appear to compete vigorously on the basis of both price and nonprice aspects of their plans. A large percentage of Twin Cities physicians have some affiliation with area HMOs, and there is evidence that they are finding these associations increasingly attractive and successful ways to maintain their practices. Hospitals are similarly looking to HMOs as a way to expand or retain their patient loads. Also, large employers are increasingly offering an array of HMO options to their employees as a competitive approach to containing the rising costs of medical care.

There is evidence that the Twin Cities health care market may, in fact, be entering a mature phase. The large employer market is being increasingly saturated. Almost 90 percent of the large firms offer at least one HMO option. A number of the HMOs are looking eagerly to the possibilities offered in enrolling a previously unenrolled group through the Medicare Capitation Demonstration. Efforts to differentiate their product and to expand delivery sites are vigorous on the part of many of the HMOs at present.

There is evidence that successes in the cost-containment objective have been achieved through the competition that exists in the Twin Cities health care marketplace. The extent to which competition does indeed exist and the precise impact that it may have had on cost containment or other health care system goals are still researchable questions. The preliminary evidence suggests that the Twin Cities market is a relevant and important context in which to explore them.

MEMBER: Would you say anything about the use of HMOs, if any, by the public aid people in the state of Minnesota, and what is their cost-containment experience?

DR. ADAY: A very small number of people are enrolled. I have some figures on that, but it is very comparable, I think, to the proportion which is included

in the Medicare system: miniscule, perhaps less than 1 percent, actually .3 percent, if I recall, who are enrolled in HMOs through the Medicaid program. Of course, there are the issues that exist in all the states of shifting eligibility requirements, so that the market has really not been dealt with effectively in that area either. It is just a handful. They really have not worked out systems for dealing with it because such a small number of people are enrolled, so there are big problems still to come.

MEMBER: Has there been any information on the financial viability of the HMOs? Are they doing well, or are some of them in a more precarious financial situation? Do you have any other information on the administrative costs?

DR. ADAY: We do not have such information per se. The best I can do is provide some long-distance impressions. It seems that each of the firms are on relatively firm footing. There is some concern that if the competition reaches a great level of intensity, there would be a tendency on the part of some of the smaller ones to merge with others or even leave the market. I am not aware of any rumblings of that kind in that area. Each of them seems to be surviving on its own terms.

MEMBER: You have a statistic that about 21 percent of the population is enrolled in HMOs. Do you have any idea what percentage of the population has an HMO option?

DR. ADAY: I think the denominator for that would be primarily the employed individuals. I am not sure of the absolute number of employed individuals in the firms that are offering this option. The number that we surveyed represented about 22 percent of all employed people in the Twin Cities. Those large firms tend to dominate the HMO market. So to the extent that that provides some kind of gross approach to those who might be eligible through the main groups that provide them, that is, the large employers, that represents about, as I said, 22 percent of all employed individuals.

HERBERT E. KLARMAN: I have a couple of comments and a question. My comment is that I do not see how one can take wide variation in premiums as evidence of competition. I thought that competition would lead to uniform rates, although I suppose one could make the other argument. You have uniform collusion, so what it really comes down to is, the data themselves are not going to tell you very much. There is absolutely no evidence of competition.

I did some rapid calculations on the possible effect of the HMO on hospital use by non-HMO type, and what I get is absolutely no change on the part of the non-HMO. So whatever factor you are looking for on the non-HMO group is not to

be found in hospital use. My question is, How can you say that a physician who is a member of two different IPAs is competing? What is the nature of the competition?

DR. ADAY: I would like to repond to your first point. I think with respect to differences in the premiums, we are looking at a particular stage of market development there. As you suggest, with time the premium differentials in a truly competitive market would not exist. We are looking at one stage of development--variant prices are offered to consumers by competing plans in an effort to collect their shares of the market.

Second, with respect to your computations regarding the changes in the hospital utilization and what that suggests for the system-wide effects, I would say that much has been claimed but not proved with respect to whether there have been system-wide effects as a result of competition in the area.

As for what physicians are doing by trying to participate in more than one IPA arrangement, perhaps that does suggest some level of schizophrenia, but it is a way in which providers presumably perceive that they may have access to a larger group of patients, and, as I said, this is a particular stage. As evidenced by the activity on the part of the Hennepin County and Ramsey County Medical Societies in their nurturance of the IPA arrangements, unaffiliated providers during the past few years are running to find opportunities to increase their shares. Whether this reflects sophisticated competitive behavior on the part of the physicians is another issue.

MEMBER: Do you have any evidence of differential risk selection? Do you use different types of HMOs?

DR. ADAY: I am not sure that I have a lot of evidence that there is differential selection. There is a greater enrollment, at the present time, on the part of Medicare-eligible people within SHARE, the federally qualified plan, so I think that that particular group would be more apt to have a somewhat different distribution. Otherwise, I am not sure that there are clear differences among the other plans in terms of differential risks. Some of the plans do elect for an experience rating option. The others are more community-based rating systems.

MEMBER: Your figures indicate a significantly higher rate of hospital utilization in Minneapolis-St. Paul than in the rest of the nation. Can you tell us what some of the reasons are for that difference, as you see it, and what that condition might be doing in terms of development of HMOs in the Minneapolis-St. Paul area?

DR. ADAY: I can offer some speculation about that. I was interested in the availability effect. Is there a tendency toward overutilization in areas which have an excess, in some respects, of hospital beds or a large number of physicians relative to the national average?

Or is there any effort to generate demand? That might be one source of the high utilization. Yet Minneapolis-St. Paul is also relatively well-off socioeconomically, so it is an area which presumably can afford these costs of care.

I do not think that the profile of the health status in this area is any less favorable than that in other communities, so the high utilization is not necessarily reflecting greater need.

I think that these are some elements which might contribute to the greater use.

MR. DAN THOMAS: One interesting point on utilization. There is a great deal of concern on the part of the employers about the high utilization rate that you are discussing. As a matter of fact, under the Foundation for Health Care Evaluation there is not a program for the private-patient utilization review, and that program is supposed to be up and running effectively July 1, 1981. So there is a lot of concern about these figures on utilization.

DR. ADAY: Odin, did you want to comment?

ODIN ANDERSON: The only observation I can make is that, if you have more than two reasons for the existing phenomenon, you do not know what the reasons are. When you list seven or eight, then we know that we are really at sea because we cannot weight them as to relative influence on the phenomenon in question, like the admission rate. And this is a very difficult research question.

MEMBER: If HMO serves no older people, serves no poor people, have you tried to compare the hospital utilization rates of that group versus the young and rich in a non-HMO participating hospital census or experience?

DR. ADAY: Basically, you want to control for the distribution of the patient mix in the respective plans. Some data are available but difficult to dig out, and we have not dealt with the data as systematically as I would like.

MEMBER: I think there is some pretty good evidence that when HMOs participate in a particular firm, they enroll the Medicare population, saving about 20 to 25 percent.

MEMBER: Medicare or Medicaid? I don't think so.

RONALD ANDERSEN: Peter might like to comment on the effect of the elderly.

DR. ADAY: Yes, that is a good point. We have an expert here in our midst.

MR. PETER WEIL: In my dissertation, the data were from 1969 and 1970. I compared seven prepaid groups and seven control groups using the Kaiser system and other systems. Although I do not have a percentage, certainly there were savings among the elderly in hospital use.

On the other hand, in terms of physician use, there were considerable overages among the elderly, so apparently that is the finding. I suggested that the pattern was that physicians develop a pattern among the younger people they treat, and that somehow carries over with the older people they treat as well. The incentive structure also has a lot to do with that.

DR. ADAY: Several studies are summarized in this HCFA report on HMOs that deal with current research comparing Medicare enrollees and prepaid versus other. Peter's studies are cited in here, as a matter of fact. There are about four studies reported here that tend to have somewhat different findings. This might be a source if you want to review it.

MEMBER: As Dr. Klarman has pointed out, both last night and this morning, except for captive populations that are included in HMOs, there seems to be no change in the behavior of the rest of the population in terms of utilization, in terms of the way the physician population reacts.

It makes me wonder just how the Minneapolis experience applies to places such as Prince George County, Maryland, with a mix of urban blacks, affluent white physicians, a shortage of physicians where you need them, a surplus of physicians where you don't need them, and all the other kinds of problems that relate to creating a viable, competitive environment. What kinds of lessons will we learn in looking a little harder at the Minneapolis experience that will help us in these situations?

DR. ADAY: We are at the beginning stages of research in trying to deal with those questions, and I think this is a laboratory with respect to examining them.

There are two kinds of issues, I think, implied in your question: One is the internal validity question, and the second is that of external validity.

The internal validity question: Can we look at what is happening within that case and say, if these kinds of things are happening in the prepaid market there, we can predict that there will be certain kinds of effects in terms of the fee-for-service market. I do not think that an effective research design has been in place there yet to address that question. We are looking at the internal market itself and saying: Okay, there is an experiment going on here; let's examine it and see what the relationships are with respect to that case study.

We are at the early stages, and as I look at more of the work that has come out on the Twin Cities area, I think this is speculative in the light of the available data base.

The second issue, of external validity, is perhaps what you were addressing when you talked about other kinds of areas with which this experience can be compared. Can what has happened there be generalized somewhere else? I think it is possible to begin to address that question by looking at what is happening in other kinds of markets and at the factors that seem to be predispositions to these kinds of effects in other markets.

MEMBER: My question had more to do with the kinds of lessons which can be learned from the Minnesota experience that might be applicable to the situations with which most of us have to contend. The Twin Cities is not typical.

DR. ADAY: In terms of trying to start a program or trying to deal with them? I think what this suggests is that there are signals out there.

GEORGE BUGBEE: Lu Ann, I think that yours was a terribly interesting paper. I do not think you have overcommitted, but we all need to know more about what is happening. I believe there has been quite a bit of marketing in the Twin Cities experience one way or the other. Yours is the sort of work of which the Center for Health Administration Studies can be very proud.



## THE INCREASING SUPPLY OF PHYSICIANS AND COMPETITION

Alvin R. Tarlov

CHAIRMAN REED L. MORTON: Our next speaker is Dr. Alvin Tarlov, who is also the associate director of the Center for Health Administration Studies and a professor of medicine. In addition to these academic appointments, Dr. Tarlov has served as president of the Association of Professors of Medicine, chairman of the Federated Council for Internal Medicine, chairman for the Association of Professors of Medicine's Task Force on Manpower Needs in Internal Medicine, and chairman of the Graduate Medical Education National Advisory Committee--among other posts.

He has made numerous contributions to scholarly literature, including service on the editorial board of the Annals of Internal Medicine and authorship of numerous articles ranging from basic biochemical investigations earlier in his career to investigations and discussions of the training and supply of physicians, particularly practitioners in internal medicine.

ALVIN R. TARLOV: I think that Reed has overstated my qualifications; what is most clear in my mind is what I am not qualified to do, namely, speak about competition and matters of public policy which have been transformed from issues of morality, social good, and the purposes of a democratic state to urgent questions of economics, expenditures, and cost containment.

Today I would like to, first, give you my view of the development of national health policy; second, integrate into that the operation of the Graduate Medical Education National Advisory Committee (GMENAC), its origin, methodology, results, and recommendations; and, finally, focus on a few of the controversial issues which have arisen since the publication of the GMENAC report, particularly those controversial issues which have direct impact on the issue of competition in medicine.

Looking back on the development of a national health policy in the United States, I think that a major change occurred as a result of the development of the Civil Rights movement. In the ten-year period from 1955 and the Brown v. Board of Education Supreme Court decision, which promised equal access to educational opportunity, to the Voting Rights Act of 1965, there arose a concept of rights as specific entitlements. Philosophically, that represented a rather significant change from, for example, the Bill of Rights which promised freedom from oppression, largely freedom of the individual from oppressive actions by

governments.

From 1955 to 1965, that concept of rights still prevailed but was fortified by a concept of rights as specific entitlements, and during that decade the concept of the right to health care evolved. The capstone and the final implementation of that process was the Medicare and Medicaid legislation. Simply stated, the policy is that equal access to high-quality health care at an affordable price is a basic right of citizenship.

I believe that one can argue philosophically and/or theologically about whether the right to health care is a legitimate right, but the government and the public behave as though health care is a right of citizenship. The evidence of a broad national consensus that access to health care is a right can be found in the specific legislative actions which have been taken since the Medicare legislation to remove economic barriers to health care and improve access to health care; the development of the HMO system, the Area Health Education Center (AHEC) system, and the Washington-Alaska-Montana-Idaho system in the North Pacific; and innumerable manpower acts--including the Health Professions Educational Assistance Act, the Health Manpower Act, the Comprehensive Manpower Training Act of 1971, and Public Law 94:484 in 1976, the Health Professions Educational Assistance Act in which the Congress declared that concern for equal access to high-quality health care involves the government in a concern for the development of manpower. This legitimates a federal role in the development of health manpower, not only that of physicians but of all other individuals involved in providing health services.

Thus it seems to me that the actions at the federal and state levels in the years since Medicare have concentrated on equal access, high quality, and the concept of rights. The programs from that point of view, I think, have been very effective. There have been some unexpected effects of the legislative intent and implementation, but nonetheless, by and large the programs have been effective.

The problem now is that there has been a ten- or fifteen-year delay in consideration of the other aspect of the national health policy, the one dealing with affordable cost. Therefore the problems of equal access, quality, equity, and rights are at the moment on a back burner and about to be compromised as the nation approaches formidable problems in regard to the high cost of medical care.

In the debates in 1976 in the Congress on the Health Professions Educational Assistance Act, both the House and the Senate introduced legislation which would regulate the number of residency positions in every specialty throughout the country. Those portions of the legislative proposals were defeated on

the floor of the House and Senate, and, instead, the Congress wrote into the legislation that 50 percent of the medical school graduates shall enter the primary-care field. They placed the burden of responsibility on the medical schools to see to it that that goal was accomplished.

When voting on that 50 percent figure, many Congressmen were very uneasy about that concept because there was an absence of data available at that time which would indicate precisely what the level was at the time the legislation was passed, how one determines national needs in the various specialties, and how one determines what the levels and needs will be in future years.

Congress was frustrated by the lack of information on that subject; it indicated that to Secretary Matthews in rather harsh terms; reprimanded the Department of Health, Education and Welfare for not gathering information which would allow the development of a rational health manpower policy; and through the Speaker of the House, Carl Albert, wrote a letter to Matthews requesting that he establish within HEW a mechanism for developing the data that would be required to rationalize a national health manpower policy.

Thus, in the closing days of the Ford administration, Secretary Matthews wrote and signed the charter creating the GMENAC. This committee's function was to advise the secretary; it had no regulatory function whatsoever. It was to advise the secretary on (1) the number of physicians needed, (2) an appropriate specialty distribution of those physicians, (3) ways to improve the geographic distribution of physicians, and (4) how to pay for graduate medical education. I would like to go through the organization of the committee, its functions, the methodology that was developed, the results, and the recommendations.

From the beginning, the organization of GMENAC was intended to provide for a collaborative relationship between the federal government and the private sector. Both sides agreed in advance that the question of health manpower and many other issues in the health field were not confined to the domain of the profession or to the domain of the government, but the day had arrived when a collaborative effort between the two was necessary.

The committee had twenty-two members, nineteen from the private sector and three from the federal government. The three government officials were high-level individuals from the Public Health Service, the Department of Defense, and the Veterans Administration.

Fifteen of the members were physicians representing many different specialties. Half came from academic life and half from exclusively private practice. Of the nonphysicians, two were attorneys (one from a large insurance

company having a major stake in health underwriting) and two were economists. There were two nurses; one ran a large inner-city health center and the other was from the labor movement. A hospital administration also served on the committee. These individuals were selected by the secretary of the Department of Health and Human Services. Many of them had been recommended by the various specialty societies, but the secretary had the final say.

Geographic considerations also entered into committee selections. In addition, there were three blacks and two Mexican Americans on the committee. I think we can safely say that the committee had a broad ethnic, cultural, and ideological makeup. And despite the diversity of the committee, the members unanimously approved the committee's report last September.

The entire staff of the operation was in the Health Resources Administration in the Office of Graduate Medical Education. There were about twenty-five employees in that office, including professional statisticians, epidemiologists, and economists. Five people staffed the technical panels or subcommittees of GMENAC on nonphysician providers, geography, modeling, education, and finance. The subcommittees were composed of GMENAC members; each GMENAC member served on two or more of these technical panels, and the staff work for them was provided from the Office of Graduate Medical Education.

The private sector contributed a great number of expert witnesses (180 physicians and 30 nonphysicians) to a modified delphi process which was established in the methodology for estimating requirements for physician services in any future year.

The GMENAC met monthly, occasionally bimonthly, for two days at a time in Washington in open public session, advertised in advance in the Federal Register and also through a postcard mailing system to 3,000 individuals who indicated an interest. The meetings were generally attended by about 100 individuals, most of whom were from the professional societies, some from consumer groups in the labor movement and other groups. The meetings were also attended by the general press as well as the scientific press. Full transcripts were made available to any one who wished them. Technical panel meetings, which were quite apart from these, were also announced and held in open public forum.

In my view, there have been three principal accomplishments of the committee. First, the collaborative relationship between the government and the profession brought to each a level of insight and understanding of the larger processes involved in elaboration of policy and the provision and funding of care, which led to a sophisticated debate that is rather unique in the health

field. Second, the methodology for determining or estimating physician supply and requirements represents innovations which, with experience and refinement, will lift health manpower planning from conjecture to a data-based science in the years ahead. Third, and more important than any of the other contributions, the report has stimulated a great deal of controversy and a great deal of insight in both the government and the health professions themselves. I would not attribute all the current ferment to GMENAC alone, but certainly it stimulated a lot of additional studies, debates, and deliberations in regard to health manpower and the physician's role in the provision of services and in cost containment.

The GMENAC was charged with the task of making recommendations which would bring physician supply and requirements into balance. We were not asked to comment about whether or not a surplus of physicians was in the national interest.

According to our methodology, we first considered physician supply with a target date of 1990. There were three direct feeds into the process: (1) the current physician supply, determined from 1978 data from the AMA master file by specialty, modified using standard actuarial techniques for death, disability, and retirement for 1990; (2) the number of medical students entering medical school every year and the number of U.S. medical school graduates subsequently entering the graduate medical educational system; and (3) the number of aliens who have studied medicine in foreign medical schools, the foreign medical graduates or FMGs, who enter the United States for graduate medical education and then remain in the United States and join the physician pool. The number in the FMG group, which in the 1960s and the early part of the 1970s was about 5,000 a year, resulted in 20 percent of U.S. practicing physicians being foreign medical graduates. That number has been sharply restricted since 1977, and this year it is about 1,600. This probably represents an irreducible minimum since most of the 1,600 enter on family preference clauses having a spouse or a close relative as a citizen of the United States.

In addition to the FMGs, another subcategory of number 3 which is particularly worrisome is USFMG--the U.S. citizen who is studying medicine abroad largely in the newly developed and substandard medical schools in the Caribbean and in Mexico. That total number in the Caribbean is almost 13,000 right now. In July 1981, 2,500 of those students returned to the United States and entered the graduate medical education system. Since those schools are not subject to the accreditation processes that the U.S. and Canadian schools are, and since

they have more or less open enrollment, they are out of control in terms of number of practicing physicians in some subsequent year unless some other mechanisms are employed to regulate their numbers.

Thus there are three feeds into graduate medical education--U.S. medical students, USFMGs and FMGs, and some current physicians--and three direct feeds to physician supply--graduate medical education, current physician supply, and the USFMGs and FMGs.

Our model of physician requirements is complicated, cumbersome, and subject to great criticism and controversy. It takes into consideration the U.S. population's need for morbidity and well care. I am not going to discuss it in detail. I simply wish to say that it is an adjusted needs-based model. It does not aim at the ultimate or ideal state for provision of medical care in 1990 but, rather, attempts to take a practical attitude, indicating that some day there may be an ideal system for medical services in the United States. For now it asks, What can we reasonably expect to happen by 1990 in regard to a great number of assumptions that go into this large-scale mathematical modeling?

According to the results of our study of physician requirements and supply, in 1978 there were 375,000 physicians in the United States and in 1990, we believe there will be 536,000. As for requirements, our modeling indicated to us that in 1978 there was a shortage of physicians of about 7 percent, and in 1990 we expect there will be a 15 percent surplus of physicians. What accounts for the steep rise in the number of physicians during the decade of the 1980s?

In 1968 in the wake of the Medicaid and Medicare legislation, there was a general perception or national consensus that there was a shortage of physicians. Inducements were provided by federal and state governments, and also from private sources, to increase the number of medical schools and the enrollment in these medical schools. As a result, when one takes the osteopathic and allopathic schools together, in 1968, there were about 8,000 entrants to medical school per year. In 1980 there were almost 20,000--that is, a two-and-a-half-fold increase in the entrants to medical school and in the number of graduates as well.

In manpower, because the pipeline is so long, when one cranks the system up in 1968 through 1975, the impact is not immediately apparent in the practice pool. But beginning in the 1980s, the entrants to medical education begin to graduate and make a large difference in supply: there will be 160,000 more physicians in 1990 than there were in 1978.

In addition to that, another factor that intersects with the importance of that increase is the emergence of the nonphysician health care provider or, for our purposes this morning, the nurse practitioner. In 1978, there were 20,000 nurse practitioners; in 1990, there will be 40,000.

Not only that, but the various Health Manpower Acts since 1965 have also stimulated the training of osteopathic physicians, chiropractors, nurse midwives, physicians' assistants, podiatrists, psychologists, psychiatric nurse clinicians, psychiatric social workers, and a whole range of other providers. So it appears to us that in 1990, despite the lower productivity of nurse practitioners and many other health providers, we anticipate that approximately 25 percent of the ambulatory medical services previously provided exclusively by physicians will be provided by nonphysician health care providers. That will compound the problem, at least in my view.

Let me just mention in passing that a surplus of 70,000 physicians, or 15 percent, is not a glut. It does not represent even a near disaster, from my point of view, but it will have certain consequences that I will deal with in a moment.

I am not going to discuss the results in regard to specialty distribution, but I will summarize by saying that shortages will continue to be felt in the psychiatric field and in preventive medicine and public health. The generalist fields of osteopathic general practice, family practice, general pediatrics, and general internal medicine will be in near balance in 1990. But there will be surpluses, some large, in most of the internal medicine subspecialties and almost all of the surgical specialties.

There were 108 recommendations from the GMENAC, and I will try to summarize them and place them into four different categories.

1. The first category is made up of recommendations that deal with the numbers of physicians. The GMENAC took an unambiguous stand in indicating that a surplus of physicians was not in the interest of the health care system and recommended that the class size be decreased 17 percent from the 1980 level, that severe restrictions be placed on the entrance of foreign medical graduates into the United States, that residency training programs in those specialties that are oversubscribed be decreased 20 percent by 1986, that no further increase in the rate of training of nonphysician health care providers be entertained, and that we encourage the surplus in the generalist fields by providing medical students and house officers with lots of information in regard to national needs.
2. The second category consists of recommendations that require medical

school and teaching hospital action. We requested that medical schools look at their curricula again and attempt to make them even more broadly based than they are today. We implored medical schools and the teaching hospitals to be more imaginative and aggressive in placing emphasis on ambulatory care. We asked the medical schools to provide a mechanism to disseminate to their faculty and medical students information on manpower data and geographic needs, and we asked the schools to increase the diversity of their students. The efforts which were made from 1968 to 1974 to increase the enrollment of minorities appear to have slowed down, and this represents a major health delivery problem, in our view.

3. The third category had to do with the geographic distribution of physicians. A considerable methodology is involved in the designation of an area as geographically properly served or geographically underserved, so I will not discuss the recommendations here in detail.

As you can see from the first three categories, most of the recommendations of GMENAC were directed at the private sector. It was the philosophy of the committee that corrective action is best brought about on a voluntary basis and that, if the information is provided to the profession, the medical schools, the professional societies, and the hospitals, corrective action would be undertaken.

4. The last category consists of recommendations directed at the federal government. Aside from special project grants for particular purposes, family practice, rural medicine, ambulatory care, and so forth, the major recommendation clearly stated that the reimbursement policy based on usual, customary, and reasonable fees needed to be reformed in order to create a reimbursement system which would help achieve national objectives in regard to promotion of ambulatory care, of care in underserved areas, and of the use of the cognitive skills of physicians--that is, use of the patient history, the physical examination, and good judgment as opposed to overuse of high technology.

The GMENAC report was published in September 1980. It has been widely discussed and circulated in many different places. What has happened so far?

1. Medical Schools are beginning to decrease their class size. I think that there is a uniform feeling or consensus, even among the deans, that a decrease in class size should occur, and some schools (Colorado, Alabama, Loyola in Chicago, and the University of Illinois) are decreasing their September 1981 entering class. My guess is that there are probably fifteen or twenty schools who have decreased their class size this September.

The deans are interested in this, I think, because the expansion of their classes has created problems of funding large faculties and has created



management problems in terms of a myriad of affiliated hospitals for teaching purposes. Moreover, the faculty members have been applying a lot of pressure on the deans to decrease class size.

2. The second result so far is that a good deal of attention is being placed on the problem of the U.S. citizen studying medicine in the Caribbean and Mexico. A widely circulated and much quoted report from the General Accounting Office indicated that the Caribbean and Mexican schools are substandard in regard to the quality of education. This report itself, I think, is substandard, but nonetheless, it is achieving a lot of notoriety, and some states are beginning to take action. New York State, for example, has indicated that it is going to accredit these schools. When the Board of Regents undertook that policy development six months ago, they did not understand the dimensions of the furor and the complexity of the problem. Apparently New York State is going to send site visitors to those schools, and almost certainly seven out of eight of them will not be accredited, which would bar their graduates or even their students from taking clerkships or house officerships in New York State.

Illinois has taken an action to require that all individuals who enter graduate medical education in our state, graduate from a medical school whose quality is equivalent to that of the medical school at the University of Illinois. The committee in Illinois looking into that has indicated, therefore, that some type of accrediting mechanism has to be in place to examine those schools, and until that happens, the committee recommended that no Caribbean student be allowed in Illinois. The Caribbean schools have sought and won an injunction against the Illinois act, and that is in the courts at the present time.

Probably most significant are the activities of the Federation of State Licensing Boards. In the April 1981 meeting in Chicago it indicated in a letter to the Caribbean schools that the State Licensing Committees and Commissions have applied pressure on the federation to accredit or to examine the schools in the Caribbean. Therefore, the federation has initiated mechanisms for attaining information initially by questionnaire and subsequently by site visit of those schools, and it has served notice on the Caribbean schools of this impending action.

The second action of the federation was a recommendation that a uniform examination--the Plex I examination--be applied to all people seeking graduate medical education in the United States and that this examination be a requirement for U.S. medical graduates. Entry into the U.S. graduate medical education

system requires successful passage of that examination.

The problems in this area are thorny. The lobby against any action against the USFMG is very strong, but nonetheless, work on the matter is proceeding.

3. Another result: The specialties themselves are directing a good deal of attention to their own training programs and are beginning to look at the GMENAC data. There are nine specialties now in the Office of Graduate Medical Education with programs to evaluate the GMENAC methodology, the assumptions that went into it, the data that went into it, and the results. So the specialties are beginning to take some actions to control and regulate their numbers.

4. Other results include controversial issues, and these can be categorized into six different controversies: The first deals with economic theory, the second with the U.S. foreign medical graduates, the third with minorities in medicine, the fourth with the role of the nonphysician health care providers, the fifth with the geographic distribution, and the sixth with the assumptions that GMENAC made in regard to specialty distribution, the fundamental assumption being that most medical care should be provided by generalists. I will focus on the economic issues.

The GMENAC recommended that a surplus of physicians be avoided and that the usual, customary, and reasonable basis for reimbursing physicians be modified. I would like to discuss the controversy that came from the recommendation that a surplus of physicians be avoided. The controversy in this regard is encompassed in the question, What's wrong with a surplus?

The economic theory of markets would predict that a surplus would do two things: It would get the physicians to practice in geographic areas that need their services, and it would have the effect of driving down the prices. But my view on that, as a lay person in economics and market theory, is that a free market does not exist, and I have tried to examine this through national statistics and also from my experiences in my own practice. The reason the free market does not exist in health care and the reason that health care does not follow the retailing of automobiles or clothing, it seems to me, is that both the buyer and the seller are relatively insensitive to the price of the product. The reason for that is that between the buyer and the seller there is a thing called the third-party payer which buffers the whole process.

The evidence for this, I think, is copious. I have my own experiential evidence on this, as well as information from GMENAC.

The GMENAC report includes a survey of the density of the physician population in the 3,084 counties in the United States. The densities vary from

county to county quite a bit, in some cases as much as twentyfold. In those areas where there is as much as a twentyfold variation in the density of physicians per capita, there is an interesting finding in regard to the use rate of medical services in those area. That is to say, if one takes two geographic areas that appear to be matched in terms of health status, age distribution, and cultural concepts in regard to access to medical care, one finds that there is an eightfold variation in use rates in those two communities. (The use rates to which I refer are numbers of visits to the doctor, numbers of hospitalizations, numbers of admissions to hospitals, days in the hospital, the use of the chemistry laboratory, electrocardiogram, endoscopic procedures, and so forth.)

This eightfold variation in the application of medical diagnosis and treatment from one community to the other is not related to differences in the health status of the populations being served, at least, not by the crude measures that we have available today. The only thing that seems to correlate with high use rates is high physician density, and it is very specialty specific. Thus if one takes two areas that are relatively homogeneous, with an equal population and equal number of physicians, but one community has a high proportion of internists and family physicians who do not perform surgery, and the other community has a high proportion of surgeons and operating family physicians, then the use rate pattern will vary. In the high medical community, you get a high application of blood counts, chemistries, electrocardiograms, and technology dealing with renal biopsy, renal dialysis, endoscopic procedures, pulmonary function tests, and so on. In the surgical community you will find a high rate of operations.

If one then calculates the numbers of physicians needed in the United States based on use rates in areas, does one choose the low use rates or the high use rates extant? For surgery we have two- or threefold variations in the recommendations for the numbers of surgeons in these fields, depending on whether one takes the low use rates or the high use rates extant in communities in the United States.

The meaning of this, in my view, is that for 20 percent of what physicians do in their practice, there is uniform agreement as to its utility or efficacy, but for 80 percent of what we do in practice, there is no consensus as to its usefulness. We call that 80 percent of the procedures and processes having a broad discretionary zone "high physician judgment," without evidence indicating that one process is better than another. There is no evidence, for example, that hypertension, which is a major killer, is treated better with twelve visits a

year than with three. There is no evidence that the patients hospitalized on internal medicine services in urban areas in the United States and who on the average have nearly three chest X-rays per hospital stay are any better off than individuals hospitalized in smaller community hospitals in rural areas who have less than one chest X-ray per hospital stay.

Therefore, the broad discretionary zone needs study to narrow it so that we can be sure of the effect of use rates and the quality of outcome. But we do not have that information at the present time, and what we have to deal with are some facts.

The facts are, in my view, that, first, the supply of physicians is independent of market forces. The medical schools are not interested in regulating their class size in the market.

Second, the supply of hospitals and hospital beds may be somewhat controlled by market circumstances, but only inefficiently because the physicians who are ordering hospitalization have a great elasticity in their discretion as to whether or not to hospitalize.

Third, as we have seen from the data, the demand for services increased with the availability of services--just the opposite, perhaps, of what one might expect.

Fourth, in regard to pricing, the unit price for services is only inefficiently related to need versus demand. This applies, I think, to physician services as well as to hospital rates, only inefficiently controlled by market circumstances. Finally, the geographic distribution of physicians is controlled somewhat by physician density in a particular area, but that control is very inefficient. I would guess that controls on geographic distribution really do not become tight until the supply of physicians reaches a very high level and extends the elasticity to the limit.

The dilemma about this is that establishment of a free market, if that is what you think is needed, probably requires the elimination of the present reimbursement mechanism. It may require elimination of some of the third-party payer systems, at least those that depend on the UCR system. It may also require that we remove government subsidies for medical education, because I really do not think that the expenditure of large amounts of government funds for medical education can continue without some system of public accountability, and that system is likely to interfere with the development of a free market. Thus establishment of a free market would require 'establishing students' responsibility for the cost of their own medical education. It seems to me,

therefore, that what is required to establish a free market represents a formidable obstacle against its establishment, so I am not at all confident that a free market can be created.

However, in my view, I think what we can look forward to is a physician surplus. What will be the consequences in 1990 of a physician surplus?

There will be 40 percent more physicians than there were in 1978. This will result in higher physician-to-population ratios. It will improve the geographic distribution of physicians and improve access to health services. With the higher number of physicians, we are destined for higher utilization rates. The price per unit service will continue to rise, and the overall costs of medical care will continue to rise, occupying an increasing proportion of the GNP and of federal and state expenditures.

The impact of the surplus on physicians will be to increase their attraction to salaried positions. Physicians will seek economic shelter in HMOs and prepaid systems of many sorts and in government service positions in prisons, in Veterans Administration hospitals, and in the military. The surplus of physicians will establish and make more popular the large multispecialty group practices. To the extent that the HMO movement has been limited by reluctance of physicians to join the plans, that limitation will be decreased, and I would expect the HMOs to receive some impetus in a positive direction as a result.

The pressures to decrease the number of foreign physicians entering the United States will continue or grow, as will the pressures to decrease the number of U.S. citizens training in the Caribbean, Mexico, and proprietary schools. That problem will be brought under some kind of control. We can also expect an increase of pressure on medical schools to reduce the numbers of medical students, and I think that a 15 or 20 percent reduction will be experienced over the course of ten or fifteen years. In view of the perception of a surplus of physicians, government support for medical schools will decrease even further, with the result that tuition charged to students will rise. There will be an increase in student indebtedness and, I think, a decrease in the number of applicants to medical schools.

What actions can be taken in response to all this? First, I think we recognize that the system is very complex, and therefore whatever action is taken should be modest, conscious, integrated, coherent, high on quality, small in size, and relatively frustration resistant--if you can imagine such a thing. A number of steps are being taken already.

The medical profession is looking into itself in a way that it had not

before, and it can be relied on to bring about some change, particularly in regard to the numbers of physicians or the specialty and geographic distributions. However, I think that the reorganization of medical practices to control costs is a matter that will have to come to the profession from outside. My guess is that there will continue to be diversity in the programs implemented to accomplish that goal.

The system is extremely complex, and it will be difficult to avoid abrupt, disjointed actions in response to the problems. However, my experience over the last three years on GMENAC is that, when the profession, the government, public needs and expectations, biomedical research developments, and time can be brought together, remarkable integration can occur in planning. And integrated planning can result in some actions.

CHAIRMAN MORTON: Since Dr. Tarlov will not be available later, this is the time to ask him questions.

HERBERT E. KLARMAN: I wonder whether you have given thought to this question; it is really an ethical question. Let us say we take seriously the recommendation that the number of physicians be reduced, that we cut down the number of students accepted, and, even if the number of applicants would decline, I think it is reasonable to expect that the number of qualified applicants will still exceed the number accepted. Then how would you go about rationing the number of spots, and indeed, how do you justify this in a relatively free country? After all, people feel quite free to follow any occupation they choose.

DR. TARLOV: I think that is an excellent question, and that arises all the time when we are debating the question of the United States students in the Caribbean. An ethical question, I have learned, does not diminish in importance in regard to the size dimension. So what I am about to say apparently has not very much ethical currency, but let me say it anyway.

Last year there were 36,000 applicants to medical schools in the United States. There were roughly 20,000 places, so 16,000 did not get in. However, of the 36,000, a great many were individuals who were applying for the second and third time, so that the ratio of the number of first-time applicants to the number of available positions is 1.2. I think that the ethical problem of disappointing 20 percent of the applicants is as significant as disappointing 40 percent of the applicants. But if I followed your line of reasoning, I think that we would have to create an open enrollment in medical education--as there

is, for example, at the University of Paris and in the Dominican Republic--and then allow the system in the medical schools to prune the classes so that the graduating class is somewhat smaller than the entering class.

But I do not think that open enrollment can be instituted in the United States because medical education is so expensive. A great deal of it is supported by the tax dollar, and politically it would not be reasonable to expect that the nation would expend that money in pursuit of freedom of choice of profession.

GEORGE BUGBEE: Dr. Tarlov, in your discussions in GMENAC, did you think of anything that might have been done to prevent this country from having such a great percentage of physicians with a very poor grade of education, either as foreign medical graduates or American citizens graduated from foreign schools? Was there anything that could have been done twenty years ago to avoid that?

DR. TARLOV: I am a newcomer in public policy, but I find it fascinating that in 1965, for example, we had this affordable cost concept but paid no attention to it in our pursuit of the other goal of the national health policy. Now, fifteen years later, we are retreating on some of the promises in order to catch up with cost control.

Between 1965 and 1970, or 1962 and 1970, when there was a perception of a shortage of physicians, there was no methodology available (maybe there is none today) to determine the requirement for physician services. There was no supply model to estimate the numbers of physicians in a future year, say, a decade down the road. So what happened was that all of the controls were released, all the inducements that could be imagined were applied to the system in the post-Sputnik, post-World War II science era when anything we wanted to do was possible. So we relaxed the immigration regulations and allowed 120,000 foreign-trained physicians into the United States on the basis of passing a state board examination which at best was cursory and did not assure a reasonable standard of either education or practice. But you see, at that time the question of quality was superseded by the question of access, the challenge of access. I find that fascinating; it happens all the time. There are conflicting goals. Or, the goals may not be conflicting but the solutions applied to one of the goals is contrary to the achievement of the other goal. And so we made a big mistake.

The Caribbean problem is simple to me, but it turns out to be very complicated to a small number of people and a small number of institutions--who, nonetheless, are very forceful politically. The PLASMA group, the Parent

Liaison Association for Students of Medicine Abroad, has 13,000 students, and each one of them has two parents, so that group is 26,000 parents. They are concentrated where their voices are heard, that is, New York, Pennsylvania, New Jersey, and California, and they are very effective as a lobby group. The other group, you could call it a lobbying group as well, is made up of a number of large urban hospitals which depend on foreign medical graduates for services in those institutions.

Thus many times a well-intended program is implemented and has unanticipated consequences; at other times, the consequences are apparent but the desire to achieve a certain goal places those consequences in a shadow, but only temporarily. That is my layman's interpretation of what is happening in health policy.



## PANEL REACTORS

Reed L. Morton, Chairman

CHAIRMAN REED L. MORTON: We are prepared to begin the reactor panel. To begin, George Bugbee has volunteered or has been drafted to provide a few comments reflecting on the symposium.

GEORGE BUGBEE: I think I should start by saying that it is no small honor that this symposium is named after me, and I appreciate those who thought of doing it.

Since 1962 when I came here, the symposium has seemed to me a venture well worth a good deal of the faculty's thought in developing subject matter. It is always a problem to be sure that knowledgeable people are going to discuss the subjects, and I certainly put a good deal of energy into trying to do just that. I think that some of the Proceedings are really a contribution to the literature in the field on various points.

This symposium seems to me unusually well structured on a major issue that we are all hearing and talking about without knowing exactly what is meant, and I think Odin Anderson assembled an unusually able group. I like the participation of members of the faculty and of the university and of people involved with the Center for Health Administration Studies.

The program has been going through a period of transition from practitioners to people more properly equipped for faculty recognition in this university. In this setting, the sort of research that the center has carried on becomes an important contribution to our understanding of the field, and I say important because I know, from working with Odin, that the research projects are not picked randomly. They are chosen because the problems being researched are major problems in better distribution of medical care and better understanding of the forces that are affecting the distribution of medical care. I think Lu Ann's paper was an unusually good example of such research.

Earlier I said that I think that the Center for Health Administration Studies program is one of the best, if not the best, of its kind. It certainly has one of the best core curricula in this business school (which is one of the best in the country), but it also has the merit of affiliation with a faculty from the health side that, through research, has really fundamental knowledge to communicate to students--and they do so. I know there are alumni who regret that the program lacks a practitioner like Ray Brown who knows the field and speaks for the practitioner. (Talk about security nets--Ray was a security net for the

alumni of this association.) However, from the standpoint of an educational program of merit for students, I think the program is at the high point in its history, and I compliment the group that is now struggling with it. It is not an easy job.

I hope those comments are germane. I mean them very sincerely.

CHAIRMAN MORTON: I believe Rich Foster also has some comments.

RICHARD W. FOSTER: I have some selective comments on the proceedings thus far and on what seems to be occurring. It would be presumptuous to try to summarize all that has gone on in the last couple of days, so I will just mention a few items.

The first is that everybody is now aware that there is a new religion out there, and the new religion says that competition is good for what ails you. But I think we are also seeing, and we have seen it particularly the last day and a half, yet a newer phenomenon. I feel a little cautious about this, a little bit like the networks on election night, being the first to detect a new trend or something like that, but it seems to me that we are also seeing a new, new religion. This new, new religion says that competition and regulation are not alternatives, that in fact, you get regulation along with competition.

This new, new religion comes in varying forms. In its mildest form, it says simply that it is not practical to eliminate regulation altogether. I do not think that anyone, certainly not I, would dispute that point. In its strongest form, it says that we are going to have just as much regulation with competition as we did before, but it will be a different kind of regulation.

I think that Herb Klarman's comments last night are quite appropriate: posing the issue as competition or regulation is a false dichotomy. In fact, as a practical matter, the issue concerns what kind of balance might be struck between the two. It is very difficult to say what the balance is, so I thought I might use the classic straw man approach and comment on the straw form of the new, new religion. I hope the comments are relevant to some thinking about where the appropriate balance might be in the future.

It is worth noting some of the remarks that Lu Ann made about the Twin Cities experience, which many people cite as the leading case study in the new competition. Only one of the seven competing HMOs in the Twin Cities area is federally qualified, and that clearly is by choice of the HMOs in the Twin Cities: they did not want to become federally qualified. As Lu Ann also pointed out, the distinctions between the federal HMO criteria and the state regulations in Minnesota are worth noting. The state regulations in Minnesota

for HMOs are much less restrictive than the federal HMO requirements, so that, to the extent that the Twin Cities turns out to be a model for much of the rest of the country, it suggests that some of the new, new religion is carried much too far. I am sensitive also to the point that has been raised at various times in the symposium that the Twin Cities is not a proven model for the future, that there are still a lot of researchable questions about just how well it is working or will work.

The second point I wanted to mention was that we have heard, and will continue to hear, a lot about selection effects. I want to contrast some of the selection effects that we heard about yesterday with some of those we are hearing about today. In particular, yesterday we heard much from the panel about selection between high-option plans and low-option plans, with examples in which the healthiest members of the group tended to select the low-option plans. In contrast, in the Twin Cities, if we think of HMOs as generally being high-option plans in terms of their coverage, a great problem in attempting to interpret the Twin Cities' evidence is the suspicion that the healthiest members of the population have selected themselves into the HMOs. So I think that there is much that needs to be explored in terms of how people make those choices, how the different plans might market themselves, and how all this contributes to different selection effects. This is an area that we will be hearing a lot more about in the future.

These are some of the things that particularly struck me during the symposium.

CHAIRMAN MORTON: Perhaps other panel members have prepared some comments that they would like to offer.

LU ANN ADAY: I have not prepared comments, but I would like to underline a few of the things that are happening in the Twin Cities which may be foci to which we want to look in understanding the viability of some of these choices which are being proposed; then I would like to consider further one of the questions that has been asked.

First, the role that the employers are playing in the Twin Cities, particularly with respect to the amounts that they provide to enrollees and their particular relationship to these alternative provider arrangements, represents an area in which we might begin to examine facets of some of the procompetition proposals before us. Aspects of these proposals are represented in the Twin Cities health care environment, and they should be studied there.

A second thing we may want to examine is the Medicare demonstration

experiment going on in the Twin Cities as well as some other cities. The enrollment of the Medicare population in HMOs is still a very small number.

The third area for examination, related to the first, is the role that the various competing provider groups play, the dynamics of interaction among those provider groups, and the impact of this environment on the behavior of the providers themselves. How, indeed, is physician behavior at the point of contact with the patient influenced by the sorts of financial incentives or organizational structures in which the physician operates?

Questions such as these are still unanswered, and the HMO environment of the Twin Cities provides a particularly relevant laboratory in which to examine them.

MR. BUGBEE: You said that your account was just a preliminary report; you are continuing it?

DR. ADAY: Oh, yes. We are in the first few months of a study to try to understand the historical development of HMOs in the Twin Cities.

HERBERT E. KLARMAN: On reflection, I wonder whether we can separate the question of what competition is from the question of whether competition is desirable. Members of the Chicago school of economics are very relaxed about what is meant by competition: they want it to be approximate and workable, in contrast to other schools of economic thought which have been very strict about the requirements for competition and have therefore, perhaps, gone much further in intervention. As you know, the Chicago school of economics is very strongly opposed to intervention. Therefore, they would be much more relaxed about what constitutes competition.

Now, if you take the relaxed view of competition, it seems to me that all you are talking about is large numbers of buyers and large numbers of sellers who act as if they had no influence on price. That, I would say, would be a definition that nobody would object to, and it is as relaxed as we can get.

It seems to me that what hospital people talk about when they talk about competition is really rivalry. I do not know if economists use that term in any uniform way, but typically, when they talk of rivalry, they are really talking about an oligopoly situation, small numbers of units which may play all kinds of games with one another. So oligopoly is not the same as competition, and I suggest that perhaps we ought to try to distinguish that.

When you deal with the procompetition proposals, I am not at all sure that it is always clear whether proposers are using the concept in the layman's sense, as would a hospital administrator, or whether they are talking like economists. But I think it may be worthwhile taking that back with you so that you can ask

yourself, On which side of the line does a particular proposal fall?  
Now, this is quite separate from the issue Burt Weisbrod addressed, namely, whether a certain situation is a good thing or a bad thing. I do not know if there is any economist who would take the position that rivalry or competition is always a good thing.

You can easily find situations in which you do want intervention. Then one must ask, If you do want to intervene, what are the forms available? Most of us, of course, think of government and of the market as the only two alternatives.

There is a very small group of economists (among whom are Burt Weisbrod and, perhaps, Kenneth Arrow) who always emphasize the importance of the voluntary, nonprofit form of organization for various reasons. I would merely point out that in the health field this form is something one does not have to invent: it is there. The question is, Does it fulfill the role of giving one a nonmarket form of intervention? Is it better than the market would be? Is it better than the government would be?

CHAIRMAN MORTON: Odin.

ODIN ANDERSON: The remarks I am going to make will have an aspect of asking for your mercy because I am the principal investigator for this Minneapolis-St. Paul project, which has an excellent but small staff and is fairly limited financially and in terms of the possible scope of exploration. I do not want anyone to expect too much in terms of fairly definitive results or generalizations from a two-year, \$85,000 project in which we do not have enough money to do any, you might say, original research, other than to ferret out the existing data which were collected for reasons other than research. The original aspect of the project may be that we are going to interview a fairly well-selected set of influentials in medical societies, insurance companies, hospitals, and the business community.

What I hope to do--and I am largely responsible for a major part of the report--is to write as thoughtful and as careful a report as I can with the available data and to pose problems and try to arrive at some generalizations which will enable us to think about these issues more clearly, perhaps, than we have done so far. I would also hope that by finding some veins which need further exploration, we will have even more to learn. Give us some more money, and we will find out some more.

I also want to mention how I find the atmosphere in the Twin Cities area: there is excitement there among the main people who are working in the HMOs and in the hospitals. I get a sense that they are on the frontier of something,

something different from what is happening in other areas. There is an enthusiasm, particularly among the newer HMOs, for great entrepreneurship and getting out into the market. There is a dynamism which I find exciting, and also there is great acceptance of this research. Everyone with whom I have been in contact is interested in a research endeavor which will, perhaps, help them understand what is going on in the Twin Cities.

I will conclude my remarks by going abroad. When I am in the United Kingdom, the problems, at least as far as the administrator, and maybe also the Treasury, is concerned, seem rather simple. Their health care system is highly structured. They know where they stand. They know how much money they have. If they have a problem, they restructure. For a few days, I feel a sort of comfort in knowing what the score is. But after I have been there for about ten days, I get tired of it and feel highly constricted as I talk with the administrators.

Then I come back to this country, and I almost experience a culture shock because the situation here is an open, steaming caldron; here I feel a lack of structure, and I get a bit lost.

In Minneapolis-St. Paul we may be moving into a structured situation which can also be highly dynamic because our pluralism is really quite chaotic. Drawing on Walt McNerney's terminology, I suggest we need a structured pluralism in a semicompetitive situation. Perhaps the Twin Cities can show us how this may be done.

I may also add that I am very pleased to have this project because it keeps CHAS staff and myself visible in a very topical area. I am always afraid I am going to disappear because of a lack of significant problems to work on.

CHAIRMAN MORTON: To insure that Odin does not disappear immediately, I trust there are some significant questions.

ROGER C. NAUERT: I wonder if the panel members would forecast for us the impact, over the next three to five years, of competition in all the marketing initiatives and as it might relate to a national health care policy. I wonder if you would also offer your recommendations on providing for the health care needs of the elderly, the poor, and the near poor--the people who now qualify for Medicaid because of absolute poverty and a growing number of people, generally referred to as the marginally poor or the working poor, who neither qualify for Medicaid nor have jobs which offer health insurance or other types of prepaid coverage, nor have the discretionary income to pay for health care.

DR. ANDERSON: The HMO development and competition concept has nothing to do

intrinsically with the aged or the poor or low-income people; rather, it has something to do with restructuring the delivery of health services. Provisions for the categories you mentioned have to be made through some other means, through subsidies or vouchers. So I do not think that the HMO development necessarily has anything to do with these particular problems. The HMO concept aims mainly at efficiency, cost containment, and so on, while the other categories of people you mentioned have to be provided for by a separate policy regarding delivery systems.

DR. FOSTER: I would echo what Odin says but add the comment that I think there is reason for concern that, since we are focusing on cost containment in the years ahead, there may be some cutbacks on services to some of the groups you mentioned. Some of these cutbacks may be promoted in the name of competition. I am concerned that competition will get an undeserved bad name as a result of that.

DR. KLARMAN: I think I did say last night that the problem of long-term care, by which we typically mean the old people, had been neglected in these proposals. However, it is fair to say that this problem is neglected in almost every proposal. Somehow we are not quite willing to face it.

As far as the poor and the near poor are concerned, there is an interesting split, I think, between Havighurst and Enthoven on this. Havighurst says that the usual channels, the traditional arrangements ought to be able to handle the small problem. He does not see any difficulty, whereas I do. I do not think that today the safety net, as we call it, is as wide and as strong as it used to be; I think that Havighurst is rather optimistic.

Enthoven suggests that we have an equal amount of subsidy made available to everybody, whether from an employer or, for the poor, from government. He would probably use the tax system to handle the near poor.

I would argue that if we did this, it would be very costly. I have not seen any estimates, but it strikes me that if you take all the people who would not get the subsidy from employers and give them a subsidy from some other source, namely, government, that would be a rather large sum. I do not see the federal government or anybody else assuming that kind of responsibility.

So my guess is that we are not going to be taking care of that problem of health care for the old, poor, and near poor. But Odin's comment is well taken: the HMOs and competition have to do with the organization of the system, so if you want to take care of the problem of delivery, you have to address it directly.

CHAIRMAN MORTON: Are there additional questions?

MR. KELLY: I would address this principally to you, Lu Ann. One of the first comments I heard about the HMO idea from people who were working in health administration was: I wouldn't go to a physician for whom there is a financial incentive to deny me services.

I wonder if there is anything from the Twin Cities experience to suggest that people realize that, first, they are ignorant consumers; second, there is a discretionary zone in medicine where treatment may not be efficacious, and part of the appeal of signing up with an HMO might be, "This will keep me out of a hospital. This will keep me from being a victim of overpractice." Is there any evidence to suggest that that is a factor which is now attracting people to HMOs?

DR. ADAY: I would like to respond from two perspectives--that of the consumer and that of the provider. I do not think that consumers really conduct analyses of their decision making in those terms. That is, I do not think that the consumers' decision making is so sophisticated that, in choosing particular health care options, they consider the providers' settings as something which could significantly affect their case. I think that other kinds of considerations influence consumers, and various factors which determine why consumers do enroll have been examined. Risk vulnerability is one; consumers have certain perceptions of their health care needs, and they look at the benefit packages and options offered with an eye to covering their need bases.

I am not sure that the consumer thinks about how his or her physicians might behave in terms of particular decision making. I think that the consumer still defers to the provider's decisions without analyzing how they are made.

When you ask consumers about how satisfied they are with the HMOs they have joined, you find relatively high levels of satisfaction, but consumers tend to report relatively high satisfaction regarding their care in general. There is some evidence from the consumer satisfaction literature that consumers in HMO plans are concerned about the inconvenience of getting appointments, and they think that waiting times tend to be longer. So there is some dissatisfaction expressed in that respect. But if you look at behavioral expressions of people's satisfaction, you see that people do remain in those plans: a survey that was carried out by Kaiser of public attitudes toward HMOs suggested that current enrollees were not terribly interested, in the main, in switching from their HMOs to some other plan. Thus, although there are some levels of dissatisfaction, people do speak with their feet, they do remain in the plans.

As for the physician's perspective, this is a very interesting matter. We



have tried to examine the question of how these various financial incentives and modes of delivery may influence physician decision making at the patient-contact level. In attempting to come up with a design to measure that, to understand the dynamics of it, we hypothesized that those kinds of things do operate at the point where physicians make decisions about how care is to be rendered for individual patients. However, in talking with some opinion-leader physicians in the Twin Cities area about that, we found that physicians do not think that they operate at that level; from their perspective, their decision making is not necessarily driven by financial consideration. Rather, physicians see themselves as having certain norms of practice which pertain to certain professional settings; some groups of physicians may have professional norms which differ from the norms of other types of physicians. But from the physicians' point of view, financial incentives are not very operative.

So I think that is a black box in terms of precisely how it operates in the physician's setting and from the consumer's point of view. I think that in large measure, consumers are relatively satisfied, and perhaps it is convenience more than quality of care that is of direct concern to consumers.

DR. KLARMAN: Among economists, there are, as usual, two schools of thought on this. One I would associate with Victor Fuchs, and it maintains that one of the things you teach medical students and residents is to take cost into account. There is also the Rashi Fein school, which would maintain that one should not go to a doctor who takes costs into account when treating patients. The system at large makes these decisions, and within the available resources, the doctor decides which of his patients will get what.

Perhaps it is not a matter of norms versus financial considerations determining the doctor's treatment of patients, if we ask, What determines the norms? Perhaps norms and finances are not in such opposition to one another. We all, including physicians, rely on norms and routine in our decision making, so we do not always think through every decision.

I cannot recall the exact words, but there is a very well-known quote from a distinguished economist, John Maurice Clark, and the gist of it is that we have this monster of an economist who has this irrational passion for dispassionate calculation. Well, I do not think economists do this, and I would not expect doctors to do it, so I think the real question has to be changed from, What happened at the point of treating the individual patient? to, What determines the norms of practice, and are those going to be influenced?

CHAIRMAN MORTON: Additional questions from the audience?

ROBERT C. HARDY: When we talk about competition, we look at the marketing. When we think about the marketing, we look at the business model. We differentiate competition from rivalry, but the business people do not do that.

We are beginning to see the tip of the advertising iceberg. A hospital in San Francisco is advertising its clinic over the radio, and as a result, it doubled the number of patients coming into the clinic.

I was wondering if this group of experts could look into the crystal ball and tell me where we are going as far as institutional hospital advertising is concerned.

DR. ANDERSON: I think it will increase. It will take a certain form--discreet, presumably. The advertisements will not, or should not, guarantee anything.

CHAIRMAN MORTON: Are there any other views on advertising? Other questions? Other comments from the panel?

If not, next on the agenda will be next year's symposium. We are certainly open to any of your suggestions, and we will take them into account.

We want to thank you for your attendance and participation, and we thank the panel as well.

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