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Among industrialized nations the United States is relatively unique in relying on a mix of public and private financing and delivery of healthcare: federal and federal-state programs, such as Medicare and Medicaid; employment-based health insurance (primarily HMOs); and state-subsidized insurance pools for high-risk individuals. In recent years, however, there have been efforts to apply the principles of private employment-based health insurance to the other forms of healthcare, and there is speculation that rising healthcare costs can only be addressed by further extending capitated payment plans. This suggests that U.S. healthcare may increasingly be organized according to market principles. For some, this represents a historic departure from an emphasis on public responsibility for healthcare and a sacrifice of the value principles embodied in health relationships between patient and provider. But defenders of HMOs and a larger role for markets argue that managed care allows for a more rational allocation of scarce healthcare resources by minimizing inefficient low-benefit–high-cost care. More individuals receive essential care if inessential care is eliminated. HMOs are also said to encourage non-HMOs to provide lower priced healthcare.

Interestingly, recent evidence suggests that HMO market share will not continue to expand through price and cost competition but only if HMOs address quality of care—in market terms, a process understood by economists as product differentiation. But there is a complication. Unlike other types of consumption, healthcare is consumed in "bundles" whose composition depends on a shared decision-making process between patients and healthcare providers. This decisionmaking exhibits nonmarket values that may constitute a barrier to the extension of market principles through product differentiation. Here, I look at these economic and social value issues to consider how healthcare delivery may evolve in the United States in the future.

HMO Expansion: Experience and Prospects

HMOs have increased market share by cost-containment strategies involving physician oversight and incentive adjustment, fewer and shorter hospitalization stays, and fewer and less diagnostic testing.[1] Their success at cost containment is due in large part to selection bias in enrolling healthier-than-average patients previously enrolled in traditional plans. To compete, non-HMOs have also had to charge lower premiums, despite being left with less healthier-than-average, more costly patients. Together this should imply lower average premiums across HMO and non-HMOs. There is evidence, however, that where HMOs have achieved large market

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share average premiums are higher.[2] Why?

Baker and Corts ask whether non-HMO premiums fall when HMO market share is low due to competitive pressures, and then rise when HMO market share rises due to changing patient pools.[3] They find that non-HMO premiums fall until HMO market share is about 15 percent, and rise thereafter. But as HMO shares rise, HMOs also cease lowering premiums because there are fewer healthy patients to draw from non-HMO plans. This reinforces the rise in average premiums. Thus average premiums are higher, and HMOs have also lost their primary means of expanding market share. Further HMO expansion, then, either requires new markets with little HMO development or that HMOs adopt new strategies of expansion.

Other factors support the conclusion that HMOs are done lowering premiums. With less price competition from traditional insurers, HMOs may choose to "shadow price" traditional insurers by charging premiums just below the latter's, irrespective of HMO costs.[4] If market entry and the acquisition of market share involves significant overhead costs, HMOs may attempt to recover initial investment costs when the pressure to maintain low premiums abates. Further, if markets are dominated by a small number of HMOs, premiums may simply rise with oligopoly pricing.

This overall picture is consistent with the emergence of a "mature" market in which a set of technical and organizational advantages is realized by innovative firms that displace less innovative firms. Having realized the advantages of organizational restructuring and patient sorting, HMOs now seem to need new ways to expand. Historically, firms in other "mature" industries have tried to differentiate their products to increase sales and gain additional market share. Evidence that HMOs have begun to adopt this strategy exists in the advertising in which HMOs now regularly engage.

Values in Healthcare versus Values in the Market

Healthcare may be represented as a bundle of different goods and services consumed to produce health, where individuals demand healthcare goods and services as inputs to a production process whose output is their own health.[5] This relationship is complicated by three factors: (1) health possesses many dimensions—physical, psychological, and social—whose relationships are often not well understood; (2) information about the ways in which health can be produced is extensive and complex, making consumers dependent on healthcare providers; and (3) individuals often wish to delegate much of their responsibility for decisionmaking to family members and healthcare providers, because their health states can change over the period of their interaction with healthcare providers.

One way of thinking about this is to focus on how patients and providers treat healthcare decisionmaking as a shared decisionmaking process.[6] Because individuals are often unclear about what health states they wish to produce, unclear about how to best make use of healthcare, and unwilling to be fully responsible for needed decisionmaking, they invite healthcare providers' participation in a shared decisionmaking process. From this perspective, point (1) suggests that individuals rely on healthcare providers to help them evaluate possible health state outcomes, given that they typically have less understanding than providers do of the likely nature of different health state outcomes. Point (2) suggests that, because medical science only predicts probable outcomes,

providers must be able to explain possibilities and tradeoffs between health states associated with different medical interventions, thus "framing" individuals' evaluation of health state outcomes. Finally, because, according to point (3), individuals may not always make clear choices regarding healthcare, determination of health outcomes again devolves partly on providers who attempt to make healthcare decisions that they believe to be in the best interest of the individual.

Emphasizing the shared character of healthcare decisionmaking draws our attention to an interaction between individuals that differs from the kind of interaction that occurs between individuals engaged in market exchange. Suppose we think of values in the most general sense as appraisals of worth. In the case of market interaction, individuals' appraisals of worth are usually taken to be their preferences. According to the usual view of market exchange, values thus understood are "external" to individuals' interaction in market exchange. Market participants need only know what goods are offered or demanded and at what prices to transact with one another. Market exchange of goods and services makes communication regarding values unnecessary, thus isolating individuals from one another in value terms. Nor, according to standard economic theory, are individuals' values altered or influenced by their market interaction with one another. In contrast, with healthcare decisionmaking understood as a shared process, individuals and providers jointly appraise the worth of possible health outcomes. Their values cannot remain "external" to their interaction, because each must reflect on what the other values to establish which health outcomes will be pursued.

The bundling of healthcare inputs under shared decisionmaking, then, involves a role for values different from the role they take on in the market process. Indeed, there is a special field of investigation specifically devoted to this distinct realm of values and the decisionmaking concerned. Bioethics, or the ethics of healthcare, investigates healthcare values and how to resolve value conflicts encountered in making choices about how to bundle healthcare goods and services. As an area of applied ethics, bioethics studies the integration of the ethics of medicine and broad moral theories of well-being and individual rights. More concretely, bioethics studies how individuals and providers reach agreement regarding desirable health outcomes. The moral theory context in which this process is explained reflects the fact that shared decisionmaking over healthcare inescapably brings up such matters as the nature of the good life, the meaning of well-being, patient and provider rights, personal dignity, and so on. In economics, in contrast, because the logic of the marketplace explains individuals' interaction, moral theory is left out the picture entirely, and the only way values can be discussed is as individuals' private preferences.

HMO Expansion and Conflict Between Market and Nonmarket Values

Product differentiation occurs when firms distinguish their own goods from those of other firms to attract consumers. Some differences are cosmetic, whereas others alter the nature of the good or add new features. The importance of this to HMOs seeking market-share expansion lies in the relative ease of each type of differentiation. Cosmetic changes, such as in marketing, business support staff tasks, and other matters incidental to the actual delivery of healthcare, can usually be

made unilaterally by HMOs. However, changes in the nature of healthcare affecting the relationship between individuals and providers cannot be made without their participation. It is this latter sort of change, however, that is ultimately most important if HMOs are to differentiate themselves in terms of quality of care.

Factor into this that past changes in HMO healthcare plans associated with cost-containment strategies (reduced hospital stays, less diagnostic workup, etc.) have been regarded by some as a stripping-down process. Although surveys show that consumers have been largely satisfied with HMOs, they also show concerns regarding quality of care. The task for HMOs, then, is to defend cost-containment strategies and also deliver what is perceived as quality care, where quality is determined by individual-provider shared decisionmaking. Consider the controversy over mothers' length of hospital stay after giving birth. Individuals and providers have been outspoken in criticizing HMOs' short hospital stay policies as harmful to the health of mothers and infants. HMOs have thus had to scale back cost guidelines or offer outpatient care seen to be of comparable quality. Because both options add to costs, neither has been adopted without pressure. In this instance, then, quality-enhancing product differentiation has not only required backtracking on cost-containment strategies but also a shift in control away from HMO managers.

Will HMOs, then, continue to expand by emphasizing quality of care? My view is that they may but that this may require introducing a significant role for nonmarket values. On the one hand, product differentiation could raise HMO sales and revenue by as much or more as it increases costs; thus profits—the HMO measure of health—need not fall and might even rise. In effect, the increased extent of the market could compensate for the higher per-person cost of care. But on the other hand, because this development would seem to involve an expanded role for individual-provider decisionmaking, it would enlarge the place of nonmarket values in HMO healthcare delivery. Ironically, then, whereas other expansions of the market into social domains previously not organized along market lines have been labeled "imperialistic" on account of the incursion of market values into nonmarket value domains, in this instance the reverse seems quite possible. The further expansion of HMOs may rather require significant compromise in market principles. Should this indeed be the case, the reason that nonmarket values might have this role would seem to come down to the atypical nature of healthcare as a commodity: its delivery and provision depends on a shared decisionmaking process between individual and provider—a relationship that makes value "internal" to exchange rather than "external" as in most other kinds of markets.

Notes

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