

Countervailing Agency: A Strategy of Principaled Regulation under Managed Competition

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MANAGED COMPETITION IS DEAD. LONG LIVE managed competition. Certain ideas in the public sphere achieve a peculiar form of immortality, undergoing successive reincarnations and receiving new names with each rebirth. Managed competition appears destined for this status. When proposed by the Clinton Administration, managed competition was derided by conservative politicians as a “dog that won’t hunt” and questioned by some academics on the grounds that it was politically or administratively infeasible. Nonetheless, its central features and philosophy have been embraced by a growing number of large private employers, state Medicaid programs, and state policy makers (Ladenheim, Lipson, and Markus 1994; Leatherman and Chase 1994; Torchia 1994; Freund and Hurley 1995). These ongoing initiatives have many, or all, of the characteristic features of the managed competition model originated by Enthoven, Ellwood, and their colleagues in the Jackson Hole group: consumers choose among competing health care plans with the assistance of a purchasing agent, paying higher premiums for the more expensive alternatives. The same features hold some allure for policy makers in other countries (Luft 1991; Jérôme-Forget, White, and Wiener 1995).

Despite its failure, the Clinton Administration’s health reform initiative cast a spotlight on these ideas. The introduction of the Health

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Security Act in 1993 encouraged managed competition enthusiasts while scaring the skeptics into planning defensively for changes that at one point were widely viewed as inevitable. Like a cohort of latter-day Johnny Appleseeds, Administration officials planted the ideas of managed competition far and wide. As they have sprouted, the enthusiasm accompanying their emergence has obscured the fact that no one has tested the instructions for the gardeners who are expected to nurture their development. The collapse of the federal reform efforts in the summer of 1994 cut short a public debate that had only begun to illuminate the appropriate roles of government agencies and private sponsors in guiding the development of managed competition among health plans (Congressional Budget Office 1994).

In each of its incarnations, managed competition has assumed different forms. The emphasis on financial incentives for consumers that was the core of Enthoven's original model was supplemented (and to some extent replaced) by contractual incentives for health plans in the Clinton Administration's approach. Subsequent versions have been arrayed between these two extremes, with private sector applications tending toward the Enthoven variant and managed Medicaid systems more often resembling the Clinton Administration model. Although differing in emphasis and in certain particulars, all these approaches share a core philosophy and display some common features.

Every managed competition approach blends regulation and targeted incentives. Indeed, this style of reform was originally referred to as "regulated competition," an appellation that fell into disfavor because of its connotations of activist government (Enthoven 1993). Although the label has changed, several regulatory strategies remain as core elements of managed competition schemes: First, managed care plans are expected to be responsive to consumer preferences (Arnould et al. 1993). Second, they are required to reveal certain information about their performance in order to facilitate consumer choice. Third, the enrollment (and in some case disenrollment) process is regulated to limit the extent to which plans can "game" the system by encouraging healthier individuals to sign up. Fourth, the ways in which plans may differentiate themselves from one another are limited, making it easier for consumers to select plans that are both high quality and cost effective.

Each of these functions emerged from a diagnosis of the minimal regulatory involvement required to fashion the market for medical services into one more like that presumed by neoclassical economics. Market-enhancing regulation is justified by the observation that "a free market

does not and cannot work in health insurance and health care. . . . Managed competition uses market forces within a framework of carefully drawn rules” (Enthoven 1993, 44). By lending the “invisible hand” a helping hand, the “managers” of the system make the market work fairly and efficiently, much as the Securities and Exchange Commission regulates the stock market. Their role is to define clear guidelines for regulatory involvement and link them to a set of principles familiar to many Americans who know little about health care. This strategy has already induced dramatic shifts in the nature of accountability in American medicine: the introduction of HMO “report cards” (Leatherman and Chase 1994); the use of state-sponsored purchasing cooperatives (Ladenheim, Lipson, and Markus 1994), and the trend toward more aggressive purchasing policies by private employers and public agencies.

These initiatives are well intentioned, but they are not all well conceived. The principles on which managed competition rests unfortunately do not adequately reflect how medical care and health insurance differ from conventional market goods. They fail to acknowledge how the interests of individual patients can differ from those of society as a whole. Nor do they recognize the extent to which both patients and society will continue in the future to depend on “agents” to represent their interests in the delivery of medical services. Consequently, conventional managed competition approaches neglect critically important aspects health care. Worse, in their neglect they are likely to exacerbate failures in these areas, producing a system unable to effectively meet the needs of either individual consumers or the larger society.

This claim is different from past critiques of managed competition, which argued that it was not possible to implement managed competition reliably for the following reasons:

1. Many communities could not sustain a sufficient number of competing plans (Kronick et al. 1993).
2. Substantial parts of the public were not sufficiently responsive to the associated incentives (Rice, Brown, and Wyn 1993).
3. The challenges of administering this system in an efficient and even-handed manner exceeded the capacities of the institutions that would be assigned these tasks (Brown and Marmor 1994; Morone 1993, 1994).

My concern is that, even if they were to be fully implemented and ably administered, conventional approaches to managed competition will

undermine the performance and add to the problems of contemporary American medicine.

My purpose in writing this article is to propose an alternative approach, which I term “the strategy of countervailing agency.” Its central proposition is that management of competing health plans must focus on two relationships: the health professional as agent for individual patients and the health plan as agent for society. By reinforcing and striking the appropriate balance between these two principal–agent relationships, public and private regulators can use competition among managed care plans to improve the performance of the health care system. In other words, *if* we are going to have competing health plans, my claim is that there is a better way to structure that competition. This begs the question of whether we should base a health care system on competing plans, which, while not a trivial question, is one that has been extensively discussed (Rice, Brown, and Wyn 1993). However, by examining some of the complexities of managed competition, this article sheds light on the question of whether we want to pursue such a strategy in the first place, a question to which I will return in my conclusion.

The remainder of the article is divided into four sections. In the first, I explore more carefully the conventional model of regulation under managed competition. The second section juxtaposes this prescription against certain key features of contemporary medicine, identifying important weaknesses. The strategy of countervailing agency is developed in the third section to address these weaknesses. The discussion illustrates how its basic principles and specific prescriptions differ from (and in some cases diametrically oppose) those of conventional managed competition schemes. I conclude by putting countervailing agency into a broader context, addressing the political and administrative challenges that must be overcome to make it feasible.

The Goals and Methods of Regulation under Conventional Managed Competition

As the managed competition model has diffused into a variety of settings, it has evolved into different forms, each with its own distinctive emphasis. It therefore makes sense to examine the role of regulation within three distinct evolutionary phases:

1. the original model developed by Alain Enthoven and propounded by his colleagues
2. the variant that became the core of the Clinton Administration's Health Security Act
3. more recent incarnations used by private employers, state-sponsored purchasing cooperatives, and state-administered managed Medicaid programs

Because the “managers” of competition are often in private enterprise, it is important to recognize that “regulation” in this context is not necessarily a public sector function, nor is it limited to requirements that carry the force of law. Instead, “regulation” refers to the strategies and instruments employed by the actors who are charged with the task of ensuring that managed competition operates in its intended manner.

Initial conceptions defined the task of the regulators—termed “sponsors” (Enthoven and Kronick 1989)—as making the market work for individual consumers. The inability to develop effective market forces had plagued earlier versions of consumer-choice health plans, including those created by Enthoven (Fuchs 1988). Consumers were purportedly unable to choose services in a cost-conscious manner when they needed medical care: too many decisions were required, time was too short, and circumstances were too laden with fear or other emotions (Enthoven 1982). To make consumers more sensitive to costs—more willing to make reasoned trade-offs between cost and quality—it was essential to refocus consumer choice on the selection of health plans that combined insurance with the provision of medical services.

Although this strategy promised to alleviate the pressure and emotions involved in consumer choices, it also created several problems of its own. First, health plans are complicated and somewhat obscure entities that bewilder most Americans (Enthoven and Singer 1995). To make reasoned choices, they need information. The plans, however, have an obvious incentive to supply information strategically because doing so can benefit them in several ways. By reporting only certain attributes and hiding others, plans can create a falsely attractive image, which allows them to charge more than the quality of their services actually merits. In addition, by adopting “gag rules,” “confidentiality rules,” and “nondisclosure clauses,” plans also limit the extent to which physicians can inform their patients about less attractive features of the plan (Kassirer 1995).

Prevailing methods of paying plans create a second incentive for disseminating information strategically. Plans receive a capitation fee based on the average cost of a prospective enrollee. Despite years of experimentation with individualized risk-adjusters for capitation rates, researchers are still unable to predict more than about a third of the variance in health care costs from objectively measurable characteristics (Newhouse 1994; Rice, Brown, and Wyn 1993). Consequently, it benefits a managed care plan to publicize those aspects of plan performance that attract younger and healthier enrollees. Conversely, few plans would advertise that they deal effectively with complex, high-cost conditions because this would attract patients who either have or are at greater risk for contracting these conditions.

Strategic behavior creates a need for the sponsor to regulate the content and flow of information to consumers, but this is not the only way in which it can skew the performance of the market for health plans. Experience has revealed that plans use marketing methods inventively to attract healthier than average enrollees (Luft and Miller 1988; Schlesinger and Brown-Drumheller 1988). Consequently, the sponsor also must oversee and regulate the entire enrollment process, facilitating enrollee switching among plans through regular “open enrollment” periods (Enthoven 1993; Ellwood and Etheredge 1993).

These tasks defined the minimum regulatory responsibilities for sponsors. Proponents of the early versions of managed competition, however, suggested that sponsors could improve market performance with some additional steps. Potential enrollees were to be charged out-of-pocket premiums that fully reflected costs differences among competing plans; they would pay for these differential premiums with *after-tax* dollars so that their choices would more accurately reflect the cost to society of greater health care spending. To assist consumers in choosing among plans on the basis of price, plans were to be restricted to offering a relatively standardized set of services. “Standardization should deter product differentiation, facilitate price comparisons, and counter market segmentation. There are powerful reasons for as much standardization as possible . . . to facilitate value-for-money comparisons and to focus comparisons on price and quality” (Enthoven 1993, 32). Finally, sponsors were to encourage the development and spread of managed care plans that closely integrated the interests of plans and providers, so that market pressures by consumers could be more readily translated into medical practices. These “organized systems” of medical care were ex-

pected to “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 . . .” (Enthoven 1993, 38).

In its Jackson Hole incarnation, the role of regulation under managed competition was thus entirely devoted to making health plans responsive to consumer choices and to appropriately establishing the guidelines for consumer decision making. Poor performance by plans, in this model, would be punished exclusively when dissatisfied enrollees departed to look elsewhere for better treatment. The version of managed competition adopted by the Clinton Administration differed from this original prescription to the extent that it was judged by some of the true believers to have betrayed the philosophy of “true” managed competition (Starr 1994; Enthoven and Singer 1994). However, it retained many of the central conceptions about the appropriate goals and bounds on regulation.

Apart from changes in terminology (“sponsors” were transformed into “health insurance purchasing cooperatives” [HIPCs] and later into “health alliances”), the Health Security Act shifted the focus of regulation away from an exclusive concern with consumer choice (Eckholm 1993; Starr and Zelman 1993). Health alliances were also expected to oversee the well-being of enrollees once they had joined a plan. This included monitoring grievances and adjudicating complaints that were lodged against the plan, establishing and enforcing national practice guidelines for health professionals, and facilitating an array of arrangements to enhance institutional quality.

Some of these changes, most notably the establishment of practice guidelines, were endorsed by the original proponents of the managed competition model (Enthoven 1993; Wilensky 1994). Others were seen as more heretical. Despite these doctrinal disputes, the Health Security Act retained the concept of regulation that formed the core of the original managed competition approach. These new versions of sponsors were still expected primarily to promote consumer choice among health plans. “A purchasing cooperative ought to be recognized, first and foremost, as the arm of the purchasers. . . . One job of the HIPC is to support that consumer decisionmaking. . . . The HIPC’s access to aggregate data and sophisticated analytic tools puts it in a strong position to act as consumers’ agent in monitoring plan performance” (Starr 1993, 58–60). Furthermore, standardization of plans continued to be a preferred strategy for facilitating informed consumer choice (Zelman 1994).

Although the Health Security Act would have granted a broader array of tools to sponsors/HIPCs/alliances, it continued to embody the belief that the relationship between individual and plan was crucial to the appropriate functioning of the health care system. In the words of two of the architects of the Act, "The purpose of this framework is to encourage consumers to make quality-conscious as well as cost-conscious decisions and to encourage plans to serve both high-risk and low-risk populations" (Starr and Zelman 1993, 11). In contrast, health alliances had little purview over the nature of relations either between patients and individual providers or between providers and plans. (An exception was the requirement that managed care plans contract with certain "essential community providers," a provision that was extensively debated during the development of the Health Security Act and eventually became a transitional requirement.)

A second, less explicit, aspect of the regulatory philosophy that the Health Security Act retained from the Jackson Hole proposals was the portrayal of health alliances as little more than technical facilitators, collecting and disseminating information but not making decisions that were in any way value laden. In the language of the Act's proponents, this function was not even really regulatory: "This is not to suggest that the purchasing cooperative should be a regulator or a planner. Certainly it must be constrained from becoming the former, and it should be restrained in its tendency to become the latter" (Zelman 1993, 50).

The spread of managed competition models in the private sector and state governments began well before the 1992 election (Ladenheim, Lipson, and Markus 1994; Leatherman and Chase 1994; Torchia 1994; Freund and Hurley 1995). The failure of the Health Security Act did little to slow this growth. Large private employers commonly rely on managed competition (Darling 1995; Roper 1995), as do purchasing cooperatives for small business that have been created by state initiatives (Ladenheim, Lipson, and Markus 1994). It has also been incorporated into the Medicaid program, which has come to rely increasingly on managed care (Horvath and Kaye 1995).

The models adopted by corporations or purchasing cooperatives tend to emulate the original Jackson Hole model. Premiums are set higher for more expensive plans, giving enrollees a financial incentive to select lower-cost alternatives, although in many cases the premiums are paid with before-tax dollars. "Regulation" is typically limited to requiring an open-enrollment period and to collecting and disseminating infor-

mation about plan performance. Many employers “prescreen” plans, thereby restricting the number of choices available to their workers, and employers increasingly require that plans satisfy industry accreditation standards, which are roughly analogous to the practice standards envisioned in the Health Security Act (Davis et al. 1995; Roper 1995).

The form of managed competition incorporated by many states into their Medicaid programs is closer to the version proposed by the Clinton Administration (Freund and Hurley 1995). The sponsors (in this case, state agencies or private contractors with their delegated authority) make consumer choice a major goal; by the end of 1995, a half dozen states had adopted HMO report cards to facilitate these choices (Horvath and Kaye 1995). Medicaid agencies, however, have developed more explicit regulations to protect individual consumers in their dealings with plans, including ombudsman programs (four states), surveys of people disenrolling from plans (14 states), and direct oversight of particular aspects of plan performance (24 states) (Horvath and Kaye 1995).

Despite the considerable variation among these different versions of managed competition, the fundamental guidelines on regulation are retained. Regulators are seen primarily as facilitators of consumer choice. Following the prescription of proponents of managed competition, a number of sponsors have attempted to make choices easier by standardizing the benefit packages offered by plans. Any additional regulatory oversight has focused almost entirely on relations between plans and enrollees, typically requiring that plans accurately inform enrollees about their average practices, protocols, and, sometimes, outcomes of care.

While this information may prove valuable, regulators have, until recently, virtually ignored the interactions between patients and providers or plans and providers (General Accounting Office 1995). Indeed, proposals that might in any way shape or constrain the ways in which plans contract with providers have been almost universally rejected by proponents of managed competition as an unjustifiable intervention into decisions best left to the market (Enthoven and Singer 1995; Darling 1995; Roper 1995). (The one consistent exception appears in Medicaid requirements that health plans contract with, or refer to, identified community providers. Although some states have pursued this approach extensively, most appear to comply only with the minimum required by federal regulations.) The primary strategy of the managed competition model remains the use of market pressure from consumer decisions to transform the manner in which health care is delivered.

From Principles to Principals: Gaps in Managed Competition Prescription

Much of the appeal of the managed competition model derives from its invocation of market principles. Its proponents argue that it rests on “generally accepted principles of rational economic behavior” (Enthoven 1993, 45). Markets are familiar to most Americans and offer a comforting format to policy makers bewildered by the complexity of health care.

Unfortunately, market principles constitute an effective guide to policy only if the reforms can transform markets for health insurance and care to match the parameters assumed in neoclassical economics. (For a more complete discussion of the limitations of partial reforms, see the treatment by Fielding and Rice [1993] of the theory of the second best applied to health care.) The conventional managed competition approach fails this test in two ways: First, it neglects the extent to which the interests of individual patients or consumers differ from the welfare of society as a whole. Second, it overlooks the importance of the relationship between patient and provider, both for overcoming persistent information asymmetries in medical care and as a valued attribute in itself.

External Costs and Societal Welfare

Advocates of managed competition typically favor eliminating tax subsidies for health insurance coverage, particularly coverage that is more comprehensive and expensive than some benchmark minimum benefit plan (Enthoven and Kronick 1989). The rationale for this change is to make enrollees’ choices among plans reflect the full societal cost of more comprehensive insurance, but it was an aspect of reform that proved to be unfeasible politically.

In the absence of tax reform of this sort, individual consumers will clearly have an incentive to purchase more health insurance and thus to seek more medical care than is in the best interests of society, although the responsiveness of consumers to such incentives remains a topic of considerable debate among health economists (Rice, Brown, and Wyn 1993). Even were tax subsidies to have no effect on the purchase of insurance, however, there remains the problem of moral hazard, of people

with insurance seeking more treatment than is socially desirable simply because the out-of-pocket cost to them is very low or nonexistent (Newhouse et al. 1993). Both of these effects impose external costs on others that stem from individuals' decisions about their health care. Both suggest that the level of treatment (and costs of health services) preferred by individual patients will be higher than socially optimal.

Several more significant externalities exist in health care markets, although they are typically overlooked in discussions of the medical marketplace (Evans 1984; Pauly 1988; Sloan 1993). Each of these involves situations in which significant social costs are imposed by the failure of patients to seek *sufficient* health care. The most obvious involves infectious diseases. Even though the costs and risks of vaccination are relatively low, for example, a substantial number of children remain unvaccinated because the apparent health consequences for any single child are essentially zero, so long as other children have been vaccinated. However, when many parents independently make the same calculations, the risk of infectious diseases is substantially increased (Lewit and Mullahy 1994).

The existence of health insurance creates a similar pecuniary externality for many preventive services. Protected from the true costs of medical care, the incentives to prevent illness from occurring in the first place are reduced. Under these circumstances, even relatively modest logistical barriers may detain people from seeking appropriate preventive care, even if that care is available at no cost (Lurie et al. 1987).

Another important externality involves the impact of medical care on productivity. By detecting disease at an early stage, prevention programs and timely treatment can reduce the subsequent costs of medical care and increase productivity, albeit often at significant aggregate cost to the medical care system (Russell 1987). The productivity benefits are often far larger than the medical costs that are avoided: hypertension prevention, for example, can lead to productivity benefits that are three to five times larger than the medical savings (Stokes and Charmichael 1975).

The fourth category of externalities involves the costs of illnesses borne by informal caregivers, which, for a variety of chronic illnesses, exceed the cost of formal services (Pope and Tarlov 1991). For example, the social costs of informal care of patients with Alzheimer's disease who continue to live in the community were recently estimated to average three times the expenditures for medical care (D. Rice et al. 1993). The

benefits of deterring the progression of chronic illness thus are substantially transferred to informal caregivers.

A final form of externality concerns the costs of illness shouldered by unrelated persons. The clearest examples involve behavioral disorders. The Institute of Medicine estimated that the social costs of the use of illicit substances (not including alcohol) were between \$50 and \$100 billion annually, of which 15 percent resulted from lost productivity by coworkers, while another 45 percent could be traced to the consequences of crime and spending on law enforcement (Gerstein and Harwood 1990). Because individuals do not directly face these costs, only a small proportion of those whose treatment might be merited on the basis of societal benefits (including, for example, pregnant women) seek treatment for substance abuse problems (King 1992; Schlesinger and Dorwart 1992).

These various externalities are common in medical care. Exactly how common depends on how one measures the prevalence of these various conditions. The costs associated with treatment provide one measure. In the mid-1980s, it was estimated that infectious diseases represented between 5 and 10 percent of the costs of all medical care, but this was before the advent of AIDS, which substantially increased those costs (Evans 1984). Preventive screening programs represent a more modest expense, perhaps 2 to 3 percent of all medical spending (Russell 1987). Chronic illness is much more costly, representing at least a quarter of all health care spending (Pope and Tarlov 1991). Behavioral disorders of various sorts involve slightly less than 10 percent of all health care spending (Frank et al. 1994). Thus it appears that at least half of current medical expenditures are associated with substantial benefit externalities.

Chronic and behavioral conditions have, in fact, become defining features of contemporary American medicine (Pope and Tarlov 1991; Cassel, Rudberg, and Olshansky 1992; Steinberg 1993). There are, therefore, two separate types of externalities in medical markets: the first encourages the excessive use of some services; the second leads to inadequate use of other forms of treatment. Both affect the level of care that would best promote societal welfare. These external effects interact with one another, making it impossible to construct any simple, across-the-board guidelines regarding the divergence between patient and societal interests. But diverge they do. Consequently, a system designed to make the health system in general, and managed care plans in particular, more

responsive to the preferences of individual consumers will not equally serve the interests of society.

Information Asymmetries and Trust in Providers

Trust between patients and health professionals is essential to effective medical care (Rogers 1994; Williams 1994). Diagnoses depend on patients conveying a complete and accurate picture of their life circumstances; compliance with treatment often requires patients' willingness to follow prescriptions that impose substantial immediate costs in return for as-yet unrealized future benefits (Mechanic 1996). Perhaps most important, the core of "caregiving" is inextricably bound up in emotional interactions that cannot exist in the absence of trust (Scott et al. 1995).

The additional information supplied to consumers under managed competition will not diminish the importance of trust between patients and providers. Performance statistics that are collected at the plan level provide little insight into the practices of individual physicians or other health professionals. Although managed competition promises to "align" the interests of physicians and health plans, actually "managing" physicians is a task that has been likened to herding cats. Experience suggests that plans are not equally successful at encouraging physicians to practice in ways that promote the plan's objectives (Moran and Wolfe 1991; Hillman, Welsh, and Pauly 1992; Staines 1993). The affiliated physicians of even the most successful plans are likely to exhibit a wide range of practices.

Even if enrollees felt that they could rely on the reputation of a plan for effective performance, this sort of "social trust" does not substitute for the "interpersonal trust" between patients and providers (Mechanic 1996). That bond depends on emotional valences that an organization cannot provide. Nor can the measures developed for plan performance be readily applied to individual clinicians in a way that reduces the need for trust. The relatively small numbers of patients or conditions encountered by a provider each year make statistical performance measures highly unreliable. Even if information of this sort was made available, it would not substitute for trust. Information about treatment and the consequences of illness is often sufficiently complex or frightening that many patients *prefer* to delegate decision making to providers and will

actively avoid information that might reduce their comfort in doing so (Strull, Lo, and Charles 1984; Hibbard and Weeks 1987; Lupton, Donaldson, and Lloyd 1991).

Not only does managed competition not reduce the importance of patient–provider trust; it actually increases its salience while threatening to undermine its existence. By introducing health plans, managed competition adds to the roles that physicians must play as agents, in this case helping patients to deal with their plans. This is most evident around the utilization review process. While dealing with reviewers imposes substantial time and costs on clinicians (Emmons and Chawla 1991), patients depend on their physicians to serve as effective advocates in this process (Morreim 1991; Mechanic and Schlesinger 1996). They must trust their providers not only to have strong clinical skills, but also to be effective negotiators on their behalf. In addition, patients rely on physicians as a source of unbiased information about the strengths and weaknesses of the health plans in which they are enrolled. A recent survey found that information about plans obtained from physicians was viewed by the average American as far more reliable than information made available by the plans themselves or provided by a government agency (Sever 1995).

Because conventional managed competition plans provide no regulatory oversight on the relations between patients and providers or providers and plans, they offer no protection in this area. Worse yet, the very processes intended to foster consumer accountability at the plan level are likely to undermine trust between patients and health professionals. Market pressures will only be effectively translated into better medical care when the interests and incentives of physicians are integrated with those of the plan. This blending of clinicians and insurers is likely to raise doubts about physicians' trustworthiness. Americans view insurers as one of the least trustworthy of contemporary institutions—quite a distinction, given the limited confidence in other institutions (Blendon, Brodie, and Benson 1995). The public is particularly uncomfortable with having providers consider the financial consequences for the plan when they make decisions about treatment (Mechanic 1989). This discomfort with insurer involvement in health care may account for the public's concerns that the Health Security Act would substantially reduce quality of medical care (Blendon, Brodie, and Benson 1995).

Even if providers and plans are not viewed by enrollees as being too closely aligned, the emphasis under managed competition on switching

plans to express dissatisfaction will in itself undermine trust between patients and providers. Switching plans often requires that enrollees switch providers, disrupting the continuity of interactions that is essential to establish interpersonal trust (Mechanic 1996). Even if enrollees do not actually switch plans, the prospect that they might do so in the future may lead them to invest less in their relationships with providers, further weakening the bonds that are necessary for trust to exist.

Principals and Agents in Managed Care Markets

There are, then, two distinct sets of interests in the health care system: those of individual enrollees and those of society. In both cases, the nature of health care is sufficiently idiosyncratic that no set of external rules, no matter how carefully crafted or thoughtfully implemented, can determine in advance what constitutes the “right” forms of medical care (Blustein and Marmor 1992). To make appropriate decisions on a case-by-case basis, the interests of both the patient and society must be represented in a reliable manner.

Societal Agency in Health Care. Although concerns about the societal consequences of aggregate medical spending were voiced throughout the 1970s, it was not until the early 1980s that observers voiced the opinion that physicians had an obligation to society to consider the social costs of the medical care they prescribed (Goldsmith 1984; McGuire 1986). This broadened definition of agency gained surprisingly wide acceptance among physicians, although some strongly resisted the role (Eisenberg 1986; Wolf 1994; Brock and Daniels 1994). By the early 1990s, the physician’s task was being described by some observers as a form of “double agency,” representing the interests of the patient as well as third parties (most generally, society as a whole) who pay for medical care (Blomquist 1991; Morreim 1991). Anecdotes suggested that practicing physicians were giving substantial weight to both patient and societal agency (Smith 1993).

It is doubtful, however, that individual physicians can appropriately balance these two agency roles. Physicians generally have only limited knowledge of the charges for the care they prescribe (which may not reflect true costs of production), let alone an accurate assessment of the medical benefits of any given treatment for their patient (Eisenberg

1986). Assessing the marginal *social* costs and benefits would be far more demanding. Medical care entails a variety of external benefits, about which clinicians have no particular expertise. Some of these involve contagious diseases; others result from an altruistic concern that the public has for those who are ill (Evans 1984). Clinical expertise may help to assess the first type of externality, but it offers little insight into the second.

More generally, there is the full array of external costs introduced earlier, ranging from effects on productivity to burdens on caregivers. It is difficult to imagine how physicians could assess the presence or extent of these external costs and benefits because many affect people with whom the clinicians have no contact. Proposals to have individual doctors make treatment decisions based on benefit–cost studies (McGuire 1986) are unrealistic, given the limited assessment of medical treatment in these terms, the difficulties in accurately measuring external costs and benefits, and the heterogeneity of health needs and treatment effectiveness for individual patients.

The limited ability of physicians to internalize the costs and benefits of medical care have led reformers to support the growth of prepaid health plans as an alternative societal agent. Prepaid health care plans were seen by their initial advocates as a means of encouraging alternative styles of medical care (Luft 1981) because the plans shared in the financial risks associated with the provision of health care services. Much of the appeal of prepaid plans to policy makers was based on the notion that prepayment led plans to internalize the future costs of illness, encouraging them to treat illness at an early (and presumably cheaper) stage and to employ efficient forms of treatment (Brown 1983).

Proponents of HMOs have argued that prepayment creates an incentive for efficient use of medical resources by making the plan face the true marginal costs associated with treatment. It does encourage plans to internalize some externalities, including some of the benefits of prevention care (Luft 1981). For these reasons, it is sometimes argued that prepaid plans act as reliable agents for society and thus require no outside oversight to ensure that their policies are optimal from a societal perspective (Boggs 1986).

This claim is demonstrably false. Although prepaid plans face the full marginal costs of medical care, they internalize the benefits of treatment much less completely. Consequently, plans will generally be imperfect agents for society. Consider some of the benefit externalities described above.

Preventive care provides much of the rationale for the purported benefits of HMOs. The incentives associated with prepayment, however, fail to reflect the full marginal social benefits of prevention. Even if plans captured the full medical cost savings from keeping enrollees healthier through prevention services, these typically represent less than half the total social benefits (Russell 1987). Nor does the plan fully capture the medical cost savings from keeping enrollees healthy. Most preventive interventions reduce health costs that would have occurred many years in the future. But enrollee turnover in HMOs, as calculated from unpublished data on HMOs operating between 1987 and 1991, is high, typically averaging about 15 to 20 percent annually. For enrollees who switch plans, the benefits of prevention are captured by their future insurers, except in the case of services like prenatal care, which has been shown to reduce the immediate medical costs of treating infants born at a low birthweight (Office of Technology Assessment 1987). Since these savings occur within roughly nine months of conception, the HMO with pregnant enrollees captures many of the benefits of prevention. But even in this case, the plan fails to internalize important benefits. Much of the social costs of low birthweight result from developmental delays in the child, which increase the subsequent costs of public education and likely reduce future productivity. These benefits of prevention remain external to the HMO. It is thus not surprising that the use of prevention services is not generally higher in HMOs than under fee-for-service insurance with comparable copayments (Luft 1981; Office of Technology Assessment 1989; Freund et al. 1989).

Benefits that are externalities for patients or physicians may also be external to prepaid plans. This is obvious for infectious diseases. The HMO has a financial incentive to deter infection among its members. But because any one HMO typically enrolls at most a small portion of each community, these incentives are significantly less than the marginal social benefits. Indeed, the goal of extensive competition among plans that is at the core of managed competition strategies makes it unlikely that any one plan will enroll a sufficient portion of any community to internalize these benefits.

A comparable situation exists for other external benefits. To the extent that treatment deters the progression of chronic diseases, the benefits accrue primarily to informal caregivers. HMOs are thus likely to inadequately provide treatment for chronic illness, relative to the level that is optimal from a societal perspective (Schlesinger 1986). Similarly, most of the costs of behavioral disorders are external to the health care

system, and many impinge on people who have no affiliation with the patient. Again, prepaid plans will provide too little treatment for these conditions.

The incentives for HMOs to undertreat certain conditions are compounded by problems of adverse selection in markets for health insurance. As noted earlier, it is in the plan's financial interest to avoid enrollees with above-average expenses and to encourage high-cost patients to disenroll from the plan (Luft and Miller 1988). Consequently, prepaid plans have an incentive to avoid prospective enrollees with chronic illness because they are predictably high-cost cases. One effective way to do this is to provide minimal treatment for their conditions, so that dissatisfied individuals disenroll and switch to other plans (Schlesinger and Mechanic 1993).

For all these reasons, one would expect prepaid plans to offer suboptimal care for a significant number of medical conditions. The extent of this departure from the ideal societal agency perspective will depend on the magnitude of the uninternalized benefits. But although prepayment does not in itself create sufficient incentives for plans to act as effective societal agents, this does not mean that the appropriate incentives cannot be created with appropriate regulatory guidance, which is the focus of the strategy of countervailing agency.

Patient Agency and Trust. Despite declining public confidence in the medical profession collectively, Americans continue to trust their individual physicians (Mechanic 1996). It does not follow, however, that physicians are necessarily reliable agents for their patients. Although studies suggest that patients can accurately assess aspects of physician practices (Davies and Ware 1988), not all patients are equally effective at making these assessments, nor are they equally capable of judging every aspect of physician performance (Mechanic 1989).

Physicians' ability to act as reliable agents for patients is circumscribed by gaps in professional understanding (Wolff 1989; Rizzo 1993). Collective medical knowledge is limited; it has been estimated that for less than a third (and perhaps as little as 15 percent) of all medical procedures is there strong evidence of clinical efficacy (Eisenberg 1986). Individual physicians apply this collective knowledge imperfectly (Sloan 1993). Physicians may also fail to be effective agents: they either falsely believe they can achieve more through treatment than is actually feasible or they fail to ascertain their patients' preferences about choices among forms of treatment (Evans 1984; Wolff 1989; Rizzo 1993).

Financial incentives come into play as well. Studies suggest that physicians respond to monetary incentives by altering their treatment practices, even though these changes do not benefit their patients (Eisenberg 1986; Pauly 1992). The consequences depend on the nature of the incentives. Under fee-for-service payment systems, physicians face incentives to provide more treatment than their patients prefer (Woodward and Warren-Boulton 1984; Wilensky and Rossiter 1983; Dranove 1988), while capitation arrangements encourage physicians to provide less treatment (Woodward and Warren-Boulton 1984).

Malpractice liability modestly exacerbates the bias toward excess treatment under fee-for-service payment. The risk of malpractice claims is significantly higher for errors of omission than those of commission; it appears to have less to do with the actual quality than with certain observable practices (Budetti and Spernak 1992). Excess treatment is more likely to occur when physicians are more risk averse and when the risk of legal action is perceived to be higher. These perceptions are often inaccurate, particularly regarding low-income patients, yet physicians tend to believe that people from low-income households are more likely than other patients to sue for malpractice, despite evidence indicating that the opposite is the case (Burstin et al. 1993).

Given these various pressures on physician decision making, it is not surprising that studies have found that well-informed patients often differ with their physicians regarding the extent or nature of preferred medical treatment (Steinwachs 1992). The growth of managed care plans has the potential to reduce these differences by identifying providers who act against patient interests. In practice, however, this sort of oversight is relatively infrequent (Schlesinger, Gray, and Perriera 1997).

Meanwhile, other aspects of managed care threaten the fidelity of physician agency for patients. As I observed above, the integration of physician and plan interests makes providers appear less trustworthy. Beyond this, the combined influences of physicians and plans over treatment makes it more difficult for patients to assess the causes of any problems that develop. Assume that patients, based on their own experience, can assess their doctors' practice styles with reasonable accuracy (Davies and Ware 1988). What the patient cannot determine from observation, however, is whether these practices are a result of the physician's own preferences or of the constraints established by the HMO. Thus, patients who are dissatisfied with their treatment and decide to switch either to a new physician or to a new plan, or both, will face the problem of determining which move is the correct one.

Given the complexities of physicians' practice arrangements with health plans, this will be a difficult call for most people to make. For example, if a person's primary care physician refuses to make a referral to a psychiatrist, is this because he or she considers that the patient's emotional problems are not that serious? because the physician does not have much faith in therapy? because the physician would have to pay for the referral out of his capitation payment? or because the plan saves money by contracting with very few mental health care specialists? Guessing wrong can lead to problems. When patients express their dissatisfaction by switching providers instead of plans, they will repeatedly disrupt their continuity of care as they fruitlessly search for a physician who is a good match for their preferred style of treatment. Conversely, switching plans inappropriately creates its own set of costs and associated externalities.

Disenrollment from one plan and enrollment into another is costly, requiring additional administrative burdens and leading to higher use of health care while enrollees acclimate to the plan's operating procedures. Studies indicate that the cost of a newly enrolled HMO member is 5 to 10 percent higher in the first year (Schlesinger, Blumenthal, and Schlesinger 1987). This extra cost represents a form of deadweight loss to the system. A second cost involves the incentives switching creates for plans because high enrollee turnover reduces the incentive of plans to invest in preventive care, thereby compounding the problem of benefit externalities associated with preventive services. Under these circumstances, there can clearly be *too much* switching of plans, particularly when the decision to switch is based on a mistaken assessment of the reason that treatment is unsatisfactory to the enrollee. Conventional managed competition strategies are so focused on maximizing enrollee choice that they pay no attention to these less attractive consequences.

An Alternative Approach to Managing Competition: The Strategy of Countervailing Agency

What I term the "strategy of countervailing agency" takes the foregoing analysis as a starting point. It is based on the following assumptions:

1. The interests of patients and society will frequently diverge.

2. A fair allocation of medical resources requires that agents be empowered to represent each of these interests.
3. In the absence of external oversight, physicians and health plans will often fail to be reliable agents.

Under these circumstances, the goal of the managers or regulators in a system of managed competition ought to be twofold: ensuring the fidelity of the relevant agency relations and achieving the appropriate balance between the interests of society and the individual patient. Because this is a more complex image of the health care system than the one on which conventional forms of managed competition are predicated, it complicates the task of remedial policies, although I would argue that the result is correspondingly more realistic. It also casts doubt on the assumption that sponsors in this system are engaged in a value-free activity. Under the strategy of countervailing agency, the managers of the system must explicitly decide how much to favor the interests and agents of individual patients relative to those of society. This is a political, not a technical, decision. It illustrates the need for sponsors to be governed in ways that effectively represent the communities in which they operate.

Because managed competition has emerged in different forms under public and private insurance, the strategy of countervailing agency must be applied differently in the two sectors. The strategies discussed here for enhancing the fidelity of patient–provider relationships should apply to all sponsors, public or private. The same is not true, however, for the efforts to redirect the orientation of managed care plans. Management interests play an important role in shaping the benefits provided through employer-based insurance. Although employers will be sensitive to some of the externalities identified earlier—particularly those related to lost productivity—they are less likely to respond to others, including burdens on family caregivers or the consequences of infectious disease.

Consequently, making health plans more responsive to the interests of employers will remedy some, but not all, of the plans' failings as agents for societal interests. And it potentially injects other biases—greater concern for workers who are less easily replaced in the labor market and perverse incentives for externalities that affect their competitors. Consider a concrete example: When an employer determines that a worker has a substance abuse problem, it may be more efficient

from the company's perspective to fire the worker rather than to treat the illness, even if—especially if—that worker is subsequently hired by other firms in the industry and his or her substance abuse problems undermine their productivity (McGuire and Ruhm 1993). Furthermore, the relative balance between collective and individual patient interests under employment-based insurance is likely to have more to do with the relative bargaining positions of labor and management than with the balance that most appropriately trades off societal concerns about access and cost containment.

For all these reasons, even if the employers are able to offer their workers a wide variety of health plans under an effective level of competition, there is little reason to expect that the amount and forms of health care that are produced will adequately serve the broader social interest. There is, therefore, an important role for public officials in overseeing the actions of private sponsors in order to ensure that the values of different perspectives are appropriately balanced. This sort of oversight is consistently ignored by proponents of conventional managed competition, who would have state agencies responsible only for the managed care received by enrollees under public insurance programs like Medicaid (Enthoven and Kronick 1989).

I will describe a set of strategies and measures that might plausibly be used to manage the health care system from this broader perspective, although some will also apply to employer sponsors. None of the proposed methods is entirely original: they all draw on performance measures and regulatory models that have been explored at considerable length over the past five years in both private and public sectors. I have selected these measures precisely with this in mind: to demonstrate that existing approaches to regulating the performance of managed care plans can be put to more innovative, and potentially more effective, ends. The strategies are different from—often diametrically opposed to—those embodied in conventional approaches to managed competition.

Enhancing the Fidelity of Agency Relations

In a system of managed care, there are two principals (patients and society) and two agents (health professionals and health plans). One could match either principal with either agent. However, discussion to this point makes one combination look more plausible than the other. Physicians and other providers are in a poor position to assess the ex-

ternal costs and benefits of medical care, whereas health plans have the administrative capacity both to assess these factors and to develop consistent policies in response to them. On the other hand, providers are well-equipped by their training and repeated contacts to deal with the idiosyncratic needs of individual patients. Large-scale health plans inevitably develop more bureaucratic tendencies, emphasizing the standardization of medical practice. The version of countervailing agency discussed here therefore presumes that health professionals are the appropriate agents for patients and that health plans are better equipped to be the agents for society.

Under all forms of managed competition, two sets of regulatory instruments can be employed: the first affects how agents are selected; the second influences the behavior of agents once they have been selected. I describe here the particular instruments that would be emphasized under a strategy of countervailing agency and the ways in which they differ from those prescribed by more conventional forms of managed competition.

The Fidelity of Physician Agency. Patients vary in their preferences for medical care, based on differences in risk aversion, the value they place on health, and their perceptions about the efficacy of medical care. Physicians differ in their practice styles. Even the most well-intentioned physician may have difficulty accommodating patients' preferences that conflict with what he or she considers good medicine (Wolff 1989; Pauly 1992). One way to improve the fidelity of agency relations between patients and physicians thus involves more closely matching patient preferences with physician predilections.

Because plans selectively contract with physicians and other health professionals, the plan's reputation may be an important means of facilitating better matches between patients and providers. Unfortunately, managed competition schemes not only ignore matching at this level; they probably discourage it. Because each health plan affiliates with a set of providers whose preferences vary, the intensity of treatment or the frequency of referrals will vary *within* the plan, depending on the variance of preferences among providers practicing in the community, the number of plans operating in that community, and the ability of plans to induce providers to practice in a manner that is compatible with their organizational goals.

The more homogeneous are physician practices within a plan, the better the plan's reputation indicates the match between an individual patient and physician. Consequently, it is important for potential en-

rollees to know something about the *variance* of practices and performance within each plan. However, the sort of information they are given under conventional managed competition schemes, even those with the most sophisticated of performance measures, typically describes only the *average* performance of the plan. Potential enrollees are thus falsely persuaded that their individual experience will match this average rather than reflecting the abilities and proclivities of the health professionals responsible for their care.

Other regulatory strategies common to managed competition schemes exacerbate the difficulty of relying on plan reputation to predict provider practice styles. Assume, for the sake of argument, that we can characterize practice styles based on how “aggressively” health problems are treated. Under a variety of conditions, one would expect that the plans operating in a community would distribute themselves along this continuum, carving out different market niches (Calem and Rizzo 1993). Some would develop a reputation for aggressive treatment, others for favoring a “wait and see” approach. Plans would signal this difference in a variety of ways, including benefit provisions, hospital affiliations, and the like. One would naturally expect that health professionals would sort themselves accordingly, affiliating with the plan that best matched their preferred practice style.

Under these conditions, plan reputation would be a reasonably good indicator of the preferences of their affiliated providers. The conventional managed competition scheme, however, promotes standardization of benefit packages. Although this has advantages in terms of limiting the efforts of a plan to manipulate benefits to attract healthier than average enrollees, it carries a high cost: potential enrollees find it difficult to have any sense of whether a plan, for example, treats mental health care, pays for postsurgical recovery, or considers treatment of chronic back pain an amenity rather than a medical necessity. Benefits are one of the few features of a managed care plan that prospective enrollees can readily comprehend (Mechanic 1989). Without this information, it becomes more difficult for enrollees either to make knowledgeable trade-offs among the plan’s health care priorities or to know whether denial of treatment reflects a failing of their individual provider or a planwide policy.

A second aspect of matching involves patients knowing when to leave a plan or provider. Although reputation may help to match patients and providers, most individuals will be able to determine that they are comfortable with their health professionals as agents only after they

have been in need of services and can assess their performance directly (Mechanic 1996). When one's provider does not appear to be acting as a reliable agent, it makes sense to look elsewhere. As noted above, however, it may be difficult for a patient to discern when a particular problem is the result of provider preferences or plan intervention. This depends in part on how plans circumscribe provider behavior. When a plan controls treatment practices through utilization review, a provider can in principle clearly advise the patient about the treatment he or she considers appropriate and can inform him or her if that treatment plan is rejected by the utilization review process. Indeed, the providers are required to do so by the AMA's code of ethics for managed care, although such notification may be prohibited by their contractual arrangements with the plan (Mechanic and Schlesinger 1996).

If, on the other hand, physicians' practices are influenced by financial incentives, they are likely to *internalize* these influences. Managed care plans rely on financial incentives to constrain costs to varying degrees, but some rely heavily on this approach (Hillman 1991). Incentives of this sort may directly compromise quality of care and physician agency. For example, in a recent survey, administrators of HMOs reported that withholding more than a certain percentage of physicians' incomes created a strong incentive to reduce treatment in a manner that compromised quality of care. Although relatively few HMOs that were surveyed withheld income to the degree described, a number did so (Hillman et al. 1991). Under these circumstances, it would be difficult for the enrollee to tell whether inadequate treatment represents their provider's preferences or those of the plan. Given the lack of enrollee's knowledge about *why* they are treated in a particular manner, they may all too often make the wrong switch if they are dissatisfied.

This problem is compounded by proposals to have physician groups assume more of the responsibility for the management of clinical practice (Kassirer 1995). This seemingly plausible approach to protecting against unprofessional constraints on treatment is exactly what is recommended by many advocates of conventional managed care, on the grounds that it will promote greater cooperation among the affiliated health professionals (Enthoven 1993). Yet it is precisely the wrong approach from the standpoint of countervailing agency. Increasing the sense of commitment that providers feel to the plan and to their colleagues inevitably undermines patients' sense that providers will act aggressively as their advocates.

Conventional managed competition schemes provide no regulatory oversight on the contractual arrangements between providers and plans. From the perspective of countervailing agency, this is a major omission. Anecdotal reports suggest that health plans are increasingly using contractual clauses to limit the information that physicians can report to enrollees, if this information would compromise the reputation of the plan (Mechanic and Schlesinger 1996). Under the countervailing agency approach, sponsors would actively discourage contractual provisions that restrict or prevent providers from explaining to patients the reasons for choosing particular forms of treatment. They would further discourage cost-containment mechanisms that cause patients to doubt the motivations of their health care providers.

Even if provisions of this sort are adopted, it is unreasonable to expect that all, or even most, enrollees will be able to assess whether their physician or other health professional is acting as a reliable agent. Particularly in those dimensions of care that patients do not directly observe—ranging from the interpretation of tests to dealing with utilization reviewers—there is considerable scope for opportunistic behavior. Under conventional managed competition schemes, such concerns are again outside the sponsors' scope of responsibility (Wolf 1994; Blumenthal 1994). Under the strategy of countervailing agency, they are at the core of their mission.

How might a sponsor address this issue? Doing so requires having specific measures of the willingness and ability of providers to act as agents (Wolf 1994). The complexity of the agency relationship makes this difficult to assess; existing HMO report cards ignore this dimension entirely. Conventional measures of service use or satisfaction are likely to be poor measures of agency in any case because agency failures are most likely to occur for aspects of treatment that patients cannot readily measure or easily observe.

Current neglect, however, does not mean that more appropriate performance measures could not be developed. One approach would involve audits of particular aspects of physician practices, including notification of patients about all treatment options (whether or not they were paid for by the health plan), time and resources devoted to obtaining treatment approved under utilization review requirements, and referral patterns under physician gatekeeper models. Because this data collection would inevitably be time consuming, the audits could be applied in a manner comparable to tax audits by the IRS. Practice audits could be

required for a small percentage of physicians chosen at random and a larger percentage for physicians for whom various measures (e.g., adverse outcomes for patients) signal potential agency problems. Audits of this sort would require granting authority to sponsors beyond that envisioned under any existing managed competition programs or proposals.

Plans as Societal Agents. The strategy of countervailing agency calls for an entirely different way of thinking about health plans. They would no longer be expected to respond to the preferences of individual enrollees, but instead would pursue collective interests in health care that would balance health care costs against other societal needs.

This goal also can be pursued either by intervening in the process of plan selection or by restructuring the incentives of the plans once they have been selected. The earliest managed competition models assigned to sponsors a significant role in selecting appropriate health plans. When managed competition was incorporated into the Health Security Act, however, the prerogatives of health alliances to contract selectively were limited, on the grounds that this gave them too much power over the sorts of health services available to individual enrollees (Starr 1993). In currently operated versions of managed competition, sponsors usually have considerable latitude in selecting or deselecting particular health plans, but, typically, as a means of protecting *enrollee* well-being. My contention is that this latitude should be used explicitly to promote collective interests.

The primary failures of health plans as societal agents relate to benefit and cost externalities, with consequences to parties outside the health plan. To compensate, sponsors might select plans that are concerned about these externalities. Several plan characteristics may serve as markers of this sort of behavior. Plans that draw most of their enrollees from a particular community are more likely to respond to geographically concentrated externalities like the social and criminal impact of untreated substance abuse (Sofaer 1995). Plans that are organized under nonprofit ownership may internalize other externalities. Historically, nonprofit health care providers have provided significantly higher levels of public goods and have responded to a variety of market failures in ways that their for-profit counterparts have not (Marmor, Schlesinger, and Smithey 1986). Little is known about the consequences of ownership structure among managed care plans. However, tax authorities at both state and federal levels are stepping up enforcement of the community benefit requirements in the nonprofit tax codes, and there is

some evidence that nonprofit managed care plans address *some* external costs more aggressively than do otherwise comparable for-profit plans (Schlesinger, Gray, and Perriera 1997).

Whatever plans are selected, however, it remains important to create incentives for plans to internalize the external costs and benefits associated with the health care they provide. This might be done in several ways. First, assigning the responsibility to plans for a broad range of health and social services ought to make them more responsive to some of the externalities associated with chronic illness (Schlesinger, Gray, and Perriera 1997). The social/health maintenance organizations (S/HMOs) embody this approach, albeit with only a limited array of non-medical services. Second, sponsors can adopt performance measures that capture the social, as well as clinical, consequences of health care. These might include (a) the number of days that enrollees lose from school or work because of ill health; (b) the amount of time that family caregivers spend assisting enrollees who are sick; or (c) measures of enrollees' ability to function in various community activities. All of these measures have been used in research on the performance of managed care plans, but have not been widely incorporated in the performance monitoring systems that sponsors currently use to assess plan performance.

A third alternative is to change the incentives for a plan to supply particular medical services that have large negative or positive externalities. This was the approach used in the British National Health Service to encourage primary care physicians to deliver preventive care. Although primary care physicians are generally paid a capitation fee, the NHS began during the 1980s to pay for preventive services under a fee-for-service system, creating an incentive to provide more services. Utilization of preventive care increased as a result (Culyer and Meads 1992). Early versions of the Health Security Act listed provisions of this sort for various types of patients, including the disabled, but they were subsequently eliminated from the legislation. No comparable provisions exist under contemporary managed competition systems.

Finally, plans may be penalized for activities that create large negative externalities. I have observed that plans with high levels of enrollee turnover have little incentive to provide preventive services because the benefits are externalized to the plans that subsequently enroll the patient. The consequences of excessive disenrollment would be decreased if plans were forced to pay for disenrollment. The size of this penalty

could be made contingent on the subsequent costs of care for the disenrolling patient. In other words, the plan from which a person disenrolls would be required, at least for the short term, to foot part of the bill for the plan that subsequently enrolls them. (A penalty of this sort would also discourage efforts by plans to encourage the disenrollment of the sickest patients to create a more favorable risk pool.)

Each of these approaches is administratively feasible. It would not prove difficult for public or private sponsors to implement them. Until it becomes clear, however, that health plans ought to be seen as collective agents, rather than as responsive to individual enrollees, managers of competition among plans are unlikely to pursue strategies of this sort, whatever their potential benefits to society.

Striking the Right Balance between Patient and Societal Interests

Under various circumstances, the interests of individual patients diverge from those of society. To the extent that health professionals act as reliable agents for patients, while health plans act on behalf of society, there is a gap between the types of medical services that providers will favor and health plans will want to authorize. The amount and types of care that are actually delivered will depend on the interactions of these two agents (Schlesinger, Gray, and Perriera 1997). More specifically, where the “balance of power” in these negotiations favors health professionals, prevailing medical care will primarily reflect patients’ interests. When health plans have the upper hand, medical treatments will come closer to the levels that match societal preferences. Consequently, one important role for state officials in a managed competition system is to oversee the balance of power between providers and plans and alter that balance when it is deemed necessary. I will consider here first the question of when the balance should be addressed and then identify several ways in which this might be accomplished.

Should Patient or Collective Interests Dominate the Allocation of Medical Resources? The relative importance accorded to these two perspectives clearly depends on the broader notions of equity that one applies to the health care system. Definitions of justice based on more individualistic notions favor the patient perspective; those based on norms of egalitari-

anism or need favor the societal perspective. There appears to be no compelling ethical framework that can be invoked to determine how these different perspectives ought to be integrated with one another (Dougherty 1988; Thomas 1993).

Given the heterogeneous values underpinning American political culture, it is not surprising that public opinion, politicians' pronouncements, and public policies reflect inconsistent perspectives on this trade-off. Studies of public attitudes toward the health care system suggest that most Americans endorse aspects of both individualistic and collective norms, and that they combine them in a more complex and fragmented way than do citizens of other industrialized democracies (Duffy 1995). Reform proposals like the Health Security Act simultaneously invoked notions of individual choice and collective commitments, without establishing priorities between these two perspectives.

Similar conflicts can be seen in existing public policy. Policy makers often balk at policies that are life-saving but costly. However, in defined instances (e.g., children trapped in wells), people willingly expend far greater resources in life-saving efforts. This reflects the fact that Americans are more easily persuaded to rescue individuals who are in dire situations than to pay for outcomes affecting society as a whole (e.g., "statistical lives") (Schelling 1968). Ethicists refer to this emphasis on actual individuals as the "rule of rescue" (Hadorn 1991). Although this conflicts with some notions of a just health care system (Evans 1984), the rule of rescue reflects deeply held social values that also affect how physicians treat illnesses and how society allocates health care resources (Menzel 1983; Hadorn 1991; Eddy 1991).

This combination of conflicting values and uneven responses suggests the difficulty of developing a consistent balance between individual and collective concerns. The situation is made yet more complicated when the sponsor represents private rather than public interests. Contemporary competition among health plans is usually managed by employers, whose concerns about health care will also diverge from those of individual employees; their focus will be on aggregate health care costs and some externalities, particularly those associated with productivity. Employers can select or induce health plans to act as their agents. Indeed, one would expect them to do this in addition to their role as employee advocate vis-à-vis the health care system.

This creates a considerable challenge for state officials. They can adopt structural reforms, regulations, and other requirements that shift

the balance of power toward either clinicians or health plans, but such tactics would affect all plans and providers equally. Because employers will differ in their concern for the social benefits of health care, as opposed to their private economic returns, the “right” balance for one employer will be wrong for the next. This suggests that structural measures will never in themselves be sufficient to ensure that the health care system reflects the right balance between individual and collective concerns. Instead, it will be necessary for state officials to oversee more actively the operation of managed care plans and to address explicitly the balance of interests within employer-based health insurance, an area that has in the past been largely considered as outside the appropriate bounds of state oversight (Zelman 1993; Darling 1995).

Altering the Balance between Providers and Plans. The policies adopted by state authorities can affect the balance of power between health plans and health professionals in various ways. Indeed, any policies that limit the freedom of either actor to influence the behavior of the other will have this effect. If, for example, limits are placed on the financial incentives that plans can use to influence provider behavior, the negotiating position of the providers is indirectly strengthened. Similarly, a rejection of any-willing-provider laws strengthens the position of the health plans.

To ensure that a system of managed competition yields the preferred balance between individual and collective perspectives, sponsors must assert the authority to oversee both the process through which providers affiliate with plans and their contractual arrangements. Most existing or proposed managed competition schemes, however, explicitly discourage or prohibit such involvement (Enthoven and Kronick 1989; Starr 1993). This restricts oversight, preventing sponsors or state authorities from ensuring that patient and societal interests are adequately considered in treatment decisions.

The Health Security Act contained one notable exception to the general neglect of relations between plans and providers. It designated a class of health facilities and professionals as “essential community providers” if they primarily serve indigent clients in low-income communities. For at least the first five years of the program, all plans were required to affiliate with these essential community providers and to pay them for services on relatively generous terms. These requirements create a strong position for the providers in their negotiations with the plans and enhance the likelihood that the treatment they provide will reflect their own objectives.

Many state Medicaid programs have explored provisions similar to these essential community provider requirements, which constitute only one of many possible ways to reshape the balance between provider and plan interests. By highlighting this role, the strategy of countervailing agency gives sponsors greater scope of authority than under conventional managed competition arrangements. It tempers this authority by establishing clearer and more appropriate objectives for this regulation. By acknowledging that regulatory policies will necessarily be value laden, it also emphasizes the need for each sponsor to create representative governance mechanisms.

Discussion and Conclusion

The managed competition model has considerable intellectual and political appeal precisely because it blends regulatory and market reforms. Its advocates, however, have been too facile in drawing analogies between medical care and other marketable commodities, thereby creating a conventional view of managing competition among health plans that neglects some of the most valued aspects of health care (e.g., trust between patient and provider), misportrays the relevant regulatory decisions as technical when they are actually value laden, and fosters counterproductive practices. In my assessment, the alternative labeled here as the “strategy of countervailing agency” is more realistic and constructive. It acknowledges and balances the two fundamental agency roles, each of which is, and will always be, imperfect. Unless sponsors are cognizant, managed competition will erode trust between patients and providers. Unless health plans are given appropriate incentives, many collective benefits of health care will go unrealized. Unless an appropriate balance is struck between providers and plans, some legitimate goals of medical care will be unduly subsumed by others.

With its emphasis on agency relations and balances of power, the countervailing agency approach may strike some readers as emphasizing theory over practice. It is important, however, to recognize that one can derive from this approach some very concrete recommendations for better managing competition among health plans. Conventional managed competition schemes call for standardizing plan offerings and maximizing the freedom of dissatisfied enrollees to switch plans. The countervailing agency perspective argues for the opposite: having plans differentiate

themselves from one another and discouraging excessive plan switching on the grounds that it will weaken the agency behavior of both plans and providers. Countervailing agency also calls for mechanisms, like disenrollment penalties, that would reduce the incentives for a plan to strategically favor selective disenrollment.

In addition, the strategy of countervailing agency suggests the incorporation into the managed competition system of different sorts of performance measures: the variance of performance within plans; provider agency; and the external costs and benefits associated with plan practices. Countervailing agency also suggests paying plans in a manner that selectively encourages services with particularly large benefit externalities.

Beginning in 1995, states have begun to pay greater attention to protecting the fidelity of the physician–patient relationship, thereby moving beyond the conventional prescription for managed competition. Spurred by public controversies over confidentiality clauses, or “gag rules,” that restricted providers’ communication with their patients, legislatures in several states prohibited these provisions (Bureau of National Affairs 1996). Although important as a first step, the scope of these initiatives is too limited. Protections on the physician–patient relationship under managed care have been passed in only a handful of states; these prohibit contractual restrictions on communication but do little to encourage more appropriate agency behavior. Furthermore, states have done little to limit the consequences of financial incentives whose effect may be as large (albeit more indirect) as that of gag rules on the fidelity of physician agency (Mechanic and Schlesinger 1996). Perhaps most important, existing efforts are almost entirely reactive, a response to public outrage over particular managed care practices rather than part of a clear strategy of state responsibility in the oversight of managed care. Consequently, one sees in the very states that prohibit confidentiality clauses initiatives to foster the spread of physician-run health plans, a development that is likely further to compromise public trust in health care professionals.

The strategy of countervailing agency seeks to lay out a more consistent approach to state regulation of managed care. Its differences from the recommendations of conventional managed competition models and of existing state initiatives are summarized in table 1. It is important to recognize that, in addition to its concrete recommendations, the countervailing agency model evokes a very different conception of the nature

TABLE 1
 Summary of Approaches under Conventional Managed Competition, Existing State Regulation,
 and the Strategy of Countervailing Agency

Issues to be addressed	Conventional managed competition	Existing state regulation ^a	Countervailing agency
Goals of overseeing health plans	<ul style="list-style-type: none"> • Plans should respond to enrollees 	<ul style="list-style-type: none"> • Developing report cards to ensure more informed choice 	<ul style="list-style-type: none"> • Plans should reflect societal interests, <i>not</i> enrollees' • Incentives for services with large externalities
Measures of plan performance	<ul style="list-style-type: none"> • Enrollee satisfaction • Limited quality measures 	<ul style="list-style-type: none"> • Satisfaction and HEDIS measures reported as means; clinically focused 	<ul style="list-style-type: none"> • Report variance of scores • Emphasize measures related to large social externalities (community health measures)
Encouragement of particular types of health plans	<ul style="list-style-type: none"> • Favor prepaid group practices 	<ul style="list-style-type: none"> • Encourage physician-run plans 	<ul style="list-style-type: none"> • Encourage nonprofit plans • Prohibit physician-run plans

Relations between plans and providers	<ul style="list-style-type: none"> •Cooperation encouraged •No sponsor oversight 	<ul style="list-style-type: none"> •Some states regulate gag rules; discussion of curbing financial incentives 	<ul style="list-style-type: none"> •Prohibit strong financial incentives •Prohibit gag rules
Approach to choice among plans	<ul style="list-style-type: none"> •Standardize benefits •Maximize potential for switching if dissatisfied 	<ul style="list-style-type: none"> •Some open enrollment requirements 	<ul style="list-style-type: none"> •Differentiate benefits •Penalize plans for high levels of disenrollment
Oversight of patient–provider relationship	<ul style="list-style-type: none"> •None 	<ul style="list-style-type: none"> •Some satisfaction measures •Requirement of full disclosure of treatment options in New Jersey 	<ul style="list-style-type: none"> •Measure trust in providers •Audits of agency behavior (appeals on UR) •Measures of provider match
Oversight of employer role	<ul style="list-style-type: none"> •None 	<ul style="list-style-type: none"> •None 	<ul style="list-style-type: none"> •Monitor balance of employer and employee interests

^aSummer, 1996.
Abbreviations: HEDIS, Health Plan Employer Data and Information Set; UR, utilization review.

and performance of social institutions than do other approaches to managed competition, which hold that states ought to play a technical and facilitative role and that the social interest in health care can be served in a nonconflictual manner by the aggregation of informed individual decision making. Countervailing agency, in contrast, is predicated on the notion that conflicts of interest over the allocation of health services are inevitable and that collective concerns will often entail compromising the scope of individual freedoms (Lupton 1995) or professional autonomy (Schlesinger, Gray, and Perriera 1997). Under these circumstances, it is essential to seek the best balance among competing interests, a process that is inherently value laden and controversial.

Although the notion of balancing competing interests is a distinctive approach to regulating managed care plans, it will strike many readers as familiar. It is deeply entrenched in American public institutions, including our adversarial system of criminal justice and the Constitutional “checks and balances” produced by mutual oversight among executive, legislative, and judicial branches of government. Indeed, parallels between the health and legal systems have been previously recognized in the emergence of utilization review in American medicine (Hadorn 1992). What has been missing from this recognition is a concrete strategy for effectively representing societal interests in this process and for ensuring the equivalent to “due process” in the ongoing negotiations between collective and individual interests.

A similar approach to balancing interests has been reflected, albeit largely implicitly, in earlier health policies. One example is Medicare’s system of prospective payment for hospitals (Bentkover et al. 1988; Frankford 1993). Medicare pays hospitals a flat rate per diagnosis to encourage them to use resources efficiently. In this sense they act as agents for the Medicare program and the taxpayers who finance it. The same incentives, however, also encourage premature discharge of patients because the hospital can externalize the cost of recuperative care to family members and other informal caregivers. Because physicians are paid in a different manner, they do not face the same incentives to reduce the use of hospital care. They can act as agents for their patients (or their families), arguing for longer stays when they consider this appropriate. This balancing of roles appears to have guarded against widespread problems of low quality, while permitting substantial cost savings (Russell 1989).

There are also some similarities between the strategy of countervailing agency and the notion of “countervailing power” that has been used to describe the forces shaping health policy in countries such as Germany (Stone 1980; Wilsford 1995). Countervailing power describes the balancing of various collective interests (physicians, sickness funds, employers, and government) in negotiations about practices ranging from fee schedules to financing arrangements for medical care. Reflecting more corporatist traditions, negotiations occur under the auspices of the central government, which requires each relevant interest group to arrange for representation so that their negotiators have legitimacy for group members and can promise that any agreements will be honored.

Countervailing agency reflects the more decentralized character of the American polity. Each sponsor will vary in its emphasis on individual relative to collective interests in medical care. Each health plan will strike a different negotiated balance with its affiliated providers. Providers dissatisfied with the negotiation in one plan have the option to switch to another, as can enrollees whose care is influenced by these negotiations. The multiplicity of negotiations and the freedom to exit provide safeguards against concentrations of authority that cause Americans to distrust government involvement in medical care (Blendon, Brodie, and Benson 1995).

Although the model of countervailing agency contains a number of attractive features, there are also potentially important barriers to its implementation. Some of these reflect the inherent complexity of medical care. Others involve factors that may limit its political feasibility.

Practical Challenges to the Strategy of Countervailing Agency

Three circumstances represent particular challenges for this strategy. The first involves “correlated agency failure,” situations in which the preferred outcomes for both physicians and plans are biased in the same direction, relative to what they would be if the two were acting as perfect agents. Consider a concrete example: the treatment of substance abuse. Because of the stigma of illicit drug use, patients may feel uncomfortable reporting related health problems to their physicians; physicians may be less motivated to advocate for patients whom they view as societal pariahs (Levine 1991). Because most of the costs of substance

abuse are external to the health care system, prepaid plans have too little incentive to provide such care.

Under these circumstances, the sponsor cannot rely on balancing the interests of plans and providers to achieve the appropriate level of treatment. No matter what the contractual arrangements between providers and plans, no matter how much providers are encouraged to act as agents for their patients, substance abuse problems will receive too small a share of medical care resources. This does not mean that sponsors cannot encourage more appropriate behavior. They could alter the incentives facing plans or providers. For example, physicians could be paid a separate incentive payment for time spent diagnosing patients with these problems, or even be paid a “bounty” for referrals to drug treatment centers. Alternatively, every plan might be required to spend a specified percentage of its budget on substance abuse treatment, where this percentage would be conditioned on the sociodemographic characteristics of the enrollee population that are known to be correlated with substance abuse.

Whatever the approach, there is no circumventing the fact that ultimately the sponsor is the one that must determine when treatment is adequate. No other actors within the medical system are in the position to make this decision; no market forces ensure that it will be indirectly revealed by private choices (Steinberg 1993). This sort of needs assessment will undoubtedly prove challenging and controversial. The strategy of countervailing agency does not create this challenge—it exists under all managed competition schemes—but it does make it more apparent than in other strategies.

A second challenge to the countervailing agency approach comes from the multidimensional nature of medical care. I have suggested that agency behavior in some dimensions (e.g., treatment of acute illness) might differ from that occurring in other dimensions (e.g., preventive services). Still other dimensions are equally salient:

1. How aggressive is treatment for patients with conditions that are probably terminal?
2. How extensively does one screen for low-probability conditions (largely a function of risk aversion and time preferences)?
3. To what extent are patients referred from general practitioners to specialists?

In each dimension, the preferred outcomes between providers and plans will differ, as will the fidelity of their agency roles.

My analysis has introduced methods of increasing the fidelity of agency relations, as well as balancing the interests of plans and providers. In some cases, the appropriate regulatory strategy in one dimension of medical care will conflict with the appropriate intervention in another dimension. For example, a sponsor might favor the intensity of treatment that is preferred by plan administrators while encouraging prevention at levels that are preferred by physicians. In the first instance, the bargaining position of the plans is favored, whereas, in the second, the providers come out ahead. So long as other instruments exist (e.g., special payments to induce the use of preventive services), this potential conflict may not create major problems. One could, however, certainly imagine circumstances, where, for example, the sponsor would be forced to balance out concerns for two aspects of care that call for regulations operating in opposite directions.

A third complication results from a different set of conflicting goals. Interventions that improve the fidelity of one agency relationship may hinder the other agency relationship or disrupt the balance between plans and providers. Consider an example: The more homogeneous are provider practices within a plan, the more readily a potential enrollee can rely on plan reputation to predict the sort of treatment he or she will receive. Giving the plan considerable discretion in how to contract with providers and how to oversee their treatment decisions increases the likelihood that the plan will be able to induce providers to conform to the plan's goals, making treatment practices within the plan more homogeneous. But the same incentives that facilitate consumer choice of plans may threaten the autonomy that physicians must have to act as effective agents for their patients. In order to protect the physician-patient relationship, sponsors or state officials may be forced to circumscribe plan behavior in a way that creates more heterogeneity within plans and increases the difficulty patients experience in choosing a plan and an individual provider.

Again, this need not be a serious constraint if there are a variety of interventions that can be used to make agency relationships more stable or rebalance the interactions of health plans and health professionals. But it is important to recognize that, even though the strategy of countervailing agency makes the objectives of regulation clearer than

in many managed competition models, it does not ensure their achievement in practice.

*Political Challenges to a Strategy
of Countervailing Agency*

A second set of challenges stems from the political constraints on health reform in general and the operation of sponsors in particular. The first hurdle is public acceptance of an active role for the managers of the health care system. The strategy of countervailing agency assigns to state authorities broad responsibilities for assessing health needs, deciding on the balance between individual and collective interests in medical care, and overseeing the relations between plans and providers as well as patients and providers.

Because some of these sponsors will be public agencies—or contractors with public agencies—the approaches suggested by the countervailing agency model might appear to conflict with Americans' discomfort with activist government. The Health Security Act was designed to reduce this tension by making health alliances extragovernmental entities. This approach did not prove convincing: in its assessment of the Clinton Administration's proposals, the Congressional Budget Office concluded that the alliances were in fact an arm of government (Congressional Budget Office 1994). This interpretation created political pressures to reduce the power and scope of the alliances' authority (Wilensky 1994).

But if there is prevailing discomfort with government regulation in general, it is less clear that this would apply to the particular instruments assigned to sponsors under the strategy of countervailing agency. Americans have long been much more supportive of government regulation in health care than in other sectors of the economy; their acceptance of an active government role for health regulation actually increased during the early 1980s, when the "Reagan revolution" was undercutting popular support for government involvement generally (Schlesinger and Lee 1993). Because public sponsors would focus primarily on the terms under which plans, providers, and patients interact, rather than reviewing the actual quality of medical care or limiting enrollee choices, the most threatening perceptions of government involvement are amelio-

rated (Blendon, Brodie, and Benson 1995). Indeed, the more sponsors are seen as protectors of a trust-based relationship between patients and providers—a relationship that increasingly appears under assault by market forces (Kassirer 1995)—the more public acceptance of their role is likely to increase (Altman 1994; Blumenthal 1994).

However, acceptance of greater authority for sponsors is predicated on clearer mechanisms for accountability than exist under most managed competition arrangements. To this point in the discussion, I have assumed that sponsors (at least in their public form) somehow embody the collective interest, that they are perfect agents for public preferences. In practice, imperfect agency will emerge here as it does in other aspects of the health care system. Economists have begun to explore the ways in which regulatory bodies act as agents for political representatives (Spiller 1990; Laffont and Tirole 1991). These analyses represent formalizations of earlier notions of “agency capture” by the very subjects that are being regulated; they also explore the importance of creating incentives to ensure that regulators do not abuse their expertise to circumvent political accountability.

The authors of most managed competition proposals have been primarily concerned with—in some cases hypersensitive about—the prospect of agency capture by providers. To reduce this risk, the Health Security Act prohibited health care providers from participating on the board directing the alliance (Starr 1993). This stricture seems neither necessary nor sufficient to protect against capture. It is not sufficient because the literature is replete with examples of capture when there were no formal relations between regulators and regulated. It is not necessary because provider influence is not in itself problematic. It is no more likely to lead to divergences from collectively optimal types of medical care than are the influences of patients or plans. The extreme fear of provider capture expressed by proponents of managed competition appears to reflect their failure to identify reliable arrangements for the governance of alliances or to establish mechanisms that can clearly ensure accountability of alliances to elected officials.

The issue of accountability seems the fundamental one. How can one assure that the “managers” under managed competition act as reliable agents for the collective interest in health care? The conventional economic analysis of agency problems in regulation suggests that the solution can be found in establishing the appropriate incentives for the

regulators (Arrow 1985). Managed competition proposals have paid virtually no attention to the problem of the incentives facing sponsors. But the same problems that complicate the formulation of agency-compatible incentives for plans and providers exist for sponsors as well. Here, too, important externalities exist. Health problems rarely respect geographic boundaries or employment arrangements, but public sponsors are typically defined by state jurisdictions, and private sponsors answer to particular employers (Gaudemans 1994). If private agencies are hired under contract to play the sponsor role, the duration of the contract will induce an undue concern for short-term health outcomes, in the same way that enrollee turnover leads health plans to the same bias. Given these incentives, some mechanisms to ensure external accountability are required so that sponsors' decisions appropriately reflect collective interests.

Policy initiatives to strengthen accountability in American medicine date to the turn of the century (Starr 1982; Emanuel and Emanuel 1996). Only in the past 30 years, however, have more democratic forms of accountability become a central focus of these efforts (Morone 1990; Thomas 1993; Kearns 1994). These can be seen as embodiments of contemporary notions of "strong democracy," which ground democratic principles in more active participation and communication (Barber 1984; Moon 1993; Hirst 1994).

Past efforts to increase democratic accountability in health care have not been successful. Even the most thoughtful and protracted initiative—for example, in connection with Oregon's Basic Health Services Act—has been roundly criticized by opponents (Brown 1991; Office of Technology Assessment 1992; Thomas 1993), and its participatory aspects have been questioned by even some of its supporters (Fox and Leichter 1991). Even failed past efforts, however, reveal lessons relevant to the accountability of sponsors within a system of managed competition. More specifically, they suggest that barriers to accountability are as much due to ignorance as interests—that is, in decentralized systems of accountability, information flows tend to be limited, so that the lessons learned in one jurisdiction are often revisited or misapplied in another. Past experience also suggests that no single approach to assuring accountability can be counted on to do the job. The simultaneous use of a variety of strategies is both warranted and necessary, particularly in the case of managed competition, where some of the "regulators" are in public agencies and others work for private employers.

Mechanisms of democratic accountability can involve a variety of strategies, three of which I will illustrate here: strengthening associational ties; requiring notification of decisions; and establishing processes of participatory decision making. By associational ties, I refer to collegial arrangements for bringing together various sponsors in a consistent manner, allowing them to compare their performances with one another and to identify and disseminate potentially useful innovations in regulatory techniques. Anecdotal reports suggest that this approach has already been successful for a number of local business coalitions. Although notably unsuccessful at accomplishing collective activities like cost containment, coalitions have been at the forefront of developing new methods of monitoring the performance of managed care plans (Brown and McLaughlin 1988; Sofaer 1995).

A second approach to promoting sponsor accountability is through notification. By this, I mean requirements that information about the goals, process, and outcomes of decisions be disseminated so that the relevant public (e.g., constituents, employees) can be informed about decision making. Although one would expect few people actually to respond to this information, the most affected will at least have the opportunity to do so. Moreover, requirements that decisions be documented can create a sort of beneficial Hawthorne effect, encouraging sponsors to articulate their rationale more carefully for particular forms of regulation. As noted earlier, many proponents of managed competition have objected to requirements of this sort, on the grounds that they hamstring sponsors. However, some appear to be increasing their support of the need to more fully inform the public (Darling 1995).

The third approach to achieving sponsor accountability is to create institutional requirements related to governance: who should control sponsor decision making and how they should be selected. This approach was explored by Zelman (1993), who identified seven different models of governance, and suggested that the most effective model for public sector sponsors would be based on appointment by elected political officials, perhaps from a list nominated by groups of affected constituents. Because most current models of public sector managed competition have been devised for the Medicaid program, the question becomes how best to represent the interests of Medicaid recipients in the decision-making process. Oregon's efforts—also focused on Medicaid reform—were not particularly successful, despite an aggressive campaign intended to include low-income residents in the process of collective

decision making (Thomas 1993). This suggests that beneficiary interests might be better represented by advocacy groups or agencies, which could appoint individuals to the governing board that regulates the managed competition process.

The situation is more complicated for private sector sponsors in several ways. Although some observers champion democratic decision making in the workplace (Hirst 1994), this policy is far from universally accepted. What then should be the standard for how employee interests are reflected in decisions about their health care benefits in general and managed competition in particular? In unionized workplaces, the union could represent employee interests, but it is unclear what could substitute in other companies.

Nor is it clear how any norms for sponsor governance ought to be enforced. Historically, states have been the primary regulators of health care and health insurance. However, the large number of employers who self-insure are exempted from state regulation under ERISA provisions (Grogan 1995). This means that only the federal government has broad authority to “regulate the regulators” under employer-based forms of managed competition. It also suggests a plausible starting point for establishing norms of sponsor governance in the private sector. Private pensions, also falling under ERISA provisions, have their own federal requirements regarding membership and process for the governing boards. One might initially emulate these requirements for the governance of health benefits, at least until schemas more directly applicable to health care are developed.

Conclusions

A strategy of countervailing agency can only be partially developed in this context. The models of agency that have been developed and applied to health care are relatively crude, omitting factors like the divergent behavior of primary care providers and specialists, the consequences of new technologies, and the multidimensional aspects of health care. Although I have identified a number of regulatory instruments that might improve the performance of the health care system, I have made no attempt either to assess their relative merits or to consider the interactions among these different approaches.

This discussion has only touched upon complicated questions of sponsor accountability under a scheme of managed competition. This topic,

and many others I have raised here, deserve more thorough analyses. However, it is clear that the complex task of health reform creates the potential for substantially restructuring the American health care system and altering the nature of the medical care that it delivers. Any such change, whether modest or sweeping, needs to balance carefully the important, but sometimes contradictory, goals nested within patient and social agency relations. More generally, for any reform effort as ambitious as that proposed under the rubric of managed competition, it is essential that the institutional reforms be firmly grounded in a shared understanding of the rationale for change, so that we have some guideposts to ensure that the adopted strategies are sufficiently comprehensive and do not entail counterproductive side-effects. Much work remains to develop fully the principles that are needed to guide practical reform efforts effectively.

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