Rural Health Care:

Improvements Through Managed Competition/Cooperation

A Draft Discussion Paper

from the Jackson Hole Group

INTRODUCTION

Sparsely populated, or rural, areas present unique challenges to health care delivery systems. It has been suggested that managed competition as described in the Jackson Hole proposals will not work in such areas. Pure managed competition, however, is not the most appropriate model for rural areas. This paper offers a proposal for those areas where pure managed competition will not be operative.

This paper discusses some of the major issues that must be considered in attempting to help those delivering care in rural areas achieve their mission. It also presents for discussion a model based on the infrastructure of managed competition but applying "managed cooperation" in areas where competition fails to achieve the goals of insuring access to quality health care for rural and frontier Americans. Recognizing that there are a variety of thoughtful and creative experiments in delivering health care ongoing across rural America, this paper offers rural health care experts the opportunity to explore those ideas in light of the concepts of managed competition and cooperation offered here.

The body of the paper carries a misleading interventionist tone. This is because the paper devotes substantial attention to the exception areas that may necessitate some form of public intervention. These are likely to be the true frontier areas of the country. Less attention is focused upon the majority of rural areas where managed competition, through flexible AHPs, can improve the quality and control the costs of health care without public

intervention.

FACTORS CONTRIBUTING TO LIMITED ACCESS AND QUALITY OF CARE

Demographic Factors. Rural health care suffers primarily from the problem of access to primary, secondary, and tertiary care, stemming largely from a shortage of health professionals. Geographic/climate barriers such as mountain ranges, bodies of water, severe weather, lack of good roads, sheer distance, and unique demographics all contribute to the problem of access.

Rural residents are excluded from the mainstream of employment-based health insurance since many are unemployed, self-employed, seasonally employed, or employed by small businesses (NRHA, 1992). Accordingly, a larger percentage of rural Americans are forced to purchase insurance in the individual market than their urban counterparts. Rural Americans are at a disadvantage due to both their socioeconomic and occupational status.

Rural populations (27% of the total U.S. population) have a larger proportion of citizens below the poverty line than the rest of the population, with the exception of inner cities (NRHA, 1992).[1] While accounting for slightly more than a quarter of the U.S. population, rural areas account for about one-third of the total population living below the federally

[1]The definition of rural used in the National Rural Health Association policy paper is non-metropolitan residents.

defined poverty line (OTA, 1990). Agricultural workers account for 3% of the work force and 14% of work-related deaths, putting farming ahead of mining as the most dangerous profession in America (Ingersoll, 1989). Such risk factors push the already high individual market premiums faced by rural Americans even higher. Rural America has also been particularly hard hit by the economic downturn of the 1980s. In 1982 the rural unemployment rate was 10.1%. By 1985 when much of the country was beginning to recover, it had dropped to 8.4%--still higher than the urban rate. These factors contribute to the higher uninsured rate--14.5% in rural areas, compared to non-rural areas -12.3% (Ries, 1987).

The above socioeconomic factors contribute major barriers to access to the health care system. The result is that rural residents postpone health care until their health problems become acute, or go without care altogether. This leads to increased long term system cost.

Workforce Factors. Recruitment and supply of primary care physicians is a significant problem throughout the American health care system, but the shortage is especially acute in rural areas. Small town practices are extremely demanding and usually lack the support and back-up systems available in cities, making it difficult to recruit and retain good physicians. The small-town physician has the same expenses as any other physicians, yet frequently lower and more uncertain sources of income, and often practices under adverse conditions. In addition, our medical education system is biased toward training specialists, rather than the generalists required in rural practices, resulting in an insufficient pool upon

which to draw.

Reimbursement Factors. Due to the high percentage of Medicare and Medicaid recipients in rural areas, rural health care practitioners and hospitals tend to be more dependent on government revenues than their urban counterparts. This reliance and the inability to shift costs prevents reorganization of facilities and services to better meet the needs of the population they serve. The Federal EACH/RPCH program and state programs in Montana, California, Kansas, Maine, Wisconsin, Oregon, and Florida are experimenting with this kind of reform now. Some of these programs have not realized expectations however, since they are still tied to the traditional segmented health system and cost-plus incentives, or are burdened with stifling regulations.

BACKGROUND - MANAGED COMPETITION

The pure model of managed competition implies more than one, and ideally many, Accountable Health Plans (AHPs) competing on the basis of cost and quality. Kronick et al. have suggested that managed competition may not work in rural areas, noting that a population of 1.2 million would be required to support three AHPs providing comprehensive services, 360,000 to support three AHPs providing primary care and shared tertiary care, and 180,000 to support three plans providing primary care. A cut-off at 180,000 encompasses 71% of the U.S. population.

We feel this study may underestimate the flexibility of managed competition (AHPs in particular). In some rural areas competition may occur among smaller, primary care facilities, or simply primary care providers. These facilities will be either independent organizations (AHPs) that contract with other providers for specialized care, or branch offices of urban AHPs. A small population can support this type of competition. For example, although an area of 20,000 could not support three comprehensive AHPs, it could support three competing primary care facilities. In areas with a very limited number of providers, competition between AHPs could take place within individual providers. That is, the provider would contract with multiple AHPs and the individuals would choose which AHP to join on the basis of other services, such as referral networks, and access to specialists, as well as cost and quality.

Under managed competition urban AHPs will be encouraged to set up branch offices with subsidies targeted for rural areas —or through demands from the large purchasers (government, large employers or groups of small employers). Fair rates of Medicare and Medicaid reimbursement (ensured through HPPC purchasing) will also entice urban AHPs into rural areas. Competition will occur as AHPs attempt to expand market share, and rural providers band together to form AHPs. The size of the population base will dictate the exact scope of services rural facilities can efficiently offer on site. It is important to note that the nature of competition in rural areas may be quite different than that in urban areas. Access is the major problem in rural areas. Therefore, rural consumers will be most sensitive to improved access. Accordingly rural AHPs will devote a larger percentage of

resources to improving access.

We believe the managed competition model to be ideal in its pure form for many rural areas as well as all urban areas, and the structures of managed competition to be the best framework in which to improve health care in the remaining rural and frontier areas. Some sparsely populated areas will clearly not support a competitive (market) model. The following proposals build upon the infrastructure of managed competition to provide a means of delivering care efficiently to our remote ares. In rural areas cooperation will replace competition as the factor most critical to success.

PROPOSALS

The problem of improving access to, and quality of, health care in rural areas can be approached from the perspective of 1) states with both large urban populations and substantial rural areas such as New York and Michigan, and 2) "frontier states" such as Wyoming and Montana where the entire state could be considered "rural." In both situations it is accepted as a given that pure managed competition will not work well where a single AHP is operational. Therefore we propose that "managed cooperation" be applied to achieve the goals of improving access and quality of care.

Rural AHP Authority (RAA). The RAA will be responsible for ensuring that tax-preferred, AHP, health care is available to rural Americans. As a general facilitator and advocate the RAA will utilize two explicit tools: subsidies and exclusive franchises. RAAs will foster community cooperation in areas where a single AHP is appropriate, and competition in areas where that is the preferable model, but not yet fully realized.

Subsidies. Subsidies will help offset high per capita fixed costs in low population density areas, but will not be as effective in helping to offset the costs of infrastructure development. Accordingly, subsidies will work best when the health care infrastructure in place is sufficient to allow AHP formation without large capital investment. The capitation subsidies will be overt, to prevent distortion of other premiums through cost-shifting.

Exclusive Franchise Agreements. When substantial investment is necessary and existing infrastructure and providers are minimal, as will be the case in some of the most remote areas with lowest population density, RAAs may have to offer more attractive enticements to persuade an AHP to commit to an area. The RAA will need government funds to distribute to facilitate development. In some cases these funds could be granted in conjunction with an exclusive franchise. In this case, the AHP would set prices with the approval of the HPPC. Any franchise agreement would attempt to ensure that residents in the area receive affordable, quality care, and would be awarded only after a competitive bidding process. Bidding AHPs would agree to charge certain premiums in exchange for a given amount of governmental assistance. Franchise agreements will work best in rural areas near urban areas where there will be AHPs with the necessary capital and expertise to make such an investment.

In rural areas where there is an existing network of providers, but population densities and distance to the nearest urban center inhibit competition, the RAA will encourage the development of a cooperative, community based AHP. In these areas there will be more to be gained from cooperation among the providers than from competition between them. The cooperative model will be pursued in areas where existing provider networks are, to an adequate extent, in place, but that can not support competition. Of course the RAA will continue to facilitate competition in areas that can support it. Managing this competition-cooperation continuum, and determining where rural areas lie, will be a major responsibility of the RAA.

Managed cooperation would entail facilitating the development of regional or state wide networks of providers to form AHPs. The "managed" part would entail the following RAA responsibilities:

1) assisting with network development utilizing existing providers

2) facilitating the appropriate model --competition versus cooperation

3) helping to obtain the proper balance of primary and secondary care facilities

4) helping to coordinate an arrange for needed tertiary care

5) providing subsidies or exclusive franchises as required to ensure provision of quality care

6) assisting with the recruitment of primary care physicians and specialists

7) managing the interface between urban and rural areas

Urban/Rural States. In states with both large urban areas and underserved rural areas the RAA will need to pay special attention to the interface area --the area where urban based AHPs are branching outwards and rural providers are organizing independent AHPs. By encouraging both of these activities in an appropriate mix, the RAA will attempt to extend competition to as large a portion of the state as is warranted. Outside of these areas, though, the RAA will pursue "managed cooperation" and will facilitate network development.

Frontier-Like States. In states that are for all practical purposes "rural" or frontier-like the RAA will focus on the network development, and cooperative activities

A major decision to be reached in sparsely populated states such as Wyoming is whether or not to establish a single state-wide AHP or several regional AHPs. Such decisions are appropriately left to the states. A second major decision will be how to handle tertiary care -i.e. to attempt to keep as much as possible in state or continue to use existing referral patterns which frequently extend out of state. In such instances quality of care and patient choice (given appropriate economic consideration) should be given preference over political and territorial considerations.

Although the Jackson Hole Group maintains that a majority of rural areas will be served by competing AHPs, it avoids categorizing rural areas. The group realizes the diversity of rural conditions and present delivery systems. The decision to pursue a more cooperative model in frontier areas, as opposed to a competitive one, will be a local one made by the RAA with input from all concerned parties including: providers, consumers, employers, and government officials.

The RAA will act as a rural advocate. Its duties will include encouraging development of infrastructure to be shared by AHPs. For example, communications systems could be shared by rural providers to reduce overhead expense. The RAA could also coordinate among the local AHPs the efficient delivery of emergency care. The RAA might also coordinate public health programs among government entities and AHPs. The RAA will also perform consultative tasks, and will take steps, including the organization of purchasers, to attract AHPs to an area before subsidies are given out. As an organization

interacting with all AHPs in a region it will be in a position to offer help and advice to rural AHPs on a continual basis.

Health Plan Purchasing Cooperatives (HPPCs). HPPCs will perform the same functions in sparsely populated areas as they will in urban areas, but will assume additional monitoring and regulating functions in order to assure adequate care is provided in rural areas under their jurisdiction. HPPCs will be charged with monitoring AHPs that operate under an exclusive franchise and/or without competition for other reasons. The later are likely to be cooperative AHPs or AHPs that have carved out a unique market niche. In areas where market forces are inadequate, in terms of meeting cost goals, the HPPC will need to compensate. HPPCs will concentrate more on cost goals because access and quality issues will be built into AHP accrediting requirements and focused on by the RAA. In evaluating AHPs, HPPCs will utilize benchmarking standards, including premiums charged by other AHPs, non-competing rural AHPs in particular, as well as standard outcomes data.

In many cases an AHP that is the sole provider in a sparsely populated area might also provide care in a highly competitive area, providing the basis for a comparison of rates to a competitive area. Legislation forbidding, or limiting, geographic rate discrimination could reduce the HPPC's responsibilities in these cases. Furthermore, competition in its true sense will be present at the fringes of AHP "territories." The HPPC can monitor competition at the fringes and use it as another source to evaluate AHP performance.

Sanctions against AHPs that do not perform. Sanctions that might be taken could include the reduction of subsidies or the cancellation of exclusive franchises. In some cases, direct regulation of premiums might be necessary if it is impossible, for practical reasons, to displace an AHP. Regulatory actions would be subject to review by the National Health Board.

Before sanctions are taken, however, the HPPC will be responsible for alerting an AHP to its substandard performance, and perhaps helping to coordinate pro-active measures with the RAA to address the problem. These responsibilities lie with the HPPC because of the local nature of the services and the attendant problems.

Accountable Health Plans (AHPs). AHPs are well-suited to deliver health care in rural areas. The coordinated care offered by an AHP will be especially beneficial in rural areas where care is presently often fragmented. AHPs will be required to provide UEHBs and will be accountable for patient health outcomes. Rural AHPs will grow and develop along regional and geographic boundaries and may often cross state lines.

The rural AHP structure and management will need to reflect the unique communications challenges of rural settings. Since it will be economically imprudent to provide some required specialty services on site, residents will receive primary care near home and will go to the appropriate urban center to receive specialized care. As rural AHPs develop, they will create networks that optimize specialists expertise and utilization. Rural AHPs are

likely to take one of two forms: An AHP could be based in the sparsely populated area, and contract with specialty services in urban areas or, AHPs in urban areas could compete for market share in surrounding rural areas by establishing branch offices offering primary care. Either option should offer the same benefits to rural practitioners, making recruitment efforts more successful. This is the interface that the RAA will need to manage. The development of rural AHPs will promote the delivery of primary and secondary care in rural areas helping to ensure the viability of appropriate rural facilities.

Physician Supply. The inability of those living in rural areas to establish a relationship with or have timely access to a primary care physician to manage their care remains a major problem that must be addressed by any rural health initiative. The alternative of accessing primary care through hospital emergency departments is both costly and not in the interest of long term quality care. The current excess of physicians with a disproportionate number of specialists (3 specialists to 1 primary care) has failed to address this problem under existing market conditions. Long term solutions to provide more primary care physicians and relatively fewer specialists as addressed in our paper "Physician Workforce Needs Under Managed Competition" are probably a decade or more from being realized. Short term solutions must, therefore, be entertained. They include:

A. Financial Incentives.

1. Reimbursement reform to compensate rural providers on par with urban providers.
2. Direct income and capital subsidies to establish practices in rural areas

3. Forgiveness of medical education loans over a period of 4-5 years of practice in a rural areas. The so called "Universal Berry Plan for Medical Students" recently espoused by Petersdorf might fit this need although implementation time could be 5-10 years. National Health Service Corps programs could be expanded to meet these needs also.

B. Indirect Incentives

1. Formal professional support by being included as an equal and valued member of a regional network or AHP. The primary care physician would enjoy the benefits of educational opportunities and collegiality from such a formal association.

2. Systems supports through ready access to consultation from specialists using telephone, teleconferencing, and teleradiology.

3. Ready access to network facilities.

C. Physicians Assistants could be used in the near term, especially in more remote areas. Telemedicine capabilities, financial incentives, and network backup capabilities will be important in their recruitment.

D. Allied Health Professional Supply

1. Nurses, technologists and other valued health care workers will be easier to recruit and maintain in a larger system where there are more opportunities for promotion and career development than in smaller units.

Rural Hospital Issues. Rural hospitals comprise nearly 50% of the nations 5600 acute care hospitals. Regulatory, reimbursement and competitive pressures have made an already

fragile rural hospital system particularly vulnerable to any change or restructuring. The environment faced by rural hospitals today is characterized by:

- decreasing occupancy, admissions rates
- decreasing reimbursement from payors
- increasing regulations and cost of compliance
- increasing difficulty in raising capital
- increasing debt/equity ratios
- negative or only break-even operating margins
- increasing competition from larger, high-tech regional hospitals

Community support through local taxes and/or private gifts is frequently all that keeps many rural hospitals open. This community support is based on a desire to maintain ready access to emergency and other services in the community and to maintain what is frequently the major industry and economic anchor of that community.

The plight of rural hospitals has not gone totally unrecognized. Medicare reimbursements, constituting 40% of rural hospital revenues, traditionally a major contributor to rural hospital financial troubles, have recently been made more equitable, but rural hospitals remain disadvantaged by the system. The Federal EACH/RPCH Program ("eaches" and "peaches"), recognizing that cooperation rather than competition may be the key to survival for rural hospitals, attempts to allow small rural hospitals to restructure their services and still qualify for Medicare reimbursement. Accompanying regulations are cited as a major barrier to program success. Managed competition would free AHPs from regulatory grid

lock by channelling federal monies through HPPCs. This would allow AHPs to restructure services in a similar, and locally as opposed to centrally determined, manner.

Other Existing Facilities. Any workable reform initiative should take advantage of existing facilities such as, Community and Migrant Health Centers (C/MHC). C/MHCs can become affiliated with AHPs. This affiliation will offer a unique opportunity for a public/private partnership to continue the indigent care mission. C/MHCs are a logical place to continue to provide care for the few remaining uncovered individuals. For this mission C/MHCs will need extra sources of government funding.

Tax Code Issues. The Jackson Hole Group recognizes that restructuring health care delivery in rural areas may take longer than in urban areas. To allow time for a smooth transition, and to guard against penalizing rural residents who will have fewer health care alternatives, we propose deferring the implementation of new tax codes in rural areas for two years. Every effort should be made to ensure that AHPs offer appropriate incentives to attract primary care physicians needed to address the access problem. Any reform initiative will likely fail if it is unable to attract primary care physicians. Tax incentives might also be explored as a means of accomplishing this goal.

Reimbursement Issues. Historically rural providers have been more dependent than urban providers on government revenues due to the high percentage of Medicare and Medicaid recipients that they serve. To address the market and system distortions caused by the

dependence on government revenues, the Jackson Hole proposal would channel all government money through the HPPCs, removing the distorting effects of Medicare and Medicaid reimbursements and the attendant slow federal waiver process. Government would pay the same, fair rate for health care coverage as other payors. Cost shifting would thus be eliminated and many of the problems stemming directly from under-compensation (especially lack of access due to unwillingness of providers to locate in these areas) will be ameliorated. With these distortions removed, the market will be free to reform the health care delivery system internally and in the most appropriate way with little need for regulation or bureaucracy. In short, specialized procedures will be concentrated into fewer centers and rural facilities will focus on primary care services. Competition and the obligation to serve a defined population will force AHPs to design efficient delivery systems that improve access and meet the needs of all Americans over extended periods of time. The result will be a restructuring of underutilized rural facilities and the creation of an efficient network of providers that delivers higher quality comprehensive medical care.

REFERENCES

Ingersoll, B. (1989, July 20). Farming is dangerous, but fatalistic farmers oppose safety laws. *The Wall Street Journal*, p.1.

Kronick, R., Goodman, D., Wennberg, J., and Wagner, E. The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition. *The New England Journal of Medicine*, Jan. 14, 1993. Vol. 328 No.2. pp148-52.

National Rural Health Association. (September 1992). *National Health Policy Reform: The Rural Perspective.*

Office of Technology Assessment (1990). *Health care in rural America* (OTA Publication No. OTA-H-434). Washington, DC: Government Printing Office.

Petersdorf, R.G. Financing Medical Education, A Universal "Berry Plan" for Medical Students. *The New England Journal of Medicine*, 1993. 328(9); 551-654.

Physician Workforce Needs Under Managed Competition: Analysis and Proposed Model. Jackson Hole Group. 1993.

Ries, P. (1987). *Health care coverage by sociodemographic and health characteristics, United States*, 1984 (Vital and Health Statistics Series 10, No. 162, DHHS Publication No. [PHS] 87-1590). Washington, DC: Government Printing Office.

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Dealing with the Excess Capacity in the Nation's Supply of Physicians

Public Sector Planning is Essential for Health Care Reform

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The US health care economy, plagued by excess capacity and runaway costs, is under increasing pressure for reform. Global limits on health care expenditures are held up by some as a necessary public sector strategy for containing costs. Others advocate managed competition as a private sector alternative to foster the growth of managed care organizations that not only contain costs, but also improve the quality of care and eliminate waste. In this paper, we identify public sector physician manpower planning as a neglected but essential component of health care reform that can significantly lower health care costs and improve the quality of life, independent of the success or failure of managed competition or regulatory efforts to impose global limits on health care expenditures.

There is good evidence that the manpower policies of the prepaid group practice form of managed care such as Kaiser Permanente or Group Health Cooperative of Puget Sound successfully contain costs. The "classic" or "C-HMO" model for managed care achieves its cost containment advantages by exercising private sector population-based health planning. C-HMOs serve a defined population, own their own hospitals and offer access to all medical and surgical specialists. They invest less in acute hospital care and more in preventive and ambulatory services than do fee-for-service systems of care. The numbers of hospital beds they use is well under 2.0 per 1,000 enrollees compared to a national average of

more than 4.0 beds per 1,000. Physician specialists are employed according to a population-based formula that is strikingly similar from one plan to another,(1) but markedly less than the number of physicians per capita available in the remainder of the U.S. health care economy.

C-HMOs have other distinct advantages not shared by unorganized fee-for-service care or by other forms of managed care such as Independent Practice Associations (IPAs). C-HMOs are structurally well situated to promote high quality care and innovation in the practice of medicine. Because the physicians work for salaries, they are free of the constraints that limit how fee-for-service physicians, including those working in IPAs, can use their time. Since their professional income does not require doing procedures, physicians can allocate their time among the many complex tasks required to manage a modern health care organization. In addition to direct patient care, they can undertake tasks to improve quality, participating for example, in outcomes research. Activities can be organized according to a physician workforce plan that includes health education and preventive services as routine tasks. The workforce plan can also accommodate the need for professional growth over the life time of the physician: learning new skills by participation on a periodic basis in education or retraining from an over- to an under-supplied specialty. The freedom from dependency on fees to generate revenues also means that C-HMO physicians can adjust to the changes in demand that inevitably occur when the preferences of patients determine the use of treatments.

While C-HMOs may be the superior model for organizing health care delivery system, we believe that managed competition is not a sufficient means for bringing these advantages to all Americans. Public sector planning is needed. At the national level, we need a manpower policy that brings the supply of physicians more in balance with the numbers required by C-HMOs. At the state and local level, we need public policies that promote population-based delivery systems along the lines of the C-HMO model. While in some states this could be largely achieved by managed competition, in many states, the population density is not sufficient to promote the C-HMO model for managed care.(1) In these regions, public sector planning will be required to rationalize the physician workforce and other aspects of the delivery system, particularly hospitals. In this paper, we discuss the excess capacity in the supply of physicians and why we need public sector planning. We outline a public sector physician workforce plan to set limits, promote the reallocation of excess capacity to more productive tasks and bring significant cost containment, independent of the results of managed competition or global limits on budgets.

The Excess Capacity in the Supply of Physicians

The number of physicians now available in this country has been determined by factors that have little to do with patient demand but much to do with federal policy and the needs of training institutions. The number of medical schools and the graduates they

produce have greatly increased as a result of federal policy based on the assumption of a physician shortage--a concept widely accepted in the 1960's and 1970's. The number of residency positions for specialty training has been determined by the training institutions themselves, aided by accreditation procedures that focus on academic standards but not the number of medical specialists needed. The result is a graduate physician workforce strongly influenced by the labor needs of the acute hospital sector, in particular the teaching hospitals. Sometimes, as in the case of inner-city public hospitals, physicians-in-training are the primary source of patient care, providing service coverage that society is not willing to pay for at full price. However, often the motivations that determine the size of residency programs concern prestige and status among educational institutions, the needs of the directors of the various residency programs and the priceless advantage of the night and weekend coverage that a housestaff offers the senior staff. Financial incentives also influence growth: Medicare, the largest source of funds for residency programs, bases their payments on the number of trainees.

The current supply of physicians does not provide a reasonable standard on which to base planning. The specialty supply in the United States is more than sufficient to meet the demand for treatments that all physicians agree are necessary, regardless of their specialty.(2,3) The available supply of neurosurgeons and neurologists, for example, is well in excess of the numbers required to perform operations on brain tumors and serious head injuries.

When new neurosurgeons enter practice, they invest much of their time in performing carotid endarterectomies (for the treatment of threatened stroke from obstruction of the artery in the neck) or spine surgery (for disc herniation and other conditions). For these conditions, other specialists offer alternative treatments: neurologists prescribe aspirin for carotid artery disease while internists or psychiatrists offer medicine and exercises for low back pain. The impact of supplier-induced demand on population use rates is vividly apparent in studies in Maine showing dramatic increases in spine surgery occasioned by the immigration of neurosurgeons.(4)

The current supply of physicians is well in excess of the number required to meet the staffing requirements of C-HMOs. We have compared the physician staffing patterns of the C-HMO to the number of physicians available in the national manpower pool. Figure 1 shows the per capita ratios for each physician specialty in the United States compared to the average for five C-HMOs.(5) The figure makes clear that for virtually every specialty, there is a significant excess from the perspective of the manpower utilization policies of the C-HMO. The ratios are "normalized" to those of the C-HMO. For example, on a per capita basis, there are about 2.5 times more neurosurgeons, 2.4 times more general surgeons and 1.4 times more urologists in the nation than in the C-HMOs.

Staffing patterns of the C-HMOs were obtained as described in reference one. Since the number of primary care specialists were

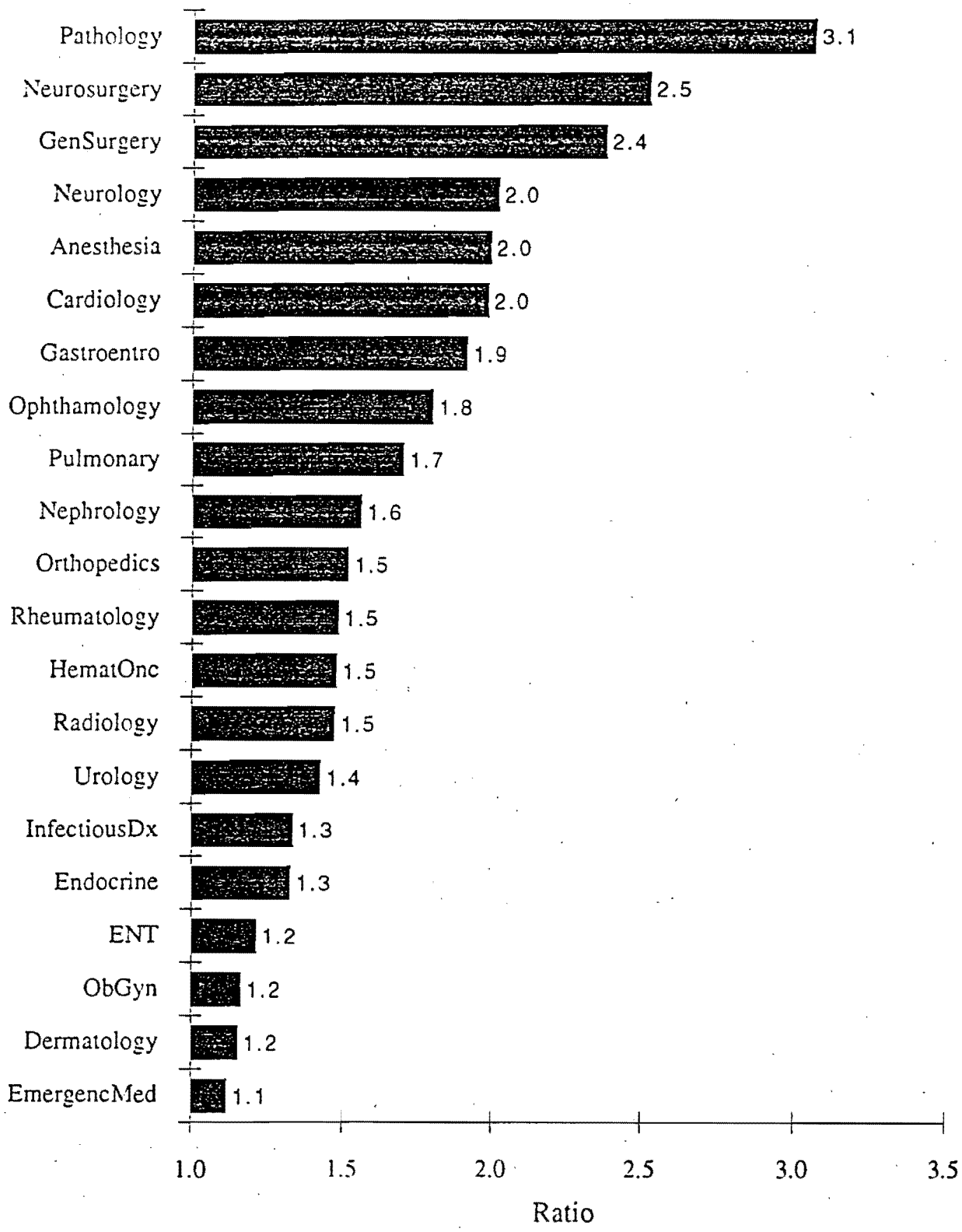
inconsistent among C-HMOs, probably reflecting their different strategies for substituting nurse practitioners and physician assistants for primary care physicians, these specialties were not included in Figure 1. The ratios are not adjusted for age differences which might decrease the discrepancy for certain specialists such as urology while increasing it for others such as obstetrics and gynecology.

<<FIGURE 1 ABOUT HERE>>

How Should We Plan Physician Supply?

Ideally, the physician supply would be based on knowledge of how treatments work and what patients want: the number of physicians and the mix among specialties needed to provide care in an economy where patients: are informed about what is known (and not known) about the outcomes of care and are free to choose among beneficial options according to their own preferences concerning the risks and benefits.

For some conditions, outcomes research and reform of the doctor-patient relationship can provide important clues about the number of physicians such an economy would support. Research funded by the Agency for Health Care Policy and Research shows that treatment controversies can be investigated, medical theories


Pathology
3.1
Neurosurgery
2.5
GenSurgery
2.4
Neurology
2.0
Anesthesia
2.0
Cardiology
2.0
Gastroentro
1.9
Ophthamology
1.8
Pulmonary
1.7
Nephrology
1.6
Orthopedics
1.5
Rheumatology
1.5
HematOnc
1.5
Radiology
1.5
Urology
1.4
InfectiousDx
1.3
Endocrine
1.3
ENT
1.2
ObGyn
1.2
Dermatology
1.2
EmergencMed
1.1
1.0
1.5
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2.5
3.0
3.5
Ratio

FIGURE 1. The ratios of per capita numbers of clinically active physicians compared to per capita numbers employed by C-HMO, by specialty, 1989.

evaluated and the probabilities for the relevant outcomes measured. Moreover, information about how treatments work (and what is not known about how they work) can be conveyed to patients using methods that make it possible for them to choose according to their own preferences. The relationship between the doctor and the patient can be transformed from the delegation of decisionmaking power to the physician to the sharing of information and the active involvement of patients in the choice of treatment; the preferences of the physician can be disentangled from those of the patient.(6)

We have seen the effect of patient preference on the demand for prostatectomy in two C-HMOs. The rate of prostate surgery dropped about fifty percent among the populations served by Group Health Cooperative of Puget Sound and the Kaiser-Permanente plan in Denver when these plans adopted the shared decision model for choosing treatments for benign prostatic hypertrophy (BPH).(7) Based on this evidence, it appears that the formula the C-HMOs used to hire urologists substantially exceeds the number required to provide the prostatectomies that patients actually wanted for this condition, even when there was no cost to the patient.(8)

Outcomes research and the implementation of the shared decision model provide an opportunity to learn about the demand for physician services in a patient-centered practice environment. There are a number of conditions for which this strategy can work, and we have listed some of them in Table 1. However, as powerful and as important as they are in improving the rational basis for clinical

decisionmaking, there are two reasons why we cannot base manpower planning on the results of outcomes research and shared decisionmaking planning.

<<Table one about here>>

First, the lead time for many evaluations is too long, and the advance of technology too rapid. The recent introduction of a new "PSA" blood test to detect early stage cancer of the prostate exemplifies this problem. In most men, early stage cancer of the prostate is most often a slow growing cancer, which prior to the PSA test was usually discovered as an incidental finding when BPH surgery was performed. Many urologists in this country do not think surgery is indicated for this condition for most men and recommend watchful waiting. Others, particularly in the Pacific Northwest, advocate radical prostatectomy(9). To settle this controversy, clinical trials are needed and these will take a long time to complete, possibly as long as ten years. In the meantime, since as many as ten percent of men 65 years of age and older may harbor disease detectable by the blood test, the opportunities for intervention under the hypothesis that surgery works are virtually limitless.

Second, most medical resources are not deployed in situations where medical discourse is well enough organized to support outcomes research and shared decisionmaking. The treatment of stable angina, menopausal symptoms, arthritis of the hip, and benign prostate disease are among the exceptions. In most situations, *the*

Table 1 Common Conditions and Their Current Treatment Options for which Outcomes Research and Shared Decision-making can Lead to the Rationalization of Patient Demand

Condition	Major Treatment Controversies
Noncancerous condition of the uterus	Surgery (by type) vs. hormone treatment vs. drugs vs. watchful waiting
Angina pectoris	Bypass surgery vs. angioplasty vs. drugs
Gallstones	Surgery vs. stone crushing vs. medical management vs. watchful waiting
Peripheral vascular disease	Bypass surgery vs. angioplasty vs. medical management
Cataracts	Lens extraction (by type) vs. watchful waiting
Arthritis of hip and knee	Surgery (by type) vs. medical management
Prostatism (BPH-benign prostatic hyperplasia)	Surgery (by type) vs. balloon dilation vs. drugs vs. microwave diathermy vs. watchful waiting
Herniated disc	Surgery (by type) vs. various medical management strategies
Atherosclerosis of carotid artery with threat of stroke	Carotid endarterectomy vs. aspirin

supply of medical care is in equilibrium with a host of implicit theories that govern the rationale for its deployment.

The decision to hospitalize sick patients rather than treat them in the clinic is a good example. A fifty percent increase in the capacity of the acute hospital sector decreases the threshold for admitting patients in a way that results in an fifty percent increase in the use of the hospital. Even in medically sophisticated communities such as Boston and New Haven, this effect occurs without awareness on the part of clinicians that their practices are actually different, despite an almost twofold difference in hospitalization rates.(3) The time interval between revisits for a patient with mild heart failure, chronic lung disease and many other chronic illness is another example. A halving of the interval between revisits--for example, seeing a patient with mild congestive failure every six weeks rather than every three months--accommodates a doubling of the supply of internists.

These dysequilibria between supply and utilization are subtle and not easily amenable to guidelines and outcomes research. They are based on a plethora of unspoken hypotheses that will not be easily rationalized. At best, outcomes research and the implementation of shared decisionmaking can help create islands of rationality in a sea that will always have strong currents of supplier-induced demand. C-HMO private sector planning achieves its cost containment advantages over fee-for-service systems by setting its physician manpower and hospital bed supply ratios at a low level.

Public policy must also seek limits through population-based planning.

On what standard should national health manpower policy be based?

Why not adopt the hiring ratios of the C-HMO as the first approximation for need? While they are not based on knowledge about the amount of resources required to optimize the health of the population served, there is evidence that they are safe for patients. In the case of the treatment of BPH, even the relatively low number of urologists per capita hired by the C-HMO was more than enough to meet demand for prostate surgery, once the patients were empowered to select the treatments they wanted. In terms of overall health status, the available evidence suggests that C-HMOs produce outcomes that are as good or better than those produced in fee-for-service settings.(10) C-HMOs provide the only examples we have of population-based systems of care that are in "equilibrium" with fee-for-service markets: the growth and stability of C-HMOs means that many people are satisfied that they meet their health care needs. While it may not be clear why the manpower ratios they use work, the fact that they pass the empirical test of the market speaks to their relevance for health care reform that stresses managed care. Moreover, if they can be more widely achieved, aggregate costs will go down, regardless of the success of other policies designed to keep costs down. For all these reasons, it seems reasonable to conclude that these ratios are safe for patients and in the public interest.

Can Managed Competition "Clear" the Market of Excess Capacity?

Managed competition is proposed by many as the best way to rid the health care economy of excess capacity. Under managed competition, the American people would be offered a choice among C-HMOs, IPAs or traditional fee-for-service care.(10) The effectiveness of Independent Practice Associations (IPAs) and related models of managed care in controlling overall costs, limiting capacity and improving quality is much less clear. They differ from C-HMOs in that they do not own their own hospitals or hire physicians covering the full breadth of specialty services according to the private sector health planning. The supply of hospital beds and specialists in the community where they are organized is an environmental "given". They must depend on selective contracting, practice guidelines and other forms of case management to control utilization. They are much more vulnerable to the excesses in current levels of supply than C-HMOs.

If implementation goes according to theory, C-HMOs would dominate IPAs and unmanaged fee-for-service care in a market where competition is based on cost and quality. As C-HMOs grow, the disparity between the numbers of physicians per capita that they hire and the per capita numbers available to the rest of the economy becomes increasingly severe.(11) Costs become increasingly difficult to manage under the IPA model, and eventually C-HMOs will prevail.

But will implementation go according to theory? There are two reasons for thinking it might not. The first relates to the fallout of a policy that, if successful, would result in massive unemployment among American physicians. For example, if C-HMO hiring practices had been in force throughout the United States in 1988, more than half of all specialists would now be unemployed. It is difficult to imagine how a model for reform that has such negative impacts on these powerful professional constituencies would proceed to this end and that managed competition could sustain the political backing necessary to rely on this mechanism as the principal means for clearing the market of excess capacity. Public policies in Canada that have sought more modest limits have failed because of "shroud waving", a tool employed by physicians to convince the public that failure to meet professional goals will result in death or serious harm to patients. The prospect of unemployment of the order required for the full implementation of the C-HMO model would create an irresistible force for reversal of the public policies required to sustain managed competition.

Politics is not the only limit, however. Demography also conditions the prospects of this model for reform. At least 40% of the American people live in areas where the population is not concentrated enough to support competition between C-HMOs that control their own hospitals and provide most specialty services. Many states have no areas where this form of competition can succeed. In these places, the opportunity for managed competition to

clear excess capacity would have to depend on the independent practice association or other models for managed care whose ability to control the per capita supply of physicians is much less certain.(1) Indeed, the task would be exacerbated by the success of C-HMO competition in urban areas that would force unemployed physicians to move into non-C-HMO territories in search of patients.

<<Figure 2 about here>>

Public Sector Health Planning as a Strategy for Dealing with Excess Capacity

This section lays out the broad goals of a public policy of intervention to reduce the supply of clinically active physicians in the United States while improving the quality of care and containing costs. Figure 3 is a schemata for a national physician workforce plan that specifies the possible points of intervention. Interventions at Points 1 through 3 affect the rate of entry into the pool of practicing physicians; Point 4 governs the rate of exit through retirement; Point 5 seeks to balance the rewards between doing procedures and counseling physicians; Points 6-7 seeks reallocation of excess capacity to places that are underserved; Points 8-10 define new areas of professional responsibilities which offer opportunities to improve the quality of care and promote innovation while, at the same time, reducing the aggregate costs of care by reducing the numbers of clinically active physicians.

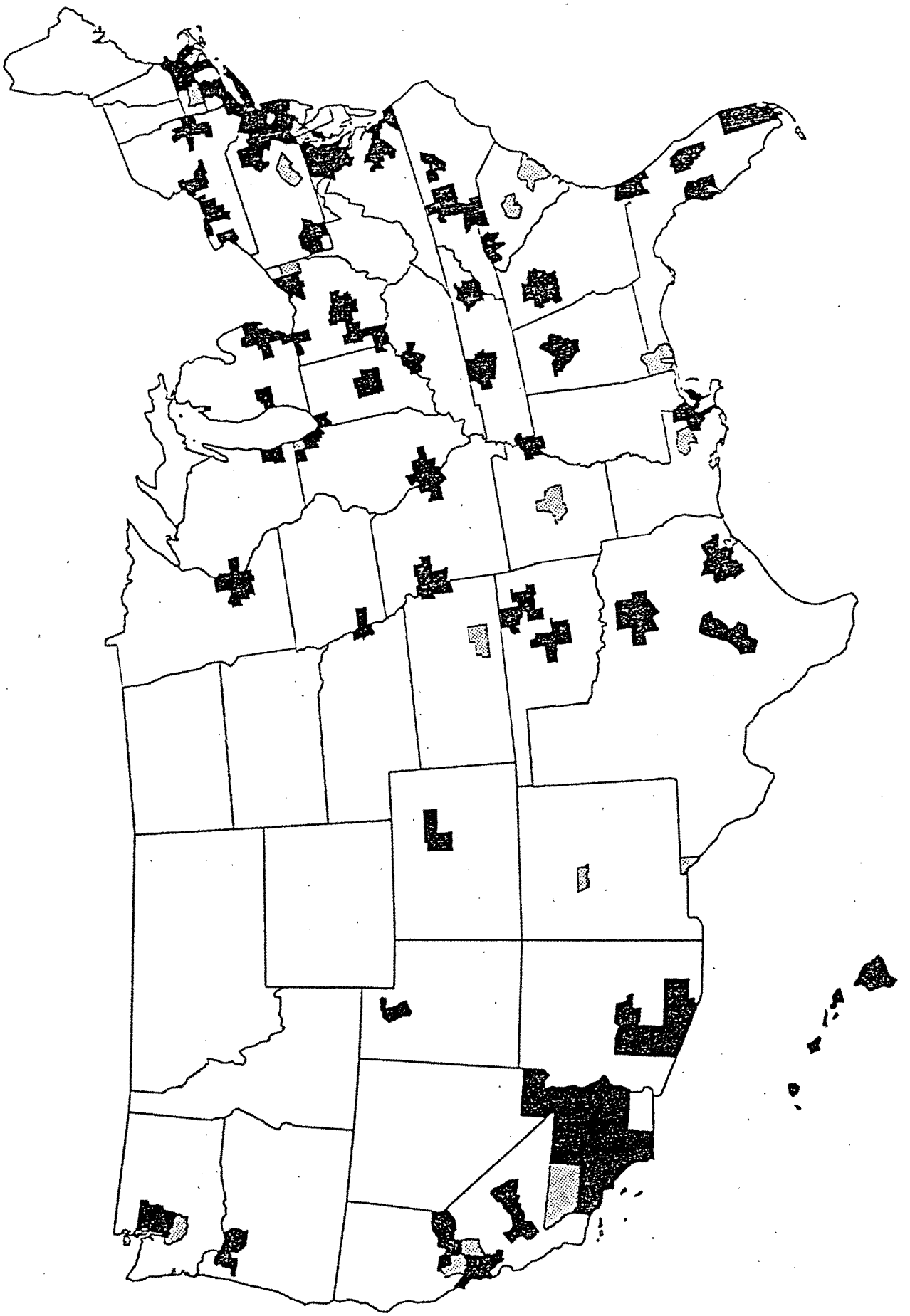


FIGURE 2

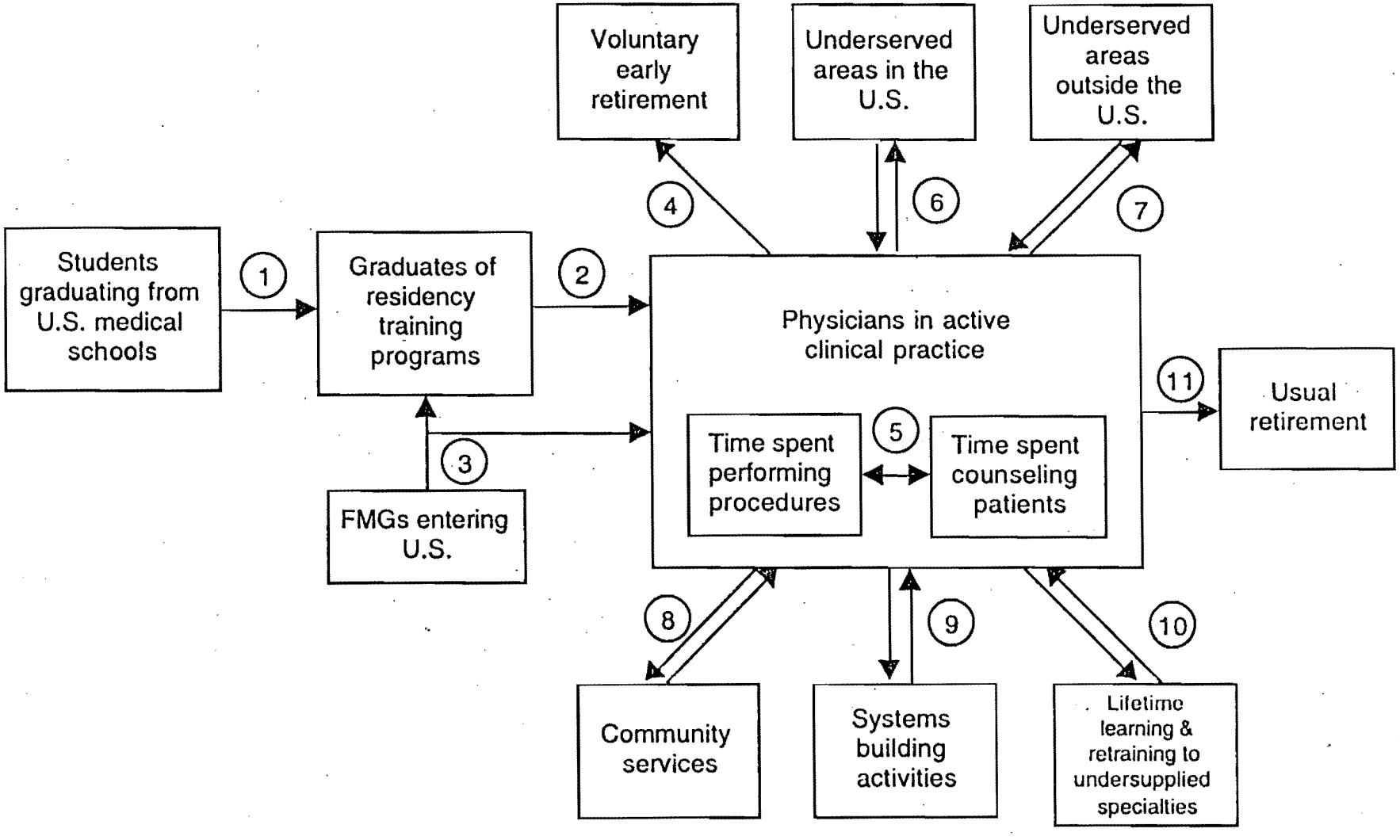
FIGURE 2. We estimate that the minimum, population size of metropolitan areas that might support C-HMO based competition is somewhere between 360,000 and 600,000. The figure shows that most of the landmass of the United States rests in zones where the population density is too low. The black are standard metropolitan statistical areas (SMSAs) with populations greater than 600,000; the grey are SMSAs with populations between 360,000 and 600,000. The black areas contain 54% of the US population; the grey, 9%.

<<Figure 3 about here>>

Barriers to the rate of Entry (Points 1-3) These are the traditional targets for health care planning and a necessary part of any strategy to control the overall supply and specialty distribution of physicians. But control of entry will prove a very inefficient strategy for reducing the supply of physicians toward the C-HMO standard. We have examined the opportunities for achieving the C-HMO standard for specialists by modifying the numbers of residency positions available in the United States. Figure 4 looks at trends in the numbers of urologists, neurosurgeons and radiologists per capita and compares them to the C-HMO standard under various targets for reducing the numbers trained.(13) The figure makes clear what many have suspected--that significant changes in available supply take a very long time, even with drastic changes in the pipeline. For example, if radiology residency programs were completely eliminated, it would still take about 20 years before the numbers per capita in the national economy approach the numbers now hired by the C-HMOs. Under the same policy, it would take more than 25 years for neurosurgeons and about 17 years for the supply of urologists to approximate the numbers employed by C-HMOs. With a fifty percent cut in residency positions, at 25 years the number of radiologists would still exceed the C-HMO standard by 50%.

These scenarios, which are typical of the situation for virtually all medical specialties, help sharpen awareness of the dilemma the nation faces. It is not feasible nor desirable to implement a public

FIGURE 3: OUTLINE OF MANPOWER POLICY MODEL

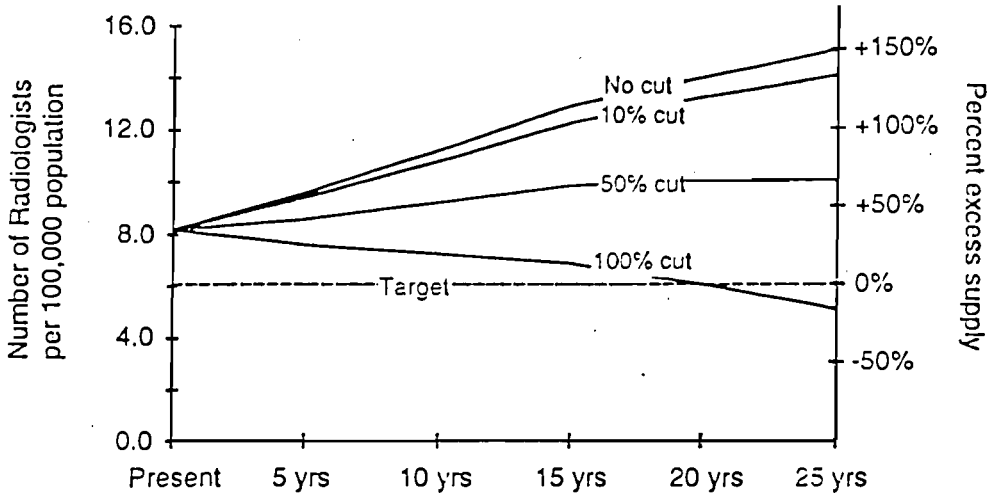


policy that reduces the training of new specialists to the point where even the best residency programs face extinction. The effects on the evolution of the specialties--the loss of succession and the power for renewal and scientific advancement that the presence of young physicians in training provides--would have a severe negative impact on the future of American medicine. Yet it would be foolish for the nation to continue the current laissez faire policy. We thus argue for national health manpower planning that adjusts the numbers of graduating specialists downward while preserving the best of the nation's residency programs.

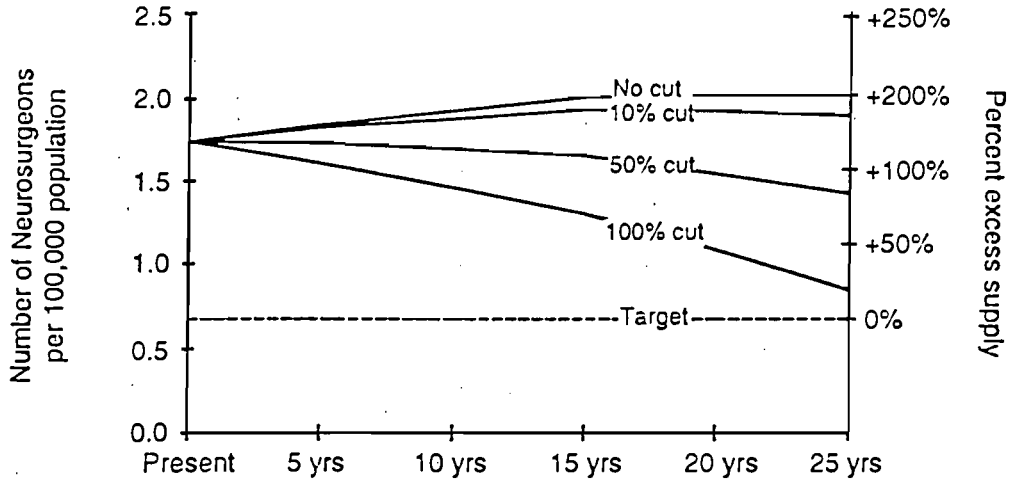
<<Figure 4 about here>>

Early Retirement. Voluntary early retirement is a common practice among the military and civil servants and, increasingly, an important strategy in the private sector for reducing excess capacity. It would be hard to argue that at a time when many US industries are undergoing massive restructuring, excess capacity in the health care industry should go unchallenged. While we do not specifically advocate this strategy--it would be exceedingly difficult to design and administer a program that was fair to all parties--a program to promote early retirement will be difficult to keep off the table for discussion.

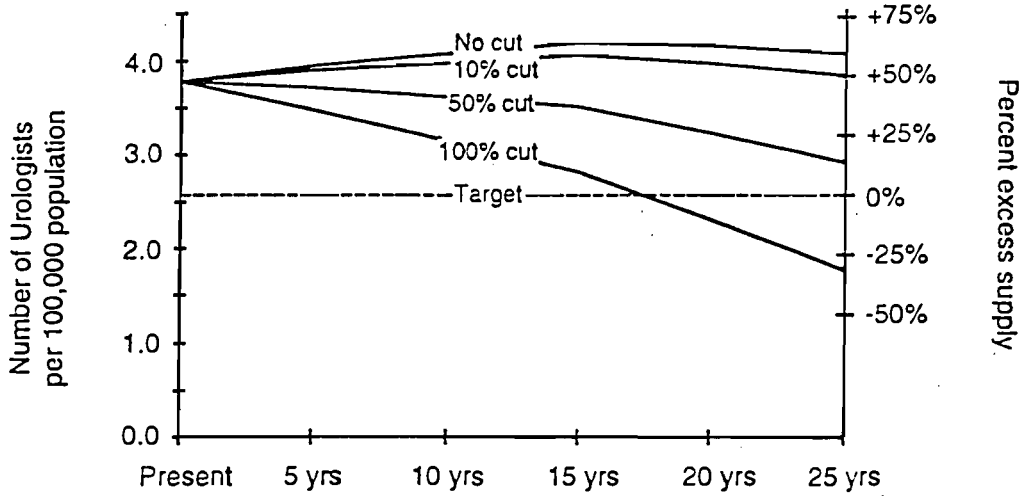
Restructuring Economic Incentives (Point 5) The adoption of the shared decisionmaking model should be a national goal. The workforce plan, therefore, calls for a fee schedule that rewards


16.0
12.0
8.0
4.0
0.0
Number of Radiologists per 100,000 population
No cut
10% cut
50% cut
100% cut
Target
+150%
+100%
+50%
0%
-50%
Percent excess supply
Present
5 yrs
10 yrs
15 yrs
20 yrs
25 yrs

(a)


2.5
2.0
1.5
1.0
0.5
0.0
Number of Neurosurgeons per 100,000 population
No cut
10% cut
50% cut
100% cut
Target
+250%
+200%
+100%
+50%
0%
Percent excess supply
Present
5 yrs
10 yrs
15 yrs
20 yrs
25 yrs

(b)


4.0
3.0
2.0
1.0
0.0
Number of Urologists per 100,000 population
No cut
10% cut
50% cut
100% cut
Target
+75%
+50%
+25%
0%
-25%
-50%
Percent excess supply
Present
5 yrs
10 yrs
15 yrs
20 yrs
25 yrs

(c)

FIGURE 4. Projected per-capita U.S. physician supply in three specialties over the next 25 years under various assumptions about the reduction in the number of residents produced. The dashed line represents the HMO-based target number of specialists (see text). (a) Radiologists, (b) Neurosurgeons, and (c) Urologists.

physicians equally for time invested in counseling patients, diagnosing disease or doing procedures. While the Medicare Program and its Physician Payment Commission are already moving in this direction, efforts should be accelerated and made applicable to all Americans in fee-for-services system of care, not just Medicare enrollees.

Reallocation to underserved areas in the US (Point 6) One of the most persistent and dysfunctional health policy myths is the belief that the best way to get physicians to locate in underserved areas is to produce such an excess in supply that physicians will move there because they can't survive economically elsewhere. A national workforce plan that seeks to reduce overall supply will need a pro-active way to meet the needs of underserved urban and rural areas; it is thus time to rethink and expand the role of the National Health Service Corps, to build it into an institution of public service, attractive to the idealism of young physicians. By linking national service firmly to a medical school loan forgiveness program, the National Health Service Corps is also a strategy for removing medical school indebtedness as an economic motive in the choice of medical specialty.

Reallocation to Underserved Areas Elsewhere in the World (Point 7) The workforce plan should create an opportunity for US physicians to help modernize the health care systems in certain third world countries or in parts of eastern Europe and the former Soviet Union. American physicians have a long tradition of helping other nations.

The desperate need in medically underdeveloped parts of the world is a natural humanitarian outlet for our excess capacity; meeting that need can be a source of national pride as well as individual fulfillment for those who participate.

New Areas of Professional Responsibility (Points 8-10) Building an innovative, population-based and patient centered health care system requires that physicians undertake many essential tasks that are not fairly reimbursed in fee-for-service medicine; for the physicians who undertake them, they are now pro bono work rather than part of everyday professional responsibility. The workforce plan thus calls for creating three "new" compartments within which reimbursed professional activities can take place:

- The "Community Services" compartment is created for professional tasks involved in disease prevention and education, sometimes in the clinical, but also in the community, in the schools, prisons, chronic disease hospitals and other places where professional activities supportive of the public health of populations occurs. (Point 8)

- The "Systems Building Activities" compartment is created for those professional tasks concerned with the infra-structure for medical practice, including doing outcomes research to improve the scientific basis of everyday practice, learning how to better organize care to produce better outcomes at a lower cost and developing practice guidelines for the use of new or established treatments. (Point 9)

- The "life time learning and re-training" compartment is for time spent in learning new skills and concepts as well as

mid career re-training--for example, adopting a new specialty. (Point 10)

The construction of these compartments for professional activity would open up a broad opportunity for innovation and improvement in the quality of care. We have in mind that at any time a significant proportion of providers--say ten percent--would be working in these compartments on a variety of important tasks: devoting two days a week to working in the schools to educate teenagers about AIDS or the problems of smoking; working a week a month on a project to reduce operative mortality rates from bypass surgery or (working with the local health department) to immunize children; participating in a crucial series of outcome studies that build the scientific basis of medicine. Some would be participating in educational programs either as teachers or students; some would be enrolled in courses to learn new skills such as how to conduct outcomes research or quality management; others would go back for new post graduate studies to learn a new specialty such as primary care that is underserved in their area or elsewhere; some might be learning to perform a procedure that shared decisionmaking reveals is needed.

Activities undertaken in the "new compartments" we defined, cost less to finance than do the many discretionary services physicians prescribe when practicing medicine. By making it possible, on a rotating basis, for a significant proportion of the fee-for-service workforce to be engaged in tasks other than practice, the

numbers of clinically active physicians can be reduced toward the C-HMO standard. While spending time in building systems of care, surgeons do not require the support of the large staff they do while operating; radiologists do not require as much capital equipment and internists do not need office staff. Learning and innovating can be friends of cost containment

Reform along these lines would also create new demands and offer new opportunities for academic medical centers. It would focus their attention on the need to support preventive medicine, promote outcomes research and participate in the system building tasks of quality management. It would also focus the attention of educators on the manpower needs for caring for the populations of their own regions; the apparent losses in role and prestige associated with the down-scaling of undergraduate medical education and the training of new residents would be offset by the new responsibility for organizing programs in life-time learning and for re-training physicians to undertake new specialties when the need arises.

Such a policy would remove substantial barriers to innovation in medicine. The idea that physicians, by virtue of their initial choice of specialty should have a life-time license to surgically or medically treat a particular organ such as the prostate, the heart, the tonsil or the uterus--regardless of the progress of information and technology--is clearly faulty. It is a rare "high tech" industry that does not provide for re-training its workers nor engage their talent in developing and evaluating new products and improving the

quality of existing ones. Innovation demands the capacity to reallocate and adapt.

A Brief Note on Implementation

The Commission on Graduate Medical Education (COGME) has called upon the Congress to establish a National Manpower Commission to set limits on the numbers of medical school graduates, residency positions and the opportunities for international medical graduates to enter US markets.(14) (Points 1-3 in the workplan.) Since the COGME proposal helps the goals of managed competition as well as those who want global budgets, it should receive wide support. Given the large subsidies that the federal government now extends to the nation's medical schools and academic medical centers,(15) their compliance with the workforce plan should also be expected. We recommend that the new Administration give immediate priority to this task

The National Health Service Corps already exists; its activities would only need to be updated to comply with Point 5 in the workforce plan.

In the parts of the country where managed competition can produce C-HMO forms of managed care, private sector health planning may be the preferred strategy to achieve most of the goals

we have outlined for achieving reallocation of the existing workforce (Points 8-10).

In other parts of the country, achieving the reallocation of the existing workforce into the "new compartments" requires new public policy thinking. A regional public sector organization is needed to take responsibility for managing the health force plan--to make contracts with physicians in the region to undertake the qualified tasks and to make certain that there is a commensurate downscaling of the delivery system. The organization must have a budget with which to make its contracts. We suggest a "tax" on insurance funds used to reimburse fee-for-service physicians (e.g., the Medicare Part B and Blue Shield programs) to create a budget for the regional organization to use in system building, community service and lifetime learning compartments. The tax would be sufficient to create the budget necessary to achieve the desired reduction in the workforce engaged in active clinical practice.

We suggest that the Federal and state policies needed to establish and manage a public sector physician workforce plan be worked out as part of the Administration's effort to achieve a broad-based approach to health care reform. The workforce plan and efforts to impose global expenditure limits should be linked. In the absence of limits on the supply of physicians, any policy which limits aggregate expenditures is an invitation to conflict between government and the profession. However, by changing historic trends in the production of physicians, reducing the numbers of

clinically active specialties and offering opportunities for fee-for-service physicians to participate in health system building tasks that now can only be easily accomplished by salaried physicians working for C-HMOs, government avoids this conflict. The workforce plan should also be linked to federal efforts to improve the scientific basis for clinical decisionmaking through outcomes research. A strong federal commitment to progress in this field is a prerequisite of innovation.

Summing Up

We have laid out a strategy for a national physician manpower policy that is compatible with and complementary to a broad spectrum of reform efforts, whether based on managed competition, regulation with a global budget or some hybrid that combines features of both. Our plan holds a reasonable prospect for reducing aggregate health care expenditure. It is also pro-innovation: it offers the opportunity to reduce the tendency to supplier-induced demand inherent in the current fee structure, making it possible for physicians practicing in the fee-for-service sector to adopt the shared decision model; it also makes it possible for physicians to participate in systems building activities, lifetime learning and provides opportunities for re-training from over to undersupplied specialties.

REFERENCES

1. Kronick, R., Goodman, D., Wennberg, J., Wagner, E. "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition. New England Journal of Medicine, 1993;328:148-52.

2. Wennberg, J., Gittelsohn, A. "Variations in Medical Care Among Small Areas." Scientific American, 1982; 246(4): 120-134.

3. Wennberg, J. "Innovation and the Policies of Limits in a Changing Health Care Economy." The Changing Health Care Economy, March 1992.

4. Keller, R. "Dealing with Geographic Variations in Hospital Use: The Experience of the Maine Medical Assessment Program's Orthopaedic Study Group" with D. F. Soule, J. E. Wennberg, and D. F. Hanley. Journal of Bone and Joint Surgery.

5. Barry, M., Fowler, F., Mulley, A., Henderson, J., Wennberg, J. "Patient Reactions to a Program Designed to Facilitate Participation in Treatment Decisions for Benign Prostatic Hyperplasia. (submitted)

6. Winslow, R. "Videos, Questionnaires Aim to Expand Role of Patients in Treatment Decisions." Wall Street Journal, February 25, 1992.

7. C-HMOs typically do not impose co-insurance or deductible for patients who undergo surgery.

8. Lu-Yao, G., McLerran, D., Wasson, J. and Wennberg, J. An Assessment of Radical Prostatectomy: Time Trends, Geographic Variations and Outcomes. JAMA (submitted)

9. Enthoven, A. C. Theory and practice of managed competition in health care financing. Amsterdam: Elsevier North-Holland, 1988.

10. Reinhardt, U. "Health Manpower Forecasting: The Case of Physician Supply. Health Services Research: Key to Health Policy Eli Ginzberg. Harvard University Press 1991: 234-283.

11.. The per capita rates of specialists in the national economy used to calculate the ratios in Figure 1 are based on the total US population and thus include those Americans who already belong to C-HMOs. The gradient between the two economies is thus, in reality, greater than the figure suggests and will become even greater if C-HMOs gain greater market penetration.

12. Projections are based on (1) age distributions of physicians by specialty as of January 1, 1990 ["Physician Characteristics and

Distribution in the United States." American Medical Association, 1992 Edition, Gene Roback, Lillian Randolph, Bradley Seidman, eds.], (2) estimated number of specialists completing their residency programs by board certification, and (3) estimated number of specialists required for the United States population based on C-HMO staffing rates.

13. Council on Graduate Medical Education. "Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century," October 1992.

14. Mullan, F., Rivo, M., Politzer, R. Doctors, Dollars, and Determination: Making Physician Workforce Policy. Health Affairs (in press)

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Contents:

Rural Health Care:
Improvements Through Managed Competition

An Outline of a Draft
Discussion Paper from the
Jackson Hole Group

I. Introduction

This paper discusses how managed competition can be applied to rural areas and to more sparsely populated frontier areas, with more emphasis on community cooperation.

II. Background -- Characteristics of Rural Areas

A. Demographics

1. The rural population is 27% of the total US population

2. Access problems in rural areas
   a) Shortage of health professionals, services, and facilities
   b) Geographic/climate barriers
   c) Due to lack of financial access and availability of services, believe underuse primary and preventive services

3. Unique demographics in rural areas lead to a high percentage of uninsured and less access to preventive and primary care
   a) Not covered by traditional employment-based health insurance system
      (*i*) Large percentage unemployed, self-employed, seasonally employed, or employed in small businesses
      (*ii*) Large percentage purchase health insurance in the individual market
   b) Larger percentage of senior citizens and citizens below the poverty line than the rest of the population, with the exception of the inner cities one-third of poverty population reside in rural areas
   c) Farming considered the most hazardous profession in America, leads to higher premiums
   d) Higher-than-average rates of unemployment

B. Manpower Shortage: acute shortage of physicians due to:

1. Small town practices extremely demanding; lack the support and backup systems usually available in cities

2. Physician expenses the same as in more populated areas, but income more uncertain
3. Medical education system biased toward specialists, not the generalist needed in rural practices

C. Financing Pressures and Distortions because more dependent on government revenues
1. Higher-than-average percentage of Medicare and Medicaid recipients

2. Constraint on reorganizing facilities and services to better meet the needs of rural populations

III. Background -- Managed Competition
A. Strict Managed Competition will not work in sparsely populated areas

B. Managed Competition in the broader sense will work in much of rural America

C. Frontier areas are still best served by the framework provided by AHPs and HPPCs

D. Competition would occur among smaller primary care facilities
1. Independent organizations (AHPs) that contract with other providers for specialized care

2. Branch offices of urban AHPs, encouraged by
a) Legislated subsidies targeted for rural areas
b) Demands from larger purchasers (e.g., government, large employers, groups of small employers)
c) Fair rates of Medicare and Medicaid reimbursement

3. Physicians could join multiple AHPs which would compete on the basis of other services (e.g., referral networks, traveling specialists, cost, quality, and improved access)

E. Nature of competition in rural areas may be quite different than in urban areas (improved access a main concern)

IV. Proposals: for areas which are too thinly populated to support competition, the following models stress community cooperation to set up an AHP and improve quality of, and access to, health care

A. Rural AHP Authorities (RAAs)

1. National Health Board will create regional RAAs
2. RAAs will ensure that AHPs serve rural areas
   a) Foster community cooperation in areas where a single AHP is appropriate
   b) Foster competition in areas where that is preferable
   c) In rural areas where multiple AHPs operate, will not directly influence
3. HPPCs will monitor rural AHPs
4. RAAs will use two incentives to attract AHPs to rural areas:
   a) Subsidies: preferred, as can better preserve beneficial market forces. Will work best when health care infrastructure in place is sufficient to allow AHP formation without large capital investments:
      (*i*) Will offset high per capita fixed costs
      (*ii*) Not as effective in helping to offset costs of infrastructure development
   b) Exclusive Franchise Agreements: used when substantial investment is necessary and existing infrastructure and providers are minimal (e.g., in the most remote areas with lowest population densities)
      (*i*) Areas operating under an exclusive franchise agreement would require special attention from the HPPC due to the lack of market forces
      (*ii*) AHP would set prices with approval of the HPPC
      (*iii*) Competitive bidding process used to ensure affordable, quality care
      (*iv*) Bidding AHPs would agree to charge certain premiums in exchange for a given amount of governmental assistance
      (*v*) Depending on investment needs, franchise can be given for shorter periods of time
      (*vi*) Should not be necessary very often as delivering rural health care does not require a large infrastructure other than a few primary care offices, linked to an established urban center. Key hospitals are in place and the needed improvements are increases in primary care physicians and better systems of communication and organization
5. RAA must prove necessity of subsidies or franchise to the NHB, due to:
   a) Inadequate density of population

b) Inadequate infrastructure
c) Failed attempts to attract an AHP (including organizing current purchasers)

6. RAA as rural advocate
   a) Encourage development of infrastructure to be shared by AHPs (e.g., communications systems, delivery of emergency care)
   b) Consultative tasks
   c) Attract AHPs to areas before subsidies given out (including organization of purchasers)

7. Cooperative model: RAAs to encourage development of cooperative, community-based AHPs in areas where there is an existing network of providers, but population densities and distance to nearest urban center inhibit competition (exclusive franchise not needed as network does not need substantial investment)

8. The decision to pursue a cooperative model, as opposed to a competitive one, should be decided on the local level, with input from all concerned parties (e.g., providers, consumers, employers, and government officials)

B. Health Plan Purchasing Cooperatives (HPPCs): will perform same functions in sparsely populated areas as in urban areas, plus some additional monitoring and regulating functions to supplement inadequate competition

1. Monitor AHPs that operate under an exclusive franchise, without competition, or with inadequate competition (e.g., cooperative AHPs or AHPs with a unique market niche)

2. Take action when AHP fails to deliver quality care at a reasonable price

3. Ways to evaluate AHP performance:
   a) Benchmark standards (e.g., premiums charged by other AHPs, both non-competing rural AHPs and standard, nationwide outcomes)
   b) Comparison of an AHPs rates in the sparsely populated area with their rates in a more competitive area, if applicable
   c) Competition at the fringes of AHP territories

4. Sanctions against AHPs that do not perform (actions subject to NHB)
   a) Reduction of subsidies
   b) Cancellation of an exclusive franchise
   c) Direct regulation of premiums.

d) HPPC responsible for alerting an AHP to its substandard performance and coordinating pro-active measures with the RAA to address the problem

C. Accountable Health Plans (AHPs)

1. Required by law to make care available and are accountable for patient health outcomes

2. Well-suited to deliver health care in rural areas with some alteration in physical structure and managerial expertise
   a) Need to reflect unique communications challenges of rural settings
   b) Create circuits to be travelled by specialists

3. Rural AHPs to grow and develop along regional and geographic boundaries and may often cross state lines

4. Forms of rural AHPs:
   a) Based in sparsely populated areas and contract with specialty services in urban areas
   b) Urban AHPs could compete for market share in surrounding rural areas by establishing branch offices offering primary care
   c) Both should:
      (*i*) Offer same benefits to rural practitioners, making recruitment efforts more successful
      (*ii*) Reverse trend of self-referral to urban providers
      (*iii*) Ensure viability of appropriate rural facilities

5. Manpower: easier to recruit providers to rural areas because:
   a) Strong backup of high-tech and low-tech communications linkage
   b) Complete outcomes data
   c) Liability coverage
   d) Referral capability
   e) Time off for vacation or training
   f) Guarantees of working conditions and hours
   g) A career track
   h) Use of mid-level practitioners to further extend access to the most sparsely populated areas

D. Existing Facilities: existing facilities can become affiliated with AHPs (e.g., Community and Migrant Health Centers) to provide care for the few remaining uncovered individuals

E. Tax Codes

1. Propose deferring the implementation of new tax codes in rural areas for two years to guard against penalizing rural residents who will have fewer health care alternatives

2. In areas where tax-preferred health care coverage is not available after two years due to recalcitrant providers who are unwilling to change practice styles, perhaps tax providers directly or force them to accept Medicare fee schedules

F. Financing: to address market and system distortions due to dependence in government revenues (i.e., Medicare and Medicaid fees):

1. Channel all government money through the HPPCs and remove distorting effects of Medicare and Medicaid reimbursements and the attendant slow federal waiver process

2. Government to pay the same rate for health care coverage

3. Results of removal of distortions:
   a) Market will reform health care delivery system in the most appropriate way (e.g., specialized procedures concentrated into fewer centers and rural facilities will focus on primary care services)
   b) Competition and the obligation to serve a defined population will force AHPs to design efficient delivery systems that improve access and meet the needs of all Americans over extended periods of time
   c) Reduction in underutilized rural facilities
   d) Creation of an efficient network of facilities that delivers higher quality comprehensive medical care

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WELCOME AND OVERVIEW

Presenters:

Nancy Barrand
Senior Program Officer
The Robert Wood Johnson Foundation
Princeton, New Jersey

M. Joycelyn Elders, M.D.
Director
Arkansas Department of Health
Little Rock, Arkansas

W. David Helms, Ph.D.
President
Alpha Center
Washington, DC

Materials:

- Agenda
- Workgroup Descriptions
- Biographical Sketches

HEALTH CARE REFORM IN RURAL AREAS

An Invitational Conference
Sponsored by

The Robert Wood Johnson Foundation
and
Arkansas Department of Health

Conducted by the
Alpha Center

March 10-12, 1993

Excelsior Hotel
Little Rock, Arkansas

AGENDA

TIME	EVENT	ROOM
Wednesday, March 10, 1993		
6:00 p.m.	**Registration**	Salon 2B Foyer
7:00 p.m. - 8:00 p.m.	**Reception**	River Valley
	Welcoming Remarks Carol Rasco Assistant to the President for Domestic Policy The White House	
Thursday, March 11, 1993		
7:30 a.m.	**Registration**	Salon 2B Foyer
7:30 a.m. - 8:30 a.m.	**Continental Breakfast**	Salon 2B Foyer
8:30 a.m. - 8:50 a.m.	**Welcome and Overview** Nancy Barrand Senior Program Officer The Robert Wood Johnson Foundation M. Joycelyn Elders, M.D. Director Arkansas Department of Health W. David Helms, Ph.D. President Alpha Center	Salon 2B

TIME	EVENT	ROOM
8:50 a.m. - 10:30 a.m.	**Overview of Managed Competition/Networks in Health Reform**	Salon 2B
Presenters:	Alain C. Enthoven, Ph.D. Professor Graduate School of Business Stanford University Stanford, California Paul Ellwood, M.D. President Jackson Hole Group, Inc. Teton Village, Wyoming	
Content:	*This session will review the theory of managed competition and how it would reorganize the financing and delivery system through the formation of health care networks. It will highlight how this model could be applied in rural areas.*	
10:30 a.m. - 10:45 a.m.	**Break**	Salon 2B Foyer
10:45 a.m. - 12:15 p.m.	**Overview of Expenditure Caps/Global Budgets in Health Reform**	Salon 2B
Presenters:	Lynn Etheredge Consultant Chevy Chase, Maryland Dan E. Beauchamp, Ph.D. Professor State University of New York Albany, New York	
Content:	*This session will review the concept and procedures in setting national spending caps and overall budgets. It will describe alternatives for implementing global budgets, including setting caps on premiums and price controls on providers. It will also describe how expenditure limits might work both with and without the framework of the managed competition model.*	
12:15 p.m. - 2:00 p.m.	**Luncheon and Presentation** **Improving Rural Health** Donna E. Shalala, Ph.D. Secretary Department of Health and Human Services	Josephines

TIME	EVENT	ROOM
2:00 p.m. - 2:30 p.m.	**Rural Issues to be Addressed in Health Reform**	Salon 2B
Presenters:	Dena Puskin, Sc.D. Acting Director Federal Office of Rural Health Policy Rockville, Maryland Ira Moscovice, Ph.D Professor Institute for Health Services Research University of Minnesota Minneapolis, Minnesota	
Content:	*The Federal Office of Rural Health Policy has commissioned a special paper for this conference to identify issues for rural areas that will need to be addressed as health care reform proposals get debated and refined. This session will outline these issues in four broad areas: (1) organization of rural networks; (2) reimbursement arrangements for rural providers; (3) impact on providers and (4) potential roles for state government.*	
2:30 p.m. - 3:45 p.m.	**Panel 1: Organization and Financing of Networks** Alain Enthoven, Ph.D. Steve Rosenberg, Ph.D. President Rosenberg and Associates Point Richmond, California Sandral Hullett, M.D. Medical Director West Alabama Health Service Eutaw, Alabama Tim Size Executive Director Rural Wisconsin Hospital Cooperative Sauk City, Wisconsin	Salon 2B
3:45 p.m. - 4:15 p.m.	**Break**	Salon 2B Foyer

TIME	EVENT	ROOM
4:15 p.m. - 5:30 p.m.	**Panel 2: Impact on Medical Practice** Paul Ellwood, M.D. John Coombs, M.D. Associate Dean of Regional Affairs and Rural Health University of Washington School of Medicine Seattle, Washington Kevin Fickenscher, M.D. Assistant Dean/President and CEO MSU Kalamazoo Center for Medical Studies Kalamazoo, Michigan Roland Gardner Executive Director Beaufort Jasper Comprehensive Health Services Ridgeland, South Carolina Dian Pecora Administrator Southern Humbolt Community Hospital Garberville, California	Salon 2B
5:30 p.m. - 6:30 p.m.	**Panel 3: State Roles** Dan E. Beauchamp, Ph.D. James Bernstein Director North Carolina Office of Rural Health Raleigh, North Carolina Denise Denton Executive Director Colorado Rural Health Resource Center Denver, Colorado Charles McGrew Director Section of Health Facility Services and Systems Arkansas Department of Health Little Rock, Arkansas Sally Richardson Director West Virginia Public Employees Insurance Agency Charleston, West Virginia	Salon 2B
6:45 p.m. - 7:30 p.m.	**Reception for Workgroup Participants**	Salon B

NEW HEALTH CARE SYSTEM:

The Consumer Perspective

1. The government will ensure that the cost of health care does not go up faster than inflation.

2. All Americans will receive a card which guarantees health security -- the right to a nationally guaranteed benefits package, no matter where you live, what you do, or for whom you work.

3. The card can be used anywhere in the country.Either your employer or a group purchaser ("purchasing cooperative") contracts with a number of health care plans and makes sure the plans you choose from offer high quality care and the complete set of benefits to which you're entitled.

4. If you move to another state or job or lose your job, you choose a plan through the purchasing cooperative in your new state or through your new employer.

5. You are likely to be able to choose from HMO-type plans (in which, at one extreme, doctors are on salary), or fee-for-service plans where you choose your own doctor who is an independent contractor.

6. Any plan you choose must take you, regardless of your age or any pre-existing medical condition, and cannot drop your coverage. Premiums will be the same, no matter how sick you are.

7. If you are unhappy with your doctor or plan, you will be able to switch to a new one (at the end of the year or perhaps monthly).

8. If you have a complaint because your doctor or plan won't give you the treatment you want or because you believe you've been mistreated, you can go to a consumer review board attached to your plan. If you don't get satisfaction there, a state health ombudsman will respond to your complaint.

9. Your employer will pay for a significant share (50%, 75%, 80% and 100% are options) of the cost of your health insurance premium. If you are not working, the government might pay a share of (or all of) your premium and co-pay, depending on your income. The amount you pay may vary according to the plan you choose.

10. You will likely be required to participate in a health program and pay your share.

11. The benefits to which you are entitled will likely be equal to the health benefits most workers have today. All Americans will be entitled to the same high quality of care.

12. The benefits to which you are entitled will also include some provisions for preventive care.

13. If you wish to purchase a supplemental package of benefits which provide more than the usual plan, you may, but this will likely come from after-tax income.

14. If you are poor, or live in a rural area, you may be entitled to some extra benefits (such as transportation or eyeglasses).

15. A social/private insurance plan may be provided/offered to all Americans for long term care.

NEW HEALTH CARE SYSTEM:

The Health Care Provider Perspective

Doctors

1. You will still be able to deliver medicine as a private practitioner.

2. As you do today, you and your colleagues will enter contracts with one or more health plans or may form your own health plan. This means that you will form a network with doctors, nursing homes, homecare agencies, outpatient surgical centers, visiting nurse centers, etc. to provide and ensure all care for your plan's enrolled population.

3. The payment you receive for treating a patient may be capped at a pre-determined rate.

4. You will have less administrative work to do since you probably won't bill for every visit, test or procedure and since there will be a simple reimbursement form and uniform quality reporting used by all plans.

5. You will likely receive greater protection from malpractice suits, though you will be subject to review by a board of your peers and consumers in your plan.

6. You will have access to "best practice" guidelines and other clinical assessment to assist you with practicing high quality medicine at affordable costs.

7. If you are a specialist, your income may decline, as there may gradually be less demand for your services in the future. If your are a general practitioner, the demand for your services may increase and your income may go up.

Hospitals

8. You and your colleagues will form contracts with one or more health plans or may form your own health plan. This means that you will form a network with doctors, nursing homes, homecare agencies, outpatient surgical centers, visiting nurse centers, etc. to provide and ensure all care for your plan's enrolled population.

How do we avoid churning? By capitation

How do we keep underwriting from occurring?

10. Your administrative costs will go down (perhaps dramatically), since there will be a simple reimbursement form and uniform quality reporting used by all plans.

11. You will likely share some high-tech equipment with other hospitals in your area and may specialize in certain types of procedure to a greater extent than you do today.

12. Your emergency room will likely be used far less and, in general, you will be deriving a greater portion of your revenue from outpatient services.

13. You will be paid for all your patients; uncompensated care will virtually disappear.

Insurance Companies

13. The health insurance business, as most of you practice it today, will likely disappear.

14. You may choose to become a managed care company which runs health plans.

15. You may choose to sell supplemental insurance policies (possibly). As a managed care company, you will compete by organizing networks of doctors, hospitals, nursing homes, etc.; and by delivering better quality care at better prices to your consumers than does your competition.

16. You may choose to provide services such as information systems management.

17. You may choose to concentrate in other lines of business.

Community rating

NEW HEALTH CARE SYSTEM:

Employers

1. You will be responsible for paying for a Nationally Guaranteed Benefits Package for your employees. You will pay under a nationally set formula (either a percent of premium, a percent of payroll, or some other payment mechanism) on a per employee amount of the total insurance costs of your employees, (the employer share will likely equal anywhere from 50-100% of the total cost).

2. You may pay the amount to a local purchasing cooperative or, if you have more than a certain number of employees (100, 1,000, 10,000 employees), you may ensure your own employees and contract directly with health networks.

3. If you wish to provide supplemental benefits to your employees, you may do so, but it will likely be taxable income for your employees.

4. If you offer health care plans to your employees that are more costly than others that are available, the differential may also be taxable income.

5. If you are a small company with low-wage workers, you may receive a subsidy from the Government for a period of time as mandatory coverage is phased in; and/or there may be a "rainy day" fund you can access if paying health insurance for your employees causes you to lose money.

6. If you are a small company now providing a good benefits package to your employees, your cost of health insurance is likely to be reduced.

7. If you are a large company now providing insurance to your employees, your cost should rise at a slower and more predictable rate in the future than you are now projecting.

8. If you are a company with an older workforce, your costs are likely to go down. If you have a younger workforce, your costs may go up. >due to community rating

9. If you are a company with a significant retiree health liability, your cost will probably go down gradually but dramatically. Because you will have equalized rate

10. If you are a company not now providing health insurance to employees or providing a "bare bones" package, your costs

will go up.

11. Worker's compensation and health insurance may be integrated, reducing current financial and administrative burdens for employers. } Key

12. In the long run, all companies will benefit as labor mobility increases, workers are healthier and health costs rise more slowly.

NEW HEALTH CARE SYSTEM:

The Federal Government Perspective

1. A new or existing federal entity would likely set the parameters for the National Health Care System. This entity would likely:

   - Oversee the Benefits Package to be guaranteed to all Americans;
   - Set budgets (or targets) for annual or bi-annual health care spending;
   - Implement short-term cost controls, if adopted;
   - Set standards for a National Health Care Information System and a National Quality System;
   - Set guidelines for purchasing cooperatives and plans to protect consumers especially vulnerable or underserved populations.

2. The federal and state governments would continue to share responsibility for subsidizing health insurance and co-pays for low-income populations (working and non-working).

3. For physician and hospital care, Medicaid will likely end as we know it -- low-income Americans will become part of the mainstream system.

4. The federal government would adopt national malpractice legislation.

5. The federal government would likely impose mechanisms to "recature" savings to finance expanded coverage, if we adopt these mechanisms.

NEW HEALTH CARE SYSTEM:

The State Government Perspective

1. State governments would likely determine how to organize purchasing cooperatives in their states and would set operating guidelines for health plans.

2. States' welfare payments will likely decrease with the removal of a barrier to job entry.

3. Administration of health care will likely become less complicated as workers' compensation, Medicaid and automobile insurance health care get folded into the new system.

4. Federal malpractice legislation will provide cover for states that would have difficulty passing contentious legislation.

5. Employer-provided coverage for all workers and federal participation and subsidies for non-workers will reduce future burdens for Medicaid and public hospitals.

TIME	EVENT	ROOM
Friday, March 12, 1993		
7:00 a.m. - 8:00 a.m.	**Continental Breakfast**	Galley Lobby
8:00 a.m. - 12:00 noon	**Workgroups:**	
	1. Rural Health Service Areas	Finley Vinson
	2. Supply of Human Resources	Dorel Rogers
	3. Networks: Structure and Formation	Hall of Fame
	4. Networks: Financing	Salon 2D
	5. Networks: Operations	Salon 2E
	6. Public Health	Salon 2F
	7. State Government Roles: Service Delivery/Network Formation	Salon 1D
	8. State Government Roles: Resource Allocation	Salon 1E
12:00 noon - 1:00 p.m.	**Lunch**	Salon C
1:00 p.m. - 1:45 p.m.	**Workgroups: Review/Complete Report**	Salon B
1:45 p.m. - 2:00 p.m.	**Break**	Galley Lobby
2:00 p.m. - 3:00 p.m.	**Brief Workgroup Reports**	Salon B
3:00 p.m. - 3:30 p.m.	**Concluding Comments and Next Steps**	Salon B
3:30 p.m.	**Adjourn**	

Workgroup Descriptions

1. Rural Health Service Areas

This workgroup will examine various approaches for defining regional "health services areas" and their implications for both the delivery and financing of health care services in rural America. It will discuss the populations needed to support various levels of health care services and specialized technology. The workgroup will consider criteria for identifying at-risk and access-critical hospital facilities. It will also explore the potential relationship between health service areas and so-called health insurance purchasing cooperatives (HIPCs) or health insurance networks (HINs).

2. Supply of Human Resources

This workgroup will discuss the availability of health professionals in rural areas and the supply of these human resources needed to provide various levels of services. It will consider differences in urban/rural practice styles, the role of non-physician providers, and how specialty services and technology will be made available for rural consumers. Participants will also discuss the potential impact of network development on recruitment and retention efforts, the role of non-physician providers, and approaches for increasing the supply of rural providers through improved health professional training programs.

3. Networks: Structure and Formation

This workgroup will discuss issues related to the structure and formation of regional health care networks. It will consider the composition, ownership and governance of networks and discuss perceived legal barriers to network formation, (e.g., antitrust laws and corporate practice of medicine rules). The network's role in defining quality, cost and access goals for the rural community region will also be explored.

4. Networks: Financing

This workgroup will consider how the health care services provided by rural networks should be financed. It will cover topics such as setting rates, distributing risk, and regulating contractual relationships. The workgroup will also consider approaches for financially protecting certain providers deemed essential for assuring access to services.

5. Networks: Operations

This workgroup will focus on how health care networks would operate on a day-to-day basis. It will discuss how network providers can coordinate their quality assurance programs, share information/data systems (including patient records), and structure referral agreements. It will examine how hospitals, emergency medical services, community health centers, long-term care providers, and other non-hospital providers would work together within a network structure.

6. Public Health

This workgroup will explore the extent to which public health services could/should be integrated with personal health services under health reform. Specific public health services that should remain outside of the health insurance system (e.g., systems for tracking and reporting disease, environmental health, etc.) will be identified. It will discuss outstanding examples of services integration and coordination in rural areas that could provide useful models for both urban and rural delivery and financing systems. Specific attention will be paid to meeting the needs of vulnerable and traditionally underserved populations.

7. State Government Roles: Service Delivery and Network Formation

This workgroup will discuss the role of states in facilitating the formation of rural health networks, certifying them, and monitoring their performance. It will examine ways that states could overcome antitrust barriers and suggest the kinds of technical assistance states could provide to help link health resources regionally and statewide. It will also discuss the state's role in designating health insurance purchasing agents (e.g., HIPCs, HINs) and their relationship to the restructured delivery system.

8. State Government Roles: Resource Allocation

This workgroup will explore the role of the state in determining how financial resources, technology, and health care personnel are deployed, especially in sparsely populated areas. This workgroup will discuss the kinds of resources needed to operate health care data-collection and planning systems. It will discuss how states can utilize both resource allocation methods and competitive markets to meet their health care access, cost and quality goals.

BIOGRAPHICAL SKETCHES OF PRESENTERS

Nancy L. Barrand

Ms. Barrand is a Senior Program Officer at The Robert Wood Johnson Foundation, where she is responsible for developing programs in health care financing and organization. Prior to that, she served on Senator Alan Cranston's legislative staff where she focused on health and related issues. She has also worked as a legislative staff member in the California State Assembly and spent a year with the Institute for Health Policy Studies at the University of California at San Francisco.

Dan E. Beauchamp, Ph.D.

Dr. Beauchamp is a professor and Chairman of the Department of Health Policy and Management at the State University of New York at Albany. Prior to this, he was the Deputy Commissioner of the New York State Department of Health's Division of Planning, Policy and Resource Development where he was responsible for leading a staff of fifty charged with developing major new policy studies and initiatives for State Department of Health. He also led the development of the department's proposal for universal health insurance, Universal New York Health Care.

James D. Bernstein

Mr. Bernstein has been director of the North Carolina Office of Rural Health and Resource Development since its inception in 1973. Under his leadership, the Office has helped to establish 54 primary care rural health centers in underserved areas of North Carolina. It also developed a recruitment program that has brought more than 1,100 physicians to the state, and provides technical assistance to small rural hospitals. Mr. Bernstein is also President of the nonprofit North Carolina Foundation for Alternative Health Programs founded in 1983 to address health care costs and access issues. In addition, he currently serves as National Program Director for *Practice Sights: State Primary Care Development Strategies,* a national initiative supported by The Robert Wood Johnson Foundation. Since 1970, Mr. Bernstein has served as a research associate for the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill and currently serves as co-director of the Rural Health Research Program at the Sheps Center.

Daniel M. Campion

Mr. Campion has been an Associate with the Alpha Center since June 1989. He is deputy director of The Robert Wood Johnson Foundation's Technical Resource Center for the Essential Access Community Hospital Program, a $20-million federal program administered by the Health Care Financing Administration. He also assists in coordinating the Foundation's State Initiatives in Health Care Financing Reform Program. Mr. Campion assists in developing and producing policy workshops for state and local government officials on behalf of the Agency for Health Care Policy and Research (AHCPR) User Liaison Program. Prior to working in health policy, he served as an interim clinic director of the Rainier Vista Community Health Clinic in Seattle, Washington. Mr. Campion graduated with honors in biology from the College of the Holy Cross and earned a master's degree in public and private management from the Yale School of Organization and Management.

John B. Coombs, M.D.

Dr. Coombs is the former vice president of medical affairs at MultiCare Medical Center in Tacoma, Washington, and has had ten years of experience in rural family practice, eight years of which were spent as chief of staff in two under-fifty-bed rural hospitals. He has been a member of the American Hospital Association Governing Council for Small and Rural Hospitals for the past five years. He is also a member of the National Rural Health Association board of directors and served as chairman of the American Academy of Family Physician Committee on Rural Health from 1985 to 1990. From 1990 to 1992, Dr. Coombs chaired the American Hospital Association ad hoc committee on practice profile analysis leading to publication in 1992 of their findings in the monograph, "Practice Profile Analysis." In addition, he is a member of the American Academy of Pediatric's committee on quality improvement, charged with developing clinical practice guidelines for children. His particular focus of interest in this responsibility has been in the area of dissemination and implementation of practice guidelines. Currently, Dr. Coombs is the associate dean for regional affairs and rural health, as well as professor of family medicine and pediatrics at the University of Washington School of Medicine in Seattle.

Denise Denton

Ms. Denton is the Executive Director of the Colorado Rural Health Resource Center. She is responsible for directing a statewide rural health office whose mission is to improve the availability of and access to quality health care in rural Colorado by creating a focal point for and coordination of rural health resources. Before coming to the Colorado Rural Health Resource Center, Ms. Denton was the Primary Care Programs Director at the Rural Health Office. Additionally, she served as the Rural Health Field Coordinator at the Bureau of Local and Rural Health in the Utah Department of Health.

M. Joycelyn Elders, M.D.

Dr. Elders is a native of Schaal, Arkansas, and has had a distinguished career in medicine. After graduation from Medical School in 1960, she worked as an intern at the University of Minnesota Hospital and as a pediatrician at the University of Arkansas Medical Center. She became a professor of pediatrics at University of Arkansas Medical School in 1976 and received a board certification as a pediatric endocrinologist in 1978. Based on her studies in growth in children and the treatment of hormone related illnesses, she has written 151 articles for medial research publications. In August of 1992, Dr. Elders accepted the presidency of the Association of State and Territorial Health Officers. She is a member of many health related organizations including the Southern Society for Pediatric Research, the Central Arkansas Academy of Pediatrics, the American Diabetes Association, the United Cerebral Palsy, the Endocrine Society and many more.

Paul M. Ellwood, M.D.

Dr. Ellwood is the President and CEO of InterStudy as well as President and CEO of the Jackson Hole Group. He and his colleagues at InterStudy have been instrumental in restructuring the U.S. health system by: introducing competition as a national health policy into the medical marketplace through HMOs, PPOs and managed care during the 1970's and 1980's; proposing the business coalition movement as a means for business to cope with rising medical care costs; and proposing and developing plans that led to the establishment of the National Center for Health Services Research and Development. Dr. Ellwood practiced medicine for 17 years and was coeditor of the Handbook of Physical Medicine. He is the first recipient of the U.S. Healthcare Quality Award for his outstanding contributions to the improvement of quality of health care in the United States. At the culmination of a career of attempting to improve the performance of the American Health System, Paul Ellwood is now concentrating on working with health care leaders to devise and implement "The 21st Century American Health System" to assure universal insurance coverage, managed competition, and health outcome accountability.

Alain C. Enthoven, Ph.D.

Dr. Enthoven is the Marriner S. Eccles Professor of Public and Private Management in the Graduate School of Business at Stanford University. Previously, he has served as an economist with the RAND Corporation, Assistant Secretary of Defense, and President of Litton Medical Products. In 1963, he received the President's Award for Distinguished Federal Civilian Service from John F. Kennedy. He is a member of the Institute of Medicine of the National Academy of Sciences and a fellow of the American Academy of Arts and Sciences. He is also Chairman of the Health Benefits Advisory Council for California PERS (Public Employees' Retirement System), former Chairman of Stanford's University Committee on Faculty/Staff Benefits, and a consultant to Kaiser Permanente. His most recent book is Theory and Practice of Managed Competition in Health Care Finance.

Lynn M. Etheredge

Mr. Etheredge is an independent consultant who works with the public and private sectors on health care financing, income security and government policy issues. He served in federal health positions during four administrations, including working on national health insurance issues in the 1970s and directing the professional health staff of the Office of Management and Budget (OMB) in both the Carter and Reagan administrations. He now consults with many government and private sector organizations. Mr. Etheredge's recent articles, among more than 40 publications, include "Universal Health Insurance: Lessons of the 1970s, Prospects for the 1990s," "Negotiating National Health Insurance," and "Managing a Pluralist Health System." He is a graduate of Swarthmore College.

Kevin M. Fickenscher, M.D.

Dr. Fickenscher is the Assistant Dean and President/CEO of the Michigan State University/Kalamazoo Center for Medical Studies. The Center is one of six campuses of the MSU College of Human Medicine. Dr. Fickenscher is an active member and past president of the National Rural Health Association. As a leader in rural health, Dr. Fickenscher participates regularly in discussions, debates and presentations related to the future of the U.S. health care system. He frequently testifies before the U.S. Congress on rural health issues and is consulted by many groups for his expertise in rural health. His primary interests include community development, leadership, community-based medical education, cost containment in health care services, and the integration of health systems. Prior to his current position, Dr. Fickenscher was instrumental in developing the North Dakota Office of Rural Health.

Roland J. Gardner

Mr. Gardner is the Executive Director of Beaufort-Jasper Comprehensive Health Services, Inc. (B-JCHS). His responsibilities include the overall operation of the corporation, including patient care, financial management, personal management, facilities, long-range planning, public relations B-JCHS provides health care for three rural counties and contiguous areas under Section 330 funding. These services include: medical, dental, laboratory, radiology, nursing, counseling, home health, nutrition counseling, pharmacy, medical social work, environmental health and transportation. Before coming to B-JCHS, Mr. Gardner was the director of the Beaufort County Department of Social Services where he was responsible for the administration of all social services programs at the county level.

W. David Helms, Ph.D.

Dr. Helms has led the Alpha Center, a private, nonprofit health policy center, since it was established in 1976. He has directed a wide range of health policy and planning projects for federal and state governmental agencies, state and local health planning agencies, and private foundations. Dr. Helms serves as Program Director for The Robert Wood Johnson Foundation's State Initiatives in Health Care Financing Reform program which is supporting state experiments to increase access to health care coverage and control health care costs. Through the Center's contract with the Agency for Health Care Policy and Research (AHCPR) and its User Liaison Program, Dr. Helms conducts workshops and develops research reviews for senior state and local health officials. He also serves as Director of the Technical Resource Center for the Health Care Financing Administration's (HCFA) Essential Access Community Hospital/Primary Care Hospital (EACH/PCH) program which is developing regional hospital networks to preserve access to health care in remote rural areas. Dr. Helms received his doctorate in public administration and economics in 1979 from the Maxwell School of Citizenship and Public Affairs, Syracuse University.

Sandral Hullett, M.D.

Dr. Hullett is presently Health Services Director of West Alabama Health Services, a community health center located in rural western Alabama. Since completing a residency in Family Practice and fulfilling a National Health Services Corporation obligation, she has developed an interest in rural health care including health care planning and delivery to the underserved, underinsured and poor of this area. Originally teaching Science and Math in rural Alabama, she later worked as a research assistant at Columbia University Institute of Cancer Research. Dr. Hullett now devotes time to direct patient care, administration, teaching and research in direct care delivery. For her efforts in rural health, she was named Rural Practitioner of the year in 1988 by the National Rural Health Association, and has received the William Henry Sanders Award by Alabama Medical Association for her public health work.

Charles W. McGrew

Mr. McGrew is the Director for the Arkansas Department of Health Section of Health Facility Services and Systems. As the Director, he is responsible for both regulation and licensure of all health care facilities (HMOs, hospitals, ambulatory surgery center, abortion clinics, ambulance services, etc.) and planning for health care systems improvements. Prior to coming to the Arkansas Department of Health, Mr. McGrew was the Director of the Missoula City-County Health Department in Missoula, Montana, where he was responsible for the operation of the largest and most complex autonomous health department in Montana.

Ira S. Moscovice, Ph.D.

Dr. Moscovice is a Professor and Associate Director of the Institute for Health Services Research at the University of Minnesota's School of Public Health. He has written extensively on the use of health services research to improve health policy decision-making in state government and rural health care delivery systems. Dr. Moscovice has directed an evaluation of The Robert Wood Johnson Foundation's Hospital-Based Rural Health Care Program and currently is involved with HCFA's evaluation of the EACH/RPCH program. He has testified several times before Congress on rural health issues and presented at numerous workshops on health issues for state and federal policymakers. In 1992, he was the first recipient of the National Rural Health Association's Distinguished Researcher Award. Dr. Moscovice received his doctorate in operations research from Yale University in 1976.

Dian Pecora, R.N.

Ms. Pecora began her health care service career in 1969 as a registered nurse at St. John's Hospital in Santa Monica, California. In 1979, she relocated to rural Northern California and joined the Southern Humboldt Community Hospital District where she has been a charge nurse and became Director of Nursing Services and, since 1986, Administrator. Her activities over the past six years have focused on maintaining access to basic health care services for the community. She is engaged in research, evaluation and the development of education systems focused on rural health care as well as the development of networking systems to improve health care access and quality. Ms. Pecora received her bachelor of science in nursing from the University of North Dakota.

Dena S. Puskin, Sc.D.

Since 1988, Dr. Puskin has been Deputy Director of the Office of Rural Health Policy in the Health Resources and Services Administration. Dr. Puskin is serving as Acting Director of the Office while the Director is on an eleven month leave of absence. In her current position, she shares responsibility for the total management of the office with the Director. Her responsibilities include coordinating and directing the staff support of the National Advisory Committee on Rural Health, overseeing grant programs, and substantial representation of the Office, through speeches, reports and academic papers. She also is responsible for overseeing the analytic policy development activities of her office, including those related to health care financing and health systems development in rural areas. In the course her career, Dr. Puskin has gained broad experience in health care financing, health services research, and the application of telecommunications technology in medicine. Prior to joining the Office of Rural Health Policy, Dr. Puskin was a senior health policy analyst with the Prospective Payment Assessment Commission (ProPAC), a commission mandated to advise the Congress on the Medicare payment system for hospitals.

Carol Hampton Rasco

Carol Hampton Rasco, Assistant to the President for Domestic Policy, is a native Arkansan who worked with President Bill Clinton in the Arkansas Governor's Office for ten years. As the President's chief domestic policy advisor, Ms. Rasco supervises and coordinates the work of the White House staff of the President's Domestic Policy Council. Ms. Rasco and her staff also work closely with First Lady Hillary Rodham Clinton on the President's Health Care Reform Task Force. In Arkansas, Ms. Rasco was Governor Clinton's Senior Executive Assistant responsible for the staff and operations of the Governor's office. From 1985 through 1992, she was Governor Clinton's Liaison to the National Governors' Association. During this period, she worked closely with the NGA's Washington staff both during Governor Clinton's Chairmanship and while he was lead Governor on welfare reform, child care and health care reform.

Sally K. Richardson

Ms. Richardson is the Director of the West Virginia Public Employees Insurance Agency in Charleston, West Virginia. In this position, she had developed strategies to correct an $85,000,000 inherited claims payment deficit, developed and implemented organizational changes to bring financial stability to a historically troubled agency, and worked with other state agencies responsible for health services payments to use state dollars to improve access to and the quality of health services. Additionally, she serves as the Vice Chair of the West Virginia Health Care Planning Commission. In this position, she has chaired a task force on finance and cost control to analyze and recommend strategies for reform and participated in drafting and editing the Commission's interim and final reports, and legislative recommendations. Ms. Richardson is also the Governor's designee to oversee work of the Legislative Commission charged with developing a system of universal access to affordable, quality health care for all state residents.

Steve Rosenberg

Mr. Rosenberg is president of Rosenberg Associates. Mr. Rosenberg is a health care financing consultant who has specialized for the last 20 years in analyzing, developing, and implementing strategies to create revenue for community and migrant health centers, rural hospitals, and school-based clinics. He has also been a consultant to several federal government agencies, including BPHC, the National Institutes of Health, and the Agency for Health Care Policy and Research, all within DHHS.

Donna E. Shalala, Ph.D.

Dr. Shalala was sworn in as Secretary of Health and Human Services (HHS) January 22, 1993. She was nominated by President Clinton January 20 and confirmed by the Senate January 21. She brings two decades of experience in management, social policy creation and analysis, and nationally recognized leadership skills to her responsibilities as head of the Department of Health and Human Services, the government agency representing 40 percent of the federal budget and including more than 250 programs. Secretary Shalala oversees the "people's department," the federal agency responsible for the major health, welfare, food and drug safety, medical research and income security programs serving the American people. HHS provides direct services or income support to more than one in every five Americans. Before coming to HHS, Secretary Shalala had served since January 1988 as chancellor of the University of Wisconsin at Madison, the first woman to head a Big Ten university. UW-Madison, the nation's sixth largest university, is the largest public research university and performs more biomedical research than takes place in any other single site in the United States except HHS' National Institutes of Health. In 1980, Secretary Shalala became the youngest woman to lead a major U.S. college when she assumed the presidency of Hunter College, part of the City University of New York System. In addition, Secretary Shalala has been on the board of the Children's Defense Fund for more than a decade, becoming its chair in 1992. She was also a member of the Committee for Economic Development that issued reports on strategies to better meet the health and educational needs of disadvantaged young children.

Tim Size

Mr. Size has been the Executive Director of the Rural Wisconsin Cooperative in Sauk City since its establishment in 1979. He spent three years as the administrator of the Hospital Metodista in La Paz, Bolivia and five years on the administrative staff at the University of Wisconsin Hospital and Clinics. In Wisconsin he is a member of Wisconsin's Rural Health Development Council, Health and Educational Facilities Bond Authority and is chair of the Area Health Education Center System Advisory Committee. He has been on the board of the National Rural Health Association since 1985 and was awarded a W.K. Kellogg Foundation National Fellowship in 1987. The Winter 1993 issue of *Health Care Management Review* contained his most recent article: "Managing partnerships: The perspective of a rural hospital cooperative?"

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OVERVIEW OF MANAGED COMPETITION/NETWORKS IN HEALTH REFORM

Presenters:

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Materials:

- Alain C. Enthoven, "Managed Competition in Health Care Financing and Delivery: History, Theory and Practice," paper commissioned by The Robert Wood Johnson Foundation for use at its invitational workshop, *Rethinking Competition in the Health Care System: Emerging New Models*, January 7-8, 1993.

- The Jackson Hole Group, "Rural Health Care: Improvements Through Managed Competition," a draft discussion paper, February 24, 1993.

MANAGED COMPETITION IN HEALTH CARE FINANCING AND DELIVERY: HISTORY, THEORY AND PRACTICE

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This paper was commissioned by The Robert Wood Johnson Foundation for use at its invitational workshop, *Rethinking Competition in the Health Care System: Emerging New Models*, held January 7-8, 1993.

MANAGED COMPETITION IN HEALTH CARE FINANCING AND DELIVERY: HISTORY, THEORY AND PRACTICE

Alain C. Enthoven

December 18, 1992

Prepared for "Rethinking Competition in the Health Care System: Emerging New Models," A Workshop Sponsored by the Robert Wood Johnson Foundation Under its Changes in Health Care Financing Initiative, Conducted by the Alpha Center, Washington, D.C. January 7-8, 1993.

I. A Brief History of Our Non-Competitive Health Care System

To understand the procompetition movement and the idea of managed competition, one must first understand the history of the noncompetitive system we have today.

The word "competition" in the economic sphere, as used by economists, if not qualified by some phrase indicating the contrary - such as "non-price competition" - means **price** competition. When there is price competition, suppliers compete to serve customers who are using their own money or are otherwise motivated to obtain maximum value for money. "Price competition" does not mean that price is the only factor influencing the customer's choice. Quality and product features also enter in. It just means that price is one of the factors. Perhaps "value for money competition" would be a more apt phrase. And one of the striking features of the United States health care economy to date is how little value for money competition there is.

In an article entitled *Free Choice as a Restraint of Trade in American Health Care Delivery and Insurance,* Weller described our traditional system of fee-for-service, solo (or small single specialty group) practice, free-choice-of-provider, and payment by a remote third party as "Guild Free Choice."[1] The principles of this system and their economic consequences were as follows:[2]

1. "Free choice of doctor by the patient" which means that the insurer has no bargaining power with the doctor because it cannot say to the doctor, "my insured patients will not go to you if you do not agree to a negotiated price."

2. "Free choice of prescription by the doctor, without outside interference" which prevents the insurer from applying quality assurance or review of appropriateness.

3. "Direct negotiation between doctor and patient regarding fees, without outside interference," which excludes the third-party payor who would be likely to have information, bargaining power, and an incentive to negotiate to hold down fees.

4. "Fee for service payment" which allows physicians maximum control over their incomes by increasing the services provided.

5. Solo practice, because multispecialty group practice constitutes a break in the seamless web of mutual coercion through control of referrals that the medical profession used to enforce the guild system.

These principles dominated the health care system in the USA until well into the 1980s, and their effects are still important today. They were enforced by legislation (e.g., guild principles were built into all State insurance codes until the 1980s and into Title XVIII of the Social Security Act), boycotts (e.g., by doctors against hospitals contracting with HMOs), professional ostracism (e.g., from county medical societies and hospital staffs), denial of medical staff privileges, and harassment.[3]

Blue Cross and Blue Shield were created, respectively, by hospital associations and medical societies, as chosen instruments to apply the guild principles to health care finance. For example, the hospitals subsidized Blue Cross plans by giving them discounts. Only in fairly recent years have providers been forced to yield controlling positions on Blue Cross and Blue Shield boards.[1]

The commercial insurance companies offered coverage based on the casualty insurance model. They comfortably accepted the guild principles because they were, and, with a few important exceptions, remain financial intermediaries with expertise in underwriting risks, not in organizing, managing or purchasing medical care.

Employers fit into this model. A few attempted to contract selectively with doctors for the care of their employees. But for the most part, this was beaten down by organized medicine.[3] In overwhelming majority, employers offered traditional "guild free choice" coverage of either the Blue or commercial variety because that was all there was. The typical pattern was virtually 100 percent employer-paid coverage. This pattern spread rapidly because health insurance was an attractive fringe benefit, it was cheap, it was tax deductible to the employer and tax free to the employee, employment groups could buy coverage at much less than the cost of individual coverage, and employer-paid health benefits were a great source of bargaining prizes for unions. In the minds of many employees, fee-for-service coverage fully paid by the employer became normal, an entitlement.

When HMOs entered the scene in large numbers in the 1970s, and employers were required to offer them, employers usually agreed to pay the premium of the HMO in full as long as it did not exceed the cost of the traditional coverage. Thus, HMOs were placed in the noncompetitive system created by the guild model.

Employment-based insurance spread to small employers. Roughly half the privately employed labor force is in groups of 100 or less, or self-employed. This added another element of noncompetition: such groups are too small to offer individual employees a choice of health care plan (see section V below).

Medicare and Medicaid adopted the dominant guild model. Section 1801 of the Social Security Act prohibits any federal interference in the practice of medicine; section 1802 is entitled "free choice by patient guaranteed."

All of this created a system dominated by the cost-increasing incentives of fee-for-service payment combined with the cost-unconscious demand of insured

patients. This, in turn, inspired greatly increased numbers of people to choose careers in medicine, especially high-paid specialties. This was fueled by federal grants to induce medical schools to expand. And this open-ended cost-unconscious demand, combined with large increases in federal funding for biomedical research, led to a huge outpouring of costly new medical technologies.

Finally, in markets that function well, there is usually an adequate supply of information to assist purchasers in making decisions. For example, under laws administered by the Securities and Exchange Commission, securities may not be sold to the public unless there are audited financial statements, certified as in compliance with generally accepted accounting principles as defined by the Financial Accounting Standards Board. In health care, not only is there no similar regulation to require the uniform production of health outcomes information (e.g.,mammography, immunization or surgical mortality rates). But providers have been active and successful in political activities to block access to such information.[4]

II. The Beginnings of "Competition"

The precursors are many.[5,6] But the origins of today's competitors are in the prepaid group practice movement, multispecialty group practices that contracted with employment groups and individuals to provide a comprehensive set of health care services in exchange for a periodic per capita payment set in advance. The pioneers of the prepaid group practice movement introduced the concept of the "limited provider" or "closed panel" plan as a significant competing alternative. They survived in the face of determined opposition by organized medicine and proved the acceptability of prepaid group practice and its economic superiority over the traditional model.[7,8] They successfully advocated dual or multiple choice, by individual subscribers, of closed panel plans as an alternative to "guild free choice." The flagships of this movement included Ross Loos in Los Angeles, started in 1929, Group Health Association in the District of Columbia (1935), Group Health Cooperative of Puget Sound (1945), and Kaiser Permanente, with roots in the 1930s.

In 1960, the federal government adopted health insurance for its employees. The Blues and the commercials sought a noncompetitive guild model. But federal employees who were members of prepaid group practices were sufficiently numerous and vocal that a compromise was adopted under which the federal government would offer a range of individual choice of plan and a defined contribution. The Federal Employees Health Benefits Program (FEHBP) had both good and bad design features.[9] On the good side was price-conscious individual choice; on the bad, nonstandard benefits and lack of a design to manage biased risk selection. But it did demonstrate on a large scale that choice of plan arrangements were feasible and comparatively economical.

These practical achievements, which were of fundamental importance, came to be reflected in the writings of scholars and public policy analysts. In 1970, Ellwood, McClure et.al. proposed a national "health maintenance strategy" that would deal with the crisis in health care cost and distribution by promoting "a health maintenance industry that is largely self-regulatory."[10] Their work led directly to the Health Maintenance Organization (HMO) Act of 1973. In 1972 and 1973, while serving in the Department of Health, Education & Welfare (DHEW) Fleming designed and recommended a proposal for national health insurance that he called "Structured Competition Within the Private Sector."[11] His proposal emphasized practical ways of extending the successful experience of the FEHBP to the whole population. In 1977, I designed and recommended Consumer Choice Health Plan (CCHP), "a national health insurance proposal based on regulated competition in the private sector," to the Carter Administration.[12] CCHP built on Ellwood, McClure, and Fleming's ideas and added design proposals to deal with such issues as financing, biased selection, market segmentation, information costs, and equity. Havighurst attacked "professional restraints on innovation in health care financing" from the perspective of antitrust law.[13] By the end of the 1970s, the idea of a competitive health care economy had attained intellectual respectability and a significant following in Congress.

An additional departure from the "Guild Free Choice" model occurred in the 1980s, starting with enactment of AB 3480 by the California legislature in 1982. AB 3480 overturned the previous prohibition on selective contracting with

providers by insurers and authorized Preferred Provider Insurance (PPI). Under PPI, the patient obtains better coverage if he or she receives services from contracting "preferred" providers. This creates an incentive for providers to contract and to accept the insurer's fee schedule and utilization controls. Many other states followed California in subsequent years.

III. From "Early Competition" to "Managed Competition"

Experience showed that Fleming's "structured competition" and my "regulated competition" did not quite describe what we had in mind. Our form of government is very inflexible. It is very difficult and time-consuming to change such things as the Medicare law and regulations which have been negotiated with financially and politically powerful interest groups that can block efficiency-improving changes that are to their disadvantage. And civil servants are not allowed to use judgment; they are supposed to administer regulations. And they can act only on evidence that can stand up in court. Both our terms were taken to suggest that the intent was to structure the market by a set of rules laid down once and for all, with purchasing by individual consumers, and a passive regulatory agency. Whatever set of rules one proposes, critics could and did dream up ways that health plans might get around them to their advantage. The critics hypothesized a contest between intelligent, adaptive health care plans and a rigid, unchanging set of rules--an unequal contest at best. As they identified actual or hypothetical problems, I would often reply, "I think that problem could be managed using the following tools ...." This led me to believe that a more accurate characterization of what actually works would be "managed competition."

Managed competition must involve intelligent, active collective purchasing agents contracting with health care plans on behalf of a large group of subscribers and continuously structuring and adjusting the market to overcome attempts to avoid price competition. I call these agents "sponsors;" they play a central role in managed competition. A sponsor is an agency that contracts with health plans concerning benefits covered, prices, enrollment procedures, and other conditions of participation. Managed competition also connotes the ability to use judgment to achieve goals in the face of

uncertainty, to be able to negotiate, and to make decisions on the basis of imperfect information. It takes more than mere passive administration of inflexible rules to make this market work.

IV. What Is Managed Competition?

Managed competition is a purchasing strategy designed to obtain maximum value for money for employers and consumers. It uses rules for competition, derived from rational microeconomic principles, to reward with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost and satisfying patients. The "best job" is both in the judgment of the sponsor, armed with data and expert advice, and informed cost-conscious consumers. The rules of competition must be designed and administered so as not to reward health plans for selecting good risks, segmenting markets or otherwise defeating the goals of managed competition.

Managed competition occurs at the level of integrated financing and delivery plans, not at the individual provider level. Its goal is to divide the providers in each community into competing economic units and to use market forces to motivate them to develop efficient delivery systems (see part VI below).

Managed competition is **price** competition, but the price it focuses on is the annual premium for comprehensive health care services, not the price for individual services. There are several reasons for this. First, the annual premium encodes the total annual per person cost. It gives the subscriber an incentive to choose the health plan that minimizes total cost. Second, it is the price that people can understand and respond to most effectively, during the annual enrollment, when they have information, choices, and time to consider them. Third, sick nonexpert patients and their families are in a particularly poor position to make wise decisions about long lists of individual services they might or might not need. They need to rely on their doctors to advise what services are appropriate and on their health plans to get good prices. For economical behavior to occur, doctors must be motivated to prescribe economically. Managed competition is compatible with selected copayments and deductibles for individual services that can influence

patients to do their part in using resources wisely, and that are price signals patients can understand and to which they can respond.

To understand managed competition, one must begin with the concept of a Sponsor.

Sponsors and Managed Competition

Markets for most goods and services are normally made up of suppliers on one side and individual purchasers on the other. That is the case in automobile or homeowner insurance and to a limited extent in health insurance. Some national health care financing reform proposals are based on that model.[14, 15] In my view, that model is unworkable in health insurance for a number of reasons, and it is not the model that actually works in most of private health insurance in the USA.

Among the reasons the market for health insurance does not work at the individual level are the following:

1. Insurers have strong incentives to group their customers by expected medical costs and to charge people in each group a premium that reflects their expected costs. This practice is known as experience rating or underwriting. The consequence is that those people having high predicted medical costs face high premiums. Many sick people find such premiums unaffordable, or at least find paying them less attractive than going without insurance and taking their chances that they will receive free care.

2. Healthy individuals face strong incentives to "free ride," that is, to go without insurance or with minimal coverage until they get sick, at which point they seek to buy comprehensive coverage. People are likely to know more about their prospective medical needs than do insurers.

3. Partly because of the behaviors induced by these incentives, and partly because of very high marketing costs to reach individuals or small groups, the administrative costs of individual health insurance policies

are very high, 40 percent of medical claims or more. This creates more of an incentive for relatively healthy people to go without insurance. Rather than bear the risks and expenses of covering individuals who are sick, even at high price that would cover their expected costs, most insurers choose not to cover them at any price.

4. Health insurance contracts are extremely complex and difficult to understand and administer. Insurers deliberately make them even more complex in order to segment markets (see below), and to make it difficult for consumers to compare prices. Only experts are able to understand and compare policies.

The model of private health insurance that works - the one that covers most employed people - is group insurance with a sponsor. Most sponsors are employers, but the federal Medicare program and labor-management health and welfare trusts are also sponsors. Examples of large employers that offer their employees such a multiple choice of health care coverage include the federal government, many states including the States of California, Wisconsin and Minnesota, and Stanford University. While some HMOs and some PPI carriers compete in the market for unsponsored individuals, most of their business is in sponsored groups. Sponsors set the rules for competition among them.

Sponsors Establish Rules of Equity

In managed competition, the sponsor has several important functions. First, through contracts with the participating health plans, it establishes and enforces principles of equity such as the following:

1. Every eligible person is covered or at least is offered coverage on terms that make it attractive, even for persons with low expected medical costs, and at a moderate financial cost. Health plans accept all eligible persons who choose them.

2. Every eligible person has subsidized access to the lowest-priced plan meeting acceptable standards of quality and coverage. Anyone choosing

a plan priced above the lowest-priced plan must pay the full premium difference with his/her own money.

3 Continuity of coverage: once enrolled, a person's coverage cannot be cancelled (except for nonpayment of premium or serious noncompliance with reasonable norms of patient behavior). Moreover, everyone can re-enroll at the annual enrollment.

4. Community rating (or limited departures from it): that is, the same premium paid for the same coverage regardless of the health status of the individual or small employment group. (This might or might not be blended with, e.g., age rating if it is felt that pure community rating requires excessive subsidies of the old by the young.)

5. No exclusions or limitations on coverage for pre-existing conditions.

Obviously, some of these principles may have to be compromised with other practical considerations, depending on the circumstances.

Sponsors Select Participating Plans

The sponsor must select the participating health plans. The freedom the sponsor can have in doing this will depend on the circumstances. A private employer will have more freedom of action then a public employer. And a public employer will be able to exercise more freedom than a Health Insurance Purchasing Cooperative (HIPC) that serves as the gatekeeper for much or all of the market in a geographic area. (See section V below for HIPCs.)

Sponsors Manage Enrollment Process

The sponsor manages the enrollment process. The sponsor should serve as the single point of entry to all participating health plans. The subscriber notifies the sponsor of his choice of plan (probably through the employer) and the sponsor notifies the health plan. This is normal in large employment groups, but is, unfortunately, not the usual practice with such public programs as Medicare and Medicaid. The purpose is to create an institutional embodiment of the principle that health plans take all comers, and to obviate

what would otherwise be a large set of opportunities for screening and selecting applicants.

The sponsor must define the enrollment procedures. The sponsor must arrange to give each subscriber an annual opportunity to switch plans. And it must establish procedures for the enrollment of newcomers and for those with changes in address or family composition.

The sponsor should prepare informative materials about the benefits covered, the characteristics of the health plans and locations of their providers, and summarizing relevant information about quality.

The sponsor establishes contractual payment terms with participating employers and individuals. And the sponsor runs a clearing house for the money.

Sponsors Create Price-Elastic Demand

Next, the sponsor must seek to create price-elastic demand. (A seller faces inelastic demand if it can increase revenue by raising price; elastic demand if it increases revenue by reducing price.) As noted above, for the most part, employers--under pressure from unions, other employees, and abetted by the tax laws--have failed to create price-elastic demand for HMOs and other managed health plans.[16] Elastic demand is a necessary condition for price competition to motivate price reduction. For there to be an incentive for health plans to cut price, demand must be so elastic that the additional revenue gained exceeds the additional cost of serving more subscribers. Managed competition is about creating such price elasticity.[16] The following are some of the main tools for accomplishing this.

1. Employer/Sponsor Contributions. The key point is that the sponsor's contribution to premium must not exceed the price of the lowest-priced plan. An essential component of managed competition, is that it must always be possible for the lowest-priced plan to take business away from higher-priced plans by cutting premium more. The lowest-priced plan must be able to widen the gap between its price and the next lowest by cutting price. Premiums of course are quoted in the context of annual

enrollments. The sponsor sets its contribution after the health plans have submitted their quotes.

2 Standardize the coverage contract to deter product differentiation, to facilitate price comparisons, and to counter market segmentation.

There are several powerful reasons for as much standardization as possible within each sponsored group. The first is to facilitate value for money comparisons and to focus comparison on price and quality. The second is to combat market segmentation, that is, dividing the market into groups of subscribers who make choices based on what each plan covers (e.g., mental health, vision care) rather than on price. The third is to reassure people that it is safe financially to switch plans for a lower price because standardized coverage contracts assure consumers that lower-priced plans did not realize savings by creating hidden gaps in coverage. The fourth is that biased risk selection can reduce demand elasticity for health plans that enroll a favorable mix of risks. This is an additional reason why the sponsor must manage risk selection (see below). Standardizing the coverage contract is one of the tools for managing risk selection.

3. Quality-related information. People will be reluctant to switch from Plan A to Plan B to save $20 per month if they have no information that Plan B is safe for their health.

The Jackson Hole Group proposes creation of a national Outcomes Management Standards Board that would set standards for outcomes reporting.[17] Sponsors should play a role in making such information available in a readable form in the local market. Sponsors are also the appropriate agencies to survey their sponsored populations regarding experience with health plans and to publish the results for consumers.

4. Sponsors should structure the market to offer annual choice of plan at the **individual** subscriber level, not the employment group level. Limitation of choice to the group level is a major barrier to price-elastic demand. (Effective managed care plans are linked to specific doctors.

Some people have strong attachments to their doctors. It is thus much harder to persuade a whole group to change plans and doctors to obtain lower premiums than to allow individuals who are willing to change to choose to do so.)

There are other opportunities for sponsors to exercise ingenuity in making demand curves for health plans more price elastic. For example, an alert sponsor might create an information system that would inform all patients of primary care physicians who contract with more than one health plan of which plan has the lowest premium so that they can switch to the lowest-priced plan covering their doctor's services. Combined with standardized benefits this could greatly increase the willingness of some people to switch plans to save money.

Finally, the present income and payroll tax laws create a heavy tax on cost containment and must be changed so that a health plan that cuts its premium by a dollar sees the full dollar transmitted to the subscriber, as an incentive for the subscriber to select that plan, therefore for the health plan to get the full marketplace reward (i.e., more subscribers) for cutting price. Thus there must be a limit on tax-free employer contributions at a level that does not exceed the premium of the low-priced plan.

This is beyond the scope of the sponsor, and is mentioned here only for the sake of completeness.

Sponsors Manage Risk Selection

Finally, in managed competition, the sponsor must manage the problem of biased risk selection.

The goal here is to create powerful incentives for health plans to succeed by improving quality and patient satisfaction, not by selecting good risks and avoiding bad ones. This is a crucial and complex issue. Here I will describe the general outlines without getting into technical detail.

Newhouse has noted that in the RAND experiment, the one percent of patients with the highest costs in a given year accounted for 28 percent of total

costs on average.[18] Most of them could not be identified in advance. But such concentration suggests it could be very profitable for a health plan to find ways to avoid enrolling or retaining such patients.

To accomplish the goal, the sponsor should manage a coordinated strategy with the following elements:

1. Establish a single point of entry: the subscriber notifies the sponsor of his choice and the sponsor notifies the health plan. The health plan must accept all enrollees. Combine this with continuity of enrollment: patients cannot be dropped from enrollment and they must be allowed to re-enroll at the periodic open enrollment in the plan of their choice.

2. Standardize the coverage contract because coverage contract features can be a powerful tool for selecting risks.

3. Risk-adjusted premiums. The general idea is as follows. Health risks are likely to fall differently among the different plans, either by design or accident. The characteristics of the population enrolled in the different plans (e.g., age, sex, family composition, retiree or disability status, diagnoses) should be measured and translated into estimates of the expected relative medical costs, independent of plan. Each plan can be assigned a relative risk index, e.g., 1.01 for a plan that got unfavorable selection that make its expected costs one percent above the whole group average. Then a dollar value is assigned to one percentage point of risk. For example, that might be one percent of the premium of the lowest-priced plan or the average-priced plan. This is a policy choice. There isn't a single obvious mathematically-correct answer. Then surcharges are applied to premiums of plans that received favorable selection; subsidies to plans that received unfavorable selection, to compensate for risk selection, to take selection out of the competition.[19]

   The natural starting point is to start with the available "demographic variables:" age, sex, family composition, retiree status. Unfortunately, these do not explain much of the variation in individual annual

expenditures. Newhouse has found that of the total variation in individual expenditures, only about 15 percent is explainable even with complete knowledge of patient characteristics.[18] Demographic variables might explain 2 to 3 of the 15 percentage points.

There is research underway to develop better risk adjustment models, based on diagnostic information. By now, a great deal of very sophisticated research has been done. It turns out to be much harder than one might think to turn available diagnostic information into good "risk adjusters." For example, among patients diagnosed in one year to have breast cancer or HIV, there will be a very wide variation in medical costs the next year. But it seems reasonable to suppose that eventually, diagnosis-based models will be available. Another approach may be to fund treatment of some conditions by fixed payments per case outside the capitation payments. Or to use specific capitation payments on behalf of people with very costly diseases. AIDS might be treated that way.

In the Jackson Hole proposal, sponsors are cast to be the final arbiters of risk selection. An interesting paper by Luft would cast the sponsor in the role of expert mediator among health plans that are in a "zero sum game" over risk selection.[20] This suggests periodic face-to-face meetings with the assembled marketing directors of all participating health plans in their territory, with the HIPC serving as honest broker. If Plan A is skimming, that hurts the other plans. The HIPC representative should lead a discussion on how this can be defined, measured, and compensated for. This is an ongoing process, not a single event.

In this regard, the sponsor must be seen as an honest broker, not a biased participant. Thus the sponsor should not have its own plan. Medicare's management of competition among HMOs has been seriously impaired by HCFA's preoccupation with protecting fee-for-service Medicare which HCFA considers to be "its plan" to be protected from HMOs. Similar problems occur in the private sector.

4. Sponsors should monitor voluntary disenrollments for evidence of risk-selecting behavior. With a brief questionnaire, they can ask people why they switched. The box to watch would be "they told me Plan B was better at treating my kind of cancer."

5. Similarly, sponsors need to examine the quality of tertiary care arrangements and also monitor access to specialty care. A good way to avoid diabetics is to have no endocrinologists on staff in the county. A good way to avoid cancer patients is to have a poor oncology department. HMO regulation now monitors such aspects. These are subtle matters in which judgment must be applied.

V. Health Insurance Purchasing Cooperatives

Large employers of, say, 10,000 or more employees in one geographic area have the size needed to perform the functions of sponsorship with reasonable effectiveness - especially if they collaborate with other large employers. But over 40 percent of the employed population are in groups of 100 or less. Such groups (and even much larger ones) are too small to:

1. Spread risks. Thus we observe wide variations - tenfold and more - in the premiums paid by small groups, depending on their claims experience.

2. Achieve economies of scale in administration. Thus administrative expense reaches 35 percent of claims in groups of 5 to 9, 40 percent in groups of 1 to 4, compared to 5.5 percent in groups of 10,000 and more.[21]

3. Acquire needed information and expertise to function effectively in this market. In theory, agents and brokers perform this function. In practice, agents and brokers have their own interests, related to the commissions carriers' pay, and brokers and agents have no competence regarding quality or value of medical care.

4. Manage competition. The sponsor's roles, described above, cannot be performed effectively in small groups.

5. Offer multiple choice of plan to the individual subscriber. Splitting small groups raises administrative costs and creates problems of biased risk selection whose satisfactory management requires large numbers.

The Jackson Hole Initiative proposes to solve these problems by establishment of a new national system of sponsor organizations - Health Insurance Purchasing Cooperatives (HIPCs) - to function as a collective purchasing agent on behalf of all small employers and individuals in a geographic area.[17] HIPCs are designed to correct the problems of market failure in the small group market, and to cut employers' administrative burdens to a minimum (e.g., administering for them the requirements of COBRA continuity and public subsidies). They provide a solid basis for determining the competitive costs of covering uniform benefits that could be used to establish a tax-exclusion limitation for each market area.

The HIPC would be a nonprofit membership corporation whose board would be elected by participating employers. The HIPC would contract with participating employers. It would accept all qualifying (e.g., by size) employment groups in its area. It would not be allowed to exclude groups or individuals because of health status. The HIPC would manage competition, applying business judgment in determining the numbers and identities of competitors. HIPCs would carry out all the sponsor functions described above.

These HIPCs would select the participating health plans. Some would favor a rule that a HIPC must offer all health plans that achieve federal certification and that wish to be offered in the HIPC's territory. That might work. Market forces might resolve the problems. It is a debatable proposition on which reasonable people can differ. But I would prefer to see HIPCs have some authority to select and drop health plans.

The presumption should favor competition. Thus, it would make sense for a HIPC to encourage participation by all provider groups in the territory, but

some discretion might be appropriate for the following reasons:

1. Federal qualification and state regulation do not guarantee financial solvency.

2. Many "managed care" plans offer overlapping provider networks (i.e. many providers contracting with many plans). Some overlap may not be undesirable. But too many carriers all offering essentially the same set of providers can add to administrative costs and weaken the sponsor's purchasing power with the providers. As noted in part IV above, managed competition seeks to motivate providers to create efficient delivery systems (see part VI below).

3. HIPCs should be able to drop health plans that persistently achieve very low market penetration.

4. HIPCs should be able to drop carriers that are persistently noncooperative with the HIPC's risk selection management program

HIPCs would administer health benefit contracts. The HIPC should act like a competent effective employee benefits office servicing beneficiary inquiries and complaints. It should interpret the contracts for beneficiaries, stand behind patients in disputes with health plans, and resolve disputes on terms that are fair to beneficiaries. This ought to be much more efficient than taking disputes to litigation.

The HIPC should monitor what is happening in the health care settings. It should survey consumer experience and make the information available for consumers. It should investigate complaints and it should aggregate complaint data to identify problem areas.

HIPCs should not bear risk. Health plans should bear all the risk for medical expenses for several reasons.

1. If HIPCs were to bear risk, we would have a whole new class of risk-bearing entity that would have to be capitalized and regulated. We do

not need new risk-bearing entities. We have more than enough of them now.

2. HIPCs should be unbiased honest brokers among risk bearing entities.

3. Health care providers--doctors and hospitals--must be at risk for the cost of care to give them powerful incentives to find ways to reduce cost.

Finally, HIPCs could contract with government agencies to cover publicly-sponsored populations (Medicaid, the otherwise uninsured, public employees).

Creating HIPCs means that persons and groups with low health care costs (this year) share in the costs of people and groups with high costs. If given a choice, people expecting low costs are not likely to do so voluntarily. Once the HIPC is operating at a large scale, there will be important benefits for small employers, even those with good health risks--including economies of scale, stable rates, competition, and individual choice of plan. But to get the HIPCs going, and to prevent a spiral of adverse selection as good risks seek more favorable experience rates outside the pool, there must be compelling incentives or legal requirements for all small employers to participate. In the Jackson Hole Initiative, small group participation in a HIPC would be a condition for exclusion of employer contributions from employee taxable income.

One large and successful HIPC is the Health Benefits Program of the California Public Employees Retirement System (PERS). PERS arranges coverage and manages competition on behalf of over 870,000 people who are employees, retirees and dependents of the state and over 750 public agencies, some of which have as few as two employees. PERS offers each subscriber a choice of plan: 23 HMOs, four PPOs offered to employee association members, and a state-wide PPO.

VI. The Role of Organized Systems of Care

Managed competition is not based on a mere hope that the market will somehow generate better models of care. It is based on the demonstrated fact

that actual successful high quality cost-effective organized systems of care that integrate financing and delivery have existed for years. To date, the strongest evidence of their economic superiority over traditional unmanaged fee-for-service/remote third-party payment ("FFS") relates to prepaid multispecialty group practices. For example, in its Health Insurance Experiment, RAND found that Group Health Cooperative of Puget Sound cared for its randomly-assigned patients for a cost 28 percent below that for comparable people assigned to FFS either 100 percent paid by insurance or with 25 percent coinsurance (up to an annual out-of-pocket limit of $1,000).[7] The evident marketplace success of Kaiser Permanente, now serving over 6.5 million people, reinforces this finding. In recent years, successful large scale HMOs based on individual practice styles have emerged. These HMOs carefully select participating physicians and arm physicians and management with strong information systems about practice patterns. These models can expand very rapidly, and they offer a practice style that is familiar to many doctors and patients. While we do not have proof of their efficacy in the form of a randomized controlled trial, we do know that some of them now compete effectively with Kaiser Permanente and Group Health Cooperative.

Compared to the traditional FFS model, there are many things such organizations can do--and, if appropriately motivated, will do--to improve quality and cut cost.

1. FFS has created a costly adversarial relationship between doctors and payors. Organized systems can attract the loyalty, commitment and responsible participation of doctors. They can align the incentives of doctors and the interests of patients in high quality economical care by appropriate risk-sharing arrangements.

2. FFS has failed to create accountability for health outcomes and the outcomes information systems doctors need to evaluate and improve practice patterns. Wennberg and others have shown the very wide variations in the costliness of practice patterns among apparently well-trained doctors.[22] Organized systems can gather data on outcomes, treatments and resource use, evaluate practice patterns and motivate doctors to choose economical practices that produce good outcomes.

3. FFS "free choice" leaves patients to make remarkably poorly-informed choices of doctor. Organized systems select doctors for quality and efficient practice patterns, monitor performance, and take corrective action where needed.

4. FFS has left us with excess supply in many specialties.. Too many surgeons are bad for one's health and pocketbook: they lack proficiency and do too many inappropriate procedures.[23] Organized systems can match the numbers and types of doctors to the needs of their enrolled populations.

5. FFS has left us with major excesses in hospitals beds, MRI machines, open-heart surgery facilities. At least some systems can match all resources used to the needs of the enrolled population.

6. Our present system is characterized by major misallocations of resources. Organized systems can allocate all resources--capital and operating--across the total spectrum of care, including less costly settings.

7. FFS has little or no capability to plan and manage processes of care across the total spectrum (inpatient, outpatient, office and home). Organized systems do.

8. Organizations that integrate financing and delivery, doctors and hospitals can practice total quality management/continuous quality improvement, the powerful management philosophy employed by the most successful world-class industrial companies.[24] This cannot be done effectively with doctors who practice fee-for-service in several hospitals and are attached to none.

9. FFS has led to a costly and dangerous proliferation in facilities for such complex procedures as open heart surgery (OHS). Such surgery done in low volumes has higher costs and higher death rates than when done in high volumes.[25] In California, OHS is done in 118 hospitals, half of which have annual volumes less than 200. Organized systems

concentrate OHS in regional centers with low mortality rates and low costs.

Such regional concentration in the most cost-effective hospitals could save a great deal of money. For example, in Pennsylvania in 1990, average charges for coronary bypass operations ranged from $21,000 to $84,000.[26] Similar variations have been reported in California.

10. Systems can organize ongoing technology assessment and facilitate a rational response to the results.

11. HMOs emphasize prevention, early diagnosis and treatment and effective management of chronic conditions. Traditional third-party coverage is usually based on the casualty insurance model: it pays very generously for costly inpatient episodes, but not for the preventive services and management of chronic conditions that can reduce the need for such care. Organized systems can use systematic management processes to make sure these services are actually delivered, not merely covered. And they can be held accountable for their enrolled populations.

Compared to the inflationary FFS model, managed competition of managed care organizations, with providers at risk, would represent a complete reversal of financial incentives.

VII. Managed Competition in Sparsely Populated Areas

People do not find it hard to visualize managed competition in San Francisco or Boston. What about Wyoming, Vermont or southern Texas, where there are not enough people to support competing systems?

Creation of a HIPC in such states would consolidate purchasing power in such a way that it could be used more effectively to meet the needs of the covered population. There is such a thing as "competition for the field" where there cannot be "competition in the field." HIPCs might request proposals from established urban comprehensive care organizations to establish and operate

a network of primary care outposts, paying doctors and nurse practitioners what is needed to attract them to provide high quality ambulatory care in rural locations, while giving them professional support in the form of telephone consultations, temporary replacements, continuing education, and transportation and referral arrangements. Organized systems are needed to accomplish this. Traditional fee-for-service solo practice has not produced satisfactory results.

In a state with a small population, but with perhaps two or three competing health plans, no one plan might be large enough to purchase tertiary care effectively. A HIPC might "reach through" and "carve out" tertiary care and contract for it on a competitive basis with one or another regional center.

In a small town, a doctor with a monopoly might refuse to contract with any of the health plans on terms acceptable to doctors in other areas. No one of several health plans might have enough patients in town to be able to support its own doctor. The HIPC might "reach through" the health plans, consolidate their purchasing power, and recruit a willing doctor from the outside to contract with all the health plans and be the only contracting doctor.

The HIPC in a small state might contract with a single primary care network HMO to cover the state in an ongoing bilateral customer-supplier relationship. The HIPC might use "benchmarking" techniques as a substitute for ongoing competition in the field. The vision of "competition" in such circumstances should not be limited to large medical center-based prepaid group practices. That is but one model. But, as noted above, modern information technology has enabled primary care individual practice networks to perform management functions that previously required physical proximity.

VIII. Why Competition?

Why attempt to bring about these changes through competition and market forces? Why not expect the government simply to order them?

First, we have an extremely wasteful and inefficient system that has been bathed in cost-increasing incentives for 50 years. We badly need a radically more efficient system. That will mean closing hospitals and putting surgeons out of work. As Charles Schultze wrote in his 1976 Godkin Lectures at Harvard:

> "Under the social arrangements of the private market, those who may suffer losses are not usually able to stand in the way of change. As a consequence, efficiency-creating changes are not seriously impeded."[27]

Government controls, on the other hand, tend to freeze industries in place. Thus we find it extraordinarily difficult to close an unneeded school or airbase. Government action is constrained by what Schultze calls the rule "do no direct harm."

Second, to offset the expenditure-increasing effects of an aging population and an expanding array of medical technologies, we need to foster a process of continuing productivity improvement and of development of cost-reducing technologies. Only an ongoing competition to provide value for money can do this.

Third, as medical technology and social and economic conditions of the population change, we need a health care system that is flexible, adaptive, that can innovate and come up with entirely new ways of organizing and delivering care.

Fourth, we need and want a system that is user friendly. Government monopoly public service agencies are notoriously user unfriendly.

Fifth, our society needs to make cost-quality tradeoff judgments. These should be made by consumers who are using their own money at the margin. For example, given a choice, many might prefer a much less costly style of care, based on limited access in tightly controlled facilities, with more use of physician-extenders, etc. They might have other worthy uses for their money, such as children's education. Others may be happy to pay more for

wider access and greater convenience. (Note, that under managed competition, they would be exercising this preference with their own net-after-tax dollars, not with pre-tax dollars and substantial tax subsidies to the more costly choice as happens today.)

Today in America we are spending nearly 14 percent of the GDP on health care services. It is altogether possible that a very efficient competitive system could get us back to 9 or 10 percent. This would free up resources that are badly needed for education and other investments in long-term economic growth. In theory, a government-imposed "global budget" might be seen as a way to reduce national health expenditures as a share of GDP. In practice, this would be extremely difficult to do if all the cost-increasing incentives of fee-for-service and all the wastefulness of the present system were to remain in place. The reduced spending would mean care denied to people who need it, and a sustained barrage of complaints by health care providers. The "global budget" would be hard for our government to sustain politically.

Finally, competition is the way to achieve a system that is driven by the informed choices of consumers who are responsible for the cost consequences of their choices. A government-controlled system is driven by political forces.

IX. Why Universal Coverage

Today, more than thirty-five million Americans have no health care coverage. In addition, many millions are "pseudo insured," that is, they have coverage that will disappear or become extremely costly when they need it. Nobody defends the proposition that people without coverage or money to pay should go without necessary medical care, or should be allowed to suffer, be disabled or die for lack of reasonable care that could prevent it. For this reason our society has developed a very complex patchwork of institutions to care for and finance the care of the uninsured. These institutions are extremely wasteful and often unfair, permitting preventable medical bankruptcies and disabilities. They lead to delayed care which can often mean serious and costly illness that could have been prevented by early treatment. They lead to care in very costly settings--hospital emergency departments--when the care could have been delivered at much lower cost in the primary

care physician's office. They permit epidemics of communicable diseases that could have easily been prevented. They generate requirements for very costly eligibility determinations. They lead to cost shifting from those who do not pay and those who provide free care to those who do pay for health insurance. They lead to the closing of hospital emergency departments because they are the major source of patients who cannot pay. This, in turn, deprives whole communities of an important resource.

By putting market pressure on providers to cut costs, market reforms promoting competition, not accompanied by universal coverage, could make access problems for the uninsured worse. (This would be true of any serious cost-containment program.) It would be more humane, economical, and rational simply to adopt a policy providing coverage to virtually everybody through an integrated financing and delivery organization that provides primary care and preventive services as a part of comprehensive benefit package.

A necessary condition for universal coverage is that everybody who can contribute to financing the system must do so, in some reasonable relationship to ability to pay. A system of universal coverage will not work if everybody is covered, but only those who voluntarily choose to do so pay for it. Such a system would be destroyed by "free riders."

Universal contributions might be achieved in a variety of ways that are compatible with managed competition, including:

1. A requirement that employers and full-time employees jointly buy coverage ("employer mandate"), combined with payroll taxes on part-time employees and taxes on nonpoor nonemployed (e.g., early retirees) with revenues used to subsidize purchase of coverage for them through a HIPC.

2. A requirement that every household buy coverage through a HIPC, or pay an equivalent tax ("individual mandate"), with subsidies to assist households with low incomes.

3. Payroll taxes or more broadly-based taxes.

X. What Managed Competition is Not

Managed competition is **not** a lot of things it has been called by people who do not understand it or who prefer central government controls to decentralized markets..

1. Managed competition is **not** a **free market**. A free market does not and cannot work in health insurance and health care. If not corrected by a careful design, this market is plagued by problems of free riders, biased risk selection, segmentation, and other sources of market failure. Managed competition uses market forces within a framework of carefully drawn rules.

2. Managed competition is **not** merely "vouchers": give people a certificate and see if they can find insurance. In managed competition, sponsors work actively to perfect the market. Everyone is given an opportunity to enroll.

3. Managed competition is **not** "deregulation." It is new rules, not no rules.

4. Managed competition is not what we have had for the last 10 or 50 years, as I explained at the outset.

5. Managed competition is **not** forcing everyone into large clinic style HMOs or other types of care they don't like. It is not forcing anything on anyone. On the contrary, managed competition emphasizes the importance of individual (not employer) choice of plan. There are many systems and styles that would be able to compete effectively, including familiar solo doctor styles in some selective individual practice models. However, managed competition does make people bear economic consequences of their choices.

6. Managed competition is **not** a reduction in the quality of care. On the contrary, far more often than not, in medical care, quality and economy go hand-in-hand. The correct diagnosis, done promptly, the appropriate procedure done by someone very proficient, without errors or complications, is best for the patient and the payor. Competing managed care plans would have powerful incentives to improve the quality of care.

7. Managed competition is **not** blind faith in an untested economic theory. We know some types of managed care can cut cost substantially. We know there are wide variations in costs for many procedures, and that the best producers have the lowest costs. We know that when given responsible choices and information, most people choose value for money. We know HPPC-like arrangements work well. All the pieces of the managed care/managed competition model are in actual successful practice somewhere. The challenge is to put "best practices" together in one complete managed competition system. The rest is extrapolation based on generally accepted principles of rational economic behavior. All reform proposals must rely on similar extrapolation.

8. Managed competition is **not** just the latest buzz word which anybody should feel free to appropriate. It has been explained, developed and debated in the academic literature for more than a decade.[28] They do not have managed competition in Canada.

   Managed competition is **not** just a grab bag of ideas that sound good. It is an integrated framework that combines rational principles of microeconomics with careful observation and analysis of what works.

9. Managed competition is not compatible with "top down" government-imposed "global budgets."

   Such "global budgets" imposed today would have to be imposed on sectors such as hospitals, doctors, pharmacies, etc. and enforced by price controls. The most plausible candidate for price controls would be Medicare payment methods and "Volume Performance Standards" that

Health Care Reform: Issues for Rural America

By Jon Christianson and Ira Moscovice
Outline of Paper

I. Introduction

A. Significant differences between health systems in urban and rural areas raise concern over impact of leading health reform proposals designed to serve the majority of the population residing in nonmetropolitan areas.

B. 11 Preliminary assumptions about the structure of health care reform

1. A mandated set of benefits is defined at the federal level.

2. All individuals and employers share the cost of health insurance, with subsidies provided for the poor.

3. Everyone, except employees of very large firms, obtains coverage through health insurance purchasing cooperatives (HIPCs) that serve defined geographical areas.

4. HIPCs contract with private health plans, including HMOs, PPOs, and one free-choice-of-provider option, and manage the enrollment process.

5. The plans are paid by risk-adjusted capitation, although providers with the plans could be paid using a variety of different methods.

6. The HIPC pays an amount equal to the lowest cost plan; a consumer choosing a higher cost plan must pay the difference between this payment and the plan's premium.

7. Community-rated premiums are charged enrollees; no medical underwriting by health plans is allowed.

8. States have authority too supervise HIPCs and license health plans. They also have the ability, with federal approval, to experiment with different administrative approaches in order to adapt to local needs.

9. The federal government employs "benchmark budgeting" by annually determining a maximum allowable rate of increase in the premiums of the "benchmark" (lowest cost) health plan option and a target for discretionary after-tax spending.

10. In areas where e managed competition does not result in increases consistent with these goals, HIPCs have discretionary authority to set

rates; they have this authority in all regions for the fee-for-service plan.

11. Medicaid is eliminated, but the elderly continue to receive coverage under Medicare, at least in the initial stages of health care reform.

II. Organization of Rural Health Networks

A. Rural providers will be organized into networks for the purpose of contracting with health plans or HIPCs.

- Network Definition: NYS "A locally directed or governed organization which provides a set of defined health related and administrative services needed in the community served by the network"

B. Structure and organization of existing networks varies significantly depending on:

- Goals of participating organizations
- Availability of providers
- Characteristics of local community

C. Types of existing networks

- 127 hospital consortia
- 14 rural-based HMOs
- Urban-based HMOs serving rural areas through contacts with physicians

D. Support for network development

- RWJF demonstration supported 13 rural hospital consortia
- EACH Program grants to seven states and 30 hospital-based networks in those states
- New York State demonstration, 4 rural networks received grants

E. Existing networks rarely provide the full range of acute inpatient and outpatient services, except for a small number of rural-based HMOs

- Little evidence of ability of rural networks to assume responsibility for all the medical care of entire community

F. What relationships will develop between rural health networks, health plans and HIPCs?

1. Proactive HIPCs will serve as catalysts for network formation

   - HIPCs may have to assemble their own networks as free-choice-of-provider entities

2. Near urban areas, rural providers will contract with urban-based health plans that already serve their communities

   - While most existing rural networks are not vertically integrated, if they broadened their composition, they could conceivably contract with multiple health plans to serve rural residents.

3. In remote/sparsely populated areas, network formation will be difficult

   - Some providers have a "captive market" with little incentive to contract with a health plan to attract new patients or retain existing ones
   - HIPCs may have to regulate prices
   - Residents could be offered the choice between a statewide PPO or a free-choice-of-provider plan with regulated fee schedules

G. What form will managed competition take in rural areas?

1. Rural provider networks could be allowed to contract with only one health plan or form their own plan, but if there is insufficient population to support more than one hospital and group of physicians, "competition" would not be achieved

   - "Franchises" could be granted by HIPCs to rural health networks to serve specific geographic areas in return for capitated payments

   - Single network would be responsible for "rationalizing" services in the area

2. Rural networks could contract with more than one health plan.

   - Standardizing benefits, administrative and data collection processes could reduce administrative inefficiencies of interacting with multiple plan

   - May be difficult for a single health plan to exercise sufficient leverage on network providers to ensure meaningful

participation in the plan's cost containment efforts

H. Issues for Organizing Networks

1. How quickly will rural providers react in developing rural health networks under the stimulus of health care reform? Will the initiative for network formation come primarily from rural providers or from urban-based health plans and health care organizations?

2. What providers will be included in rural health networks?

3. What steps should HIPCs take in areas where rural providers decline to participate in health plans or otherwise coordinate services to improve quality of care and contain costs?

4. Should rural networks be encouraged to participate in multiple health plans? Or, should they be awarded "franchises" to serve designated geographic areas?

III. Reimbursement of Rural Providers

A. Providers in Prepaid Health Plans: Most will continue to be reimbursed under some form of fee-for-service payment, whether they participate in a prepaid health plans or their rates are regulated under a global budget approach. Will be required to assume some financial risk. Two main models:

1. Lower risk: "Urban-based IPA-model" -- fee schedule with a 20 percent withhold

2. Higher risk: "Franchise model" -- Network is owned and administered by the rural providers. Network receives a capitated payment for each enrollee to provide all covered medical services

- Could buy reinsurance to protect against substantial losses

B. Providers in PPOs or Free-Choice- of Physician Plans: Reimbursed on a fee schedule establish through negotiation with the plans

1. "PPO Model": Participating providers accept discounts from their usual fees in return for the potential to increase number of patients. Enrollees face higher cost-sharing for choosing out-of-network providers.

- If PPO's premiums increase more rapidly than targets set by HIPCs, rural providers will likely face reductions in fee schedules and tougher utilization management

2. "Free-Choice of Provider Model": Providers reimbursed using a fee schedule establish by the plan, all providers can participate in the plan

   - This model has the least flexibility/leverage to control costs of providers

C. Issues for Reimbursing Providers

- How should rural providers be grouped for risk-sharing purposes?
- Under different reimbursement approaches, how strong should the financial incentives be for rural primary physicians to control or alter referrals to specialists?
- How will fee schedules be established and enforced for rural physicians?
- Will rural networks have sufficient capital to accept financial risk under prepayment?

IV. Impact on Medical Practice

Rural physicians may be receptive to organization and delivery system changes that improve circumstance in their practice: telephone consultations, temporary replacements, continuing education, transportation and referral arrangements. Changes must be sensitive to local needs.

Five aspects of the possible transformation of rural medical practice:

A. Response to increased management and oversight

1. Rural physicians could rebel against increased "micro-management"
2. Gatekeeper role can increase the status of rural primacy care physician vis avis specialists, but may be an uncomfortable position for many rural solo practitioners with minimal experience in risk-bearing roles

B. Location and Availability of Specialist Services and Technology

1. Consortia participation, mobile technology and specialty outreach clinics can increase the availability of specialty services/technology in rural areas, but as some level, subspecialty services will need to be provided in larger facilities in metropolitan areas

2. It is very unclear as how such efforts will mesh with health plan strategies under managed competition or global budgeting

C. Differences in urban/rural practice styles

1. Availability of technology and access to specialty services/consults are major factors that promote differences in urban and rural practice styles -- how these get resolved between physicians in the same network is unclear

2. A federal board could set standard to eliminate unnecessary care an assure the use of the most cost-effective technology. Level of participation of rural providers in establishing these criteria would be critical to their acceptance.

D. Physician relationships with hospitals and other entities

1. Many rural physicians have little experience with managed care systems and formal linkages with hospitals and other providers

2. Network development provides an opportunity for rural physicians to assume joint responsibility with other entities for providing a range of services to rural communities

3. The availability of a complete range of services may significantly affect the acceptability of health reform efforts to rural residents

E. Physician recruitment and retention

1. The central issue in many communities is not cost, but achieving and maintaining an adequate supply of physicians and other health professionals

2. Technical, collegial and referral support are needed to decrease the perception of isolation, overwork, and marginality among rural physicians

3. Isolated areas are particularly difficult; frontier doctors are characterized by their extreme independence and may avoid practicing as part of an organized medical system

F. Issues relating to the impact on rural medical practice

1. How will rural physicians react to increased management and oversight of their practice?

2. How will the location and availability of specialist services and technology be affected by health care reform? Which services and technology will be provided locally in rural areas? How will referrals to specialists be managed?

3. How will differences in urban/rural practice standards be addressed?

4. What implications does network development have for organizational relationships between rural physicians, hospitals, and other health providers?

5. Will the recruitment and retention of rural physicians be enhanced by health care reform?

V. Roles for State Government

A. Purchasing health care

1. Some proposals would eliminate states direct purchasing of care through Medicaid, general assistance programs, and public employees plans, but allow states to provide for these populations by contracting with or forming HIPCs.

2. Possible ways states could ensure that rural concerns were addressed by HIPCs:

- Facilitating entry of new health plans and networks
- Requiring HIPCs to assure geographic access to services
- Awarding exclusive franchises
- Requiring HIPCs to have rural advisory boards
- Maintain state-run safety net insurance program
- Require HIPCs to enroll persons of all income levels in the same plans

3. Key question is whether states have the capacity and willingness to go "at risk": for the financing and delivery of heath care services, such as is isolated areas?

B. Building network capacity and infrastructure

1. Use loans/grants to support capital investments
2. Provide reinsurance
3. Protect CHCs, RHCs, FQHCs, and migrant health centers
4. Provide technical assistance to local providers in establishing networks
5. Incentives for providers to participate in networks

C. Balancing antitrust enforcement and network establishment

1. Federal and state governments may need to "adjust" the enforcement of antitrust laws to permit HIPC-approved joint ventures and networks

2. "State action" immunity for state-sanctioned arrangements require two elements:

   - conducted pursuant to a clear state policy to supplant competition, and
   - actively supervised by the state

D. Informing consumers

1. Collecting and analyzing utilization, expenditure and outcomes data

   - Establish relevant comparison groups for isolated rural areas that may be served by only one provider or health plan
   - Analyze patient referrals

2. Monitoring quality of care and financial and geographic access

3. Establishing state data commission with mandatory disclosure requirements

4. Disseminate performance and cost information a "consumer reports" format

5. Certifying "centers of excellence" for certain procedures

6. Developing and monitoring consumer grievance and complaint system

E. Allocating and enforcing budgets

1. States may be given freedom for experimenting with various approaches for setting and meeting a budget; or

2. Federal government may need to set state expenditure targets and created disincentives for exceeding targets

   - Must clearly define which items would be included in a state budget constrained by expenditure limits

3. Must create mechanisms for containing costs of providers not participating in health plans, such as in underserved areas

F. Issues relating to roles for state government

1. Should state go at risk for the financing and delivery of health care services, particularly in higher risk, underserved rural area?

2. What are the most effective ways for states to stimulate rural network formation? How can existing capacity-building programs be incorporated into a managed care system reimbursed under capitated rates?

3. How aggressive should states be in enforcing antitrust laws when considering rural network formation? Will state action immunity be a successful strategy for permitting joint ventures that improve access and contain costs for rural populations?

4. What role should the state play in collecting and disseminating health care information to the public? How will the special considerations of rural environments (e.g. low volume, relevant comparison groups, interest in patient referral process) be addressed?

5. How will a federally determined global budget be allocated to the states? Would budgets be based solely on historical expenditure levels, which have typically been lower on a per capita basis in rural areas? What role should states play in implementing and enforcing budget limits?

Networking for Rural Health:
Essential Access Community Hospital Program

Key Points
from
Selected Articles

Alpha Center
March 1993

"EMS: The Missing Link in Rural Health Networks"

• Emergency medical systems are noticeably absent from most rural health networks. In the near future this will be an issue of great concern for EACH/PCH grantees for several reasons:

- Federal program rules specifically mention the development and support of emergency transportation systems as one of the purposes on which grant funds can be spent.
- EMS is a critical part of the rural health safety net
- National trends are increasing the demand for EMS in rural areas (more elderly people, growing public expectations, earlier hospital discharges, etc.)
- Profound concerns of rural citizens for maintaining EMS services

• EMS is more complex than basic ambulance transportation. It starts with emergency access (e.g. CBs, 911 lines) and dispatch capabilities, rescue squads and ambulance services, but it also includes communication with physicians during transport, hospital emergency departments, transfer to specialty facilities, and overall medical direction and quality assurance.

• Structural problems facing rural EMS systems often seem overwhelming:

- Volunteers are hard to recruit and must be provided with high quality training
- Outdated or weak communication infrastructures
- Major sources of financing for emergency services are often inadequate
- Many rural areas lack qualified physicians who have the time and interest to supply vitally important medical direction

• There have been some strategies that have contributed to successful EMS systems development:

- Heavy emphasis should be placed on careful planning by all potential players in the system. EMS system components are almost always handled by multiple organizations. It is imperative that these various groups be coordinated in an efficient manner.
- Networks must deal with cultural issues when developing an EMS system. The community must be active in the development process.
- Medical direction is key. Two types of direction are important: 1) on-line or real time medical direction, i.e. the actual giving of orders or giving of permission to do certain interventions, and, 2) physician oversight of all aspects involving patient care of a pre-hospital system.

"Antitrust Facts and Fears: Skidding on Ice?"

- Because the EACH Program develops networks that often involve arrangements between hospitals to apportion services, consolidate operations, and perhaps even close some facilities entirely, antitrust has become a major concern of many of the networks

- Antitrust law has few hard and fast principles or regulations, and when dealing with these rural networks the issue becomes even more complex

- In general, antitrust enforcement has been favorable toward joint ventures in the health care arena because they can be pro-competitive. They can produce efficiencies by reducing transaction costs, consolidating research and development, or pooling resources, all of which can allow organizations to compete more effectively.

- Networks that help to introduce new products or allow entities to buy or share services and equipment that they could not have done on their own are also viewed as pro-competitive.

- Networks become more suspect when the joint venture is undertaken by competitors to disguise anti-competitive conduct.

- The key test for networks concerns the effect on competition; if a bona fide joint venture promotes competition, then judges are more likely to rule in favor of the arrangement.

- A 1943 Supreme Court decision in *Parker v. Brown* exempts state actions from antitrust law. Thus state entities and state employees acting pursuant to a clear authorization from the state are protected. Furthermore, a 1980 Supreme Court decision clarified that state action doctrine also immunizes private entities from antitrust liability if the state has: 1) clearly articulated a policy to displace competition with regulation; and 2) the state actively supervises the anti-competitive conduct.

- An antitrust lawyer advised the EACH/PCH networks to consider the strength of the arguments they can to support the "rule of reason" test, which is used by judges to examine the particular effects of a particular activity on competition. In order to have a violation of the rule of reason, there has to be substantial adverse effect on competition that is not out-weighed by pro-competitive benefits.

"Throwing the Dice? Risks and Realities in Rural Health Network Financing"

- The Health Care Financing Administration has not developed an official set of regulations regarding the designation of EACH/PCH facilities. Consequently, rural hospitals had been asked to make choices about financing and licensure status before they knew the final rules and implications. Because of this uncertainty, it remains unclear which set of financing strategies will be most favorable for certain ural hospitals.

- Almost any reimbursement alternative to the Medicare prospective payment system (PPS) has been welcome news to small rural hospitals. Because many of the hospitals have been financially harmed by PPS, a cost-based reimbursement system may appear to be a blessing.

- However certain rural hospitals may not find it to their advantage to abandon the PPS system just yet. Federal legislation that changed PPS rules in OBRA 1989 is beginning to improve the financial picture for many rural hospitals.

- Three grantee state conducted studies on the various reimbursement options came to the conclusion that a successful financial strategy is dependent on the allocation between inpatient, outpatient, and long-term care services and not solely on whether a PCH is reimbursed on a cost or risk basis.

- The studies indicate substantial benefits may be possible by beefing up primary care services and billing for them using a blended rate of facility costs and professional services, which are paid on the basis of reasonable costs.

- While hospitals are still unsure about the financial implications of the EACH Program, the studies stressed the importance of performing financial analyses and ongoing efforts to reorganize or improve the management of existing services.

penalize sectors that increase volume by offsetting reductions in the next year's prices. Such controls block efficiency-improving reallocations across sectors, such as doctors working harder to keep people out of hospital. They create a "tragedy of the commons" as the most economical doctors are penalized. They leave all the cost-increasing incentives in place, even intensify them as providers struggle to maintain target-incomes.

Top-down "global budgets" if imposed on capitation rates of integrated financing and delivery organizations would avoid some of the worst inefficiencies and disincentives. But they would focus the whole health services industry on political efforts to raise or maintain the ceiling as a percent of GNP. The British refer to the likely behavior as "shroud waving." Such government-imposed limits deny consumers the opportunity to choose more or less costly systems of care. Such "global budgets" would raise a whole maze of paradoxes and conundrums: would they be equal per capita across states? If unequal, on what basis? How would one deal with high cost vs. low cost states? Could one justify locking Massachusetts and Arkansas, with a nearly two-fold difference in per capita spending, into the same equal percentage rate of increase forever? Who decides? On what basis?

The whole history of government-imposed price controls is that they do not lower cost to consumers.

Managed competition puts "global budgets" in the hands of the managements of health care organizations, and uses impersonal market forces to motivate managements to improve quality and cut cost.

10. Managed competition will not take until the year 2100 to transform the health care financing and delivery. It does not depend merely on the steady growth of existing prepaid group practices. In response to managed competition, thousands of hospitals and their medical staffs could quickly form integrated organizations and begin accepting capitation contracts. Many individual practice and network model HMOs could expand very rapidly. And Blue Cross and/or Blue Shield

plans must now have statewide-preferred provider networks in existence in practically every state.

XI. Conclusion

The managed competition idea attracted widespread support in 1992, in recognition of the urgent need to do something serious about costs, and as an alternative to federal price controls. Senator Tsongas adopted it as his health platform. In developing its proposal, the Bush Administration began with a managed competition model.[29] Unfortunately, for political reasons, they withdrew some of the essential features needed to make it effective, especially the limit on tax-free employer contributions to employee health care, and the powerful tax incentive needed to motivate small employers to join HIPCs. In April, the 60-member Conservative Democratic Forum in the House of Representatives announced its support for the Jackson Hole Initiative. They introduced a bill, the Managed Competition Act of 1992, in September.[30] A similar bill was introduced in the Senate and drew bipartisan support. In October, Governor Clinton said, "Managed Competition, not price controls, will make the budget work and maintain quality."[31]

Managed competition is compatible with a variety of ways of financing universal coverage, from a tax-financed approach as in the proposal of California Insurance Commissioner Garamendi[32] and my 1977 proposal to the Carter Administration,[12] to an employer/employee mandate plus an individual mandate and subsidies for the nonemployed, as in the Jackson Hole Initiative, to an individual mandate. Thus, it can appeal to liberals whose main concern is universal access, and to conservatives who have strong preferences for decentralized private markets and against centralized government power.[33]

Like any serious reform proposal, attempts to enact a national managed competition model will be controversial. Some of the most powerful Congressional leaders distrust market mechanisms and prefer direct government price controls. Many of the specific features of managed competition will be opposed by various private sector interests seeking to hold onto the present market imperfections that favor them. However,

recent months have seen considerable movement among private sector interests toward support of real managed competition as it becomes apparent that government will be forced to act decisively to contain costs.

In the coming debate, managed competition has the important advantage that it is compatible with strong American cultural preferences for limited government, voluntary action, decentralized decision-making, individual choice, multiple competing approaches, pluralism, and personal and local responsibility.[34]

NOTES

1. C. D. Weller, " 'Free Choice' As a Restraint of Trade in American Health Care Delivery and Insurance," *Iowa Law Review* 69 (July 1984) no. 5: 1351-1392.

2. A. C. Enthoven, *"Theory and Practice of Managed Competition in Health Care Finance,"* 1987 Professor Dr. F. de Vries Lectures (North-Holland/American Elsevier 1988.)

3. L.G. Goldberg and W.Greenberg, "The Emergence of Physician-Sponsored Health Insurance: A Historical Perspective," in E. Greenberg, ed. "Competition in the Health Care Sector, Past, Present, and Future. (Aspen Systems Corp., Germantown, M.D. 1978).
J.G. Smillie, *Can Physicians Manage the Quality and Costs of Healthcare? The Story of the Permanente Medical Group* (McGraw Hill, New York 1991).

4. S. J. Singer, "Problems in Gaining Access to Hospital Information," *Health Affairs* (Summer 1991): 148-151.

5. P. Starr, *The Social Transformation of American Medicine"* (Basic Books, New York, 1982).

6. R. Stevens, *"American Medicine and the Public Interest"* (Yale University Press 1971).

7. W. Manning, et.al., "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services," *New England Journal of Medicine* (June 7 1984): 1505-1510.

8. E. M. Sloss, et.al, "Effect of a Health Maintenance Organization on Physiologic Health," *Annals of Internal Medicine* Vol. 106 (1): (January. 1987).

9. A. C. Enthoven, "Management of Competition in the FEHBP," *Health Affairs* (Fall 1989): 33-50.

10. P.M. Ellwood, et.al, "Health Maintenance Strategy," *Medical Care* 9(2) (May 1971): 250-256.

11. S. Fleming, "Structured Competition Within the Private Sector." Unpublished Memoranda within the Department of Health, Education and Welfare, by the Deputy Assistant Secretary for Health Policy Development, Washington, DC, May 1973.

12. A. C. Enthoven, Consumer Choice Health Plan: A National Health Insurance Proposal. Memorandum to DHEW Secretary, Joseph Califano Sept. 22, 1977. Reprinted in Luke RD and Bauer JC. *Issues in Health Economics*, Aspen Systems Corp., Rockville, MD 1982, 509-532.
A. C. Enthoven. "Consumer Choice Health Plan: A National Health Insurance Proposal Based on Regulated Competition in the Private Sector," *New England Journal of Medicine*, 298, nos. 12 and 13, (23 and 30 Mar. 1978): 650-658 and 709-720.

13. C. Havighurst, "Professional Restraints on Innovation in Health Care Financing," *Duke Law Journal* Vol. 1978, no.2(1978):304-388.

14. M. V. Pauly, et.al. "A Plan for 'Responsible National Health Insurance'," *Health Affairs* (Spring 1991): 5-21.

15. S. M. Butler and E. F. Haislmaier, *A National Health System for America*, The Heritage Foundation, Washington, D.C. (1989).

16. A. C. Enthoven. "Why 'Competition' in Health Care Has Failed: What Would it Take to Make it Work?" The 1992 Clemens Lecture, St. John's University, Collegeville, MN.

17. P.M. Ellwood, A.C. Enthoven and L. Etheredge, "The Jackson Hole Initiatives for a Twenty-First Century American Health Care System," *Health Economics* Vol. 1 (1992): 149-168. 'The Jackson Hole Group' is an informal collection of health industry leaders, public officials, and health services researchers that started meeting in the mid-1970s in Paul Ellwood/s living room in Jackson Hole, WY.

18. J. Newhouse, "Rate Adjusters for Medicare Under Capitation," *Health Care Financing Review* (Annual Supplement, 1986): 45-56.

19. For recent literature, see M. C. Hornbrook, *"Risk-Based Contributions to Private Health Insurance, Advances in Health Economics and Health Services Research"* Vol. 12, (JAI Press, Greenwich, CT. 1991).

20. H. Luft, "Compensating for Biased Selection in Health Insurance," *The Milbank Quarterly* Vol. 64, no.4, (Fall 1986): 566-589.

21. 101st Congress, 2d Session, Subcommittee on Health, of the Committee on Ways and Means, U.S. House of Representatives, "Private Health Insurance: Options for Reform," (U.S. Govt. Printing Office, Washington D.C. 1990), WCMP 101-35.

22 J. Wennberg, and A. Gittlesohn, "Variations in Medical Care Among Small Areas," *Scientific American* 246 (1982): 120-126.

J. Wennberg, K. McPherson and P. Caper, "Will Payment Based on Diagnosis Related Groups Control Hospital Costs?" *New England Journal of Medicine,* 311, (Aug. 2, 1984a): 295-300.
J. Wennberg, K. McPherson and P. Caper, "Dealing with Medicare Practice Variations: A Proposal for Action," *Health Affairs* 3 no. 2,(1984b): 6-32.

M. R. Chassin et.al. "Variations in the Use of Medical and Surgical Services by the Medicare Population," (RAND, Santa Monica, CA. January 1986).

23. M. Chassin et.al., "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?" *Journal of the American Medical Association* Vol.258, no. 18 (13 November 1987):2533-2547.

C.M. Winslow et.al. "The Appropriateness of Carotid Endarterectomy," *The New England Journal of Medicine*Vol. 318 no.12 (24 March 1988): 722-728.

C. M. Winslow et.al. "The Appropriateness of Performing Coronary Artery Bypass Surgery," *Journal of the American Medical Association* Vol.260, no. 4 (2 and 29 July 1988):505-509.

24. D. Berwick, A.B. Godfrey, and J. Roessner, *Curing Health Care* (Jossey-Bass, Inc., San Francisco 1990).

25. H. Luft, J. Bunker, and A. C. Enthoven, "Should Operations Be Regionalized?" *New England Journal of Medicine* 301 (20 December 1979): 1364-1369.

26. R. Winslow, "State Rates Heart Surgeons by Mortality," *Wall Street Journal* (20 Nov. 1992): B1.

27. C. L. Schultze, *"The Public Use of Private Interest"* (Brookings, Washington D.C. 1977).

A. C. Enthoven, "Consumer Choice Health Plan," *New England Journal of Medicine* 298, 12 and 13 and 709-720 (1978):650-658.

28. A. C. Enthoven, *"Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care,"* (Reading, MA. Addison-Wesley, 1980).

A. C. Enthoven, "Managed Competition in Health Care and the Unfinished Agenda," *Health Care Financing Review* (1986 Annual Supplement.)

A.C. Enthoven, "Managed Competition: An Agenda for Action," *Health Affairs* (Summer 1988) 25-47.

A. C. Enthoven, "Theory and Practice of Managed Competition in Health Care Finance, 1987," Professor Dr. F. de Vries Lectures (North-Holland/American Elsevier 1988).

A. C. Enthoven and R. Kronick, "A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy," *New England Journal of Medicine* 320 (5 and 12 January 1989):29-37 and 94-101.

A. C. Enthoven and R. Kronick, "Universal Health Insurance Through Incentives Reform," *Journal of the American Medical Association* Vol.265, no. 19 (15 May, 1991).

29. The President's Comprehensive Health Reform Program, The White House, (February 6, 1992).

30. Mr. Cooper, Mr. Andrews, and Mr.Stenholm et.al. 102d Congress, 2d Session, HR 5936, September 15, 1992.

31. Clinton/Gore '92 Committee, P.O. Box 615, Little Rock, AR 72203 (October 8, 1992).

32. J. Garamendi, Insurance Commissioner, State of California, "California Health Care in the 21st Century, A Vision for Reform," (February 1992).

33. P. Starr, *The Logic of Health Care Reform* (Whittle Direct Books, 1992).

34. A. de Tocqueville, "Democracy in America," New York, Alfred A. Knopf, 1948, (first published in French in 1839.)

Rural Health Care:

Improvements Through Managed Competition

A Draft Discussion Paper

from the Jackson Hole Group

INTRODUCTION

Because sparsely populated, or rural, areas present unique challenges to health care delivery systems, it has been suggested that managed competition as described in the Jackson Hole proposals will not work in such areas. This paper discusses how managed competition can be applied to many rural areas to achieve substantial improvements in rural health care through a basic restructuring of services. It also describes a health care reform for more sparsely populated, frontier areas that is compatible with managed competition, but stresses community cooperation. In either case the end result will be improved access to health care through AHPs which are legally obligated to deliver, and publicly accountable for the outcomes of, the uniform effective health benefits (UEHB). Recognizing that there are a variety of thoughtful, creative, and successful experiments with health care delivery systems ongoing across rural America, this paper offers rural health care experts the opportunity to explore those ideas in light of managed competition concepts, and to critique and comment on the proposals offered here.

The body of the paper carries a misleading interventionist tone. This is because the paper devotes substantial attention to the exception areas that may necessitate some form of public intervention. These are likely to be the true frontier areas of the country. Less attention is focused upon the majority of rural areas where managed competition, through flexible AHPs, can improve the quality and control the costs of health care without public intervention.

BACKGROUND - CHARACTERISTICS OF RURAL AREAS

Demographics. Rural health care suffers primarily from the problem of access, stemming from a shortage of health professionals, services, and facilities; geographic/climate barriers such as mountain ranges, bodies of water, severe weather, difficult/slow roads, and sheer distance; and unique demographics.

Rural residents are left out of the traditionally employment-based health insurance system because a larger percentage of them are unemployed, self-employed, seasonally employed, or employed by small businesses (NRHA, 1992). Accordingly, a larger percentage of rural Americans are forced to purchase insurance in the individual market. Here again, rural Americans are at a disadvantage, due to both their economic status and their occupations.

Rural populations (27% of the total U.S. population) have a larger percentage of senior citizens and citizens below the poverty line than the rest of the population, with the exception of inner cities (NRHA, 1992).[1] While accounting for slightly more than a quarter of the U.S.

[1] The definition of rural used in the National Rural Health Association policy paper is non-metropolitan residents.

population, rural areas account for about one-third of the total population living below the federally defined poverty line (OTA, 1990). In addition, the occupational hazards of the agricultural sector have put farming ahead of mining as the most dangerous profession in America. Agricultural workers account for 3% of the work force and 14% of work-related deaths (Ingersoll, 1989). This pushes the already high individual market premiums faced by rural Americans even higher. Rural America has also been hard hit by the economic downturn of the 1980s. In 1982 the rural unemployment rate was 10.1%. By 1985 when much of the country was beginning to recover, it had dropped to 8.4%--still higher than the urban rate. These factors contribute to the number of people uninsured--14.5% in rural areas, 12.3% in non-rural areas (Ries, 1987).

The result is that those citizens who could benefit the most from preventive and primary care frequently have little or no financial access to those services. This means they are postponing or going without health care until their health problems become acute.

Manpower Shortage. Recruitment and supply of primary care physicians is a significant problem throughout the American health care system, but the shortage of physicians is especially acute in rural areas which have been chronically underserved. Small town practices are extremely demanding and usually lack the support and back-up systems available in cities. The small-town physician has the same expenses as any other physician, and more uncertain sources of income. In addition, our medical education system is biased toward training specialists, rather than the generalists required in rural practices.

Financing Pressures and Distortions. Due to the high percentage of Medicare and

Medicaid recipients in rural populations, rural health care practitioners and organizations tend to be more dependent on government revenues. This reliance on government payments often prevents reorganization of facilities and services to better meet the needs of the population. The Federal EACH/RPCH program and state programs in Montana, California, Kansas, Maine, Wisconsin, Oregon, and Florida are experimenting with this kind of reform now. Some of these programs have not met expectations however, because they are still tied to the traditional segmented health system structures and cost-plus incentives.

BACKGROUND - MANAGED COMPETITION

Strict Managed Competition, as based on comprehensive organized delivery systems competing on the basis of cost and quality, does not apply to sparsely populated areas. But a broader understanding of managed competition, the forms it can take, and the possible structures of an AHP, will show that managed competition will work in much rural America. And in the remainder of rural areas (true frontier areas) the basic institutions of managed competition, Accountable Health Plans (AHPs) and Health Plan Purchasing Cooperatives (HPPCs), still offer the best framework in which to improve the access to, and quality of, health care. Most criticisms suggest that successful managed competition depends on a heavily populated area in which a number of AHPs could compete offering a full range of services. But one of the strengths of the American health system is its diversity, and the ability to offer effective services in many forms.

In many rural areas competition will occur among smaller, primary care facilities. These facilities will be either independent organizations (AHPs) that contract with other providers

for specialized care, or branch offices of urban AHPs. This type of competition does not require the same density of population as required by larger, full-service AHPs. For example, although an area of 20,000 could not support three comprehensive AHPs, it could support three competing primary care facilities. In areas with a very limited number of providers, competition between AHPs could take place within individual providers. That is, the provider would contract with multiple AHPs and the individuals would chose which AHP to join on the basis of other services, such as referral networks, and traveling specialists, as well as cost and quality. Urban AHPs will be encouraged to set up branch offices with legislated subsidies targeted for rural areas—or through demands from the large purchasers (government, large employers or groups of small employers). Fair rates of Medicare and Medicaid reimbursement (ensured through HPPC purchasing) will also entice urban AHPs into rural areas. Assuming a rural primary care physician can serve an average of between 1,500 and 2,000 patients, these offices will require fewer subscribers to sustain them than full-service AHPs. Competition will occur as AHPs attempt to expand market share, and rural providers band together to form AHPs. The size of the population base will dictate the exact scope of services rural facilities can efficiently offer in site. It is important to note that the nature of competition in rural areas may be quite different than that in urban areas. Access is the major problem in rural areas. Therefore, rural consumers will be most sensitive to improved access. Accordingly rural AHPs will devote a larger percentage of resources to improving access. In general, by relying on market forces, managed competition will ensure that delivery systems work hardest to fix the worst problems.

In response to competing HMOs, Mayo Clinic is setting up primary care branch offices to be available to all inhabitants within 120 miles of Rochester. No Mayo subscribers in this area

will need to travel more than 30 minutes to see their physician.

Much of what is considered rural America can be served by managed competition. Some more sparsely populated areas, though, will not support competition. The following proposals which utilize the basic structures of managed competition (AHPs and HPPCs) are targeted towards those areas that are unable to support competition --frontier areas. These models stress community cooperation to set up an AHP and improve quality of, and access to, health care. Quality and efficiency will be assured by a community that realizes the economic importance of a quality health system and the use of benchmarking in evaluations by the area HPPC. In either case competition and cooperation will both focus on the unique barriers to access in rural areas.

PROPOSALS

Rural AHP Authorities (RAAs). The National Health Board will be charged with creating regional Rural AHP Authorities, which will in turn be responsible for ensuring that AHPs serve rural areas. RAAs will foster community cooperation in areas where a single AHP is appropriate, and competition in areas where that is the preferable model, but not yet fully realized. Other rural areas, where multiple AHPs operate, will not be directly affected by RAAs. HPPCs will be responsible for monitoring the rural AHPs. The monitoring and formation functions are separated to prevent the HPPC from having a vested interest in the success of one AHP over another.

On top of advisory and other advocacy functions, the RAAs will use two incentives to attract AHPs to rural areas: subsidies, and exclusive franchising. Of these two, subsidies is the more desirable, being better able to preserve beneficial market forces.

Subsidies. Subsidies will help offset high per capita fixed costs in low population density areas, but will not be as effective in helping to offset the costs of infrastructure development. Accordingly, subsidies will work best when the health care infrastructure in place is sufficient to allow AHP formation without large capital investment. The capitation subsidies will be overt, to prevent distortion of other premiums through cost-shifting.

Exclusive Franchise Agreements. When substantial investment is necessary and existing infrastructure and providers are minimal, as will be the case in some of the most remote areas

with lowest population density, RAAs may have to offer more attractive enticements to persuade an AHP to commit to an area. The RAA will need government funds to distribute to facilitate development. In situations where the AHP, even with the subsidy, will have to make a substantial investment, the RAA may have to offer the additional incentive of an exclusive franchise for a significant period of time. In this case, the AHP would set prices with the approval of the HPPC. Any franchise agreement would attempt to ensure that residents in the area receive affordable, quality care, and would be awarded only after a competitive bidding process. Bidding AHPs would agree to charge certain premiums in exchange for a given amount of governmental assistance.

Where implementation funds are larger, or the necessary investment smaller, an exclusive franchise may be unnecessary--or could be granted for a shorter time period. In either case, areas operating under an exclusive franchise agreement would require special attention from the HPPC due to the lack of market forces.

It should be noted that delivering rural health care does not require a large infrastructure. Actually developing the facilities for a new AHP with full-time providers should be an expensive exception. Since the key hospitals are already in place, increases in the number of primary care physicians and better systems of communication and organization are the needed improvements. In most cases, the infrastructure would amount to a few primary care offices, linked to an established urban center. Therefore subsidies alone, without the exclusive franchise, should be enough to attract AHPs to most markets.

The RAA will need to petition the NHB for subsidization and implementation funds and for

the right to offer exclusive franchise. In either case, funds or authority will only be granted after the RAA has proven necessity. The RAA will need to demonstrate some, or all of the following: inadequate density of population, inadequate infrastructure, and failed attempts to attract an AHP (including organizing present purchasers).

The RAA will act as a rural advocate. Its duties will include encouraging development of infrastructure to be shared by AHPs. For example, communications systems could be shared by rural providers to reduce overhead expense. The RAA could also coordinate among the local AHPs the efficient delivery of emergency care. The RAA will also perform consultative tasks, and will take steps, including the organization of purchasers, to attract AHPs to an area before subsidies are given out. As an organization interacting with all AHPs in a region it will be in a position to offer help and advice to rural AHPs on a continual basis.

In rural areas where there is an existing network of providers, but population densities and distance to the nearest urban center inhibit competition, the RAA will encourage the development of a cooperative, community based AHP. In these areas there will be more to be gained from cooperation among the providers than from competition between them. The cooperative model will be pursued in areas where existing provider networks are, to an adequate extent, in place, but that can not support competition. This should be distinguished from the exclusive franchise model where substantial investment will be necessary to create networks.

Although the Jackson Hole Group maintains that a majority of rural areas will be served by

competing AHPs, it avoids categorizing rural areas. The group realizes the diversity of rural conditions and present delivery systems. The decision to pursue a more cooperative model in frontier areas, as opposed to a competitive one, will be a local one made by the RAA with input from all concerned parties including: providers, consumers, employers, and government officials.

Health Plan Purchasing Cooperatives (HPPCs). HPPCs will perform the same functions in sparsely populated areas as they will in urban areas, but will assume additional monitoring and regulating functions in order to supplement inadequate competition in some areas. HPPCs will be charged with monitoring AHPs that operate under an exclusive franchise, and AHPs that operate without competition, or inadequate competition, for other reasons. The later are likely to be cooperative AHPs or AHPs that have carved out a unique market niche. In all of these areas where market forces are inadequate the HPPC will need to compensate with increased monitoring and regulating capabilities. The HPPCs will be given the authority to take action if the AHP fails to deliver quality care at a reasonable price. In evaluating the AHP to make this determination, HPPCs will utilize benchmarking standards, including premiums charged by other AHPs, non-competing rural AHPs in particular, as well as standard, nationwide outcomes data.

Since in many cases an AHP that is the sole provider in a sparsely populated area might also provide care in a highly competitive area, a comparison of rates in the sparsely populated area with rates in the competitive area will help further to evaluate an AHP's performance. Legislation forbidding, or limiting, geographic discrimination could reduce the HPPC's responsibilities in these cases. Furthermore, competition in its true sense will be present at

the fringes of AHP "territories." The HPPC can monitor competition at the fringes and use it as another source to evaluate AHP performance.

Sanctions against AHPs that do not perform. Sanctions that might be taken could include the reduction of subsidies or the cancellation of exclusive franchise. In some cases, direct regulation of premiums might be necessary if it is impossible, for practical reasons, to displace an AHP. These regulatory actions would at least be subject to review by the National Health Board.

Before sanctions are taken, however, the HPPC will be responsible for alerting an AHP to its substandard performance, and perhaps helping to coordinate pro-active measures with the RAA to address the problem. These responsibilities lie with the HPPC because of the local nature of the services, and the problems that might arise.

Accountable Health Plans (AHPs). With some alteration in physical structure and managerial expertise, AHPs are well-suited to deliver health care in rural areas. The coordinated care offered by an AHP will be especially beneficial in rural areas where care is presently often fragmented. AHPs are required by law to make care available and are accountable for patient health outcomes. Rural AHPs will grow and develop along regional and geographic boundaries and may often cross state lines.

The rural AHP structure and management will need to reflect the unique communications challenges of rural settings. Since it will be economically imprudent to provide some required specialty services on site, residents will receive primary care near home and will go to the

appropriate urban center to receive specialized care. As rural AHPs develop, they will create circuits to be traveled by specialists, so that more specialized care will be delivered in rural areas. Rural AHPs are likely to take one of two forms: An AHP could be based in the sparsely populated area, and contract with specialty services in urban areas or, AHPs in urban areas could compete for market share in surrounding rural areas by establishing branch offices offering primary care. Either option should offer the same benefits to rural practitioners, making recruitment efforts more successful. This organizational structure will help to reverse the current trend of self-referrals to urban providers and ensure the viability of appropriate rural facilities.

Manpower. As rural centers of care become affiliated with AHPs, rural providers will find a strong backup consisting of high-tech and low-tech communications linkage, complete outcomes data, liability coverage, referral capability, time off for vacation or training, guarantees of working conditions and hours, and a career track. This improved support system will make it easier to recruit providers to rural areas where such support is lacking now. Rural physicians will benefit from the complete knowledge base of a large AHP in treating patients. When a specialized procedure is necessary, the patient can be readily referred to a more appropriate facility. As AHPs design their delivery networks, they are likely to incorporate the use of mid-level practitioners to further extend access to the most sparsely populated areas.

Existing Facilities. Any workable reform initiative should take advantage of the opportunity to incorporate existing facilities such as, Community and Migrant Health Centers (C/MHC). C/MHCs can become affiliated with AHPs. This affiliation will offer a unique

opportunity for a public/private partnership in fulfilling the indigent care mission. C/MHCs are a logical place to continue to provide care for the few remaining uncovered individuals. For this mission C/MHCs will need extra sources of government funding.

Tax Codes. The Jackson Hole Group recognizes that restructuring health care delivery in rural areas may take longer than in urban areas. To allow time for a smooth transition, and to guard against penalizing rural residents who will have fewer health care alternatives, we propose deferring the implementation of new tax codes in rural areas for two years. It is still possible that in some rural areas residents will not have access to tax-preferred health care coverage, even after the two- year period, due to recalcitrant providers who are unwilling to change practice styles. Thought should be given to either taxing those providers directly or forcing them to accept Medicare fee schedule payments. But first every effort should be made to ensure that AHPs are able to offer, and actually do offer, attractive partnership agreements to rural physicians that include fair reimbursements, the availability of networking, and other support services. Any reform initiative will, and should, fail if it does not promote attractive arrangements of this nature.

Financing. Historically rural providers have been more dependent than urban providers on government revenues due to the high percentage of Medicare and Medicaid recipients that they serve. To address the market and system distortions caused by the dependence on government revenues, the Jackson Hole proposal would channel all government money through the HPPCs, removing the distorting effects of Medicare and Medicaid reimbursements and the attendant slow federal waiver process. Furthermore, government will pay the same, fair rate for health care coverage. Many of the problems stemming directly

from under-compensation (including lack of access due to unwillingness of providers to locate in these areas) will be ameliorated. With these distortions removed, the market will be free to reform the health care delivery system in the most appropriate way. In short, specialized procedures will be concentrated into fewer centers and rural facilities will focus on primary care services. Competition and the obligation to serve a defined population will force AHPs to design efficient delivery systems that improve access and meet the needs of all Americans over extended periods of time. The result will be a reduction in underutilized rural facilities and the creation of an efficient network of facilities that delivers higher quality comprehensive medical care.

References

Ingersoll, B. (1989, July 20). Farming is dangerous, but fatalistic farmers oppose safety laws. *The Wall Street Journal*, p.1.

National Rural Health Association. (September 1992). *National Health Policy Reform: The Rural Perspective*.

Office of Technology Assessment (1990). *Health care in rural America* (OTA Publication No. OTA-H-434). Washington, DC: Government Printing Office.

Ries, P. (1987). *Health care coverage by sociodemographic and health characteristics, United States*, 1984 (Vital and Health Statistics Series 10, No. 162, DHHS Publication No. [PHS] 87-1590). Washington, DC: Government Printing Office.

We welcome, and encourage, any comments you might have regarding this document. Feel free to call or return this document with your comments. Your name, address, and telephone number would be appreciated, to enable efficient follow-up on comments. Thanks!

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