

NOTES ON HEALTH CARE FINANCING AND FREE MARKETS

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Abstract

This article applies economic theory to the financing of health care. The authors point out that rent-seeking and government intervention into the health care market raise the cost of health care and reduce its quality. The authors call for health care to be financed privately without government intervention.

National politicians are claiming credit for a model of bipartisan cooperation in crafting a balanced budget for the year 2002. The Federal "budget" is the presentation of two opposite flows of money--Federal revenue collections (mainly taxes) and Federal spending. But the supposed "balance" of inflows and outflows is like a mirage in the desert--in the distance it may appear real, but as we get closer to it (that is, to the year 2002), it vanishes. One of the main reasons the "balance" will vanish will be the growth of Medicare spending. Medicare is part of the

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insurance scheme, called "third-party payment," which pays for our health care. One of the fatal flaws of Medicare is that it is treated as a "free lunch."

The popular saying, "There is no such thing as a free lunch," is a variation of the fundamental idea in economics that anything which is free or priced below market level will be over-consumed (Butler, 1989, Dolan and Goodman, 1995, National Center, 1994, Robbins, et.al, 1994). Any government program which subsidizes purchases or which causes them to appear to cost less than they in fact do, will encourage consumption beyond that which can reasonably be provided at the artificially low price. In the end, consumers as a group, or taxpayers as a group, will wind up paying the true, higher cost. Thus, "there is no such thing as a free lunch." Somebody always pays (Dolan, 1969). True, if a private payment arrangement were to shield consumers from the true costs of their expenditures, it, too, would have similar deleterious effects. But there is one fundamental difference between governments and market participants which must always be kept in mind: when the former engages in such activities, it can do so in the long run, and with impunity. Any losses created by such uneconomic acts can be made up for with tax revenues. In contrast, when private parties such as employers or insurance companies do so, this must of necessity be a short run phenomenon, which can only last as long as bankruptcy can be staved off.⁴

Consumers of health care, unlike consumers of other goods and services, are often not confronted with the true cost of the material and human resources devoted to this end. In freely competitive markets, the interplay of supply and demand, unfettered by interference from external players, communicates to

⁴ This holds only if government does not bail out or subsidize such private misallocative behavior. If the state does support it, then, again, we arrive at that institution, not the market, as the real explanation for the shielding of the consumers from the true costs of their choices.

buyers the true costs are of what they consume and permits them to make informed decisions. In contrast, through the advent of Medicare in 1965, and more generally through the tax-subsidized provision of private health insurance programs by employers since World War II, individual consumers have not been confronted with the real cost of treatment, nor has this information been available to individual care-givers at the point of making treatment decisions (Santerre and Neun, 1996).

In other words, we get the services now at a direct price to the consumer that is very low relative to actual costs, and, presumably, worry about increases in the insurance premiums later. Those who are insured will ultimately pay the full bill through higher premiums, but the group, as individuals, is not faced with those costs at the point of service. A government-sponsored financing mechanism--Medicare and tax-subsidized employer-sponsored insurance⁵--has been put into place which does not allow the usual economizing incentives to work (Manning, et. al., 1987; O'Grady, et al., 1985). The recent "reform" of third-party insurance through the advent of "health maintenance organizations"--HMOs--is supposed to ameliorate adverse demand-side effects by interposing a third party in the decision chain for medical care (Wholey, et al., 1997; Mark and Mueller, 1996). Certainly HMOs have squeezed the margins of providers and notched down the rising trend line of costs. But recent data indicating increasing health plan premiums puts at question whether HMOs are the panacea they are often portrayed to be (Ginsburg and Pickreign, 1996, 1997).

How did we get into this mess, and what are the chances of extricating ourselves from it?

Some writers maintain that the difficulties in health care stem to a great degree from the fact that the goods and services provided are

so expensive and are continually rising in cost. In addition, insurance companies have been placed between the providers of health care and the consumer who pays for the services. The increases in costs are spread over large groups of consumers and the charges incurred by individual consumers are not viewed as directly linked to the insurance premiums. Were this not so, the difficulties of balancing budgets, providing a provision for the poor, pricing the middle class out of the market, would all be far more tractable.

These explanations, while not totally irrelevant, are only superficial. For, as we have seen, only the state can maintain artificially low prices for medical goods and services over the long haul. No insurance company could make profits under such a scheme, and without profits would eventually have to declare bankruptcy. However, high and rising prices do play a role, for they drive a large and increasing sized wedge in between market and controlled prices. That is, if government is going to artificially lower prices, the lower costs are the less disruption it will cause.

Why, then, are physicians services (a large part of the total medical bill) so exorbitant in price? For the answer to this question we must resort to the fundamental economic analysis of supply and demand. Let us take them up in that order--supply, then demand. Doctors' earnings are high and increasing because the American Medical Association (A.M.A.) has been able to impose cartel-like restrictions on entry into the medical profession (Benham, 1978; Friedman, 1970; Gellhorn, 1956; Goodman and Musgrave, 1993; Goodman, 1980; Hamowy, 1979, 1984; Hyde, et. al., 1954; Kessel, 1958; Kett, 1968; Lindsay and Buchanan, 1974; Rayack, 1968). When the supply of any good, service or commodity is artificially limited, and there is an unchanging and downward sloping demand, it necessarily follows that price will rise. Doctors' services constitute no exception to this rule. Hamowy (1984, pp. 285-290) reports physician's salaries far in

⁵ Not only is employer sponsored health insurance supported by tax policy, the entire practice owes its inception to government action. See footnote 9, below.

excess of those of dentists, lawyers, engineers, accountants⁶ and college professors whose human capital, one might think, would in a free market confer on them similar earnings. The control over market entry by the A.M.A., however, one which has been conferred by government, accounts for the observed disparity.

It must be conceded at the outset that this explanation of medical licensure is an unexpected one, particularly in the minds of the general public, and others ignorant of economics, such as sociologists. In the popular mind, the A.M.A. has been allowed to limit the supply of doctors not to elevate salaries, but rather to ensure high quality health care.⁷ Certainly, the prospect of a "sawbones," or an uneducated "healer" is not a very savory one. The presumption is that without licensing, people would be widely exploited by "quacks."

But this is erroneous. Any gain in information as to the training of a physician available from licensing is also

⁶ All of whom benefit from restrictive practices on their own, albeit to a lesser degree than that of doctors. A certification, as distinct from a license (Friedman, 1970) is merely an acknowledgement of approval from an agency set up for that purpose. A license, in contrast, amounts to a special governmental privilege: anyone practicing without one is subject to fines or even imprisonment. Accountants, for example, are presumed to be certified, e.g., as in Certified Public Accountant (CPA). But the fact is that most states award the CPA certificate to individuals who pass the Uniform Certified Public Accountant Examination. In order to obtain a license to practice, the state requires the applicant to meet experience and continuing education requirements. A CPA must have a license to practice in order to perform attestation functions such as an audit, compilation or review. Non CPAs as well as those CPAs who do not possess a license to practice are legally prohibited from performing audits and other attestation services. A non-CPA may prepare tax returns or provide consulting advice about the adequacy of the firm's information system, but the audit report for a publicly listed company must be signed by a CPA. This indicates that accountants are really licensed, in addition to being certified.

⁷ See Flexner, 1910, as a case in point. This report has been credited for setting up the institutional arrangements regarding doctors that remain in place to the present day (Goodman, 1980; Hamowy, 1984).

ascertainable from certification. Licensing is limited to the government; hence, there is only one examiner, a necessarily monopolistic one. With certification, there can be a competitive industry supplying information about doctor's skills. And the presumption is always that better quality and lower prices are attained not by monopoly, but through competition.

Even were it true that quality were increased through licensing, moreover, this need not necessarily redound to the benefit of the final consumer. For example, we could certainly improve the average quality of automobiles if we were to ban all makes below the engineering specifications of the Mercedes-Benz. But we would scarcely improve the welfare derived by car use in such a manner. Surely, if there is room for a Chevy car on the highway, a "Chevy Doctor" can also make a positive contribution to the well being of patients.

But it is by no means clear that licensing even improves quality. The Jewish doctors emigrating from Austria to escape Nazism were prevented from practicing their profession in the U.S. in the late 1930s because they were forced to take the qualifying exam in English (Friedman, 1970).⁸ The A.M.A. claimed this was necessary in order to "protect" American patients from doctors who could not speak their language. Evidently, there was no cognizance of the fact that some sick people spoke German or Yiddish, as did these doctors; that some would be unconscious, and thus language disparities would play no role at all; and that interpreters could in any case ensure that there would be no medical misunderstandings.

The evidence suggests that the A.M.A. organized medicine now being practiced in the U.S. is a version of the medieval guild system, where practitioners are frozen out in order to increase the economic returns of those fortunate enough to be permitted inside

⁸ The Cuban physicians escaping the Castro brand of Communism in the 1950s experienced a similar welcome from the profession in the U.S.

the gate. One step, then, toward alleviating the medical crises would be a move from licensing to certification.

What of the demand side? Here the difficulties arise not from limited entry, but from "moral hazard" (Freiberg and Scutchfield, 1976). This depicts the fact that demand curves slope in a downward direction. The lower the price, the more will be purchased. And at a zero price, the typical demand curve approaches the x-axis only asymptotically; that is, an indefinitely large amount of the good will be desired. And this applies whether we are discussing ships or sealing wax, fish or bicycles. Physician's services, again, are no exception to this general economic rule.

This is the "Achilles Heel" of all medical insurance, whether public or private,⁹ which is given out for "free" or with minimal user charges: people have a tendency to overstate their true needs. That is, at a small or zero price, they, quite rationally, demand far more than they would at a market price which reflects the full costs of the service. Even were entry into the medical profession as unregulated as that that applies to, say, baby-sitting, newspaper delivery or caddying at golf courses, the price would still be far from zero. At the price, people would tend to use health care relatively sparingly. If it costs \$100 to see a doctor, patients will do so only if their plight is a serious one; they will, at the margin, take better care of themselves, engage in less risky behavior, and utilize self medication or home remedies. At, say, \$3 for an office visit, the same care to economize on a scarce

⁹ According to some writers (Friedman, 1993), the U.S. experience with socialized medicine came about as a result of the wage controls of World War II. At that time, we were involved with maximum wage legislation, not the more modern variety compelling minimum wages. Of course, under these conditions, the demand for labor exceeded the supply. Employers were finding it difficult to attract a labor force. So, to "sweeten the deal," e.g., in effect evade the wage maxima, they offered "free" health care as a bonus. Once accustomed to this fringe benefit, it became difficult to withdraw it. This explains the common modern practice of paying part of wages in the form of health care.

resource will simply not be taken. On the contrary, people will treat the service, in effect, as if it were a free good. It almost need not be said that hypochondriacs would vastly prefer socialized or insured health care.

In order to see this point more clearly, consider the case of milk. Currently, people are reasonably cautious as to how they use this fluid, because its costs are substantial. No one need do without, at least in the U.S., not even the poor, or babies, etc. But it is very rarely wasted. Suppose, however, that we organized distribution of this product along the lines that now prevail for medical services (Musgrave, et.al., 1992; Weisbrod, 1991). That is, we were enact a new "milk tax," based on present consumption. If individuals, on average, spend \$1000 per year on this substance, we simply raise taxes by that amount on a per capita basis, and then distribute it to people at a zero or merely nominal price. Surely, under these circumstances, our estimates of total milk consumption would be very low, for much more would be demanded at the new low price than was before, at (present) market prices. If given away for free, this item would be used more extravagantly, and even very differently: milk baths would become the order of the day for everyone seeking more beauty, not just for the pampered rich; instead of having "water gun" fights, small boys would have "milk gun" fights; cooking recipes would substitute this agricultural product for now relatively more expensive inputs. Why wash your car, or your dog with water, when milk might give a better result?

With vast demands for milk, some people would have to do without, while others used it in these new ways. New regulatory machinery would have to be set up, and the new bureaucrats would have to step in to solve the "milk crisis." They would take steps painfully similar to those that are now in operation in the medical area. Surely the parallels with many current political attempts to "reform" health care provision and pricing are apparent. The extremely cumbersome quasi-governmental "purchasing cooperatives" envisioned by President Clinton's health care reform

act confirm the saying that “controls beget controls” (Zelman, 1994; Enthoven and Singer, 1994; Pauly, 1994). Clearly none of this will really suffice, whether for socialized medicine, or for “socialized milk,” because it does not attack the problem at its roots: extremely low or zero prices, set up “moral hazard” problems, which exhibit themselves as excessive demand or shortages.

This difficulty will of course beset *any* pricing regime that features excessively low or zero cost service, whether health care or any other. However, as we have seen, these arrangements occur in both the public and private sector. Why has the latter been far more successful than the former in dealing with the problem? The reason is simple. If a firm cannot overcome the dilemma, it will go broke. Surviving firms, then, almost by definition, are the ones who have succeeded in this regard. To avoid declaring bankruptcy, governments increase taxes to cover the additional costs. Thus governmental units do not have the same incentives to effectively deal with the problems.

Recent investigations of Columbia/HCA, major investigations of overcharging the Medicare program, and tales of vast sums of money changing hands in health care mergers, suggest that, in addition to physician groups, the hospital industry, the pharmaceutical industry, and other components of institutional health care are not really part of a free market but rather are dominated by firms possessing monopoly power conferred on them by government. The combination of institutional providers with great political power and government-mandated insurance arrangements which hide the true costs from the consumer is a sure-fire recipe for major future difficulties in financing health care (Newhouse, 1992). Physicians in many ways, like patients, have become pieces in a giant “Monopoly” game, subjected to political forces. Somehow the United States has managed to develop a health care system which, reduced to its bare elements, is a huge bureaucratic machine. The market has not been allowed to work.

Any review of the professional writings on this subject will reveal great variation in reform proposals (Cutler, 1994; Ellwood and Enthoven, 1995; Enthoven and Singer, 1995; Moeller, 1995; Newhouse, 1994; Ozanne, 1996; Reinhardt, 1993; Teisberg, et al., 1994; van Barneveld, et al., 1996). However, our problems, both of high expenditures for that part of the population with assured financial access to health care, and of lack of assured access for another (and increasing) part of the population, is linked to our peculiar financing and reimbursement mechanism and to the licensure system. Fundamental reform of the insurance (demand) side of this business and the provider monopoly (supply) side, in line with market precepts, is the challenge that everyone who is concerned with future availability and cost of health care must face. In the end, consumers must be treated as they are in other, more efficient private markets. That is, they must be directly exposed to the financial burden.¹⁰ “Impossible” financial burdens melt away, as did “impossible shortages” of crude oil in the 1970’s, with the advent of the actual market situation when unencumbered by government attempts to rectify the problem. “Impossible” financial medical burdens are met with the intervention of private charity and the economizing effects of cost-benefit comparisons in the minds of consumers, when consumers are allowed to make those comparisons.

At the same time, certification must replace licensure in reforming the supply side of the health care market. There is

¹⁰ This does not mean, of course, that in a market oriented private health care industry the poor need do almost entirely without medical services, or even need rely totally on private charity. Consider clothing in this regard. There is no vast regulatory insurance scheme in operation in that industry. Instead, the poor are given funds out of general tax revenues. There are no HMOs for jackets, shirts and shoes. There is no government imposed insurance scheme in operation. The point is, health care could be run on a private basis, just as now obtains in clothing. Whether it is justified to use transfer payments through the welfare system for either medical services or clothing is an issue outside our present concerns.

simply no warrant for government to set itself up as a super nanny. Traditionally, in the classical liberal philosophy, the state, if it has acted at all (Rothbard, 1973, Hoppe 1993a, 1993b, Benson, 1990) has limited itself to suppressing fraud (Murray, 1997, Boaz, 1997). Without licensing, experience suggests that the market for certification of quality will function in this area as it has done in many others (e.g., engineering, chemistry, etc.) Moreover, since the presumption is that private markets will always work better than government monopolies, we can expect to have better information as to the quality of doctors than at present.

There is also a tension, not to say a downright logical contradiction, between licensure and our democratic institutions. If people are so stupid as to not be able to consult a certified doctor, when practice by non-certified quacks would no longer be prohibited by law, then why should we allow them access to the ballot box? On the other hand, if they are legitimately entitled to vote, then surely they may be trusted to pick their own physicians without any compulsion by the government.

References

- Benham, Lee, *Guilds and the Form of Competition in the Health Care Sector*, in Greenberg, Warren, ed., *COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT AND FUTURE*, Germantown, MD: Aspen Systems Corporation, 1978.
- Benson, Bruce L., *THE ENTERPRISE OF LAW: JUSTICE WITHOUT THE STATE*, San Francisco: Pacific Research Institute for Public Policy, 1990.
- Boaz, David, *LIBERTARIANISM: A PRIMER*, New York: Free Press, 1997.
- Butler, Stuart M., and Haislmaier, Edmund, eds., *A NATIONAL HEALTH SYSTEM FOR AMERICA*, Washington D.C.: Heritage Foundation, 1989.
- Cutler, David M., *A Guide to Health Care Reform*, *JOURNAL OF ECONOMIC PERSPECTIVES*, Vol. 8, No. 3 (1994), pp. 13-29.
- Dolan, Edwin G., and Goodman, John C., *ECONOMICS OF PUBLIC POLICY*, St. Paul: West Publishing, 1995.
- Dolan, Edwin G. *TANSTAAFL: THE ECONOMIC STRATEGY FOR ENVIRONMENTAL CRISIS*. New York: Holt, Rinehart and Winston, Inc., 1969.
- Ellwood, Paul., and Alain C. Enthoven, *Responsible Choices: The Jackson Hole Group Plan for Health Reform*, *HEALTH AFFAIRS*, Vol. 14, No. 2 (1995), pp. 24-39.
- Enthoven, Alain C., and Sara J. Singer, *Market-Based Reform: What to Regulate and by Whom*, *HEALTH AFFAIRS*, Vol. 14, No. 1 (1995), pp. 105-119.
- Flexner, Abraham. *Medical Education in the United States and Canada*, Bulletin No. 4, The Carnegie Foundation for the Advancement of Teaching, Boston: D.B. Updike, The Merrymount Press, 1910.
- Freiberg, Lewis, Jr., and F. Douglas Scutchfield, *Insurance and the Demand for Hospital Care: An Examination of the Moral Hazard*, *INQUIRY*, Vol. 13 (March 1976), pp. 54-60.
- Friedman, Milton, *CAPITALISM AND FREEDOM*, Chicago: University of Chicago Press, 1970.
- Friedman, Milton, *The Folly of Buying Health Care at the Company Store*, *THE WALL STREET JOURNAL*, Feb. 3, 1993, p. A14.
- Gellhorn, Walter, *INDIVIDUAL FREEDOM AND GOVERNMENTAL RESTRAINTS*, Baton Rouge: Louisiana State University Press, 1956.
- Ginsburg, Paul B., and Jeremy D. Pickreign, *Tracking Health Care Costs: An Update*, *HEALTH AFFAIRS*, Vol. 16, No. 4 (1997), pp. 151-155.
- Ginsburg, Paul B., and Jeremy D. Pickreign, *Tracking Health Care Costs*, *HEALTH AFFAIRS*, Vol 15, No. 3 (1996), pp. 140-149.
- Goodman, John C., and Musgrave, Gerald L., *PATIENT POWER*, Washington D.C.: Cato Institute, 1993.

- Goodman, John C., *THE REGULATION OF MEDICAL CARE: IS THE PRICE TOO HIGH?*, Washington D.C.: The Cato Institute, 1980.
- Hamowy, Ronald, *The Early Development of Medical Licensing Laws in the United States, 1875-1900*, JOURNAL OF LIBERTARIAN STUDIES, Vol. 3, No. 1 (1979), pp. 73-119.
- Hamowy, Ronald, *CANADIAN MEDICINE: A STUDY IN RESTRICTED ENTRY*, Vancouver: The Fraser Institute, 1984.
- Hoppe, Hans-Hermann, *Fallacies of the Public Goods Theory and the Production of Security*, in *THE ECONOMICS AND ETHICS OF PRIVATE PROPERTY: STUDIES IN POLITICAL ECONOMY AND PHILOSOPHY*, Boston: Kluwer, 1993a.
- Hoppe, Hans-Hermann, *THE ECONOMICS AND ETHICS OF PRIVATE PROPERTY: STUDIES IN POLITICAL ECONOMY AND PHILOSOPHY*, Boston: Kluwer, 1993b.
- Hyde, David R., Wolff, Payson, Gross, Anne, and Hoffman, Elliott Lee, *The American Medical Association: Power, Purpose and Politics in Organized Medicine*, YALE LAW JOURNAL, 65, 1954.
- Kessel, Reuben A., *Price Discrimination in Medicine*, JOURNAL OF LAW AND ECONOMICS Vol. 1 (October 1958) pp. 20-53.
- Kett, Joseph F., *THE FORMATION OF THE AMERICAN MEDICAL ASSOCIATION: THE ROLE OF INSTITUTIONS, 1780-1860*, New Haven: Yale University Press, 1968.
- Lindsay, Cotton M., and Buchanan, James M., *The Organization and Financing of Medical Care in the United States*, in *HEALTH SERVICES FINANCING*, London: British Medical Association, 1974.
- Manning, Willard G., Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, AMERICAN ECONOMIC REVIEW, Vol. 77 (June 1987), pp. 251-277.
- Mark, Tami, and Curt Mueller, *Access to Care in HMO's and Traditional Insurance Plans*, HEALTH AFFAIRS, Vol 15, No. 4 (1996), pp. 81-87.
- Moeller, John F., *Gainers and Losers under a Tax-Based Health Care Reform Plan*, INQUIRY, Vol. 32, No. 3 (1995), 285-299.
- Murray, Charles, *WHAT IT MEANS TO BE A LIBERTARIAN*, New York: Broadway Books, 1997.
- Musgrave, Gerald L., Tripoli, Leigh, and Yu, Fu Ling, *Lunch Insurance*, REGULATION, Fall 1992, Vol. 15, pp. 16-24.
- National Center for Policy Analysis, *The Myth of Universal Coverage*, BRIEF ANALYSIS 103, May, 11, 1994.
- Newhouse, Joseph P., *Medical Care Costs: How Much Welfare Loss?*, JOURNAL OF ECONOMIC PERSPECTIVES, Summer, 1992, Vol. 6, No. 3, pp. 3-22.
- Newhouse, Joseph P., *Symposium on Health Reform*, JOURNAL OF ECONOMIC PERSPECTIVES, Vol. 8, No. 3 (1994), pp. 3-11.
- O'Grady, Kevin F., Willard G. Manning, Joseph P. Newhouse, and Robert H. Brook, *Impact of Cost Sharing on Emergency Department Use*, NEW ENGLAND JOURNAL OF MEDICINE, Vol. 313, No. 8, (August 22, 1985), pp. 484-490.
- Ozanne, Larry, *How Will Medical Savings Accounts Affect Medical Spending?* INQUIRY, Vol. 33, No. 3 (1996), pp. 225-236.
- Pauly, Mark V., *What Happened to the Tough Choices?* HEALTH AFFAIRS, Vol. 13, No.1 (1994), pp. 147-160.
- Rayack, Elton, *Restrictive Practices of Organized Medicine*, THE ANTITRUST BULLETIN, 1968.
- Reinhardt, Uwe E., *Reorganizing the Financial Flows in American Health Care*, HEALTH AFFAIRS, Vol. 12 (Supp. 1993), pp. 172-193.
- Robbins, Gary, Robbins, Aldona, and Goodman, John, *Inefficiency in the U.S. Health Care System: What Can We Do?* NCPA Policy Report No. 182, Dallas Texas: National Center for Policy Analysis, 1994.

- Rothbard, Murray N., FOR A NEW LIBERTY, Macmillan, New York, 1973.
- Santerre, Rexford E., and Stephen P. Neun, HEALTH ECONOMICS: THEORIES, INSIGHTS, AND INDUSTRY STUDIES, Chicago: Richard D. Irwin, 1996.
- Teisberg, Elizabeth Ohnsted, Michael E. Porter, and Gregory B. Brown, *Making Competition in Health Care Work*, HARVARD BUSINESS REVIEW, Vol. 72, No. 4 (1994), pp. 131-141.
- Van Barmveld, Erik M., Rene C.J.A. van Vliet, and Wynand P.M.M. van de Ven, *Mandatory High-Risk Pooling: An Approach to Reducing Incentives for Cream Skimming*, INQUIRY, Vol. 33, No. 2 (1996), pp. 133-143.
- Weisbrod, Burton A., *The Health Care Quadrilemma*, JOURNAL OF ECONOMIC LITERATURE, June, 1991, Vol. 29, No. 2, pp. 523-552.
- Wholey, Douglas R., Jon B. Christianson, John Engberg, and Cindy Bryce, *HMO Market Structure and Performance: 1985-1995*, HEALTH AFFAIRS, Vol. 16, No. 6 (1997), pp. 75-84.
- Zelman, Walter A., *Rationale behind the Clinton Health Reform Plan*, HEALTH AFFAIRS, Vol. 13, No. 1 (1994), pp. 9-29.