Chapter Twenty-two

Is Managed Competition the Answer?[1]

Mother Jones MJ93: The godfather of managed competition May/June 1993

Most of the problems of single-payer health care insurance are well known to policy makers and government officials and even to many ordinary citizens in countries with national health insurance. Many of the obstacles posed by the politics of medicine also are well known.

As a result, throughout the 1990s there was growing interest—particularly in Europe—in a new type of system, one in which health care resources would be allocated by competition in the marketplace rather than by politicians. Such a system would not be a free market in the ordinary sense of that term; rather it would be a market in which the rules of competition were set and managed by government. So long as the competitors played by the rules, market forces rather than political forces would determine who got health care and how much. Such a system is called managed competition. And to obtain a model of it, Europeans turned, of all places, to the United States.[2]

The competition that exists in these programs, again, is not the same as one would find in a free market. It takes place under artificial rules managed by the employer or some other sponsoring organization. During its first term, the Clinton administration proposed such managed competition nationwide. Its adherents, including Stanford professor Alain Enthoven, still think this is the answer to the nation's health care woes.[6]

MANAGED COMPETITION VERSUS MARKET-DRIVEN HEALTH CARE

One of the ironies of health policy is that some of the strongest critics of national health insurance are also some of the strongest advocates of managed competition; Alain Enthoven is one example. Yet, the closer we come to the ideal world of managed competition, the more likely we are to experience outcomes similar to those of socialized medicine. Moreover, this conclusion is not tied to the design of any particular employer plan. There is a sense in which our entire employer-based system functions as a loose system of managed competition.

Ordinarily, we think of the labor market as being literally a market for labor, with health insurance tacked on as a fringe benefit. But imagine for a moment that it were the other way around. Imagine that employers offered health plans with the provision that you must take a job in order to enroll. Farfetched

Continued resistance to managed care. Employers' efforts to control costs through the use of "managed care" were temporarily successful in the 1990s. For a few years they brought the growth of health spending into line with U.S. gross domestic product (GDP), mainly by squeezing provider payments and shortening hospital stays, strategies that have been played out. They did not bring about a fundamental reform in the way health care is organized and delivered.

INSURANCE REFORM: EMPLOYER INSURANCE

WEB EXCLUSIVE 28 May 2003

Employment-Based Health Insurance Is Failing: Now What?

A strategy, based on managed competition, to free employers from the health care cost spiral and produce effective managed care.

by Alain C. Enthoven

ABSTRACT:

Employment-based health insurance is failing. Costs are out of control. Employers have no effective strategy to deal with this. They must think strategically about fundamental change. This analysis explains how employers' purchasing policies contribute to rising costs and block growth of economical care. Single-source managed care is ineffective, and effective managed care cannot be a single source. Employers should create exchanges through which they can offer employees wide, responsible, individual, multiple choices among health care delivery systems and create serious competition based on value for money. Recently introduced technology can assist this process.

Employment-based health insurance is failing. Costs are once again rising out of control.

POLITICS (/POLITICS)

MotherJones MJ93: The godfather of managed competition

—By **Priscilla Yamin** (/authors/priscilla-yamin) and **Robert Dreyfuss** (/authors/robert-dreyfuss) | May/June 1993 Issue (/toc/1993/05)

2 (#disqus_thread) Tweet 0 Like 0

If managed competition sounds like something designed by an accountant rather than a caregiver, that's because its creator has spent decades using computers to devise systems that have an unfortunate impact on real people.

The standard sobriquet attached to Alain Enthoven is "a Stanford economist." Less often is it mentioned that Enthoven got his start in public policy at the Pentagon in the 1960s as Robert McNamara's chief "Whiz Kid." As head of systems analysis for the Department of Defense, Enthoven worked on everything from nuclear warfare strategies to Vietnam body counts.

In a recent interview with *Mother Jones*, Enthoven said, "I fear that journalists may not know enough about the health-care system," and therefore "don't get it quite right." He said it was "particularly unfortunate" that "people go after you for suspected financial interests rather than [looking at] the quality of the ideas." Enthoven was especially bothered by a *Washington Post* story alleging a financial connection between the Jackson

Although an investigation by *Mother Jones* did not uncover any direct links between Enthoven and the insurance industry, it did establish that he is a paid consultant to Kaiser Foundation Health Plan, Inc., an HMO that would presumably benefit if and when his vision of managed competition becomes the law of the land. Enthoven refuses to divulge his compensation from this work, stating simply: "We have an agreement, and how much is my business."

In addition, Enthoven spent four years as a director and stockholder of PCS, Inc., a "pharmaceutical managed care" company that was taken over by the drug distribution giant McKesson Corporation in 1989. In addition to his $10,000 annual retainer as a director of PCS, Enthoven held one thousand shares of the company's stock, which he sold to McKesson for approximately $20,000 on April 16, 1990. (In its latest annual report, McKesson notes, "With PCS, [we are] in a prime position to benefit from the rapid growth of managed-care health plans.")

At a recent forum in Washington, D.C., Enthoven--tall, aloof, and patrician in appearance--rattled off statistics about the growing toll of America's collapsing health-care system. Nowhere in his presentation, however, did he evoke sympathy for the uninsured, the underinsured, people without long-term care, or the need to provide basic human services. Instead, Enthoven coolly suggested that the problem with the U.S. health-care system is that people get too much health care and consume too much medicine.

Enthoven's image as a somewhat cold advocate of efficiency over human needs parallels his earlier role as McNamara's number-cruncher in the Vietnam-era Pentagon. According to Deborah Shapley, author of a recent McNamara biography called *Promise and Power*, Enthoven created a database specially tailored to the needs of his military superiors, who needed to rationalize U.S. involvement in the war in terms of enemy "body counts," however fancifully derived.

In fact, Shapley writes that the phrase "managed competition" actually came from McNamara, who used the concept while he was president of Ford Motor Company to force the various divisions of the automaker to streamline corporate workings. Shapley says that McNamara later used the same phrase to describe his strategy of playing off the armed services against each other. Enthoven, however, dismisses this etymology as "fanciful" and "preposterous," and maintains that he came up with the term for his health-care system himself, in 1986.

Computers, Electronic Data, and the Vietnam War

by **DONALD FISHER HARRISON***

> *The government are very keen on amassing statistics. They collect them, raise them to the nth power, take the cube root and prepare wonderful wonderful diagrams. But you must never forget that every one of these figures comes in the first instance from the village watchman, who just puts down what he damn pleases.*[1]

Acrobat File Edit View Document Comments Forms Tools Advanced Window Help (0:45) Tue Sep 10 6:44 AM
11490-13139-1-PB.pdf
4 / 15 enthoven

attention to anything but realities ... It was most helpful in forming a just and comprehensible view of the innumerable facts and figures which flowed out upon us."[8] In the 1950s political scientist Samuel P. Huntington called for "proper staff assistance for the Secretary" which would remedy the "greatest single deficiency" in the Department of Defense.[9] To meet this critical need McNamara established the new position of Assistant Secretary of Systems Analysis, and appointed Alain Enthoven as its first incumbent. Eventually this office did for McNamara what the statistical department did for Winston Churchill in the Second World War, and it filled the void in the Office of the Secretary of Defense (OSD) which Huntington identified in 1957.[10] Enthoven assembled a staff of bright but relatively inexperienced personnel to institute a new programme in the OSD called the Planning, Programming, Budgeting System (PPBS), which called for broad use of statistical evidence as the essential characteristic of operational research and as the basis for decision-making. This required the installation of new computers. Hereafter no decision was seriously considered without computer analysis to support it.[11]

McNamara introduced these innovative techniques at the beginning of the Kennedy years and continued them through the Johnson Administration, but during his tenure they were viewed with mixed feelings both in and out of the Department of Defense. Introduced by civilians, the techniques were opposed by the military, who were angry about the analytical approach to the management of war. It should be said that the military schools and promotion system had not prepared any officer for such a radical change. Officers found themselves unprepared to cope with the Secretary's methods. Their feelings ran deep. One military writer said that McNamara's analysts "had an educated incapacity to see war in its true light," and the PPBS had dismissed the principles of war as "a set of platitudes that can be twisted to suit almost any situation."[12]

Officers could accept the use of statistical evidence to acquire money and materiel during the annual budgetary fights with Congress. Efficiency cuts such as closing naval

Acrobat File Edit View Document Comments Forms Tools Advanced Window Help Tue Sep 10 6:47 AM
11490-13139-1-PB.pdf
8 / 15 enthoven

Figure 1: *Conducting a War by Computer, Vietnam, ca. 1968. Photo by Philip Jones Griffiths.* Courtesy: Philip Jones Griffiths/Magnum Photos Inc., New York City.

In the age of computers, it is not enough to speak in terms of paper records, when in fact

Acrobat File Edit View Document Comments Forms Tools Advanced Window Help (0:42) Tue Sep 10 6:47 AM
11490-13139-1-PB.pdf
5 / 15 enthoven

Part of the fallout from the widespread dissemination of the *Southeast Asia Analysis Report* was that high ranking military leaders perceived (at least indirectly) that their own personal performance was monitored by McNamara's computers. Whatever was entered

into the computer in Assistant Secretary Alain Enthoven's Systems Analysis Office at the Pentagon had a profound influence on running the war. Many officers imagined the Secretary keeping a report card leading to future promotions, dismissals and transfers simply by counting enemy bodies, trucks destroyed, sorties flown, and bombs dropped. One officer bitterly complained that his local analysts were generating data exclusively for the computers in Washington. "I hope that we never repeat that. The conduct of the war is an art form. It is not something that is quantifiable and I hope we never again revert to a practice that almost crippled us."[15]

Public Health Then and Now

1994

Editor's Comments: Plurality of Views

In view of the timeliness and seriousness of the issues under discussion, the Editors agreed to publish the following exchange between Howard Waitzkin and Alain Enthoven on the history of managed competition. The proposals for health care reform currently under national discussion span a broad range from "single payer" to the unfettered free market, and we recognize that these different proposals inspire strong feelings and opinions. The American Public Health Association has long been a strong proponent of national health care reform and historically has endorsed the principles of the single-payer position. Although the editors of the *American Journal of Public Health* welcome spirited argument on the issues of health care reform, we would like to emphasize that this journal is open to a plurality of views, and we reject any implication that one approach is more "American" than another. ☐

Elizabeth Fee

The Strange Career of Managed Competition: From Military Failure to Medical Success?

Howard Waitzkin, MD, PhD

ABSTRACT

Managed competition remains untested as the basis of a national health program. However, key principles of managed competition first emerged in the military. For this study, published works on systems analysis and the planning-programming-budgeting system (PPBS), developed by Alain Enthoven and colleagues at the US Department of Defense during the 1960s, were compared with published presentations of managed competition. The influence of PPBS waned after it generated controversy and opposition. PPBS and managed competition represent similar managerial strategies of policy reform. Although the origin of managed competition in failed military policy does not ensure failure in the medical arena, this history also does not augur success. (*Am J Public Health*. 1994;84:482–489)

> Beyond its uniqueness and eclecticism, I would like to say that the art of weapon systems analysis, like the art of medicine, should be based on scientific method, using that term in its broadest sense.[1]
>
> *—Alain C. Enthoven, 1963*

Since managed competition as the basis of a national health program remains untested anywhere in the world, by what yardstick should it be judged?

Current debates do not recognize that key principles of managed competition arose historically in a completely different, nonmedical arena: the military. These principles briefly became influential at the US Department of Defense and certain other parts of the federal government. However, this approach to policy-making eventually fell into disfavor because of both its failure to achieve policy goals and the widespread opposition that it generated in the military sector, other administrative branches of government, Congress, and the general public.

The origins of managed competition in military policy help clarify what can be expected from a similar managerial strategy of health care reform. Through a critical review of published works, this article traces the history of managed competition, compares complementary themes in the military and medical arenas, and presents implications for future decisions about a US national health program.

Origins of Managed Competition in Military Policy Analysis

The conceptual framework of managed competition originated in the military situation that confronted the United States during the Cold War of the late 1950s and early 1960s. Professor Alain Enthoven, an economist and the princi-

The author is with the Department of Medicine and School of Social Sciences, University of California–Irvine.

Requests for reprints should be sent to Howard Waitzkin, MD, PhD, University of California–Irvine, North Orange County Community Clinic, 300 W Romneya Dr, Anaheim, CA 92801.

pal intellectual architect of managed competition, was a driving force behind systems analysis at the Pentagon between 1961 and 1969, and his conceptual approach to health care owes much to the analytic work that he and his colleagues carried out during that period. Military systems analysis and managed competition in health care represent similar managerial approaches to policy reform.

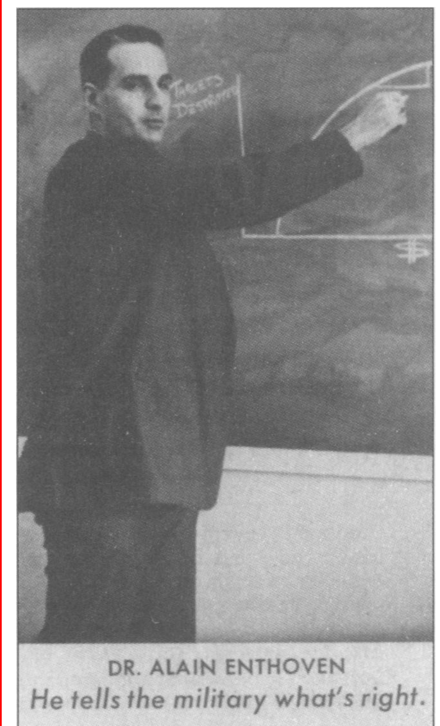
After John F. Kennedy became president in 1961, he appointed Robert McNamara, chief executive officer of the Ford Motor Company, as secretary of defense. An advocate of strong management, McNamara selected Charles Hitch, an economist based at the RAND Corporation, as assistant secretary of defense. While at RAND during the 1940s and 1950s, Hitch had spearheaded the Economics Division, which was funded mainly by the Air Force and whose purpose was to apply economic analysis to choices of weapon systems and strategies; this work at RAND culminated in an influential book that spelled out how economic analysis could guide defense policy decisions.[2] Hitch brought with him to the Pentagon several colleagues from RAND, including Enthoven, who helped establish the Office of Systems Analysis and later also rose to become assistant secretary of defense. Enthoven presented the accomplishments of this office in a series of articles appearing in military and economics journals during the 1960s, as well as in two books.[3,4]

At the Pentagon, Enthoven and his coworkers emphasized the planning-programming-budgeting system (PPBS) and cost-benefit analysis.[4] PPBS aimed to develop "plain statements" of national purposes in defense programs. Based on such formulations, each defense program could be evaluated and compared with alternative programs aimed at achieving the same purposes. In considering military goals, this approach tried to express costs and benefits quantitatively (see photo). An independent analytical staff, composed mostly of civilian specialists such as economists, prepared technical reports comparing the alternatives that the secretary of defense and other key officials used in decision making. The independence of this staff was viewed as essential to balance the narrow interests of military officers, defense contractors, and politicians who sought to influence decisions.

As systems analysis gained prominence, several policy decisions reflected the impact of PPBS. These decisions concerned deployment of troops in the North Atlantic Treaty Organization; development and proliferation of nuclear weapons; and initiation of new bombers, missiles, and other weapon systems.[4] Because of the apparent rationality and high-level sponsorship of this approach, President Lyndon Johnson in 1965 mandated the gradual implementation of PPBS throughout the federal government.[5]

At various points in the Vietnam War, systems analysts sought to train military officers through hypothetical exercises such as the evaluation of resupply operations by ground versus air.[6] According to Enthoven, PPBS also contributed to the war effort by evaluating troop deployment plans, developing alternatives to "body counts" as measures of success in the war effort, estimating aircraft attrition, and measuring progress in the Vietnam "pacification" program. But despite its attempt to reform military policies through a strategy of strong and rational management, systems analysis generated controversy and opposition both within and outside government, and its influence began to wane as US participation in the Vietnam War increased during the late 1960s.

In a retrospective account, Enthoven and K. Wayne Smith, a colleague at the Pentagon, acknowledge this opposition.[4(pp267–308)] Administrators of other cabinet-level departments did not consistently implement President Johnson's mandate. Professional military leaders, defense contractors, and civilian analysts at the Pentagon were antagonistic toward PPBS. Politicians in Congress grew impatient with quantitative analyses of defense policies (see photo of Gardiner L. Tucker).[4(pp309–313)] Antiwar activists argued that cost-benefit analysis led to inappropriate policies because it clouded the ethical dimensions of important decisions, especially those about nuclear weapons and Vietnam. But despite its claimed advantages in cost controls, PPBS did not prevent or modulate a rapid increase in military expenditures, which remained unsurpassed until the mid-1980s (Figure 1).[7(p336)] This rate of increase in military expenditures during the 1960s reflected the pressures of the Vietnam War and concerns about nuclear conflict, and PPBS was not in a position to control



Alain C. Enthoven lecturing on systems analysis in the military, 1963. On the chalkboard, the vertical axis is labeled "targets destroyed" and the horizontal axis is labeled "$." Reprinted with permission from Time, Inc.[50]

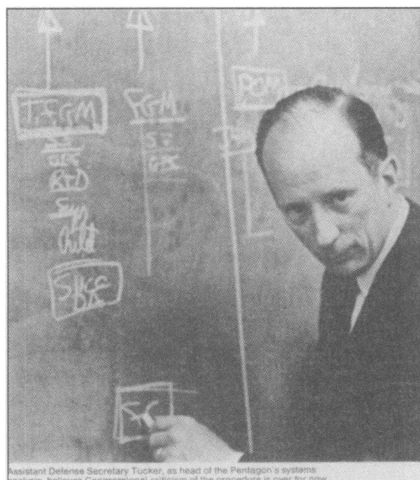
overall costs in the context of these broad political forces.

Thus, while Enthoven and his associates continued to defend PPBS, they acknowledged that their principles had little impact on military policies during the late 1960s. Accordingly, Enthoven's retrospective view conveys disappointment and failure:

> The Systems Analysis office did not have a prominent, much less a crucial, role in the Vietnam war. . . . It had no policy role in determining the overall totals of men to send to Vietnam, or in figuring out what they should do when they got there. . . . If we make no other point in this book, we want it to be clear that the full value of systematic analysis in making decisions on the conduct of a war has yet to be tested.[4(p270)]

Already in eclipse, PPBS continued to lose prominence in policy-making, and its impact in other spheres of government remained minimal. As Enthoven and Smith point out, President Richard Nixon promised to "root out the

was a distraction



Gardiner L. Tucker, Enthoven's successor as head of the Office of Systems Analysis at the US Department of Defense, 1970. The caption refers to congressional criticism of systems analysis. Department of Defense file photo that appeared in *Business Week*.[51]

whiz kid approach at the Pentagon."[4(p333)] Although the Office of Systems Analysis survived, its activities became much more circumscribed. Temporary decreases in military spending during the mid-1970s mostly reflected the scaling back of operations in Southeast Asia rather than the impact of PPBS, which by that time contributed in a very minor way to budgeting at the Pentagon. PPBS did not enjoy a comeback under the administration of Jimmy Carter, and it remained uninfluential during the peacetime military buildup of the Reagan and Bush administrations.

After a brief excursion into private industry between 1969 and 1973 as vice president and then president of Litton Industries, a major military contractor, Enthoven then joined the faculty of Stanford University in 1973 as a professor of both management and health care economics.[8] There his work on health policy incorporated the principles of management and systems analysis that he had previously advocated at the Pentagon.

By 1977, only 4 years after leaving the defense sector, Enthoven offered to the Carter administration a proposal for a "Consumer Choice Health Plan," based on regulated competition in the private sector. This proposal built in part on prior initiatives by Paul Ellwood for a national health maintenance strategy and by Scott Fleming for structured competition within the private sector.[9(pp65–67)] Although Carter rejected the plan, Enthoven soon afterward published the proposal in the medical literature[10] and in a separate monograph.[11] In this early work, Enthoven presents the basic conceptual structure of all subsequent proposals for managed competition. As discussed later, this proposal for health care reform contains important concepts from the military policy work that Enthoven had spearheaded a few years earlier at the Pentagon.

During the 1980s, Enthoven collaborated with Ellwood, other proponents of health maintenance organizations (HMOs), corporate executives, and officers of private insurance companies in refining the proposal. An emphasis on managed competition arose during the mid-1980s in response to concerns raised by economists and business leaders that the original proposal conveyed free-market assumptions requiring modification through closer "management" of the program.[12] The new name also conveyed a message of managerial control that proved attractive to business leaders.

After publication of a revised proposal in 1989,[13] the coalition supporting managed competition broadened to include officials of the largest US private insurance companies, which were diversifying into managed care. These business leaders met regularly with Enthoven and other proponents of managed competition at Ellwood's Wyoming home as part of the so-called Jackson Hole group. The managed care sector of the private insurance industry provided major funding for this group, as well as financial and logistic support for Bill Clinton's presidential campaign and consultation for the Presidential Health Care Task Force.[14,15]

Most recent proposals for managed competition—including that of the Clinton administration—have emerged from this intellectual tradition. These proposals use fixed premium contributions by employers and government to encourage enrollees to choose less expensive plans; the proposals also use price competition among health plans to help control fees paid to doctors and hospitals.[16,17] Certain proposals have suggested modifications in the conceptual structure outlined by Enthoven and his colleagues. For instance, although managed competition traditionally has encouraged employer-sponsored plans with participation by private insurance companies, other proposals have separated employment from insurance through the creation of a single, tax-financed, globally budgeted public fund, which would contract with private plans for a minimum benefit package.[18–20] All managed competition proposals, however, incorporate concepts initiated by Enthoven and his colleagues, and all of them call for large-scale changes in the ways medicine is practiced and choices are made by physicians and consumers.

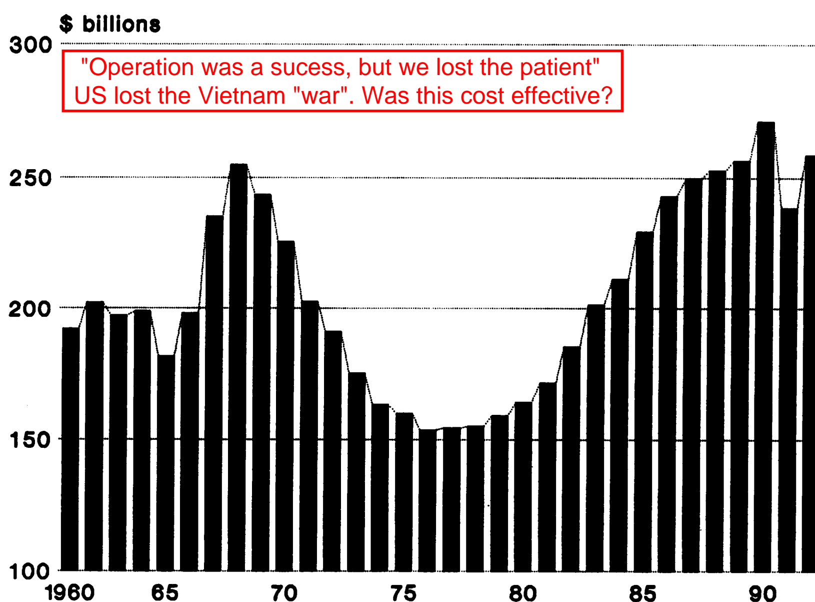
This has failed (again)

Complementary Themes in Military and Health Policy

As has been seen, the theoretical advantages of strong management techniques, as advocated by Enthoven and his colleagues, did not lead to enduring improvements in defense policy. This failure derived not only from the self-interested opposition of military officers and members of Congress, but also from the limitations of PPBS in addressing the political and ethical dimensions of major public policy decisions. Because the theory of managed competition in health care, which seems to be heading for its possible first test, contains unmistakable elements of PPBS, the limitations and complementary themes in these two approaches to public policy merit closer critical scrutiny than they have received thus far. Table 1 summarizes these themes.

Distrust of Professionals

PPBS argued that professional military officers held vested interests that led them to advocate ever-expanding investment and program development in their own narrow areas of expertise. For instance, the chiefs of the army, navy, and air force promoted new weapon systems with little critical appraisal of those systems' contribution to the national interest and without coordination among the services. While expressing formal respect for the professional competence of military officers, Enthoven and other proponents of PPBS argued that defense policy must counterbalance the vested interests of military brass through technical analyses of costs and benefits performed by civilian personnel. Independent analysts were needed to foster informed and cost-conscious defense policy decisions.[4(pp42–44)]



Note. Military expenditures increased rapidly during the 1960s, including the early years of the Vietnam War, when PPBS, which encouraged cost-conscious policy decisions, was in effect at the US Department of Defense.

Source. The data are from *Statistical Abstract of the United States* (Table 525, p 336, 1992 edition; data not given for 1962).[7]

FIGURE 1—Growth in US military expenditures, in constant (1982) dollars, from 1960 to 1992.

TABLE 1—Complementary Themes in Military Planning-Programming-Budgeting System (PPBS) and Managed Competition in Health Care

	Focus of Theme	
Theme	PPBS	Managed Competition
Distrust of professionals	Military brass	Medical guild
Trust of managers	Independent analysts	Managers of organizational sponsors
Choice among competing alternatives	Weapon systems, military strategies	Organized health plans
Scientific method	Cost-benefit analysis in case studies	Cost-benefit analysis in case studies
"Tools" for managers	Cost-benefit analysis, 5-year defense plan, draft presidential memos, development concept papers	Techniques to prevent "market failure": pricing, cost-benefit analysis, annual enrollment, quality assurance, subsidy management
Incrementalism with strains	Military officers, corporate contractors, members of Congress	Physicians, middle-class consumers, private insurance companies not equipped for managed care
Cost analysis but not necessarily cost reduction	No budget ceiling for military expenditures	No budget ceiling for health care expenditures

In managed competition, distrust of professionals manifests itself in a very critical assessment of physicians' vested interests. According to Enthoven, physicians function as a guild, which reduces the ability of market forces to control costs or encourage quality. From this perspective, the guild structure permits free choice of doctor by patient, free choice of prescription by doctor, direct negotiation between doctor and patient regarding fees, payment based on fee-for-service, solo practice, and professional control over medical licensure.[9,10] Managed competition, on the other hand, calls for concerted action by independent analysts and purchasers to curb decision-making power based on physicians' professional self-interest.

Trust of Managers

In arguing for the role of civilian analysts at the Department of Defense, Enthoven and his colleagues placed confidence in "active management at the top." In this model, implemented at the Pentagon, the secretary of defense received proposals about programs and weapon systems from military officers through the joint chiefs of staff. But independent analysts then subjected these proposals to rigorous analysis of costs and benefits in light of precise statements of the national interest. Memoranda prepared for the president presented conclusions of these analyses, thus encouraging more informed and objective decision making.[4(pp73–116)] Throughout this process, it was assumed, civilian managers would prove less guided by vested interests than would the professional brass.

Likewise, the wisdom of managers mostly based outside the medical profession has emerged as a basic tenet of managed competition. Under this approach, the locus of decision making moves from the medical guild to a cadre of managers, who administer the organizational "sponsors" of group health plans. (Under recent proposals, these sponsors are called "health insurance purchasing cooperatives" or "health alliances.") Incentives encourage physicians to organize themselves into competing economic units. Managers of the sponsors, which could include employers, labor-management health and welfare trusts, the federal Medicare system, state governments, and other large organizational entities, make prudent choices among competing plans on behalf of individuals and families. Guided by managerial principles, the sponsors serve as "active, intelligent, collective agents on the demand side who structure and adjust the market in a continuing, but never completely successful, effort to overcome its tendencies to failure."[9(p75)]

TABLE 2—Example of the Planning-Programming-Budgeting System as Applied to Nuclear Weapons: Comparative Effectiveness of Two Hypothetical Missile Pay Loads,[a] by Number of Targets Destroyed

Type of Target Destroyed	Ten 50-Kiloton Warheads Totaling One-Half Megaton	One 10-Megaton Warhead
Airfield	10.0	1.0
Hard missile silos	1.2–1.7[b]	1.0
Cities of 100 000 population	3.5	1.0
Cities of 500 000 population	0.7	1.0
Cities of 2 000 000 population	0.5	0.6

Source. Reprinted with permission from Enthoven and Smith.[4(p182,Table 8)]
[a]Both assumed to be reliably delivered.
[b]Variation depends on target hardness, delivery errors, and number of warheads allocated to each silo.

This view also calls for a reduction in decision-making discretion for individuals and families as consumers of services. Because of technical complexity, managers assume a paternalistic role in making rational decisions on behalf of consumers. As Enthoven writes: "This isn't a market in which the invisible hand will do the job. Some visible hands, which I call sponsors, must manage the demand side to make the market achieve desirable results."[9(p113)] Managerial input would shape not only the range of health plans offered to consumers but also the basic benefits package. Like PPBS, managed competition places faith in the ability of technically oriented managers to make decisions that are independent of any particular interest group. Thus, as decision making moves to high-level managers, managed competition is expected to foster administrative authority wielded in an enlightened effort to reconcile the interests of physicians, patients, business, and government.

Choice among Competing Alternatives

PPBS sought to analyze the marginal costs and benefits of competing alternatives to similar policy goals so that high- level managers could make informed choices. In the case of nuclear weapons, Enthoven and his colleagues tabulated hypothetical data on the projected number of enemy cities destroyed by multiple warheads, each containing a relatively small nuclear payload, as opposed to fewer warheads, each with a much larger payload (Table 2). Through these tabulations, it became apparent that multiple warheads with smaller payloads would prove more cost-effective since more cities with larger cumulative populations could be destroyed for a given level of investment in nuclear weapons.[4(pp165–195)] In the context of Cold War pressures, this analysis coincided with one of the largest overall buildups of nuclear weapons in history, and the ethical dimensions of such policy alternatives received very little attention.

By a similar logic, managed competition encourages the development of competing health plans, among which managerial sponsors would choose on behalf of consumers. In making informed choices, managers would consider data on the relative costs and benefits of competing alternatives. In some instances, choice would also be offered to consumers, but they would have to pay more for health plans that provide benefits beyond the basic minimum package. The main locus of choice, however, will reside with the managers of large organizations that contract with competing health plans. From this viewpoint, the theoretical advantages of managerial choice are seen as superior to alternative policies such as a single-payer system, which controls costs through monopsony financing while permitting substantial choice for individual patients and doctors.

Scientific Method

At the Pentagon, PPBS introduced quantitative, cost-oriented analyses into policy deliberations. This approach conveyed scientific rationality, as opposed to prior procedures that were based on subjective opinion and the power positions of military and congressional leaders. A frequently used method of analysis was the case study, such as the study of nuclear warheads and payloads cited above, in which the costs and benefits of alternative weapon systems or military strategies were compared. The complexity and esoteric features of such studies tended to make them inscrutable to military officers and congressional representatives unschooled in economics.[4(p62)] For policymakers, decisions often involved nonquantifiable considerations, mostly value judgments, which proponents of PPBS referred to as "imponderables."[2] Further, PPBS required assumptions that simplified complex realities of military operations. Analysts at the Pentagon often used theoretical or hypothetical exercises that, despite their sophistication, proved much less useful than hoped in guiding concrete operational decisions, such as the deployment and resupply of equipment in Vietnam.[6]

The aura of scientific method also pervades arguments on behalf of managed competition. Again, rather than calling for more powerful scientific methods, such as random controlled trials on a regional or state level, to evaluate managed competition as opposed to single-payer or other policies, Enthoven uses case studies selectively to justify key claims. For instance, he uses the Kaiser system as a case study to demonstrate the cost-saving potential of HMOs.[9(pp42–58),10(pp68–69)] In this case study, however, Enthoven downplays prior and subsequent evidence showing that, in contrast to Kaiser, most managed care organizations, such as independent practice associations and preferred provider organizations, have not shown consistent cost savings.[21–23] He and other proponents of managed competition also cite certain cost reductions noted for prepaid group practices within the RAND health care experiment, but they do not emphasize that this random controlled trial did not evaluate managed competition per se.[13] In his case study of Kaiser, Enthoven also does not address data that show similar or lower levels of patient satisfaction in HMOs than in fee-for-service settings.[24–26] Similarly, he uses Canada as a case study and alludes to the work of economist Robert Evans,[27] which showed increases in payments to physicians under Canada's national health program; however, while Enthoven cites a small facet of Evans' work to argue against a single-payer

system,[9(p36)] he does not refer to the larger corpus of Evans' or other investigators' work that has yielded favorable evaluations of the Canadian system.[28–31]

The science of managed competition therefore remains based in theories of market forces and selective application of case studies, rather than in evaluation using more powerful methods available in health services research. Like PPBS before it, managed competition thus becomes a set of scientifically oriented principles to be implemented without prior scientific test.

"Tools" for Managers

New analytic "tools" became corresponding elements of both PPBS and managed competition. In PPBS, chief among these tools were the hypothetical case studies that considered costs and benefits of alternative policies, especially regarding weapon systems. Other tools introduced by Enthoven included a 5-year defense plan, draft presidential memoranda, and development concept papers that presented competing policy options for executive decision.[4(pp48–60)] Efficacious military policies depended on the disciplined use of these tools by systems analysts and their superiors in top management.

The tools of managed competition, again envisioned mainly by Enthoven, are techniques that managers of organizational sponsors can use to counteract "market failure." These tools include methods of pricing, construction of standardized benefit packages based on analysis of projected costs and benefits, annual enrollment and disenrollment procedures, quality assurance methods, management of subsidies, and various "pro-competitive actions" that restrict the economic power of health care providers.[9(pp98–118)] A manager's task would be to use such tools to reduce the impact of market failures, such as continuing access barriers, selection of low-risk enrollees, and cost overruns. Practical impediments to using these managerial tools remain understated, as was the case with similar tools at the Pentagon.

Incrementalism with Strains

Proponents of PPBS acknowledged that their methods implied drastic changes in military policy-making. Incrementalism, the only route ideologically acceptable in the "free world," comprised the process by which advocates believed such changes would occur.[32,33] Career officers, corporations that received military contracts, and people in Congress who supported the traditional way of doing business experienced the inevitable "strains" of incremental change. Military and congressional resistance to such strains eventually contributed to the decline of PPBS as a managerial technique in government. Again, PPBS proved unrealistic in its assessment of US political realities as it underestimated the difficulties of achieving fundamental policy shifts through slow, incremental processes.

Under managed competition, the guild of medical professionals, patients unaccustomed to making cost-conscious decisions, and private insurance companies unequipped for managed care would experience the main strains of change, which again would occur through an incremental process. Arguing that "incrementalism is a fundamental law of behavior in democratic governments," Enthoven advocates a coordinated strategy to "break up the medical guild."[9(pp119–124)] This strategy includes legislation that permits selective contracting with preferred providers, outlaws boycotts by physicians, prohibits price fixing, and restrains other "concerted refusals to deal" by medical professionals. To achieve the widest impact, Enthoven suggests that incremental reforms start with the "educated middle class," who are already accustomed to cost-conscious choices. In discussing incrementalism, however, Enthoven again tends to downplay opponents' ability to undermine processes of slow, incremental change. Moreover, he and his colleagues also discount an alternative view of social change: that democratic societies are capable of making fundamental changes rapidly and successfully, as happened when the United States implemented Social Security in 1935 or when other countries enacted single-payer national health programs.

Cost Analysis but Not Necessarily Cost Reduction

While it analyzed competing alternatives in terms of costs and benefits, PPBS never promised to reduce costs overall. Aiming to achieve the "fullest value per dollar spent,"[5] its advocates viewed PPBS as a better way to manage that was compatible with higher, lower, or unchanged costs. For instance, Hitch noted that cost-benefit analysis remained neutral regarding the unit cost of a particular weapon system.[34] In arguing for explicit consideration of both costs and needs, Enthoven opposed arbitrary budget ceilings that would restrain overall increases in military expenditures.[4(p203)] As previously noted, PPBS coincided with an unprecedented rate of growth in military spending (Figure 1).

Similarly, proponents of managed competition are careful to note that it will not necessarily lower health care costs. Again opposing a cap on overall expenditures, Enthoven favors, on theoretical grounds, market forces that encourage cost-conscious choices, with a goal of maximizing value for money. He and his colleagues predict short-term increases in health care expenditures, as the costs of new layers of administration are added to those of expanded services for the currently uninsured. While longer-term savings may result from managerial decision making, Enthoven and his colleagues acknowledge that such savings remain largely hypothetical and will take years of organizational change to achieve.[9(pp119–135)]

Conclusion

Managed competition has had a strange career. Although this approach remains untested as the organizing principle of any other country's national health program, its intellectual progenitor enjoyed a brief heyday in military policy. By developing and promoting PPBS at the Pentagon, Enthoven and his colleagues worked through many of the economic and analytic procedures later resurrected in the theory of managed competition. In lieu of other yardsticks to evaluate the claims of managed competition, the history of PPBS provides a sense of what may lie ahead in health care.

PPBS failed as a coherent approach to military policy—a failure that deserves attention as managed competition, a similar managerial strategy of reform, gains ascendancy in health policy. PPBS unrealistically gauged the political and ethical dimensions of major public policies. Generating widespread opposition among military professionals, corporate contractors, members of Congress, and peace activists, this managerial strategy of reform exerted little long-term impact on military operations and expenditures or on other spheres of

public administration. Similarly, professional opposition has undermined managed care initiatives in several European countries, both earlier in this century and more recently[35,36]; thus, it is unlikely that medical professionals and their organizations in the United States, seldom lacking in ingenuity in the past, will accept without resistance the administrative control that managed competition here promises to enact. Moreover, the touted advantages of PPBS and managed competition in scientific method, expanded choice, and cost-conscious decisions by high-level managers have not achieved prior successes in policy-making at the national, regional, or state level. Incrementalism with strains, seen as the process of change under both PPBS and managed competition, reflects an ideological, or at least debatable, view of historical processes. The analytic tools of PPBS and managed competition have not lowered overall costs in either the military or medical sector, nor were they intended to do so. Although the origin of managed competition in failed military policy does not guarantee failure in the medical arena, this history also does not augur success.

Aside from this history, both supporters and opponents have raised major concerns about managed competition.[37–41] Demographic limitations would restrict its impact since about 30% of the US population live outside metropolitan areas that could support three or more competing managed care plans. Whether managed competition could control costs remains unclear; states with the most extensive managed care programs have shown costs to be as high as or higher than elsewhere.[42–44] Moreover, administrative costs, already more than 20% of overall health care expenditures,[45] likely would increase still further since managed care is administratively intensive and new organizational sponsors would introduce additional managerial layers. Despite a laudable intent to use research on effectiveness and outcomes to define the uniform minimum benefits package and to assess quality of care, such research has produced verified data about only a small number of medical conditions and procedures. Although "outcomes research" may be construed as increasing professional accountability, proposals for managed competition have not clearly described who would carry out such research or whether access to data would remain within the public domain and in usable form. How practice guidelines would achieve accountability within for-profit entities that compete on the basis of price, while not alienating providers and patients, remains unclear.

Several practical concerns have also arisen regarding the acceptability of managed competition to providers and consumers.[15,36] While expanding the decision-making power of large insurance companies that already have entered the managed care field, managed competition probably will reduce consumers' freedom to choose practitioners, and micromanagement of clinical decisions likely will increase. Because the ability to buy additional coverage beyond the basic benefits package will depend on income, this provision will perpetuate unequal, multitiered coverage. Whether managed competition will succeed in curbing insurance companies' selection or exclusion of patients by risk of costly illness remains in doubt. Managed competition likely will create higher out-of-pocket payments and taxes for a substantial part of the population who currently are insured. Several polls have shown less public support for managed competition than for other alternatives.[46] Evidence that managed competition would solve the access problem while controlling costs remains less convincing than evidence that exists in support of a single-payer option.[47,48] For instance, the US Congressional Budget Office has reported that prospects for cost containment under managed competition are uncertain at best and that the only countries that have successfully contained costs are those using single-payer financing.[21]

The powerful coalition built up around managed competition may succeed in enacting this policy. Although it may address some of the concerns raised about managed competition, the Clinton team is unlikely to change the basic structure of the proposal. This reluctance to consider other options seriously may stem partly from the support that the Clinton campaign received from the managed care sector of the private insurance industry,[14,15] as well as from a perception that simpler and more popular options, including a single-payer approach, are unlikely to pass in Congress.

Failure to achieve a workable national health program would generate great disappointment as well as financial waste. Some analysts believe that failure of managed competition is a necessary step toward adoption of a simpler approach such as a single-payer option. A less sanguine view holds that the United States may get only one chance to establish a workable program during this decade and that failure would lead to retrenchment, cutbacks, and a return to the present paradox of pervasive access barriers coupled with high costs.

Ultimately, should market principles of competition, derived largely from failed attempts at managerial reform of military policy, be accepted as cornerstones of national health policy? It is unnecessary to expound on the ways in which health care differs from military procurement. But having emerged historically from military policy analysis, managed competition contains assumptions about the superiority of managerial decision making and discretion, even as they are applied to the micromanagement of clinical processes. Such assumptions about managerial wisdom may lead medicine down a path inconsistent with the aspirations of many health workers and patients. Rather than Enthoven's equation of the art of weapon systems analysis and the art of medicine, an alternative vision might be Wendell Berry's:

> Rats and roaches live by competition under the law of supply and demand; it is the privilege of human beings to live under the laws of justice and mercy. It is impossible not to notice how little the proponents of the ideal of competition have to say about honesty, which is the fundamental economic virtue, and how *very* little they have to say about community, compassion, and mutual help.[49(p135)] □

Acknowledgments

This study was supported in part by grants from the Poverty and Race Research Action Council (Washington, DC) and the US Health Resources and Services Administration (PE 19154).

I thank Stephany Borges, Carolyn Clancy, David Himmelstein, Don Light, Vicente Navarro, Steffie Woolhandler, members of the Health Services Research Seminar at the University of California–Irvine, Elizabeth Fee, and anonymous Journal reviewers for helpful comments on an earlier draft of this article. I am grateful to Michelle Stone and Wendy Wagner for bibliographic assistance.

References

1. Enthoven AC. Choosing strategies and selecting weapon systems (address before the Naval War College, Newport, RI, June 6, 1963). In: Tucker SA, ed. *A Modern Design for Defense Decision: A McNamara-Hitch-Enthoven Anthology.* Washington, DC: Industrial College of the Armed Forces; 1966.

2. Hitch CJ, McKean R. *The Economics of Defense in the Nuclear Age.* Cambridge, Mass: Harvard University Press; 1960.
3. Tucker SA, ed. *A Modern Design for Defense Decision: A McNamara-Hitch-Enthoven Anthology.* Washington, DC: Industrial College of the Armed Forces; 1966.
4. Enthoven AC, Smith KW. *How Much Is Enough? Shaping the Defense Program, 1961–1969.* New York, NY: Harper & Row; 1971.
5. Johnson LB. Introduction of new government-wide planning and budgeting system (statement by the president to members of the Cabinet and heads of agencies, August 25, 1965). In: Tucker SA, ed. *A Modern Design for Defense Decision: A McNamara-Hitch-Enthoven Anthology.* Washington, DC: Industrial College of the Armed Forces; 1966.
6. Snyder WP. An illustrative example of systems analysis (prepared for instructional purposes, US Military Academy, spring 1964). In: Tucker SA, ed. *A Modern Design for Defense Decision: A McNamara-Hitch-Enthoven Anthology.* Washington, DC: Industrial College of the Armed Forces; 1966.
7. *Statistical Abstract of the United States.* Washington, DC: US Bureau of the Census; 1992.
8. *Who's Who in America.* Chicago, Ill: Marquis; 1992.
9. Enthoven AC. *Theory and Practice of Managed Competition in Health Care Finance.* Amsterdam, the Netherlands: North-Holland; 1988.
10. Enthoven AC. Consumer-choice health plan. *N Engl J Med.* 1978;298:650–658, 709–720.
11. Enthoven AC. *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care.* Reading, Mass: Addison-Wesley; 1980.
12. Enthoven AC. Managed competition in health care and the unfinished agenda. *Health Care Financ Rev.* 1986;(suppl): 105–119.
13. Enthoven AC, Kronick R. A consumer-choice health plan for the 1990s. *N Engl J Med.* 1989;320:29–37, 94–101.
14. Shapiro B. Zoe Baird. *Los Angeles Times.* January 7, 1993:B11.
15. US health reforms: clichés, cost, and Mrs C. *Lancet.* 1993;341:791–792.
16. Ellwood P, Enthoven A. Etheredge L. The Jackson Hole initiatives for a twenty-first century American health care system. *Health Econ.* 1992;1:149–168.
17. Rice T, Brown ER, Wyn R. Holes in the Jackson Hole approach to health care reform. *JAMA.* 1993;270:1357–1362.
18. Garamendi J. *California Health Care in the 21st Century: A Vision for Reform.* Sacramento, Calif: California Department of Insurance; 1992.
19. Starr P. *The Logic of Health-Care Reform.* Knoxville, Tenn: Whittle Direct Books; 1992.
20. Starr P, Zelman WA. A bridge to compromise: competition under a budget. *Health Aff (Millwood).* 1993;12(suppl): 7–23.
21. Langwell KM, Staines VS, Gordon N. *The Effects of Managed Care on Use and Costs of Health Services.* Washington, DC: Congressional Budget Office; 1992.
22. Gabel JR, Rice T. Is managed competition a field of dreams? *J Am Health Policy.* 1993;3:19–24.
23. Glaser WA. The United States needs a health system like other countries. *JAMA.* 1993;270:980–984.
24. Davies AR, Ware JE Jr, Brook RH, Peterson JR, Newhouse JP. Consumer acceptance of prepaid and fee-for-service medical care: results from a randomized controlled trial. *Health Serv Res.* 1986;21: 429–452.
25. Health care in crisis: are HMOs the answer? *Consumer Rep.* 1992;57(August): 519– 531.
26. Rubin HR, Gandek B, Rogers WH, Kosinski M, McHorney CA, Ware JE Jr. Patients' ratings of outpatient visits in different practice settings. *JAMA.* 1993; 270:835– 840.
27. Evans RG. Beyond the medical market place: expenditure, utilization, and pricing of insured health in Canada. In: Andreopoulos S, ed. *National Health Insurance: Can We Learn from Canada?* New York, NY: Wiley; 1975.
28. Evans RG. *Strained Mercy: The Economics of Canadian Health Care.* Toronto, Canada: Butterworths; 1984.
29. Evans RG, Barer ML, Hertzman C. The 20-year experiment: accounting for, explaining, and evaluating health care cost containment in Canada and the United States. *Ann Rev Public Health.* 1991;12: 481–518.
30. Fuchs VR, Hahn JS. How does Canada do it? a comparison of expenditures for physicians' services in the United States and Canada. *N Engl J Med.* 1990;323:884–890.
31. Redelmeier DA, Fuchs VR. Hospital expenditures in the United States and Canada. *N Engl J Med.* 1993;328:772–778.
32. McNamara RS. Managing the Department of Defense (1964). In: Tucker SA, ed. *A Modern Design for Defense Decision: A McNamara-Hitch-Enthoven Anthology.* Washington, DC: Industrial College of the Armed Forces; 1966.
33. Enthoven AC. US defense policy for the 1960s (address at Loyola University, Los Angeles, and at Seattle University, February 1963). In: Tucker SA, ed. *A Modern Design for Defense Decision: A McNamara-Hitch-Enthoven Anthology.* Washington, DC: Industrial College of the Armed Forces; 1966.
34. Hitch CJ. Cost effectiveness (lecture at the University of California, April 1965). In: Tucker SA, ed. *A Modern Design for Defense Decision: A McNamara-Hitch-Enthoven Anthology.* Washington, DC: Industrial College of the Armed Forces; 1966.
35. Abel-Smith B. The rise and decline of the early HMOs: some international experiences. *Milbank Q.* 1988;66:694–719.
36. Glaser WA. The competition vogue and its outcomes. *Lancet.* 1993;341:805–812.
37. Hadley JP, Langwell K. Managed care in the United States: promises, evidence to date and future directions. *Health Policy.* 1991;19:91–118.
38. Iglehart JK. Managed competition. *N Engl J Med.* 1993;328:1208–1212.
39. Kronick R, Goodman DC, Wennberg J, Wagner E. The marketplace in health care reform: the demographic limitations of managed competition. *N Engl J Med.* 1993; 328:148–152.
40. Relman AS. Controlling costs by "managed competition"—would it work? *N Engl J Med.* 1993;328:133–135.
41. Clancy C, Himmelstein DU, Woolhandler S. Questions and answers about managed competition. *Int J Health Serv.* 1993;23: 213–218.
42. Socolar D, Sager A, Hiam P. Competing to death: California's high-risk system. *J Am Health Policy.* 1992;2:45–50.
43. Kosterlitz J. Monopoly medicine? *Natl J.* 1993;25:1746–1749.
44. Access and affordability monitoring project, Boston University School of Public Health. Health costs rose faster in states with higher HMO enrollment during the 1980s. Cited in: Center for National Health Program Studies. *Managed Competition: Interim Update to the National Health Program Chartbook and Slideshow.* Cambridge, Mass: Harvard Medical School/ The Cambridge Hospital; 1993.
45. Woolhandler S, Himmelstein DU. The deteriorating administrative efficiency of the US health care system. *N Engl J Med.* 1991;324:1253–1258.
46. Blendon RJ, Altman DE, Benson JM, Taylor H, James M, Smith M. The implications of the 1992 presidential election for health care reform. *JAMA.* 1992;268:3371–3375.
47. *Canadian Health Insurance: Lessons for the United States.* Washington, DC: General Accounting Office; 1991. GAO publication GAO/HRD-91-90; B-244081.
48. Marmor TR. Commentary on *Canadian Health Insurance: Lessons for the United States. Int J Health Serv.* 1993;23:45–62.
49. Berry W. *What Are People For?* San Francisco, Calif: North Point Press; 1990.
50. The whizziest kid. *Time.* June 28, 1963:18.
51. The new mission of systems analysis. *Business Week.* July 4, 1970:70.

The Permanente Journal

Search the Journal
Find Site Index

HOME TPJ ARCHIVE SUBSCRIBE FOR AUTHORS CME ANNOUNCEMENTS LINKS STAFF CONTACT US

••Summer 2004/Vol. 8, No. 3

Editorials
Letters to the Editor
Permanente Abstracts
Commentary
Clinical Contributions
Soul of the Healer
A Moment in Time
KP in the Community
Health Systems
Permanente in the News
Book Reviews
The Lighter Side of Medicine

Commentary

Alain Enthoven: An Outspoken Champion for the Prepaid Group Practice

Alain Enthoven describes the reforms needed in the health care marketplace to pave the way for a 21st-century health care system built around the strengths of prepaid group practices.

By Jon Stewart

> **"This book should be required reading by every physician in the United States .... Doctors could learn a tremendous amount about their own medical practice and its marvelous potential by reading this book."** -- Rep Jim Cooper (D-TN), in a Health Affairs review of Enthoven and Tollen's new book on prepaid group practice.

Alain C Enthoven, PhD, is the Marriner S Eccles Professor of Public and Private Management (emeritus) in the Graduate School of Business at Stanford University and a Senior Fellow in the Center for Health Policy at Stanford's Institute of International Relations. He holds degrees in economics from Stanford, Oxford, and the Massachusetts Institute of Technology. In 1977, while serving as a consultant to the Department of Health and Human Services in the Carter administration, he designed and proposed the Consumer Choice Health Plan, a plan for universal health insurance based on managed competition in the private sector. The plan, based on the existence of integrated delivery systems such as Kaiser Permanente (KP) and Group Health Cooperative (GHC), provided the foundation for what became the Clinton administration's proposed health care reform plan in the early 1990s. Dr Enthoven continues to publish and speak widely on the subject of the managed competition model and the value of integrated delivery systems. Most recently, he co-edited (with Laura Tollen of KP's Institute for Health Policy) the book, *Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice.*[1]

The following interview was conducted by Jon Stewart, *The*

Permanente Journal's Editor for Public Policy.

***The Permanente Journal* (*TPJ*):** Dr Enthoven, you've been advocating the notion of "managed competition" built around competing organized delivery systems for many years as the best way to promote more efficient, higher quality health care. Yet today, in the wake of the rejection of managed care, the market seems to be moving in almost the opposite direction--toward loose, unmanaged networks of providers, less-than-comprehensive coverage plans, along with soaring health care costs. What went wrong?

Dr Enthoven: What went wrong was that employers panicked. In the 1990s, after the Clinton reform plan was defeated, employers tried to impose managed care, meaning HMOs, without giving employees a choice and without visibly showing them the savings to be achieved. The whole thing appeared to employees to be a loss of freedoms they previously had, and without seeing any savings personally. Research showed that the dissatisfaction with managed care was concentrated among those people who were there without a choice, which is not surprising. I think they made a terrible mistake. What employers should have done was what we do at Stanford University, where we say to employees, we're going to offer you five plan choices reflecting different delivery systems and care models, and the university will pay for the low-priced plan and give you your choice among the alternatives, but you'll have to pay the difference in price. In that case, the consumer is empowered and nobody is in managed care who doesn't choose to be, because we include non-managed care options, and people reap the personal savings from choosing the managed care plan, which is typically the low-cost plan.

TPJ: You've noted that the health care marketplace today is not very conducive to the growth of prepaid group practices (PGPs), like KP. Can you describe the kind of market that would promote PGPs and the reforms that would be needed to make that happen?

Dr Enthoven: The first thing is that the markets need to be open to consumer choice. A big problem today is that most people in this country work for an employer who offers only a single carrier.

TPJ: That was once a foundational principle in KP's genetic code, was it not?

Dr Enthoven: Right. KP advocated that consumers should have a choice because doctors didn't want patients in the plan involuntarily because it would be hard to have a good doctor-patient relationship with someone who was suspicious and resentful and didn't want to be there--the same reasons people resented being forced into managed care plans in the 1990s. I think it's very important to remind Permanente physicians of that today, because there's been a bit of backsliding on that principle, and the only way you can get into some small groups is to be a single carrier. That's why I like

models like the KP-Health Net dual-choice model in California and the BENU dual-choice model with KP and Cigna in Oregon or with Group Health and Cigna (GHC) in Washington State, in which an HMO partners with a non-HMO-type plan to offer employees a range of coverage choices under what looks to the employer like a single organization. I think it's really important for people to have a choice--to be there because they want to be there.

TPJ: Besides choice, what are the other characteristics of a market that would help promote PGPs?

Dr Enthoven: The next thing would be to let the consumers keep the savings from choosing a lower-cost plan. At Stanford University, as I said, if an employee chooses KP rather than a preferred provider organization (PPO), s/he saves thousands of dollars. Besides that, there need to be comparable benefits offered by all the competitors so that the more comprehensive plans, like PGPs, don't attract all the sickest people with chronic conditions. It won't work if you have one policy with a $2000 deductible, and the competing policy offers first-dollar coverage (no deductible). Not only will you get adverse risk selection, but you'll get opportunistic risk selection because people will take the high-deductible policy with the low premium until they expect to need medical care, and then they'll switch to the no-deductible plan.

That leads to the next thing we need for a fair market, and that's risk adjustment of premiums, based on a diagnostic assessment. That's important because PGPs are strong in disease management, and it's important that they not be penalized in the marketplace because of that strength.

And then finally, there needs to be a single regulatory environment among the competitors. The problem is that, because of ERISA, states don't regulate employer self-funded programs, and so these plans have a lot a freedom that PGPs, which are regulated by states, do not have, such as freedom from state-mandated benefits.

So I think those five things--choice, financial incentives for exercising responsible choice, comparable benefits, risk adjustment of premiums, and a level regulatory playing field--define a market in which PGPs could grow and prosper.

TPJ: You mentioned as the second characteristic an arrangement that would allow employees to reap the savings of choosing a more efficient plan. Isn't it a fact that the structure of most employer plans represents an actual disincentive to choosing an efficient, lower-cost plan? In other words, aren't many employers actually encouraging their employees to choose more expensive plans?

Dr Enthoven: That's right. People just don't understand that. But I talk with a lot of employers who pay the whole premium for whatever plan the employee chooses or pay 80% to 90% of the plan of the employee's choice, and each of those represents a very high tax on efficiency because there's little or no incentive for employees to choose an economical health plan. And the income tax laws don't help, because we can choose a more costly health

plan and pay the difference with pretax dollars, which means that everybody subsidizes the more costly plans. On the other hand, among those few organizations that allow employees to keep the savings from choosing lower-cost plans, such as the big public employee groups like CalPERS (California Public Employees Retirement System), PGPs do very well.

TPJ: Why does this practice persist? How do these big employers justify benefit policies that give incentives for choosing the least efficient plans?

Dr Enthoven: Intellectually and in private, most employers agree with me, but they resist making the change because they fear that those employees who would lose the effective subsidy they'd been getting would make more noise than those who would reap a benefit.

TPJ: PGPs and other organized systems have staked their claim to what you call a level playing field and a fair market on their ability to deliver superior value in the form of greater efficiency and quality than the disaggregated system. But what's the evidence for that claim?

Dr Enthoven: The evidence is shown in two chapters in our new book, *Toward a 21st Century Health System.*[1] As for value and cost, I don't think anyone questions that PGPs can provide high-quality, comprehensive care at a lower cost. In my preface, I talk about the RAND experiment comparing GHC with its fee-for-service (FFS) competitors, and they found that GHC provided high-quality care that achieved outcomes comparable with FFS outcomes but using 28% fewer resources. And they did that without any serious competition, which might have driven even better results. And a chapter by Steve Shortell from the University of California, Berkeley, shows that organized delivery systems have engaged and invested in more activities like prevention and disease management and information systems than the disaggregated plans. And then a chapter by Harold Luft, Adams Dudley, and Kenneth Chuang shows, through a literature review, that PGPs come out better on health outcomes but not as well on patient satisfaction, although they comment that those studies have not been adjusted for the issue of choice, in other words, whether the members were in a plan by choice or not, which affects satisfaction. But the main point they make is that most existing studies look at HMOs in general (including network models) versus FFS and don't isolate PGPs from other forms of HMOs; so, the PGPs get lumped in with forms that are based on FFS doctors who have FFS practice patterns. Other chapters show that PGPs have more effective management of the pharmacy benefit and more effective utilization of the medical workforce.

TPJ: We see the market today moving in the direction of these so-called consumer-directed health plans with high deductibles and higher copays and less comprehensive benefits. And, of course, KP is now offering these kinds of plans itself to remain competitive. But under these plans, can the core advantages of PGPs survive in an increasingly FFS environment?

Dr Enthoven: Yes, I think so, because their advantages are fundamental. They offer care that is much better organized and managed and has greater value for money. I'm sure many people in KP regret to see the arrival of the $1500 deductibles in KP, and I hope and trust that KP will do that in a way that the preventive and disease management services are not lost but are covered before the deductible kicks in. I don't think that the high-deductible approach is going to be effective in controlling costs in the long run, because so much of the costs are incurred by people who have very high costs that go way above the deductible. So, the incentive effect for consumers in having to manage that first $1500 in costs--that is, having to think twice before you go to the doctor--is all going to be lost when people find themselves in the hospital, which is where most of the costs are. On the other hand, the high-deductible plan is going to let the employer, who is facing a 15%-per-year upward trend in health costs, convert a greater share of that cost to the employee. So, employers will get some temporary relief, but they'll soon find that the rising cost trend will continue unabated, and they won't have done much good, but will have threatened the viability of preventive services. A better approach for employers would be to address the health status of their employees, working with their health plans, to keep the employees healthy by persuading them to live healthy lifestyles, to get them on the right medications if they're diabetics or asthmatics or whatever. In the long run, there's more hope for mitigating cost growth that way than by just making people pay for the first $1500 of costs out of pocket.

TPJ: It seems today that many employers are more interested in distancing themselves from health care than in engaging in their employee's wellness.

Dr Enthoven: It's very understandable for them to do that. But it's important to realize that employers are feeling pretty desperate and pretty burned, because they thought they were doing a good thing when they went to managed care, but it blew up in their faces.

TPJ: What's next in health care, beyond yesterday's managed care and the current cost-shift strategy? Do you see a chance, for instance, that consumers will get wise to what's happening and will eventually demand that the government step in and take action?

Dr Enthoven: I think that's fairly likely. One scenario is that the winning candidate in November 2008 will have campaigned on the slogan "Medicare for all, now." And the Fortune 500 companies--as well as small business--and the unions will both strongly back that approach. It would be an understandable reaction. I would just regret that Medicare is still basically an FFS program except for the relatively small share of people in Medicare Advantage. So that could be very bad news for PGPs, because the federal government has done a very poor job of letting PGPs compete in the way they can in the federal employee health benefits program, for instance. But I can already see signs in the air for that direction.

TPJ: Can you envision a model of a national health system that would work for PGPs?

ACA does this- still ties insurance to employment

Dr Enthoven: Two modest incremental proposals that I've been looking at would include government requiring employers above a certain size to offer their employees choices of delivery systems; and whatever the employee contributes would be in the form of a fixed dollar amount instead of a set percentage, so that the employee who makes the economic choice gets to keep the savings. Beyond that, we could buy access for the uninsured into the federal employee health benefits program. That would be good, if not perfect. Back in 1978, I proposed a model published in *The New England Journal*[2,3] in which everybody would be in a consumer choice model, with the government paying their way into the low-priced plan and then running it on managed competition lines with risk adjustment of premiums and standard benefits. But the challenge today is how to get there, and I think incremental steps in which the government assumes more and more retiree care costs and more of the high-priced care is the most feasible pathway.

TPJ: Can you see a realistic roadmap that would take us in that direction?

Dr Enthoven: The boundaries of the roadmap are not clear, but the principles are pretty clear: Open the markets to consumer choice; let the consumers keep the savings of choosing the economical plan; apply risk adjustment; provide comparable benefits.

TPJ: Are you at all optimistic?

Dr Enthoven: I've put a lot of energy into getting employers to change over the years, and today I'm quite pessimistic about that. I just don't see the comprehension and the willingness to change. Then, if you look to the government for change, I don't see much wise public policy out of there either. All you see is government responding to well-financed special interests. The principles of the competition model took a beating in the new Medicare legislation. The Bush Administration started out with the idea that the tradeoff for government drug coverage would be a reformed, competitive delivery system, but they backed off when they saw the possibility of enacting the prescription drug coverage as a way of enhancing the President's chances of reelection.

TPJ: Given your pessimism about change, do you still believe that the organized delivery systems, like GHC and KP and others, can have a healthy future?

Dr Enthoven: Yes, I think so. Society is not going to deal them out. But we have a big chore ahead of us in terms of public education, and that's why I felt that this book was such an important thing to do.

TPJ: Thank you.

References

1. Enthoven AC, Tollen LA, editors. Toward a 21st century health system: the contributions and promise of prepaid group practice. San Francisco (CA):

Jossey-Bass; 2004.

2. Enthoven AC. Consumer choice health plan (first of two parts). Inflation and inequity in health care today: alternatives for cost control and an analysis of proposals for national health insurance. N Engl J Med 1978 Mar 23;298(12):650-8.
3. Enthoven AC. Consumer choice health plan (second of two parts). A national-health-insurance proposal based on regulated competition in the private sector. N Engl J Med 1978 Mar 30;298(13)709-20.

To full contents list >>

Home | The Journal | Subscribe | For Authors | CME | Announcements | Links | Staff | Contact Us

The Permanente Journal
500 NE Multnomah St., Suite 100, Portland, OR 97232
503-813-4387 / fax: 503-813-2348

Copyright The Permanente Journal, Kaiser Permanente. All rights reserved