DEATH OF A PARADIGM: THE CHALLENGE OF COMPETITION

by Jeff Goldsmith

Prologue: While Washington's philosophical debate pitting the advocates of market principles against believers of government regulation simmers, Jeff Goldsmith argues that the realities of the American medical care system are quite different. Indeed, Goldsmith says the industry is already in the throes of twin revolutions in the financing and delivery of care and public policy makers have played only a minor role thus far. Goldsmith, a nationally respected analyst of the health sphere, holds a Ph.D. in sociology from the University of Chicago. He is the author of a book entitled, Can Hospitals Survive?, which was published in 1981. After completing his doctorate in 1973, Goldsmith spent two years working for Illinois' Republican governor at the time, Daniel Walker, as a budget analyst, an experience which he says proved "radicalizing." Goldsmith came away from that stint with a belief that markets were a far better way to allocate resources than were governments. While his belief in markets is fervent, Goldsmith has a respect for the professional component of medicine that distinguishes him from some of the other members of this philosophical school. "Medicine is not a business, but there is a market for its services," Goldsmith says, "and how management accommodates itself to physicians will tell a lot about the future configuration of the system." From 1975 to 1982, Goldsmith worked for the University of Chicago Medical Center, directing its health planning and regulatory affairs. Two years ago, he formed his own consulting firm, Health Futures, Inc., and also became allied with the accounting firm of Ernst & Whinney as its national technical advisor.
Whether one is attempting to cure a disease or solve a social problem, a critical first step is to build a model of the problem one is trying to solve. The model must not only describe accurately the phenomenon one is seeking to change, but must also be evocative of solutions. All models have a common defect. They are static. And as facts and circumstances change, models that were descriptive in an earlier phase in the evolution of a problem may be neither descriptive nor useful in later phases. Those who cling to an outmoded model of a problem become prisoners of their own formulations and unwittingly limit their ability to influence the conditions they wish to change.

This circumstance may well be the case in health policy today. For the last fifteen years, American health policy has been influenced by a model of how the U.S. health care system behaves. That model could be paraphrased as follows:

“Health care is different from other services and goods in the U.S. economy. Both because of health care’s intimate nature and critical importance to people’s well-being, the demand for health services does not obey any of the conventional economic forces that animate markets. Because of the impact of illness and the patient’s lack of knowledge as to its causes and the appropriate remedies, patients lack the information or the power to respond as would consumers to alternative methods of resolving their problem. The patient is therefore a pawn in a medical “game” controlled almost entirely by providers of care. The demand for care is provider-driven. Since providers of care are rewarded economically by a provider-dominated payment system for delivering more care, the demand for care is effectively limitless. As the population ages and as new medical technologies provide opportunities for physicians, hospitals, and others to enhance their prestige and augment their income, the cost of care can only escalate to the point where rationing of services will be required.”

Variations of this model have been propounded by health economists and policymakers to the point where it has almost become a litany. Many health policymakers have ceased to examine its validity since it seems to lead in a direction with which they feel philosophically comfortable—greater centralization of control over health resources in the hands of the government. The compound proposition is buttressed by some evidence, from correlational studies by health services researchers. The thesis of this article is that policymakers have become prisoners of a formulation that, because it is static, increasingly fails to describe the realities of a dynamic U.S. health care system. In fact, the U.S. health care system is in the throes of twin revolutions—in the financing and the delivery of care—in which policymakers have as yet played a relatively minor role. Examining the impact of these revolutionary changes will help in assessing the validity of the above-described health policy formulation and
perhaps help envision a new one.

Provider-Dominated Payment Systems?

In The Social Transformation of American Medicine, Paul Starr chronicled the successful accumulation of economic, social, and political power by American physicians. Starr showed how professional power was cemented through provider initiative in structuring the U.S. health care payment system along lines that protected professional discretion and the doctor-patient relationship. Specifically, payment systems insulated the doctor-patient relationship from lay interference and preserved the physician’s right to untrammelled use of his own and the hospital’s resources to resolve the patient’s medical problem. What has happened in the last two short years is that economic power so carefully accumulated and nurtured for the better part of five decades has begun to shift from those who provide care to those who pay for it. The shift in power transcends public and private sectors; indeed, it is a characteristic of both. Increasingly, those who pay for care are demanding economic accountability from those who provide it and are altering many of the historic ground rules Starr described.

Only one of these major changes within the financing system has attracted significant public notice. Policymakers had a major role in this change, namely the transformation of Medicare hospital payment from retrospective, cost-based payment to prospective, DRG-based payment. Dazzled by the technical complexity of this system, policymakers, journalists, and others have missed the fundamental import of diagnosis-related groups (DRGs). With the enactment of DRGs, Congress awakened to the fact that it was purchasing better than 40 percent of the hospital industry’s product and had attained enough economic power to dictate to hospitals the terms, product structure, and price of their product. Even though the Medicare recipient continues to believe that he or she has an entitlement to health care, the dollar value of that entitlement for hospital care was capped through DRG-based prospective payment. If providers of care are unable to deliver the services required by the patient’s diagnosis within the price the government has set, the difference between what it costs and what the government pays will be provider, not government or patient, responsibility.

Another important impact of DRGs has been to alter the economic relationship between the doctor and the hospital in the delivery of services to Medicare patients. Under the old, cost-based system, both doctor and hospital won economically when more care was delivered. Under DRGs, the doctor wins, but the hospital loses when revenues expended for caring for patients exceed a certain amount. In effect, DRGs place the hospital at economic risk for physician decision making and inject
concern about the hospital’s future financial well-being into the patient care decision. Through what is admittedly a back door route, DRGs compel physicians to take a greater measure of responsibility for the economic consequences of their treatment of the elderly than they did under the old cost-based system. Though the incentives for the physician to economize are indirect, they appear to have had a powerful impact nonetheless in the first year of DRGs. The widely reported 15 to 20 percent reduction in inpatient hospital length-of-stay for Medicare patients during the past year is not coincidental, but represents an unexpectedly early payoff for the boldest policy experiment since the program’s inception.

However, several other forces operating in the health care financing system may be of far greater long-term significance to physicians, hospitals, and patients than the movement of Medicare to prospective payment. Few people outside the insurance industry fully understand the degree to which the most recent episode of health care cost inflation has damaged our nation’s private health insurance system. Private health insurers including the nation’s Blue Cross-Blue Shield plans have incurred billions of dollars in underwriting losses in their health care lines in the last few years.

Though insurers have blamed the losses on provider shifting of costs in response to public sector program cutbacks, additional factors were at work including the failure to accurately estimate future rates of cost increase in making rate decisions and the skimming off of relatively healthy populations of insured patients by health maintenance organizations in many markets. However, a major additional factor undermining the private insurance system has been the erosion of the system’s economic base.

Few people understand that a majority of the nation’s major employers no longer use conventional health insurance to cover their health benefits risk. Following trends in property and casualty insurance generally, an increasing number of the nation’s employers have withdrawn health benefits dollars from insurance premium pools locally and nationally and have gone “self-funded.” Rather than continuing to pay health insurance premiums to insurers, employers have increasingly segregated their premium dollars in benefit trusts and put the management of benefit claims processing out to bid. The initial impetus for this strategy was growing corporate sophistication in cash management. In moving to self-funding, employers can not only decide to time their payments into the fund to meet their unique cash flow cycles but can keep the interest on that float. That interest had been an important element in offsetting health insurance underwriting losses in past years. In addition, through self-funding, employers were able to avoid paying a portion of insurance industry overhead including premium taxes levied by state governments.

As a result, many employers were able to cut overhead costs related to
health insurance by 50 percent or better through self-funding. The result was an erosion of the economic base of private insurance plans, the extent of which is graphically illustrated in Exhibit 1. It can be seen that premiums paid to commercial insurance and Blue Cross plans represent a progressively declining percentage of the health insurance dollar. By the late 1980s the total purchasing power represented in these independent benefit plans will have exceeded all commercial insurers combined and probably equaled that of all of the nation’s Blue Cross plans combined. Any major resurgence of health care inflation or prolonged high interest rates will only increase the incentives for employers to escalate their withdrawal from the private insurance system.

Why should these developments concern health care providers? Simply enough, physicians, hospitals, and other providers have generated their operating margins through the rates paid by private health insurance plans. It is becoming apparent as the one-time savings associated with the movement to self-funding have been absorbed, employers can achieve additional savings through the redesign of their health benefits and the assertion of their medical purchasing power in the health care marketplace. Employers are examining the experience of the California Medical contracting program under which hospital providers gave discounts averaging $170 below Medicare cost to continue to care for the poor. If Medical could achieve such dramatic rate reductions through competitive bidding, what can those who represent patients for whom providers have historically competed do when they unleash their purchasing power? Employers are increasingly examining whether direct
brokering of services with alternative health care providers such as health maintenance organizations, preferred provider organizations (PPOs), and other networks can assist in reducing their health costs.

Caught in the middle of this process, insurers face some very difficult strategic decisions. If insurers cannot exert economic leverage sufficient to reduce the rate of increase in health benefits cost to their customers, many of them will be forced out of the health insurance marketplace over the next few years. Health insurers face the choice of becoming increasingly entangled in economic negotiation with providers of care through provider preference or health maintenance, prepaid products or being pushed out of the insurance and into business claims processing and benefits management. In the former arena, they are competing against well-established actors such as Kaiser and aggressive, entrepreneurial new firms such as Maxicare and Health America, with a distinctly proprietary, profit-oriented approach. In the latter arena, they will find themselves facing down such corporate giants as McDonnell Douglas (through its McAuto subsidiary) and, unbelievably, General Motors (through its recently acquired EDS subsidiary). Though commercial health insurers seem to be rising to these marketplace challenges, their principle response to economic pressures has been to seek the government-created shelter of public utility style regulation of provider rates.

An even more striking response is being noted in the nation’s Blue Cross plans. Historically hospital industry cooperatives, Blue Cross plans have increasingly been compelled to reexamine their historical alignment to hospitals in their respective marketplaces. No more striking evidence of the transformation in Blue Cross plans can be witnessed than that of Blue Cross of Southern California, which was the first California health insurer to offer a limited, preferred provider program in the Southern California market. This market-driven response repudiated a nearly fifty-year history of Blue Cross commitment to the broadest possible base of provider participation in their programs in the name of economic survival. Blue Cross Prudent Buyer plans are spreading rapidly into other markets. Blue Cross’s future role in health care payment may be determined by how aggressively it can assume a credible adversary posture to their traditional sponsors. The era of provider-dominated payment systems is coming to an end. Exit providers, chased by a bear.

The Patient As Pawn?

Dramatic changes are taking place as well in the patient’s role in the health care system. Of all the imagery in the dominant health policy formulation, none is more demeaning or patronizing than that of the patient. To health economists and policymakers? the patient is helpless, passive, rendered infantilized by illness and incapable of playing an
active role in his or her own health care. One famous health services researcher once referred ironically to the patient’s role in the health care system as that of the “breathing brick.” That is, the patient’s role is limited to lying there and letting things be done to him or her which generated revenue for the providers of care. How accurate is this image?

Over the past several years, the author has interviewed hundreds of physicians in his fieldwork and consulting activities. From these interviews, a different composite impression of the patient has emerged, as seen through the eyes of the physician. According to physicians, patients are increasingly vigilant and demanding. They are increasingly suspicious of medical direction, particularly women. They are increasingly specific about their needs and how they want them met, and increasingly sophisticated regarding medical technology, and diagnostic and therapeutic options. When a woman comes to see her doctor about having a baby, she is likely to bring a typed list describing exactly how the experience is to go. If the obstetrician is not philosophically attuned to the woman’s needs or able to provide the services and facilities she desires, the woman will probably switch physicians until she has found someone who is willing to let her “have it her way.” Consumer surveys suggest that patients (particularly younger ones) are increasingly willing to switch physicians and to shop for physician care on the basis of price. What happened to the breathing brick?

In his book, Health Plan, Alain Enthoven wondered whether “flat of the curve” medicine was being practiced in the United States. Were Americans really receiving an increment of social benefit in the form of increased health status for the increasing amount of dollars committed to health care? At the level of individual patients and families, it is becoming apparent that the curve was indeed exceptionally flat. The recent findings of the Rand Corporation Health Insurance Study have established that as patients are enfranchised in the economic consequences of health care use (through increased patient cost sharing) they use dramatically less care. The fact that this reduction in care used may not necessarily result in diminished health status has greatly disturbed an entire wing of the health policy community. However much one may wish for a $70 million ten-year study of the issues before taking any action, the Rand study confirmed what many people will concede about themselves in a quiet moment of candor and self reflection, that they tend to spend their own money more carefully than someone else’s The economic corollary of that proposition is that the demand for anything of value that people view as free is likely to be unlimited. Perhaps in this important respect the demand for health care is not as different as has heretofore been believed.

As a society, Americans are making the difficult discovery that they have lavishly insured for what has been, at least in part, the consumption
of health services on a discretionary basis as well as the response to acute need. Rather than abandoning the casualty model of health insurance as some critics have proposed, employers and insurers seem to be moving towards a stricter application of that model, in effect, catastrophic coverage for the most serious medical conditions and increased patient economic exposure at the discretionary end of the need spectrum. During the past two years employers aggressively redesigned their benefits. As can be seen from Exhibit 2, the number of firms whose policies required deductibles for hospital care more than doubled in a two-year period. It can also be seen that the economic thresholds for patient cost sharing have been increasing. Further increases in deductibles and coinsurance are likely. Growing patient economic responsibility for and consequent involvement in the health decision appears likely to play a major role in the more conservative use of health resources.

Should everything in medicine have a price? Clearly for those who do not have the ability to pay, society is going to have to redouble its efforts (which have slipped noticeably in recent years) to provide them with quality health care. At the same time, many things should be provided free to the public by employers or by the government, not only in the social interest, but in enlightened self-interest as well. Immunization, health screening and education, and employee assistance are only a few such items.

### The Omnipotent Physician?

In that dominant health policy formulation cited above, the image of the physician was unique. The physician was viewed by policymakers as nearly omnipotent, economically and politically. Physicians were felt to have enough economic leverage to be able to set a target income. If
patient volume did not materialize sufficient to meet the income, physicians were thought to have the option of either increasing the amount of services provided to the patient or simply raising their fees until that target income was met. The last decade’s market experience has cast that physician’s power in a slightly different light. Specifically, it is difficult to manipulate economically patients who never show up in the physician’s office. According to the American Medical Association, over the last ten years, the typical American physician has experienced a 25-percent reduction in his or her office visit volume. This reduction has been produced by two factors. The typical American is visiting the doctor less each year than he or she was only ten years ago. Physician encounters by patients grew by only 0.3 percent per year during the last ten years, a rate that trailed population growth in the U.S. During that same period of time, the supply of physicians increased by close to 40 percent. Though nominal physician income rose during this period, on an inflation-adjusted basis, physician income fell. During the 1980s when physician supply is expected to increase by better than 40 percent, physician incomes are likely to fall in nominal as well as inflation-adjusted terms. Physician economic power is being eroded as well by the growth of alternative delivery systems based on capitation, rather than fee-for-service payment.

The confounding of three generations of rising expectations for professional achievement and income has produced physician reactions bordering on panic in many physician communities. Popular publications for physicians are warning of the impending demise of private medical practice. Established professional publications such as The New England Journal of Medicine are warning physicians of the impending absorption of their practices into large health care corporations.

In this increasingly unfriendly environment, Physicians are at risk for the economic consequences of their professional conduct. Physicians are increasingly concerned about taking actions that will result in the loss of patients. Employers are becoming much less reluctant to assert their economic interests in physician decision making. Exhibit 3 shows the dramatic increase in utilization review activities mandated by health coverage, pre-, during, and post-hospitalization.

In this new environment the ability of the physician to abuse the patient and the society economically is being hedged by the increased unwillingness of society to tolerate irresponsible professional conduct. DRG-based prospective payment under Medicare took society a giant step in the direction of encouraging more responsible physician conduct by placing the hospital at economic risk for physician behavior. DRGs have stimulated a constructive dialogue between administrators and physicians about how to use the hospital more conservatively without sacrificing quality. This dialogue has begun the process of isolating the abusers
within medical staffs.

Extensive fieldwork in the last several years has convinced the author that norms of responsible professional conduct do exist in most medical communities. The surgeon from whom no gallbladder is safe, the internist who routinely prescribes massive batteries of office-based tests for his patients, are no heroes among their professional colleagues. The task of policymakers and others interested in health care cost containment is to activate the norms of responsible professional conduct among physician communities. Those norms will begin to bite and affect physician behavior when the physicians who abuse patients damage the standing of their colleagues or the institutions that they care about.

Coincident with the increased market risk associated with economically irresponsible physician conduct, there has been a rapid growth in provider risk sharing: the willingness on the part of physicians, hospitals, networks of physicians, alliances between physicians and hospitals, and other types of organizations to assume a portion of economic responsibility for the cost of health care through capitation or negotiated rates.

The 1980s are likely to be a period of declining economic influence of physicians. Those physicians able to harness medical technologies and modes of practice that save money and are willing to assume the economic risk associated with health care cost are likely to distance themselves economically and professionally from those colleagues who believe that they are able to conduct their professional affairs independent of the economic well-being of their communities.

The Hospital Use Juggernaut?

The mainstream health policy paradigm attributed to hospitals as well as physicians the power to induce demand. If a hospital was constructed or
DEATH OF A PARADIGM

expanded, inexorably the demand for hospital services in a community would grow. The so-called Roemer effect, based on a correlation between bed supply and inpatient hospital use, became enshrined among health policymakers as a verity. Qualifiers disappeared. Correlation became causation. A whole regulatory mechanism, certificate of need, arose, based upon the proposition that containing hospital capital spending and bed expansion was a key to containing hospital costs. After nearly two decades of experimentation, it has become apparent that constraining hospital capital spending merely encouraged hospitals to increase their intensity of services and to spend capital on those items that were not regulated. Even in the most stringent regulatory environments, no conclusive relationship between capital spending restraint and cost containment has been demonstrated. Intellectually and politically bankrupt, the mechanism seems yet to sail along like the Marie Celeste, powered only by periodic gusts of protectionism from segments of the hospital industry itself.

If supply created demand for hospital services under cost-based reimbursement, it is puzzling why per capita hospital use in the U.S. peaked in 1975, during the heyday of cost reimbursement and continued growth in supply of both doctors and hospital beds. Exhibit 4 shows per capita inpatient hospital use for various age-groups and the population as a whole.

The decline in utilization rates during the late 1970s was largely invisible to Washington because it took place among the non-Medicare/non-Medicaid population. Young people aged 15-44 used 25 percent less hospital days per capita hospital in 1982 than in 1965, a decline which apparently accelerated from 1982 to 1984 with a drop in hospital admissions among this group. In attempting to unravel the reasons for this mysterious decline, the author has conducted fieldwork in a number of hospital districts.

### Exhibit 4
Days Of Care Per 1000 Population By Selected Age Groups (1965-1989)
Short-Stay Nonfederal Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>All ages</th>
<th>Under 15</th>
<th>15-44</th>
<th>45-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965</td>
<td>1203.4</td>
<td>406.6</td>
<td>1040.2</td>
<td>1710.9</td>
<td>3443.5</td>
</tr>
<tr>
<td>1970</td>
<td>1172.7</td>
<td>332.9</td>
<td>903.9</td>
<td>1550.0</td>
<td>4015.4</td>
</tr>
<tr>
<td>1975</td>
<td>1254.9</td>
<td>328.0</td>
<td>885.1</td>
<td>1748.9</td>
<td>4165.9</td>
</tr>
<tr>
<td>1982</td>
<td>1186.0</td>
<td>326.4</td>
<td>742.0</td>
<td>1536.7</td>
<td>4026.2</td>
</tr>
<tr>
<td>1984</td>
<td>1073.0</td>
<td>310.0</td>
<td>660.0</td>
<td>1380.0</td>
<td>3650.0</td>
</tr>
<tr>
<td>1989</td>
<td>908.9</td>
<td>290.0</td>
<td>520.0</td>
<td>1120.0</td>
<td>3125.0</td>
</tr>
</tbody>
</table>

Note: 1984-1989 projections, Health Futures, Inc.
highly competitive markets in which hospital use rates have dropped far more rapidly than for the nation as a whole. These markets exhibited a common feature. In all of them demand for alternatives to the hospital—health maintenance organizations, out-of-hospital ambulatory services such as ambulatory surgery and urgent care, and after-care services to the elderly—all experienced rapid growth (though in differing proportions in each market place. See Exhibit 5).

For example, in Phoenix, a community which experienced a doubling of its elderly population during the 1970s, inpatient hospital use rates fell by nearly 300 days of care per thousand between 1972 and 1981. During this same period health maintenance organization enrollment went from
0 percent to almost 9 percent of the Phoenix population. Ambulatory surgery went from less than 10 percent of all surgery performed to between 35 percent and 40 percent. Nursing home census figures doubled just during the last five years of the period studied and noninstitutional services such as home health care grew explosively.

The ability to perform complex therapies such as continuous action peritoneal dialysis (CAPD), enteral and parenteral nutrition, and chemotherapy in the home setting has enabled physicians to send patients with serious medical problems home that would have generated multiple-week hospital stays only a few years ago. Some specialists that follow technology trends in “least invasive surgery” believe that by 1990 as much as 55 to 60 percent of all surgery will be conducted on an ambulatory basis at reduced patient risk and at substantially reduced cost relative to the inpatient alternative. In addition; in response to the pressure of large numbers of competing physicians, many physicians began doing an increasing amount of diagnostic work in their offices, absorbing such complex technologies as ultra-sound, nuclear medicine, and CAT scanning into the office setting.

Growth of alternatives to hospital services has provided a variety of cost-effective pathways for patients besides hospitalization. In the process, the hospital’s patient care franchise has eroded dramatically. Milton Friedman referred to hospitals as the department stores of medicine. In the last few years, that department store has lost its monopoly on the forms of care-surgery, complex diagnostic services, emergency care, and routine obstetrics- that built it in the first place.

Use rates appear to have fallen more dramatically in communities where regulation was relatively limited and competitive forces have been permitted to operate. It is not unrealistic to expect that the relatively modest national use rate reductions will accelerate to the point where age-adjusted national hospital use rates will converge on those currently experienced in the western U.S. (Exhibit 6)

Policymakers are also beginning to realize that there is nothing inevitable about the extraordinary regional variation in hospital use rates. A consensus seems to be emerging that the substantial regional variation in hospital rates do not have an underlying epidemiological reality. Indeed, this journal devoted an entire issue (Summer 1984) to the larger vexing question of how to solve the problem of unexplained regional variation in physician practice styles.

As economic pressures from DRGs, PROS, and progressive employer cost controls increase, the potential exists for substantial (that is, 30-40 percent) reductions of use rates in parts of the country that have persisted in hospital use patterns substantially above the national average. Alternative cost-effective methods of spending the society’s health care dollars do exist. The fact that many of these alternatives may not only save money
but expose the patient to less health risk suggests that quality may actually increase as cost-effective medicine is pursued. The idea that the only way to contain costs is to sacrifice quality simply is not supported by an enlightened view of medical technology and changing medical practice.

### The Policy Challenge

Far from suggesting that our nation’s health care system is in a state of crisis, an examination of today’s health care marketplace reveals a vital, active enterprise in the midst of revolutionary change. Powerful economic forces are reshaping the U.S. health care system in a way that will cause it to diverge increasingly from the centrally managed, national health care systems in other countries. A major reallocation of the economic risk associated with health care cost is underway within the U.S. health care system. This reallocation spans public and private sector distinctions, and is, for the first time, significantly implicating patients and providers alike in society’s health cost problem. Regulatory mechanisms have failed to contain health care costs in the U.S. precisely because they failed to penetrate and reshape physician-patient decision making. These mechanisms relied on indirect, external means of forcing institutions to behave in certain ways. Marketplace pressures, however, are bringing both the physician and patient to the point where they too have a stake in more conservative use of health care resources. The very real risks of marketplace failure are confronting hospital boards and managers, and encouraging more conservative planning.

The U.S. health care system in the mid-1980s is experiencing an unprecedented level of experimentation with new forms of health care delivery, new least-invasive medical technologies, and new organizational}

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### Exhibit 6
Regional Variation In Aggregate Health Care Indicators. 1982

<table>
<thead>
<tr>
<th>Region</th>
<th>Age-sex adjusted admission rate per 1,000 people</th>
<th>Age-sex adjusted ALOS</th>
<th>Age-sex adjusted days per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>144.26</td>
<td>7.2831</td>
<td>1047.77</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>163.24</td>
<td>8.4521</td>
<td>1379.72</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>169.88</td>
<td>6.9259</td>
<td>1176.57</td>
</tr>
<tr>
<td>East North Central</td>
<td>179.63</td>
<td>7.4843</td>
<td>1344.55</td>
</tr>
<tr>
<td>East South Central</td>
<td>211.83</td>
<td>8.6807</td>
<td>1415.34</td>
</tr>
<tr>
<td>West North Central</td>
<td>192.13</td>
<td>6.7484</td>
<td>1296.57</td>
</tr>
<tr>
<td>West South Central</td>
<td>197.31</td>
<td>6.0893</td>
<td>1201.48</td>
</tr>
<tr>
<td>Mountain</td>
<td>183.20</td>
<td>5.8260</td>
<td>950.80</td>
</tr>
<tr>
<td>Pacific</td>
<td>148.03</td>
<td>5.8763</td>
<td>869.86</td>
</tr>
<tr>
<td>U.S.</td>
<td>172.86</td>
<td>6.9784</td>
<td>1206.28a</td>
</tr>
</tbody>
</table>


*a* includes newborn days
forms and relationships. Despite the anxiety of those who benefited from the past reimbursement system, many of whom continue to deny the reality of and need for change, physicians, hospital management, and boards of trustees in many parts of the country are searching for an economically defensible framework to continue to serve their communities.

To suggest that the U.S. health care system is so rigid, and the demand for care so monolithic that only rationing health care can save our society from an erosion in quality and access to care is to adopt an emotional rather than rational view of this system. Mechanisms and technologies abound for making more effective use of the health care resources currently available. The structure of the health care system is malleable, even if difficult to move by direct government intervention. Those who deliver health care are increasingly motivated to participate in the search for solutions to the health care cost problem American society faces. As market forces emerge as a powerful feature of the U.S. health care system, the real task of the policymaker is not to supplant, but to leverage those marketplace forces.

Rather than continuing to rely upon regulatory strategies which have proven either inefficacious or only marginally effective in containing costs or to wait for a nonexistent pendulum to swing back to an era of greater governmental oversight and control of health care, government policymakers should turn their attention to the two unavoidable policy challenges which the marketplace cannot effectively address. They are (1) assuring that the government functions as an economically rational, humane yet prudent buyer of health services for the population it represents, and (2) devising a humane, responsible system for financing care to the nearly 30 million uninsured people remaining in this county. National health insurance or all-payer rate control may not be the most cost-effective solution to either problem. Thanks in part to prescient policy research work at the Health Care Financing Administration and to aggressive experimentation and program redesign at the state level, there is a wealth of new information and experience with contracting and control of costs which can be applied in both tasks.

It is the author’s belief that the tools and the framework for controlling health care expenditures while improving both quality and access to care already exist. The challenge to policymakers is to see this emerging health care marketplace through a new set of lenses and to make creative use of the considerable leverage they do exercise to meet the substantial needs which remain.