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The overarching theme of the conference in November 2001 was directed toward the evaluation and delivery of health care services. We ask about the quality of health care: can we afford it? And can we identify it? Most discussions of the quality of care emphasize its immediate determinants, such as the kinds of protocols or tests that should be adopted in response to particular conditions. Thus, the Institute of Medicine's publication *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) has defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the current professional knowledge." This definition entails an emphasis on matters of short-term delivery of health care, relative to competent technique, shared decision-making, and cultural sensitivity. Often the key questions ask about the underuse of certain needed procedures (e.g., vaccinations) or the overuse of others (e.g., antibiotics).

There is little that any lawyer can say sensibly about the design of professional medical standards. But the influences on health care are indirect as well as direct,

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and this paper will focus on the indirect influences. As the title of the conference suggests, issues that relate to the quality of health care go beyond the immediate matters of health care protocols to larger questions of system design and organization, and the impediments that these might place in the path of quality health care. Furthermore, the question marks in the conference title reveal a widespread skepticism about our collective ability to solve these structural problems.

The standard drill when addressing such issues takes a familiar two-step form, and has been applied to such markets as agriculture, education, and housing, to name only a few. We start our analysis by positing a universe with hothouse conditions that are ideal for the emergence of rational markets, and then we relentlessly show how these conditions are not, and cannot be, satisfied. Our myopic remedy usually calls for the infusion of additional cash into the sector that we champion—here health care—with scant regard for the dislocations that these funding decisions will have on those activities exposed to the new taxes, or on those rival activities that do not receive an infusion of funds equal to that committed to the preferred activity. It is all too common to ignore the "excess burden" associated with all taxes—the reduced output that comes when certain activities are foregone because the consumer pays more than the producer receives (Gwartney and Stroup 1987, pp. 110–11). The tax increment will presumptively reduce the resource base. It is equally misguided to forget that selective subsidies will distort the relative prices of goods and services that should compete with each other on level ground. Finally, it is wrong to assume that we can form any social consensus on which activities should be benefited and which should be taxed. The political infighting could easily exhaust any subsidy that might be provided.

However, whatever its political dangers, I think that the first part of this two-step approach works methodologically. Begin with the idealized universe, and then ask whether it offers a benchmark for evaluating the imperfect institutions with which we inevitably work. What to do then requires more consideration, because the second half of the problem is equally important. Given the constraints that we face, what compromises do we make with the ideal? Which unhappy outcomes are we prepared to accept in one arena in order to improve outcomes elsewhere? To see how the process often goes and should go, let us start with the idealized model and then examine the extent to which it survives more real-world assumptions.

IDEALIZED AND REALISTIC MODELS

Idealized models are always risky because they are artificial. Yet these models are always necessary because they illuminate relationships that would otherwise be too complex to understand. A proper analysis, I believe, combines the ideal and the real as follows. First, one identifies the assumptions of the ideal model, and then one sees what happens when these are relaxed one at a time. Our ideal

model embodies a number of assumptions. We assume, first, that we can embed this particular activity or market in a larger universe that operates efficiently. In some cases it is sufficient that transactions in adjacent areas are conducted on a rational basis. But in other cases we need make only the weaker assumption that any identifiable defects are confined to their own sphere (market or government), without negative spillovers onto the area under study. This assumption has the happy consequence of allowing us to do a partial equilibrium analysis. Second, our ideal structure envisions situations with many individuals on each side of the market, so that voluntary pairing of, for example, buyers and sellers, yields strong gains to all parties, without having to escape the dark cloud that monopoly casts over voluntary arrangements. Third, we assume that all individuals have sufficient knowledge to act rationally on their own behalf and thereby avoid the pervasive conflicts of interests that characterize principal-agent relationships (Jensen and Meckling 1976). Our rational actors can search the other side of the market before making their ultimate choices. Fourth, we assume that the market participants are competent to deal with the technical issues they face. Finally, and more doubtfully, we assume that all individuals have sufficient wealth to be effective market participants. Large differences in wealth do not undercut the essential logic of markets, which rests on the ability to obtain mutual gains through voluntary exchange no matter what the initial endowments of the parties (Epstein 1997). Yet by the same token, political intervention into markets becomes more likely the greater the disparities of wealth, and the greater the perceived essential nature of the services supplied. By these standards, health care becomes an obvious target for state intervention.

Let us now start with an ideal world with a sound external environment, multiple competent players, full information, and a rough equality of resources that meets with general social approval. Under these conditions, the price and quality of health care would be "ideal" and, by and large, would be perceived as such. Given those high levels of satisfaction, we would not observe any groundswell for government regulation or private reform. It is not that everyone in the system would choose to buy the best health care available at any cost, any more than all people would choose to buy the fanciest car or the finest cuisine; an omnipresent wealth constraint (that is, the inevitable scarcity of system-wide resources that no egalitarian vision can remove) ensures that people will optimize relative to their budget. Thus no one should mandate some minimum dollar figure for health no matter what other needs present themselves. More concretely, in this environment, budget constraints would make it a mistake for people to rank health care first in their market basket of goods. The better course of action would be to make sure that the last dollar spent has the greatest marginal value. It might be wiser for people to purchase goods and services that would help them steer clear of the disease and injury that trigger the need for health care services in the first place. Rational people would avoid deluxe health care that

came at the cost of, for example, substandard housing. Accordingly, we expect some individuals would gamble by leaving some conditions untreated or undertreated. Those same people would be likely to express ex post regrets at their decisions, even if these were rational (i.e., maximized expected value) when made. Yet the robust condition of the overall voluntary health care market would keep these isolated complaints from dominating the political debate over the quality of health care.

Clearly, health care markets in practice do not display this level of vigor. Quite the opposite—why else is the public estimation of health care services so low? Kenagy, Berwick, and Shore (1999) write: "If banks, airlines, maintenance companies, financial services, package delivery firms, and hotels treated their customers to levels of waiting, unanswered questions, inconvenience, and obscure instruction that are the norm in health care, they would be unable to survive." The authors then proceed to describe the pitfalls in the operation of hospitals and health clinics, most of which concern the simple mechanics of supplying coherent forms, using adequate signage, offering adequate parking, and hiring courteous people to answer the phones and give instructions. In a service-intensive industry, these factors can detract from the overall level of patient and family satisfaction, even if medical and surgical treatment is first-rate. Any overall assessment of the current levels of health care is bound to be mixed, whether we speak of HMOs or the more traditional forms of health care delivery (IOM 2001, p. 238). Nonetheless, all too often the non–health care services fall far below the level of the basic health care provided, leading upper-income customers especially to avoid these costly hassles and delays.

Part of the problem here is making the correct diagnosis. Anyone who has eaten airplane food, read a computer manual, attended an inner-city school, or waited in line at the post office knows that service businesses are hard to run—period. Any differences in service levels are thus a matter of degree across industries and are subject to wide variation within industries. But that said, it would be hard to gainsay the common perception that on average the quality of services in health care seems to be lower than it is in most private industries, if not necessarily lower than the quality of other government services. To the extent that we look to private firms as the quality benchmark, the quality-of-care puzzle only gets deeper. If these firms have the levels of efficiency attributed to them, then why don't they (or their successful managers) invade en masse the sacred precincts of health care services? This invasion is in fact possible. First, firms with expertise could compete with the incumbents who lack the skills to take on the routine portions of the health care business. Alternatively, health care businesses could subcontract out some portion of their work to firms who have expertise in collateral fields: food courts could displace hospital-run cafeterias; hotels could provide room service to patients; parking facilities and janitorial work could be farmed out as well. Indeed one suspects that this movement has

already begun. Yet the perceived lag in health care delivery remains. What possibly accounts for it? Much of the answer can be found by looking at how our idealized assumptions break down.

BREAKDOWNS IN HEALTH CARE

Independence of the Private Health Care Market

At this juncture, it is useful to run through the assumptions about idealized markets, starting with the assumption of the well-ordered behavior in adjacent markets. All too often the debate over health care ignores the indirect but profound influences these markets have on health care. What should be done, for example, to counteract a monopoly condition in an industry that is a key supplier or competitor to health care? We know that this monopoly will drive the price of inputs away from the competitive ideal. But the size and extent of the movement will be hard to detect, and the policy options available to actors within the health care area are limited, owing to the difficulty of securing political changes in someone else's turf. But the adaptive response within the health care industry is likely to be imperfect if the monopoly in some adjacent area is not regulated or broken up, assuming that these alternatives do more good than harm (Demsetz 1968). Health care is stuck with the collateral imperfections.

Nor is the field able to escape the complexities of regulation in adjacent sectors. Every service component of hospital care is subject to extensive regulation in the name of health and safety. Many of these regulations crimp the flexibility of suppliers of ancillary services because of greater precautions that have to be taken in the preparation of food for internal use, the need for high levels of air purity, and so on. These constraints reduce the freedom and increase day-to-day costs. However, hospitals must necessarily worry first about regulatory compliance and only then about consumer satisfaction.

Next, other institutions loom large in influencing the levels of health care quality. Until 1974 hospitals were exempt from the National Labor Relations Act, but now unionization is allowed, and extends not only to ordinary staff workers but to interns and residents as well (Boston Medical Center Corporation 1999). At one time, too, other forms of direct regulation of the employment relationship were relatively limited. But today minimum wage, equal pay, antidiscrimination, mandatory retirement rules, and the rest impact health care just as they do other sectors in the economy. Although this regulatory regime does not doom health care to inferior services, it may well have greater impact in this sector relative to others: safety concerns with hospitals are obviously greater, for example, and the high concentration of nurse's aides and other low skill workers make union issues important. Advocates for better health care cannot have it both ways. A unionized workforce for medical personnel, support staff, and back-end business of hospitals reduces management flexibility and increases the

labor costs. It is therefore ironic that many critics of health care costs also support labor laws that contribute to the problem.

The question of adjacent distortions, however, runs deeper than this. There is also the question of the structure of the entire medical care industry. Here two of the dominant realities of the provision of modern health care are Medicare and Medicaid, with their different target populations and their formidable regulatory tangles. Discussions of the quality of health care frequently speak about the risk of the overuse, underuse, and misuse of medical resources in diagnosis and treatment. At one level these allocation shortfalls are surely a consequence of errors that are likely to creep into the health care system no matter what legal regime governs. But a huge chunk of the problem comes from the incentive structures that are created by public regulation.

The basic structure of Medicare, for example, insulates the health care consumer from any information about the marginal costs of the consumption of health care services (Epstein 1997). Huge portions of the cost of the system, today in excess of three-quarters of its cost, are pushed back on to one form of general revenue taxes or another, including of course the 2.9 percent Medicare tax on earned income for all workers. In addition, the portions of Medicare that are paid for by patients are paid in a front-end lump sum, so that extra consumption does not trigger extra costs. The predictable, structural effect of the system is to induce at the margin (i.e., with each additional unit) overconsumption of the relevant service within the field, which it is difficult to counteract by nonprice mechanisms of service review.

This behavior exerts a profound effect, moreover, on the availability and use of health care services for individuals who do not fall under the Medicare umbrella. These consumers now face greater competition from individuals with subsidized services, which reduces the range of services available to them and increases the cost of those services that remain. Medicare compensation levels (which are to some extent pegged to private compensation levels) in turn move up with the increase of "reasonable fees" in the private sector. In the current political landscape, it seems unrealistic to expect any major change in the provision of Medicare, except perhaps for some additional expansion in its coverage, either by increasing the number of covered procedures or by reducing the age or other eligibility requirements for the system. The increased quantity of medical services demanded has a negative effect on their average quality.

These distortions are increased by the erratic coverage patterns that Medicare provides for various goods and services. It gives first-dollar coverage for hospital and physician services, but does not include any kind of a drug benefit. The obvious result, which is checked only in part by the availability of private insurance for prescription drugs, is to skew Medicare patients toward physician and hospital care and away from drug therapy. Hospital stays with their concomitant costs could easily be longer, and hence higher, than might otherwise be the case. It might be a sensible reform to cut down on hospital and physician services in

conjunction with comparable increases for prescription drugs. Thus a sensible insurance regime might offer reimbursement for, say, 80 percent of hospital, medical, and drug costs up to some pre-assigned limits, instead of providing 100 percent of hospital and medical benefits but none for non-hospital prescription drugs. Although one has to be cautious, that new system could place a more effective cap on the overall level of health care expenditures while reducing the current distortions among the types of treatment that are given.

But it will not happen, at least in the short run. The current political climate is too strong to tolerate any cut in any existing benefit for doctor or hospital services. Accordingly, we are now faced with the unhappy choice of having to decide whether greater resource misallocations come from the odd skew in the current coverage—which does not track private plans—or from the infusion of new funds for full (or even substantial) drug benefits without requiring offsets elsewhere. The now distant economic boom of the late 1990s pointed toward expanded coverage. The austerity and external difficulties of the present times—defined as the post–9/11 era—seem likely to doom the major expansion of any welfare program in the short run, as is evident in the way in which patient rights legislation has languished in Congress.

The organization of Medicaid is different, but it too places a drag on the overall level of health care. Here the levels of care supplied are manifestly lower than they are with Medicare. Even so, there is no present political support for a major upgrading of the system: poor people do not form a critical component of any winning political coalition. Parity between Medicare and Medicaid is not politically doable if it requires either a substantial leveling down (for Medicare) or a substantial leveling up (for Medicaid). With Medicare, the critical policy question stems from the overuse of subsidized services; with Medicaid it is more difficult to decide what structural defect needs the most urgent attention. For anyone who measures the need for medical care without regard to the ability to pay, Medicaid looks like an under-provided system. But the risk of deviant behavior by non-compliant patients (a topic that does not get much discussed in polite company) makes reform more difficult: even a small fraction of wayward recipients can inflict extensive system-wide damage. Similarly, even in the vast number of cases in which no deviant behavior is involved, any increased public subsidy for health can easily be negated, at least in part, by changes in private behavior toward riskier activities that in turn generate greater needs for health care. The problem of social control is therefore more acute. Furthermore, median voters will not support massive infusions of capital for programs in which they do not participate (Cooter 2000).

In our two major public programs, we have problems of underuse, overuse, and misuse in different proportions in different populations. None will be easily cured. But the competition for resources within the voluntary system remains. The private market must operate more inefficiently when surrounded by these two large and immovable ancillary systems, because these systems draw away

resources that would otherwise make their way into the voluntary market, and the reduction in supply raises prices systematically. We cannot assume a separation between the two markets when the same individuals and institutions are supplying the same types of services to two related programs.

Licensing laws, which are particularly strong in places like California and Florida, create yet another barrier to competition. Ideally, we would have a national market in which physicians (most of whom pass National Boards) could be free to follow their older patients from cold to warm climates. But licensure laws reduce the level of mobility and thus confer at least some limited amount of monopoly power on those physicians who have already made it under the wire in one of the lucrative, patient-rich jurisdictions. Other professions may have similar geographical restrictions, but the restrictions are far less important. For example, a lawyer licensed by any state can practice in any federal court; transactional work does not require licenses in the particular state, at least if one local lawyer (usually needed in any event) can sign the appropriate papers. Although the effects are indirect, one cannot ignore the long-term influences: the less mobile the physician pool, the less responsive health care providers can be to quality-of-care concerns.

Thus far I have made it appear that all the external effects are negative, but this too is a mistake. In many areas we have seen undeniable improvement in the quality of health care services in large measure because of advances in technology. I know little of the particulars, but even to an outsider it is evident that the risks associated with the use of anesthesia have declined markedly in the last 25 years, and that much of this improvement stems from the comparative strength of the large technology industry that has been able to bring forward a steady rate and pace of technical innovations. In many ways, this research market has been strengthened by the improvement of the venture capital markets, which do a better job than a generation ago in assisting the transition from bright idea to marketable product. The pace of innovation in the drug markets (and the speedier FDA processes) also bears notice, because the improvement of these therapies often allows the substitution of relatively safe drug treatment for more dangerous surgeries, as, for example, with peptic ulcers. All things considered, the rate of medical innovations that comes from basic research has also improved radically as well. So the scorecard of the role of collateral markets and regulation is hard to total up. On balance, the long-term struggle pits improvements in technology and innovations against regulatory imperialism, producing a confused situation that to this outsider looks something of a wash.

Competitive Market Structures

The second of our assumptions—large number of independent players on both sides of the market—has become more dubious in health care markets of late. Fifty years ago, the dominant form of practice was fee-for-service medicine. Hospitals were more numerous, and the government was not the sole provider

of medical care for large fractions of the population. Today, antitrust in health care is big business (Sneed and Marx 1990). The ever-increasing concentration in health services makes the monopoly question loom larger today than it did in previous times. Yet the antitrust blunderbuss could easily interfere with certain market efficiencies—for example, by making it more difficult for firms to share safety data. This market does not look to be perfectly competitive, but structural reforms are likely to be hard to come by.

Information and Competence

So we now come to the third and fourth of these external influences, which are heavily intertwined: whether people are competent to assemble and digest the information needed to make intelligent decisions about health care services. At some level, problems of imperfect and asymmetrical information, like those of conflicts of interest between various market participants, are pervasive across markets. Difficulties in ascertaining needed information frequently drives individuals to enter into contracts with *observable* payoffs, even if they are less than ideal. Many people think that net profits rather than gross receipts is the better measure of the value of leased property, for example; yet it is far easier, and thus far commoner, to tie percentage leases to receipts, which are more observable. The inevitable trade-off between the validity and reliability of a measure often requires the use of proxies for the real thing. This vexed relationship between measurement and proxies arises in every market (housing, education, brokerage services, etc.).

That said, the information problem is especially acute in health care markets. First, the information that must be assembled is often hard to process. Second, the individuals who are asked to process this information often suffer from predictable levels of individual incompetence. Most individuals suffer from both cognitive limitations on how to process the information they receive, as well as emotional distress in having to deal with novel and life-threatening conditions to themselves and their families. Needless to say, people find it hard to gather accurate information to choose the right physician or health care institution. What is to be done?

Individual Supervision

Individual consumers can devise a number of strategies to respond to these manifest deficiencies. The most obvious approach is to rely on help. In the economics literature, this strategy is often spoken of as substituting an "agency" problem (how to make sure that the person on whom you rely has your interest at heart) for an information problem. But these two problems need not have the same magnitude: a lot depends on the choice of the agent, and the checks, both legal and informal, that can be exerted to constrain his behavior. When the agent is a knowledgeable family member or friend, these conflicts of interest may be kept at a minimum. But they increase for people who are socially isolated

from a knowledgeable professional, or whenever some real scientific expertise is needed. In some cases, internists fill a critical role by lining up the various specialists to treat a given patient, by monitoring their behavior, and by facilitating their exchange of information with patients. No one can say that these approaches are foolproof. What can be said with some confidence, however, is that the persistence of these practices suggests that the information risk removed is greater than the agency risk assumed, which is all one can ask for in a world in which incremental improvements are, of necessity, the norm.

Institutional Supervision

The desired help today does not come solely from other paid agents. The role of the internet as a guarantor of health care is likely to continue to increase. It has long been hard to separate out advice on whether to purchase services from the services themselves. The mechanic who repairs cars has a built-in incentive to recommend repairs. The same conflict arises when the physician who makes the diagnosis stands to undertake the surgery needed to correct it. Before the rise of the internet it was expensive to track down independent sources of information. Today on-line services and chat groups offer other avenues to attack the information problem and reduce the patient's abject dependence on his or her physician. With better information flows, patients and their families can participate proactively in treatment. The overall competence problem should become less severe, allowing better solutions to the quality of care questions.

In many contexts, individual monitors are not enough. Good health care requires systematic controls that are not initiated by individual patients. Much of health care today is provided through employer health plans and similar groups. Their selection and oversight of health care providers is critical for the overall success of health care markets. Ideally, monitoring offers continuous overall assessments of the quality of health care provided to plan members. To be functional, such programs involve the creation of aggregate databases, uniform and comprehensive medical histories, and standard protocols of treatment and assessment.

The effort to acquire and use system-wide information creates a conflict between the discretion of the individual physician (who has knowledge of the peculiarities of the case) and the health plan officials (who have better knowledge of the overall base rates). Adequate treatment requires the integration of information from both sources; yet no one knows whether the plan, with its better databases, or the management team, with its more accurate information, should be in the driver's seat in charting the course in difficult cases. Systems of divided control are inherently awkward; systems of unitary control cut out or downplay one source of information. Both defects are substantial and reciprocal: one cannot be cured unless the other is exacerbated. No one claims to be able to identify the proper mix of control, but it is clear that control has slipped away from physicians and toward plans, and will continue to do so (Epstein 1999).

It should be no real surprise, therefore, that the organization, presentation, and

use of information about patients and treatments is difficult even for a single (nationwide) employer, with respect to the multiple health care plans it must supervise, or with hospitals and health care groups that supply similar services to a broad base of clients. It is still more difficult to make assessments across employers or health care providers when it is far from certain that the information obtained has been organized and analyzed on an apples-to-apples basis. Do we—or better, how do we—control for age of population, income effects, national origins, geographical variables, and the like? The point here is of no small consequence, given the reluctance of individual health care providers to join in comparative ratings. The charitable explanation is that the rating systems are fundamentally flawed, so that the use of tabular information simply misrepresents more than it reveals. The suspicious explanation is that low-performing firms have every incentive to conceal their shortcomings.

THE LEAPFROG MODEL

In an ideal world, we should strive to overcome all these difficulties of measurement before making any judgments about the quality of health care. But the informational demands of the continuous supervision model are at this point beyond the capacity of any single individual or firm to implement. A different tack is needed altogether. I shall take a leaf from the Leapfrog Group (2002) and explore the possibility of a different strategy for assuring the quality of care that may work, at least in the short run. Stated simply, the appropriate attitude on this question is this: pick the low-hanging fruit first and worry about the fine points later.

To see how the principle plays out, it is useful to begin with a quick aside about the law of medical malpractice. Anyone who reads the reported cases on medical malpractice must assume that the fundamental difficulty within the field comes from policing the distinction between negligence in treatment and unfortunate outcomes from proper care (*Hirahara v. Tanaka* 1998; *Lama v. Borras* 1994). But we must recall the basic principles that govern the "selection" of cases for litigation—that is, the nonrandom processes that indicate which cases get settled and which get litigated (Priest and Klein 1984). Easy cases on liability one way or the other are quickly settled, and thus never grace the appellate reports. But easy cases also constitute the huge bulk of ordinary medical malpractice. Huge damage awards can arise in complex surgeries because of a routine error in blood typing. Simple errors kill in unambiguous ways.

This melancholy fact offers a profound lesson that should shape much of the debate over the quality of care. The first line of attack is not to try to make case-by-case assessments of quality. It is to do exactly the opposite. It is to break down complex cases into simple processes and then make sure that those processes are soundly executed. In effect, the first objective with respect to quality control is to make sure that ambitious plans are not submarined by small failures. Thus in

the work of the Leapfrog Group for Patient Safety, the first task is to figure out a way to automate the delivery of routine health care services, such as physician prescriptions. The point of the exercise is to take one constituent of undeniable relevance with respect to complex treatments and make sure that errors in its execution are reduced to a minimum by using standard forms and templates that allow orders to be checked and reviewed for error. The point here is one on which there can be little disagreement in principle, for it does not force anyone to take sides on the thankless question of where discretion should be lodged in the treatment of complex cases. Getting the simple points right forms a welcome addition, no matter how those larger issues are resolved.

The consequences of this "simple" reform must be regarded as profound if it could eliminate some 15,000 or so deaths per year. But programs like this require a large investment in front-end capital even if they have low marginal costs, so that the problem in many cases is to find ways to nudge managers into adopting these precautions. That task is not easy even in a market system, if the front-end costs have to be borne by hospitals who fear that after installation they will be stuck with the full capital cost of the system while each user offers to pay for (only) the marginal cost of its additional demands. So the structural problem is how to persuade folks to design and implement these protocols.

The second approach is to find gross measures of quality that do not require case-by-case supervision. In this regard, there seems to be widespread agreement that hospitals and surgeons that perform procedures often perform them well. Indeed, this one piece of information removes the need for having case-by-case scrutiny of individual cases to make the *ex ante* decision of where and to whom to turn. Providers need to ask various organizations to supply this information and then to act on it. The worrisome side to specialization is that it can serve as the handmaiden to monopoly, which carries with it the risk of inferior service for patients and antitrust liability for health care providers. My own response to this quandary is that ordinarily this will not be the case, for two reasons: first, the pressures are market-driven in the best sense, so that it is hard to find any systematic intention or effort to form a cartel. Second, the more difficult the procedures, the greater the likelihood of finding variations in quality. Patients will then seek access to national markets, so that the competition becomes in part between urban centers as much as it is within them.

Finally, the Leapfrog initiative proposes that specialty training be offered in intensive care units, an issue on which I have much less knowledge and confidence to judge. But, again, the strategy is to insist that the work be done, but not to provide the blueprint by which it is done.

Having talked about the low-hanging fruit approach, several issues remain. How does this strategy address problems associated with patient competence and with differential levels of access to the health care system? On both these scores, I think the approach comes off fairly well. The effort to develop standardized protocols for orders and to concentrate difficult cases in centers with extensive expe-

rience is something that allows poorer and less informed consumers to piggyback on the accumulated knowledge of the largest employers. The success of the system depends on its inclusive nature; the trickle-down theory has some use, after all. It also means that employees in large firms, even at the lowest level, gain some degree of protection by virtue of having a strong intermediate represent them when it matters most. Of course, some differentials in health care services survive: the CEO of a Fortune 500 Company will get better care than his ordinary line workers. But much of this will be in non-medical benefits, such as private rooms and shorter waiting times in hospital lobbies. The upshot is that I would predict that the level of variation that one finds (top to bottom) in the provision of critical health care services will be *lower* than that found in wages or other workplace amenities. And that is just how it should be. Income is not a good proxy for survival, and we should expect that even low-level employees will value these benefits highly. It follows therefore that some (sensible) portion of the egalitarian movement in health care will be realized through market forces.

ACCESS TO HEALTH CARE

This analysis has important implications for the general question of access to health care. The usual approach to this question is to find some way to provide a state subsidy for lower-income people whose care falls below some socially defined minimum. The costs of that strategy were mentioned above: the tax burdens and political dislocations mean that improvements in health care for some can only be achieved by imposing massive dislocations on others. Leapfrog and other private initiatives suggest an alternative, but indirect, strategy for improving access to health care. Change the regulatory environment so as to reduce the cost of health care for anyone who wants to buy it on the voluntary market. Once those costs are reduced, more individuals will flock to health care, and they will do so in an environment that avoids the twin risks of systems of subsidy and taxation.

If this message is correct, then we should recognize that indirect causes can have major impacts, negative as well as positive, on the quality of health care. Every time the minimum wage law or some restrictive statute keeps a worker out of the voluntary market, it cuts him off from the health care that this market can provide. So the point is to grow all companies, so that the percentage of people who cannot avail themselves of these new, system-wide advances shrinks. Standardized procedures, supplied on a nondiscriminatory basis, clearly help those who have limited competence as well as limited wealth, and for the same reason: it is generally safer to piggyback on those who are more knowledgeable than yourself than it is to strike out boldly in some uncharted direction.

In sum, I think that we can now state a reasonably coherent two-prong attack on health care quality. First, at the macro level, reduce the barriers to entry and other structural impediments to competitive markets. The comprehensive reduc-

tion in general costs will free up more resources for the health care system and will bring more people into the voluntary market. Next, dealing with the quality dimension, put the systematic effort into dealing with the nagging problems of routine administration that free up other resources to deal on a case-by-case basis with individual matters. Since we cannot repeal scarcity, nothing will "solve" the problem of quality in health care. But much can be done to ameliorate its severity.

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