Consumer-Driven Health Care
To George Herzlinger, my husband—
     My life partner and best friend
     and
Ella and Alexander Elbinger, my parents—
Whose iconoclasm and optimism, in the face of
overwhelming opposition, inspired me
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Consumer-driven health care is fundamentally about empowering health care consumers—all of us—with control, choice, and information. Consumer control will reward innovative insurers and providers for creating the higher-quality, lower-cost services we want and deserve. In this consumer-driven system, government will protect us with financial assistance and oversight, not micromanagement.

In these ways consumer-driven health care is a revolution—a radical turn away from the technocratic, top-down policies that just say no to providers and consumers both in the United States and abroad.

This book explains how consumer-driven health care works.

The eight chapters in Part One of this book, which I wrote, explain the theory and workings of consumer-driven health care. Parts Two through Five amplify these themes in chapters written by some of the leaders who will make this vast transformation work. Throughout this book the chapters describe the shortcomings of our present third-party health insurance system, delineate the desired characteristics of a consumer-driven health care insurance system, and assess the impact of the consumer-driven system in some early adopter organizations. They also explain how consumer-driven health insurance will increase the productivity of the health care system, and describe the innovations created by the insurance, provider, technology, and government entrepreneurs who have already begun to craft the essential ingredients of this insurance.
In the last chapters of Part One, I rebut those critics of consumer-driven health care who aver that it will fail to control costs, injure the sick, increase disparities in access, confuse the consumer, and focus on the role of government in overseeing and enabling a consumer-driven health care system.

To your health!

February 2004

Regina E. Herzlinger
Boston, Massachusetts
This book is about consumer-driven health care—the why and the how of enabling people to obtain the health care they want at a price they are willing to pay. The American public supports the idea of consumer-driven health care. When people ask me the title of my latest book, the almost invariable reaction to its name, Consumer-Driven Health Care, is, “Well, it’s about time!” whether the person is the barista at the local Starbucks, a business executive, a cabdriver, or a doctor.

Like them, I favor the notion of consumer-driven health care.

ABOUT CONSUMER CONTROL

Indeed, I like the idea for all spheres of human endeavor. You see, I owe my academic career to consumer control.

Back in 1972, when I joined the Harvard Business School faculty, student evaluations of courses and instructors were coming into their own, one aspect of the revolution in higher education fashioned by the self-absorbed, self-actualizing baby boomers. Student evaluations are one form of consumer control, through which the customer holds providers accountable for the quality of their services. I viewed them as my savior.

Before the 1970s, prior to the counterculture revolution that asserted the students’ pivotal role, higher education was controlled primarily by the faculty and
staff. The students’ role was to listen adoringly to the wisdom of their elders. An archival photograph, circa 1950, of a Radcliffe program for women interested in business administration exemplifies this role. It shows a lecturer, nattily attired in a bow tie and horn-rim glasses, standing on a pedestal surrounded by a sea of upturned, smiling, beatific women’s faces.

In those days students had no evaluative voice. Peer review was the norm. I recall the baffling, lobotomizing lectures I endured at MIT and Harvard, my alma maters, that were mysteriously hailed as pedagogical miracles by the instructors’ peer group. Irrelevant, pedantic harangues on Bayesian statistics, feathers falling in elevators, and the miracles that accompanied government “investments” were lauded as the equals of Warren Buffet’s thoughts on finance or Crick and Watson’s views on the future of genetics. Of course the instructors’ peers loved the stuff—many of their lectures were dull and abstract too.

Yes, student evaluations existed even back then, but they were ignored. A standing joke at MIT was that the winner of the Best Teacher prize would never receive tenure. Like most comedy the joke was a callus that protected against the painful kernel of truth within. Students were bright, empty vessels to be filled by the teacher’s erudition. Faculty who valued students’ feedback were seriously flawed—clowns who catered to the masses. (Even today, student evaluations continue to be scorned. In 2002, the dean of faculty of Williams College said of a student-run faculty-rating Web site, “It is incredibly humiliating,” denouncing it as part of the “troubling trends of consumerism” in higher education.1)

I had no chance of success in a peer-reviewed academic institution. I was so different from my peers.

I believed in Jefferson: I sought feedback from all sources.

They believed in Hamilton: they sought feedback only from the elite.

And to top it all off, I was a woman in male-dominated academia. A professor who had consulted for me in the job I held prior to joining the Harvard Business School faculty spoke for others when he asked of my appointment, “Surely, they are not asking a woman to teach business?”

But the advent of serious student evaluations, driven by the relentlessly self-seeking 1970s’ counterculture, changed my view of my career prospects. A consumer-centered system of accountability would give an out-of-the-mold person like me the chance to succeed—or to fail. A peer-led educational system would have consigned me to the trash heap.

Mind you, I did not know whether I would succeed as a teacher. Indeed, the thought of leading the one hundred–person, primarily male, Harvard Business School MBA sections, composed of people roughly my own age, filled me with dread. The school’s famous case method is a very challenging teaching technique. A case is like real life. It is an open script. The learning process comes from the students’ participation in analyzing and solving the issue it poses. Orchestrating the discussion is like herding cats. A case cannot be taught by
dusting off last year’s lecture notes. The case method demands deep preparation, immense concentration, quick response, and broad competence from all its participants. I worried that I was not up to the job.

But I loved my subjects, loved research, loved people, loved to write, loved to talk, loved to listen. Rightly or wrongly, an academic career seemed appropriate for me.

Then, too, I had benefited from accountability before. The New York State Regents examinations, administered to all the high school students in the state, and the national SAT exams, had convinced MIT that I was the equal of their other admits, although they had never before had an applicant from the small, women’s parochial high school in which I was enrolled.

Gambling on my future, with a consumer-led accountability system as my sole support, I left a position in which I had the title of vice president, a large staff, and an even larger salary, and took a two-thirds cut in pay to become an assistant professor at the Harvard Business School, with a staff of one-third of one secretary.

My first student evaluations, from the participants in an executive health care program, were disastrous. But I learned from the feedback. To my own surprise, and that of my peers who believed that women could not teach business, the students’ ratings of my teaching typically topped the charts in my area. In 1980, I became the first woman to earn tenure at the Harvard Business School (HBS).

Nearly thirty years after teaching my first class, I continue to learn from my students’ feedback. Although I was elected one of HBS’s two best instructors in an inaugural vote by first-year MBAs, I found some of my other students less enthusiastic about my efforts. My peers benefited from student feedback as well, even in an institution as dedicated to teaching as the Harvard Business School. Published evaluations of business schools in U.S. News & World Report helped all of us too.

Accountability has had similar effects on public schools in states that publish school performance ratings. Alabama’s 750,000 public school students, for example, performed better on the Stanford Achievement Test in 1997 than in 1990, with fourth and eighth graders scoring higher than the national average in many subjects. The reason? “The only variable that changed statewide . . . was the implementation of a (public) ranking system,” noted one official.2

When the consumer’s voice was finally heard, it improved education.

Consumer control has improved other sectors as well. For example, a newly found focus on consumers’ notions of quality has enabled U.S. manufacturers to succeed in the international businesses where they had once failed. Pressured by competition and the loss of the vast camera, watch, and color TV markets to high-quality, foreign competitors, manufacturers tossed out their old notion of quality—conformance to internal requirements—and supplanted it with quality measures that internalized their customers’ preferences.3
Better quality reduced failures.
Reduced failures lowered costs.
But only when quality was defined from the consumers’ perspective.

THE NEED FOR CONSUMER-DRIVEN HEALTH CARE

All of this is to clarify why I compiled this massive tome, *Consumer-Driven Health Care*. When consumers drive health care, it too will become better and cheaper.

Presently, health care systems are controlled by third parties who are neither consumers nor providers. In the United States, it is the employers and their human resource agents who select, price, and purchase health insurance policies and their insurance intermediaries. Many employees have a “choice” of only one policy. Even those who have a choice of more than one find all the policies depressingly similar, with features that are largely standardized. And most of the public sector payers, both here and abroad, offer no choice at all. They are monopolies.

The absence of health care information that can help consumers choose also hobbles their role. The little information that exists comes primarily from health policy experts residing in academia and think tanks; captive, industry-dominated accreditors; foundations; and lobbying groups, who advise the third-party payers and insurers. This information only rarely responds to consumer needs. To see their mind-set more clearly, review this bit of prose from a member of a self-styled health care “policy elite”: “There is one foe confronting a policy elite that seeks universal entitlement—Americans. . . . National health insurance can be attained in America [only] if the policy elite imposes a solution that (the) . . . electorate has not attained.” As for those who advocate consumer-driven health care, they are “an ideological fox in sheep’s clothing.”4 (Apparently the policy elite’s mastery does not extend to simple English.)

Thus, when I purchase a pair of eyeglasses in a consumer-controlled market, I can readily find many evaluations of the quality of different stores and price comparisons to inform my selection. But when I chose a physician to oversee the birth of my children, I had no information at all about the quality of his care or his price. Because the information that exists is only the little that is voluntarily disclosed, bad news can be hidden. For example, in 2002, low-quality health insurers were found to be much more likely to suppress quality disclosures about their performance than were higher-quality ones.5

The health care system is much like the old higher-education system—controlled by insiders, closed to consumers.

Do not get me wrong. Most of these people—bureaucrats, insurers, and technocrats—are like most of us: they do the best they can. They want to do good.
They do not want to do bad. But their perspective is upside-down. Rather than supporting consumer choice and control, they choose to supplant it. Their view is top-down, not bottom-up.

Thus it should come as no surprise that many of them oppose consumer-driven health care. In the fall of 2002, Blue Shield of California launched a first strike when it threatened the brokers who sell such products with termination: “There are some companies that are using high-deductible plans in the 2–50 (employee) market. . . . The employer, [sic] through the help of the company, purchases a high-deductible plan and then uses the savings to self-fund the actual benefits they want. Blue Shield of California does not endorse or encourage any type of these programs. . . . Any deviation from the broker responsibilities outlined . . . may result in termination of the Producer Agreement with Blue Shield.”

But in the absence of consumer-input, costs can run rampant, while consumers cannot obtain the health care they want. No wonder the productivity of health services has declined over the past two decades.

Health care will not improve until consumers drive it.

This book, Consumer-Driven Health Care, describes how to make that happen. The new consumer-driven health insurance system will enable consumers to choose from a large array of differentiated health insurance options with the support of employers or other groups who will help to provide the pretax money to buy them. New intermediaries will supply enrollees with information and assistance so they can select intelligently among these options. Consumer-driven innovators will create newly productive, high-quality health care services and technology that respond to consumers’ needs. And a newly consumer-driven government will oversee the suppliers and protect the consumers.

THE HISTORY OF CONSUMER-DRIVEN HEALTH CARE

I believe so strongly in consumer-driven health care, that I have been writing various versions of this book for more than twenty years. My first public advocacy for consumer-driven health care came in a 1979 Harvard Business Review article, “Can We Control Health Care Costs?” I echoed the theme in a 1983 Wall Street Journal editorial, which was followed by a series of mid-1980s’ Harvard Business Review articles. Although my work won research awards, it had the practical impact of a feather. To the contrary, by the late 1980s, the managed care plans then coming into vogue had turned away from consumer-driven health care. To me, they were a wrong turn—right into an abyss. Although they were marketed as “market-driven,” in truth most of them were controlled by third-party technocrats rather than innovative providers intent on re-creating health care in a way responsive to consumers’ needs for efficient, personalized services.
Virtually the sole exception was Kaiser Permanente, a well-established, California-based managed care organization with a deep-rooted, provider-driven culture. But most of the managed care plans were no Kaisers. They lacked its organizational structure, leadership, and culture. Then too, the Kaiser model was hardly a universal favorite. Busy, assertive Americans have so disliked its stringent requirements that limit care to Kaiser-affiliated physicians and hospitals that the market share of this type of HMO plummeted from 40 percent of enrollees in 1993 to 18 percent in 1998, and some, including its own nurses and government officials, grew concerned about the quality of its care. The model was also ferociously expensive to set up, requiring massive up-front outlays for financing the physician groups and hospitals exclusively devoted to the insurance plan.

In lieu of following Kaiser’s costly model, most managed care plans cobbled together a network of independent providers who reluctantly accepted low payments and “gatekeeper” oversight in exchange for the custom of the patients enrolled with the plan. As a gatekeeper, a provider had to obtain approval for many patient referrals from an insurance executive.

Managed care as market driven?
What an odd idea.

Market-driven solutions rely on interaction between supply and demand, customers and providers. But with managed care, a third party, a technocrat, controlled all the action. To most Americans, this version of managed care had the cold, hard heart of an underripe cheese.

A technocrat’s notion of managing care is to reduce payments to hospitals and doctors and to wean consumers away from wasteful, expensive specialists. Most managed care organizations did not seek to re-create the way health care is delivered through competition among different services for the consumers’ custom. Noted an expert 2002 analysis, “Most (but not all) HMOs have not accomplished what their proponents had promised: changing clinical practice processes and improving quality of care relative to the existing system.”

To the contrary, the founders of the managed care movement wanted to standardize insurance products. Their version of managed care inhibited innovation. Instead of fostering change, it controlled costs with “just-say-no” policies—no to enrollee requests for referrals to specialists and hospitals and no to providers’ price schedules. In 1999, for example, 72 percent of physicians with managed care contracts were financially rewarded for productivity by the insurers and only 24 percent were rewarded for patient satisfaction. Of course, many of the no’s were justified, to redirect inappropriate, extravagantly priced care, but they were not consumer driven. (Chapter Two analyzes managed care’s impact on costs.)

It did not take long for this version of managed care to unravel.
Following the principles of Economics 101, fragmented providers who felt bullied by large buyers combined into groups whose united front could effectively counter managed care’s demands for discounts. In Boston, for example, the 1993 “partnership” of the world-famous Massachusetts General Hospital with the Brigham and Women’s Hospital created a Goliath that employed more than 4,000 of the area’s doctors and 2,500 of its registered nurses. When a health care plan demanded discounts from this renowned institution, guess who blinked first? Meanwhile, consumers, frustrated with gatekeeper hurdles, placed massive pressure on their employers to loosen access to the health care providers they wanted.

Today, these managed care policies are so widely deplored that they have become the stuff of political humor. For example, one Web site posted a satirical article that began:

**New HMO Strategy: Pay Health Claims**

*Analysts Skeptical; Doubt Insurers Equipped to Handle Job*

Minneapolis, Minn. (SatireWire.com)—Moving into what insurance executives concede is “uncharted territory,” five of the nation’s leading HMOs announced yesterday they will begin paying health insurance claims for sick and injured people.

Plans that provide easier access to specialists and hospitals now dominate. Yet even when their just-say-no strategy was coming apart at the seams, some managed care executives retained much of the expensive gatekeeper infrastructure—and their organizations’ administrative costs significantly exceeded those of loosely managed plans. This time around, the executives promise to control costs by actually managing care, especially for the victims of chronic diseases and disabilities, rather than just saying no.

Yet this new version of managed care is unlikely to reverse upward cost trends. Sure, it is the right idea, because most health care costs are incurred by people who suffer from chronic diseases and whose care is mismanaged. But insurers are unlikely agents of change. Ostrichlike executives moan and groan about providers’ “low compliance” with insurers’ care management advice, mysteriously baffled by the reluctance of independent professionals who are legally liable for the quality of care to “comply” with the strictures of health insurance officials who not so long ago made these professionals’ lives a misery.

Indeed, the fundamental premise of a top-down strategy that asks an insurer to re-create how hundreds of thousands of independent physicians, multibillion-dollar medical technology firms, and thousands of hospitals deliver medical care to millions of people is dubious. It is as questionable as a premise that automobile insurers could rescue the automobile industry by telling manufacturers how to make better, cheaper cars.
Productivity gains arise primarily from innovations in production, not from saying no. Entrepreneurs, not technocrats, create the innovations that increase productivity. We celebrate Thomas Edison, Henry Ford, and Sam Walton because they transformed how energy was used, cars were manufactured, and goods were sold. We do not celebrate them because they muscled down their suppliers’ prices and barred consumers from needed goods.

Nevertheless, the health care policy world was delirious about the happy prospects of managed care. After all, it put policymakers’ technocratic skills of evaluating people and things front and center. A 1984 article in the prestigious New England Journal of Medicine presented the Twin Cities in Minnesota, whose insurance markets were heavily penetrated by HMOs, as a national model. “The Twin Cities system is as good an example of health-care reform—American style—as one can find.” Even politicians as astute as former U.S. president William Clinton and his wife, Hillary Rodham Clinton, swallowed the bait. It was a costly mistake. They failed to achieve their laudable aim of universal insurance, in large part because they chose managed care as the centerpiece of their health care reform plans.

Bucking the tide, I predicted the downfall of managed care in a 1989 Harvard Business Review article, “The Failed Revolution in Health Care,” and a 1991 Atlantic Monthly article, “Healthy Competition.” This time around, my predictions elicited a response: they were greeted with almost universal loathing. No more research awards for me. To the contrary, the Harvard Business Review’s mailbag bulged with negative responses and the Atlantic’s editors even tried to rewrite my article into a more politically acceptable, pro–managed care formulation. Fittingly, one of the earliest negative voices came from the CEO of Oxford Health, a major U.S. managed care organization that heralded the failure of the movement with its collapse in 1998.

Despite this response or, more accurately, because of it, I felt my message was getting warmer. After all, where there is smoke, there is usually a fire.

In 1997, I tried once again, with the book Market-Driven Health Care. It was about markets—suppliers and demanders, health care providers and consumers. Market-Driven Health Care told the tales of industries entirely reshaped by paying attention to their customers—retailing, finance, manufacturing—and of the entrepreneurs who were beginning to do the same in health care. The book argued that the assertive, smart consumers who had already reformed much of the U.S. economy could, and would, do the same for health care, acting in concert with providers. As a result the reconstructed U.S. health care system would become better and cheaper, like the rest of the U.S. economy. Once again, I stressed that technocratic, third-party fixes—managed care organizations and hospitals vertically integrated with salaried physicians and owned insurers—were doomed to failure because they could not respond to the consumers’ needs. Their just-say-no and big-is-beautiful
philosophies ran counter to the decentralized, personalized responses Americans wanted and deserved.

Stung by their omission from this calculus, the policy types struck back. Their journals roundly panned the book. For example, Health Affairs titled its scathing review with what was apparently the most negative headline the editorial staff could imagine—“The Apotheosis of the Health Care Consumer.” Horrors!

But Market-Driven Health Care received positive reviews in the provider and business press, such as the Journal of the American Medical Association, Fortune, the Wall Street Journal, and The Economist. Ultimately, the book became a current events bestseller for a number of years, won the Health Care Executives’ book of the year award, was translated into foreign languages, and remains available today in paperback. It had obviously hit a responsive chord. I continue to receive letters from new readers six years after the book’s initial publication.

WHY THE TIME IS RIGHT FOR CONSUMER-DRIVEN HEALTH CARE

Buoyed by the success of this message, I felt the time for a consumer-choice health care system was finally nearing. Many factors were pushing it along, but fundamentally, a consumer-driven health care system was inevitable because activist U.S. consumers and other powerful groups in our society wanted it.

Consumers wanted it because the type of managed care so ardently advocated by the health care policy experts had failed them so badly. The promises that managed care would lead to better quality and cost control had not been kept; employers were once again facing large increases in health care expenses—13 percent for Fortune 100 firms in 2002 alone, and employees both disliked it—even top HMOs earn only 55 percent approval ratings—and questioned its impact on their health.

Providers were also dejected. Everywhere I went on my lecture tour for Market-Driven Health Care, I met physicians who told me they were leaving the field because they could no longer practice medicine as it should be practiced. The persistent decline in medical school applications has been widely attributed to managed care’s hobbling of the profession. A nurse who is no longer caring for patients speaks for many others with the statement, “I love nursing. I just can’t do it anymore.” Many providers thought that consumer-driven health care would free them of the shackles of managed care.

Even the sorts of politicians who view government as the solution, not as the problem, got the message. Thus, the activist former U.S. senator Bill Bradley
advocated a consumer-driven health care system during his bid for the Democratic nomination for U.S. president.\textsuperscript{35}

Other powerful forces wanted it too. One was the employers who in the early 2000s were facing double-digit health insurance premium increases while their profit growth was languishing. Many knew that when it came to costs, the worst was yet to come. For one thing, the patient protection legislation pending in various legislatures seemed likely to unleash a squadron of skilled lawyers, armed with costly pain-and-suffering lawsuits, on vulnerable managed care insurance plans.\textsuperscript{36} If they won, one way or another, it would be the business community that would fund the resulting massive judgments. The magnitude of the anticipated haul was indicated by the caliber of the lawyers showing an interest in this legislation. Among them were David Boies, who pled Al Gore’s presidential election case before the Supreme Court, and “Dicky” Scruggs, an architect of the successful multibillion dollar tobacco lawsuit settlements.\textsuperscript{37} Adding to employers’ concerns about future costs was the surge in the baby boomer population; now in their fifties baby boomers are used to getting their way. Although the boomers will experience less disability than prior elderly cohorts, these empowered, manipulative elders will insist on treatment with the drugs that will be developed through the marvelous new genomic cartography of our bodies.\textsuperscript{38} The cost of such drugs is staggering—for example, Genzyme’s designer drug for the victims of Gaucher’s disease, a rare, deadly genetic disorder, costs approximately $170,000 a year per user.\textsuperscript{39}

Concerned CEOs correctly feared that corporations’ bottom lines would bear the brunt of all this.

Because health care is such a large expense—accounting for 10.5 percent of total gross payroll in 2000—and so highly valued by employees—outranking even compensation in importance by a 2 to 1 margin in a 2002 survey—employers are desperately seeking a silver bullet.\textsuperscript{40} Short of a government-run health care system, there are no more arrows in the quiver. After all, managed care had not only annoyed their employees but also failed to control costs.

From this perspective, why not switch to consumer-driven health care?

In 2000, the tide began to turn.

A number of powerful, well-regarded firms offered innovative consumer-driven health care products to their employees. These firms included such titans of U.S. industry as Medtronic and Johnson & Johnson.\textsuperscript{41} Simultaneously, a bevy of entrepreneurial firms sprang up to deliver consumer-driven health care products—innovative health insurance plans, information, support, and health care services.

In late 1999, I felt that consumer-driven health care was so imminent that I hosted a large conference at the Harvard Business School to discuss the subject. The Consumer-Driven Health Care Conference was a major stylistic departure for me. I rarely attend academic health care conferences because I am repelled