Prologue: Although long-term health system reform likely will involve elements of government regulation, competition, and voluntarism, Americans historically have preferred the latter in seeking solutions to society’s problems. Private foundations form a key part of the voluntaristic community effort, providing funding and leadership in areas where governments lack effectiveness. In 1984, The Robert Wood Johnson Foundation embarked on a $15.2 million, four-year initiative, known as the Community Programs for Affordable Health Care (CPAHC), which intended “to demonstrate that community-based groups could work cooperatively and effectively to contain health care costs at the local level,” according to a foundation spokesman. As part of its ongoing commitment to evaluation, matched by few other foundations, the foundation gave $436,000 to Lawrence Brown and Catherine McLaughlin to evaluate CPAHC. In this essay, they summarize their evaluation findings, which constitute a direct assault on this community coalition model that, for many people involved, held much promise in containing rising health care costs. Brown, of Columbia University, is one of the few American political scientists who has engaged the intersections between politics and health policy during an era when economists dominate the scene of analysis and commentary. Brown received a doctoral degree in government from Harvard University and has spent a distinguished career in various academic settings. He served as editor of the Journal of Health Politics, Policy and Law and has written numerous books and articles. McLaughlin, who received a doctoral degree in economics from the University of Wisconsin, is an associate professor in the Department of Health Services Management and Policy at the University of Michigan School of Public Health. She has published extensively on health maintenance organizations and price competition.
The year 1990 marks the end of two decades of intense debate about and experimentation with strategies to contain the costs of health care in the United States. Since 1970, both public regulation and competitive rivalry among payers and providers have grown steadily. But as the 1990s open, all this activism can claim only one clear outcome: The system preaches cost containment but practices cost shifting. The era of the prudent purchaser, like a mirror or microcosm of the egocentric, money-minded 1980s) has rewarded economic individualism while permitting aggregate system costs to rise unchecked—years after most comparable Western nations, faced with similar cost pressures in the 1970s—achieved relative restraint.

The dismal outcome of U.S. cost containment policy comes accompanied by a striking process correlate that may also carry strong causal significance: The public and private sectors have largely gone their separate strategic ways. Government purchasers have adopted increasingly stern and extensive measures that regulate providers’ budgets. On the other side, business and other private purchasers have labored during the 1980s to integrate the new competitive revelations into their deep traditional faith in community-centered, voluntaristic approaches to the delivery and financing of health care and have remained all the while aloof, on preference and principle, from the increasingly regulation-minded public buyers. As each of the two key purchaser blocs has opted for the road less traveled by its counterpart, cost shifting has resulted.

If cost shifting is the problem and purchaser fragmentation its cause, then the basic policy challenge for the 1990s is to find ways to make these wayward purchaser paths converge. Federal and state governments will probably continue down the road of budgetary regulation, and for a very good reason. Whereas their intermittent efforts to devise broad, procompetitive reforms rarely left the drawing board, these payers have reaped significant short-run savings from the Medicare prospective payment system (PPS) and state rate-setting programs. The policy “ball” therefore lies in the court of the private purchasers, namely, the business community, which has for decades deferred leadership in health affairs to voluntary providers and payers (that is, the nonprofit hospitals and Blue Cross and Blue Shield). American business also has, for more than a decade, assumed that cost containment need not threaten the continued autonomy of the voluntary institutions whose boards it runs and whose coffers it fills, so long as these community bodies are disciplined (not too severely, of course) by the new fabled market forces, immeasurably superior to government’s heavy, dead hand.

In this essay, we argue that the strategic reasoning of business and the world view that supports it are thoroughly mistaken; that misguided
thinking among private purchasers is today the single most formidable obstacle to a sensible cost containment debate; and that the communitarian, voluntaristic faith must be shaken and reformed if policy is to move beyond ever more elaborate labyrinths of cost shifting. We develop and defend this argument here by demonstrating and discussing the failure of an ambitious foundation-sponsored program intended to promote cost containment by energizing voluntarist and market forces in a number of diverse communities.

Community Programs For Affordable Health Care

In 1981-1982, The Robert Wood Johnson Foundation (RWJ), troubled that rising health care costs imperiled the gains in access and quality it had sought in its first ten years of existence, entered the arena of cost containment. A quintessential third-force institution—a non-profit, private-sector organization with close ties to hospitals, insurers, and medical schools with a similar sectoral identity—it set forth with predictable skepticism about the ability of governments and markets (the two dominant collective decision-making mechanisms to which the nonpublic, nonprofit “third force” offers an alternative) to slow costs. The foundation turned for counsel to a familiar and comfortable set of allies, the “Chicago crowd,” especially those paragons of voluntarism and community service, the American Hospital Association (AHA) and Blue Cross and Blue Shield. A mere three years after the collapse of the hospital industry’s “Voluntary Effort” (VE) at cost containment, AHA and Blue Cross and Blue Shield theoreticians presented the foundation with what an RWJ staffer later derided as “the VE in drag.” “Community forces”—public-regarding leaders in the community-serving voluntary hospitals and Blue Cross and Blue Shield—would assemble at the local level to develop potent but socially responsible cost containment schemes. The Robert Wood Johnson Foundation agreed to support the planning and implementation of these “community programs for affordable health care” (CPAHC), as the effort came to be called. Robert Sigmond, a veteran strategist and enthusiast of community forces, became the program’s executive director.

Drawn though it was by organizational instinct and inclination to third-force allies, the foundation was not free of anxiety about foxes guarding chickens. Staff members therefore urged that CPAHC supplement local health care elites with purchaser power, that is, business and labor. Fortunately, there was then emerging a “movement” to launch community cost containment coalitions under the leadership of John Dunlop, Harvard professor emeritus and former secretary of labor, and his
“Group of Six” (the Business Roundtable, organized labor, Blue Cross and Blue Shield, AHA, the Health Insurance Association of America, and the American Medical Association). Unlike the business-only coalitions favored by the Washington Business Group on Health, the Dunlop group’s preferred vehicles were exactly what the foundation envisioned: multiparty community bodies that assembled high-level representatives of business, labor, hospitals, Blue Cross and Blue Shield, and (if feasible) other interests. Intrigued, RWJ officials persuaded Dunlop to chair the program’s national advisory committee.

CPAHC, set in motion in 1982, was certainly no model of clear expectations and shared understandings. Protagonists never fully resolved differences about whether they aimed to promote coalitions (engines of bargaining as viewed by Dunlop) or “community forces” (high-minded transcenders of local particularism as portrayed by Sigmond); about the relative importance of process and outcome in the programs (some thought that promoting interchange among powerful locals was a contribution in itself; others, that the sole valid measure of the program’s worth was whether and how it registered demonstrable savings); and about the role of competition in local projects (some viewed it as inescapable in any modern assault on costs; others, as an unforgivable admission of money changers into the temple).

Beneath these and other chronic conflicts, however, one could discern some fairly clear and common presuppositions about structure, process, and outcome. The program’s designers assumed that local program building would, by improving understanding and communication among local health elites, encourage behavioral change and, therewith, community progress in containing costs. They found this production function plausible because they never doubted that the local elites anointed by CPAHC would commit themselves enthusiastically to the program’s mission, forge agreement on strategies that were sound and doable, and then marshal the power (heavy hitters that they were) to implement the changes they had endorsed. And they agreed that the object of the exercise—the outcome against which the program’s structures and processes would be judged—was a significant reduction in the growth of community health care costs, achieved without such unpalatable side effects as cost shifting and reductions in access for the disadvantaged. The program was, in short, as elaborate an articulation of a communitarian, voluntarist cost containment scheme as one is likely to find and as ambitious a test of it as one is apt to encounter. CPAHC offers a classic commentary on—and, we think, critique of—the theory and practice of the private purchasers’ chosen battle plan against voracious health care costs.

Beginning in 1982, RWJ invested $15.2 million of a budget once
projected to run as high as $19 million (in 1986, $4 million was withdrawn because the program was faltering) in program building in sixteen communities. Eleven sites moved successfully from planning to implementation—Atlanta, Boston, Detroit, Iowa, Mecklenberg County (North Carolina), New York City, Pittsburgh, Topeka, Tulsa, Twin Cities (Minnesota), and Worcester (Massachusetts). Five others—Northwest Pennsylvania (Erie), Phoenix, Queens (New York), Richmond (Virginia), and San Diego—for one reason or another, received only planning grants. In 1985, the foundation engaged us to evaluate CPAHC. We conducted interviews and reviewed documents in all the above-mentioned communities except Queens, Erie, and Phoenix. We also added to these thirteen sites another eight [Cleveland, Dallas, Fort Lauderdale, Little Rock, Los Angeles, Portland (Oregon), Rochester (New York), and Salt Lake City] that promised instructive contrasts with regard to size, region, or cost containment activities. We analyzed data from the Area Resource File (ARF) on all metropolitan statistical areas (MSAs) with populations of 250,000 or more (the minimum size eligible for CPAHC). We present here the major conclusions of a much longer report completed for the foundation.

Evaluation Findings

Given the expectations of the program’s sponsors within the foundation, our evaluation sought evidence that CPAHC achieved its major goal, namely, a significant contribution to cost containment in the communities in which it was implemented. (A fortiori, the question whether the rise in costs was slowed in a socially responsible fashion is valid only if costs were in fact contained.) We began with such (imperfect) statistical assessments as seemed defensible. Unfortunately, data on community-level spending are limited in both time (figures from 1980-1986 were the most recent available) and scope (measures of hospital spending and use are the best outcome indicators at hand). Data were collected for all 159 MSAs for seven years, 1980-1986. In all cases, the 1983 definition of an MSA was used. Most of the data came from the ARE Additional information on health maintenance organizations (HMOs) was obtained from InterStudy’s annual HMO census; on freestanding surgicenters, from an annual survey conducted by their association in 1985 and 1986; and on coalitions, from our 1986 survey.2

In the early 1980s, the sixteen CPAHC sites had statistically significantly higher hospital spending per capita and admission rates than the 159 MSAs with 250,000 or more population. One can conclude, then, that the program did indeed focus on some of cost containment’s
neediest cases. There is little indication in the data, however, that the rate of growth of health spending in CPAHC sites slowed in contrast with comparable communities.

**Hospital spending.** An examination of the growth in hospital expenses from 1980 to 1986 reveals that each site can be seen as its own control, allowing for a before-and-after CPAHC intervention comparison (starting in 1984 for most sites). Several of the CPAHC sites experienced a decrease in the growth of real hospital expenses per capita, often beginning in 1983, prior to the intervention. This was true for several of our comparison sites as well, however. In fact, real per capita hospital expenses decreased, on average, for all MSAs, most likely reflecting the initial effect of Medicare PPS. The rate of growth in real per capita hospital expenses increased again in 1985 for many CPAHC and comparison sites, reflecting the national trend. Clearly, various determinants of hospital expenses were changing at different rates in different MSAs.

**Admission rates.** A more discriminating look at the components of hospital spending isolates price per unit \((p)\) and the number (quantity) of units of care used \((q)\). No CPAHC site worked directly on price-nome had rate-setting leverage, for example-and the program denied implementation funds to the one project that developed a preferred provider organization (PPO) (San Diego). Utilization review was a popular strategy, however, and a measure of its effects may be obtained by examining trends in \(q\) (specifically, admissions per thousand). Exhibit 1, giving admission rates for those sites with a utilization review program, shows a mixed and ambiguous record. Admission rates in Pittsburgh and Boston declined more slowly than the (declining) national average, whereas

### Exhibit 1
**Admissions Per Thousand By Selected CPAHC Sites With Utilization Review Projects, 1980-1986**

<table>
<thead>
<tr>
<th>Year</th>
<th>Iowa</th>
<th>National</th>
<th>Boston</th>
<th>Charlotte</th>
<th>Pittsburgh</th>
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</thead>
<tbody>
<tr>
<td>1980</td>
<td>125</td>
<td>175</td>
<td>150</td>
<td>175</td>
<td>175</td>
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<tr>
<td>1981</td>
<td>120</td>
<td>170</td>
<td>140</td>
<td>160</td>
<td>160</td>
</tr>
<tr>
<td>1982</td>
<td>115</td>
<td>165</td>
<td>135</td>
<td>155</td>
<td>155</td>
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<tr>
<td>1983</td>
<td>110</td>
<td>160</td>
<td>130</td>
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<td>1984</td>
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<td>140</td>
<td>140</td>
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<tr>
<td>1986</td>
<td>95</td>
<td>145</td>
<td>115</td>
<td>135</td>
<td>135</td>
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</table>

*Source: Bureau of Health Professions, Area Resource File, various years.*
Atlanta and Charlotte experienced larger-than-average decreases. In both cases, however, the trend began in 1982, two years before the start of Charlotte's program and three years before the start of Atlanta's. The contribution of either utilization review program to lowered admission rates is difficult to isolate. Although average rates may mask underlying variation across areas within Iowa, the overall admission rate there decreased dramatically from 1980 to 1986. Some direct or indirect signal was being sent to physicians in Iowa to decrease hospital admissions, independent of the efforts of the CPAHC team.

**Length-of-stay.** A suggestive related indicator of “savings” is trends in average length-of-stay. Exhibit 2 displays the record of four CPAHC sites that addressed length-of-stay by means of utilization review (Pittsburgh, Atlanta, and Charlotte) or efforts to promote early discharge from hospitals (New York City). The average length-of-stay in all of our sites decreased from 1984 to 1986, in part reflecting the incentives built into the Medicare diagnosis-related group (DRG) payment scheme. On average, length-of-stay decreased by 4 percent over this three-year period. Average length-of-stay in New York City, greater than the national average over the entire time period and greater than other CPAHC cities with utilization review programs monitoring length-of-stay, decreased by 7 percent during the period. Again, however, the average length-of-stay was decreasing by more than 7 percent from 1980 to 1984, making it difficult to attribute to CPAHC any change witnessed during the pro-

Exhibit 2
Length-Of-Stay In Short-Term General Hospitals For Selected CPAHC Sites, 1980-1986

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<tbody>
<tr>
<td>New York</td>
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<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
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<tr>
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<td>9</td>
<td>8</td>
<td>7</td>
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<tr>
<td>Charlotte</td>
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<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>National</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Atlanta</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Bureau of Health Professions, Area Resource File, various year
gram’s implementation. Charlotte shows a sizable decline from 1983 onward, but this occurred before the implementation of the site’s CPAHC project and can hardly be explained by it.

**Outpatient surgery.** A final utilization-related measure is trends in outpatient surgery, a strategy pursued most vigorously by the CPAHC project in Detroit. The number of outpatient surgeries per thousand residents did increase in Detroit; in 1986, Detroit had one of the highest rates in the country (fifty per thousand, versus a national average of forty-five per thousand). The total number of surgeries (both inpatient and outpatient) per thousand, after increasing from ninety-three in 1980 to ninety-eight in 1984, stayed constant during the program. Therefore, the percentage of total surgeries performed on an outpatient basis increased. The location of ambulatory surgery also changed, with a shift from hospital outpatient surgery to freestanding clinics. This trend may result in cost savings. The effect of the CPAHC program is hard to measure, however. Although the percentage of total surgeries performed on an outpatient basis in Detroit is one of the highest, that has been true since 1980. The increase in the percentage of outpatient surgeries from 1985 to 1986 in Detroit was lower than the national average and lower than in several other of our sampled cities (Los Angeles, Portland, and Worcester) where pressures from local HMOs to lower inpatient surgery rates were more intense.

Of course, an examination of trend lines on charts is not a definitive source of judgment on CPAHC, but these patterns of expenses, admissions, average length-of-stay, and outpatient surgery do suggest that the timing of such cost-containing effects generally fails to make a case for the efficacy of the program. The questions arise, then, whether CPAHC mainly correlated with (and perhaps helped advance at the margin) changes in the larger health care environment and, if so, what the most salient of these changes might be. To address these questions, we used multiple regression.

**Effects of participation.** We wanted to estimate the effect of participation in CPAHC on a community’s hospital utilization and expenses. A simple cross-sectional analysis, however, may lead to false conclusions. For example, in any given year, most of the cities that participated in CPAHC had above-average expenses. What is of most interest is the change in those expenses. Unfortunately, a seven-year time trend does not provide enough degrees of freedom to estimate the effect of CPAHC on the annual growth in utilization or expenses for each site. In addition, we lose the ability to compare growth rates across sites.

Pooling of the data in a fixed-effects model allows us to treat each MSA as its own control, to look at changes in hospital use and expenses over
time, controlling for both observed determinants of hospital use and expenses (for instance, HMO enrollment rates, average income per capita, and physician supply) and unobserved determinants that do not vary across time (for example, practice patterns and consumer attitudes on the efficacy of hospital medical services). There is a price to pay, however, for this increased information, namely, problems of serial correlation. (This year’s level of hospital expenses is highly correlated with last year’s. In fact, tests revealed that the correlation was as high as .99, suggesting that the medical care system moves very slowly, propelled by last year’s legacy with little movement away from the projected path, whatever the changes in the system.) We also detected heteroskedasticity problems (the variation in utilization was positively associated with population size, a common relationship). We corrected for both problems by estimating a weighted first difference equation, in which the weights are the square root of the population, and all variables are measured as the change from year \( t \) to year \( t+1 \). The results show that participation in CPAHC at any level had no significant effect on admission rates. Participation in a Stage II project, however, was associated with statistically significantly higher hospital expense per capita and per admission. Physician supply was associated with significantly higher admission rates and per capita expenses. Enrollment in prepaid group practices appeared to have a significant dampening effect on both admission rates and per capita expenses. The final significant explanatory variable was income per capita, associated with significantly higher admissions rates but significantly lower hospital expenses per capita, per admission, and per day.\(^3\)

Because prepaid group practice enrollment was the sole variable related to CPAHC projects found to be significantly associated with reductions in admission rates and per capita expenses, we decided to investigate more closely CPAHC’s microlevel prepaid group practice effects in Worcester, Massachusetts. The promotion of HMOs by Worcester’s CPAHC project has been widely touted as one of the program’s shining successes.\(^4\) As Exhibit 3 shows, HMO penetration in Worcester grew much more rapidly than in the average MSA. Worcester moved from having the twenty-fourth largest HMO penetration rate in 1980 to the seventh in 1986. Similar moves occurred, however, in Milwaukee, Rochester (New York), and Lansing (Michigan). In each case, approximately 5 or 6 percent of the population belonged to an HMO in 1980, and approximately one-third in 1986.

Again, the impact of CPAHC is hard to quantify. The HMO market in Worcester began its rapid growth in 1982, before the project was implemented in August 1984. Apparently, the climate was ripe for the
Exhibit 3
Percent Of Population Enrolled In Health Maintenance Organizations, By Selected CPAHC And Comparison Sites, 1980-1986

Source: Interstudy, National HMO Census, various years.

expansion of HMOs in Worcester quite aside from CPAHC’s vigorous efforts to instill the principles and practice of market competition. It is notable that Rochester, lacking CPAHC funds and enmeshed in a highly regulated environment, achieved the same HMO penetration as did Worcester.

One of the major changes expected to accompany the growth of HMO enrollment is a reduction in hospital admission rates. Exhibit 4 examines rates of admission per thousand in Worcester and other sites with high HMO penetration rates as compared to the national average. Interestingly, with the exception of Worcester, the sites in our sample with high HMO enrollment rates show a greater-than-average decrease in admission rates during this seven-year period. The decrease in the admission rate from 1984 to 1986 in Worcester was also lower than that in the average MSA over that time.

In sum, our data seem to yield no evidence of hospital cost containment outcomes that can be plausibly attributed to CPAHC. Repeatedly, promising candidates for success turn out to be spurious, that is, riding broader trends that predated the program in the community in question, or best ascribed to variables (especially PPS) outside the program.5

Explanations For Failure

Theories about CPAHC’s failure abound. Some blame the program administrators for taking too narrow and rigid a view of acceptable local
initiatives. Others contend that parochialism and poor judgment by the national advisory committee when selecting sites led to the inclusion of weak prospects and the exclusion of stronger ones. Still others argue that CPAHC was a victim of unlucky timing. When CPAHC was implemented in the mid-1980s, the upsurge of competition and the arrival of Medicare PPS suddenly destabilized the environment in which health care institutions worked and, by promoting anxiety and aggressive self-protection, impeded the large-minded cooperation the program required. According to these views, CPAHC was (and remains) a fine idea denied a fair chance of success. A more convincing explanation of the program’s lack of positive results, however, is that it was an implausible theory that ran against the realities of the political economy of community health care.

**Failures of will.** The basic reason why the CPAHC mission did not succeed is that it was always “mission impossible.” That mission required that community leaders organize themselves into stable negotiating structures that would exert within the health sector economic discipline of sufficient rigor to slow the rate of growth of local health care costs and do so only by socially acceptable and responsible means. The program’s reach vastly exceeded the communities’ grasp.

One fundamental reason for the intractability of CPAHC’s core tasks is that most communities, most of the time, cannot summon the collec-
tive will that cost containment demands. In some, health care is a very big business. Health institutions in Boston, Cleveland, Atlanta, New York, and many other cities are major sources of employment and prestige. Others—Topeka, for instance—see in health care high-tech, recession-proof relief from the ups and downs of such industries as oil, timber, and farming. Business leaders know that health care costs too much, but their willingness to act on the problem usually ends at the benefit manager’s door. Endlessly willing to try to shift costs to employees by “benefit redesign” (a narrow strategy CPAHC did not condone), they are generally unprepared to incur the conflict entailed by tilting against the system. Some business leaders sit contentedly on the boards of trustees of hospitals whose interests in survival and growth they faithfully protect and advance. Many executives are quickly frustrated by the peculiar economics of health services, and as generalists with complex organizations to run, they seldom care to take the time to puzzle it all out under the suspect tutelage of providers eager to “educate” them. They are no more willing to sustain the conflicts inherent in public quarrels with providers. But if not business, who?

The much-mentioned waning of professional sovereignty is not a uniform cultural development; rather, it proceeds at different paces in different settings. Sovereignty has indeed waned in the eyes of academicians and government budgetmakers, but amidst communities and their elites, hospitals and physicians still retain enormous legitimacy. Nor, for all the talk of a national cost crisis, is there much direct incentive at the community level to attack costs. The famous lack of fiscal equivalence in the incidence of health care benefits and costs means that the costs of benefits enjoyed locally tend to be diffused regionally and nationally. The lesson that Harvey Sapolsky drew for health planning holds equally well for such third-force endeavors as CPAHC: bottom up is upside down.

Given a suitable stimulus and scope for action, community leaders can exert substantial force in local health affairs, but their efforts usually support expansion and improvement in the system, not curtailment or reorganization. Enhancing locally available technology, extending specialized services, and attracting high-quality medical practitioners are popular local projects that honor a widely shared boosterish consensus bolstered by the claims and pressures of special groups in the community. In some sites, the plight of the homeless, people with acquired immunodeficiency syndrome (AIDS), the mentally ill, and the uninsured may move community elites to action, though the controversial nature of the groups and lack of agreement on what concretely to do for them often quickly shrink leaders’ attention spans. Sometimes leaders persuade themselves (and perhaps a foundation) that gap filling or reorganization
also promotes cost containment. In these cases, however, the leaders’ energies derive largely from the satisfaction of doing good; estimates of, indeed interest in, cost containment are afterthoughts at best. Community leaders generally want to see their health care institutions thrive and prosper; seldom are they willing to compromise these expectations from concern about costs whose incidence is largely diffused and whose “containment” (a diminution of a percentage point or so in the annual rate of growth of one or another indicator of spending) confers little or no credit on those who helped achieve it. CPAHC’s insistence that community leaders devote time and political capital to cost containment ran strongly against the political and cultural grain. The equation of “more” and “better,” generally discarded in government budget circles and academic texts, retains a large following in many communities. Cost containment is always someone else’s job.

Failures of knowledge. Even if every major force within the community was sincerely convinced of the need for aggressive local cost containment, little would happen in many, perhaps most, communities because the protagonists would not agree on what should be done. Business believes in cost containment but does not want to fight with providers and employees or to cooperate with government to get it. Labor wants more slowly rising costs so long as policy preserves expanding benefits and avoids takeaways. Blue Cross and Blue Shield plans long to see costs contained, but not if it means greater competition or interference with their freedom to set rates, define enrollment eligibility, and otherwise run their own shops. Hospitals want costs checked so long as they can go on expanding and charging as they see fit. Doctors favor responsible cost containment, but no one will tell them how to practice medicine. The public, too, clamors for an assault on soaring health care costs so long as benefits remain broad and access to high-quality care is easy. If representatives of the various health elites are assembled around a table within their communities, the “logical,” outcome is a protracted exercise in cost shifting-each tries to contain his or her own costs by transferring them insofar as possible to other actors and sectors. If all participate on more or less equal terms, the sole “logical” outcome of the exercise is stalemate: an eternal shifting of costs around and around or a collective refusal to act at all. The funding and prestige of a foundation grant such as CPAHC can change the pattern, but only marginally and superficially. The “coalition” funded will reach agreement on lowest-common-denominator projects that threaten no one very much (and therefore change things very little), or will adopt projects imposing “threats” that are already widely familiar (hence the popularity of voluntary utilization review projects in CPAHC), or will redefine the mission.
in hopes that service- and benefit-extending activities can be sold as cost containment, or will incautiously embark on bold initiatives soon abandoned under fire (downsizing projects are a perennial illustration). The notion that community forces can be led by the shining beacon of “enlightened self-interest” to embrace important reforms in business as usual gains little support from CPAHC’s record.

To suggest that community elites cannot agree on how to contain health costs is not an indictment of community forces per se. In U.S. society, no other levels or forces can agree on the issue either. Twenty years of windy debate over competition versus regulation have produced little slowing in the rate of growth of costs and have elicited more numerous and subtle strategies for squeezing the health cost balloon. The evasions of responsibility displayed at the community level in CPAHC are equally evident at the national and state levels and in the activities of the powerful organizations that sat on CPAHC’s national advisory committee. This is understandable; players in these groups do not rise to chief executive status by “selling out” their organizations’ interests for the sake of a greater good.

In health affairs, the notion that major interests will reach agreement on significant change if only enough of them chat long enough at the negotiating table is profoundly fatuous. An advisory committee member nicely summarized the problem in a sardonic reference to Dunlop’s indefatigable traveling and convening, reminiscent of President Eisenhower’s pledge to “go to Korea.” Eisenhower might productively go to Korea because he could commit military and other resources directly pertinent to engineering a settlement there. Dunlop might go to Des Moines as often as he pleased and yet achieve little because he lacked effective means of converting talk into action and controlled no resources highly valued by the local “sides.” After a point, discussion retains value only if it is disciplined by the participants’ knowledge that failure to reach significant agreement will result in salient costs to themselves. This knowledge, this disciplining framework of stakes and expectations, basic to collective bargaining, was entirely absent in CPAHC. The hospital industry’s Voluntary Effort to hold its costs down in the late 1970s was coextensive with the threat that President Carter’s regulatory hospital cost containment plan might pass; when the bill died, so did the industry effort. Major institutional players consented to play along with CPAHC when-and only because-they perceived that the program permitted them to win modest benefits without incurring any significant costs.

Except in Rochester, the one local force that might exert effective discipline-business leadership-has declined to do so. In the genteel state of nature that is the world of community health care forces, Thomas
Hobbes’s insight into the importance of a central power to “keep them in awe” is a penetrating piece of policy analysis. That constraining power might derive from the market or from government, but it will not emerge from the third force.

**Failures of power.** Even if community forces were dedicated to containing costs and agreed on how the job should be done, their best efforts would produce little, for the simple reason that many of the causes of, and most of the cures for, rising health care costs are not to be found at the community level. Federal and state governments set benefits and payments for Medicare, Medicaid, and other public programs at the national and state, not community, level. Blue Cross, Blue Shield, and other large payers set benefits and premiums on a state or regional basis, or for national accounts; most such insurance plans abandoned community rating long ago. Such regulatory programs as peer review organizations, certificate of need, and rate setting are organized statewide; the localistic health systems agencies, government-sponsored efforts to marshal community forces in the service of cost containment, were widely judged a failure and lost their federal authorization and funds in 1986. If corporate chains that own or manage hospitals identify a community as a promising “market,” there is usually not much the community can do to block or shape chains’ decisions that limit Medicaid’s capacity to address these problems. Most of the major decisions that govern the flow of dollars into the system are neither made at nor subject to much influence by the community level. Nothing dramatizes the locals’ dilemma better than the federal government’s sudden adoption in 1983 of PPS for inpatient services in Medicare. Having labored in 1982 to devise cost-containing projects in their familiar world of actual cost reimbursement, CPAHC planners found that (as many of them said) “the world changed,” undercutting or rendering moot their designs and relegating them to the role of coping with new, powerful environmental imperatives.

As an unsuccessful CPAHC grant seeker in Portland, Oregon, contended (with more acumen than sour grapes): “CPAHC was a wonderful program for the 1950s,” that is, for an era untouched by Medicare; Medicaid; federally encouraged competition; federal and state regulation of utilization, capital, and rates; the near-ubiquity of third-party payment; large national accounts; and the other centripetal forces that leave communities on the outside looking into the determination of the system’s benefits and costs. Nor is it clear that CPAHC would have made sense even in those halcyon days. Of the two (and only two) concrete exemplars of the ideals CPAHC embodied—Pittsburgh and Rochester—the former fell from glory in the 1960s and the remarkable results of the latter seem to rest on a series of heroic corporate exertions that have not
come close to emulation anywhere else. Lacking power, community forces at most can help mediate local adjustments to changes whose sources lie above and beyond their reach.

Lessons For Policy

A Robert Wood Johnson Foundation staffer described CPAHC as “the last big shot to see if anyone in the voluntary sector would take on the cost issue.” CPAHC’s record suggests that the answer is an unambiguous “no.” The policy implication is equally clear: Voluntary efforts and third-force alternatives will not supply policymakers with an easy exit from the dilemmas of cost containment in the 1990s. The U.S. health care system is already extremely bottom-heavy. One (though not the only) reason why the United States spends more than 11 percent of its gross national product on health care is that for decades it has allowed community forces to make weakly constrained decisions about the introduction, diffusion, and use of technology; the construction and service mix of hospitals; and the generation of the actual costs and usual charges for which providers have been reimbursed. Community forces are now finally being given to understand that rights (to treat and spend) carry responsibilities (to discern and pursue value for money). Cost controls will mean new limits on the supply of resources and new restrictions on payments. Voluntary forces cannot be expected to generate such innovations at the community level, for such change threatens their missions and incomes.

Cost containment, as distinct from cost shifting, can be achieved only by slowing the flow of dollars into the system as a whole, and this probably would require extending regulatory budget controls—prospective pricing—to virtually the whole range of payers, providers, and procedures. Such cost containment would restrain the free play of resources within health care institutions at the community level, not by reviewing and then approving or rejecting the details of individual decisions, but by capping the funds available to decisionmakers, who would then respond managerially as best they could. State or regional ceilings on capital spending by hospitals and other institutions might well be part of the package. Sharing of technology would probably ensue. Hospitals might invent such structures as the Rochester Area Hospitals’ Corporation to redefine their individual roles in the light of newly constrained resources. Physician incomes would grow slowly, and capitation payments, or ones allocated by a relative value scale coupled to expenditure targets, would seek to curb the recouping of losses on price by increases in volume. For most services, insurers would pay providers what a public authority tells
them or allows them to pay. The rate of growth of health care spending might be linked to some broad economic indicator, such as the rate of general inflation plus x percent, or the rate of growth of gross national product. Global budgets would fix the size of the health cost balloon, and new payment rules would limit the squeezing the balloon could sustain.

A strict framework of budgetary constraints would stimulae the development of negotiating structures at the national and (probably) subnational levels. In theory, government might issue commands and controls from on high, and payers and providers might declare their principled refusal to participate in a new system they oppose. In practice, however, U.S. government has never shown much taste for “command and control” regulation, preferring to engage the consent and constructive contributions of the governed, and payers and providers would clamor for seats at the bargaining table the minute they concluded that government finally meant business. Strange to say, if such multiparty negotiating structures as CPAHC or the health systems agencies (or any number of other real or imaginary models) did not then exist, government would have to reinvent them. In a sense, CPAHC was born both too late and too soon: a nice idea for the 1950s) its time could come again in the 1990s. Such negotiating structures are never sufficient sources of discipline in themselves, however, and will become necessary and desirable only within the constraints of a systemwide budgetary regulation yet to be installed. Absent this framework, CPAHC has all the dynamism of a cart without a horse.

None of these major policy and institutional departures has come, or is likely to come, from the community level or the voluntary sector. The “market” (large corporate purchasers) has so far dismissed such constraints as excessively regulatory. Steps toward realistic cost containment to date have been almost entirely the province of government, but they suffer two serious limitations. First, they have been designed largely for the benefit of government itself, the self-proclaimed “prudent purchaser” that is content to let costs shift to nonpublic payers. Second, these measures are afflicted with sectoritis. Last year, hospitals were out of control, so the inpatient payment system must be tightened; this year, physician spending is the conspicuous problem, so relative value scales come into vogue; next year, some other sector will bulge and be squeezed in turn. Sequential “solutions” imposed on public payments to discrete sectors invite entrepreneurialism, gaming, and litigation as providers identify loopholes and exploit unregulated terrain. A sectoral strategy fails to address the source of the cost shift and the basic policy problem, which is the fragmentation of purchasers between and within the public and private spheres. The federal and state governments, alternative
delivery systems, and large and small corporate purchasers approach providers with no semblance of unity and thereby invite them to regain revenues lost to “prudent” purchasers from the coffers of less watchful or more vulnerable ones.

**Three options for public policy.** Distasteful though they are, sequential confrontations with provider sectors over the terms of public payment are far more palatable politically than would be the policies required to conquer fragmentation among purchasers. Three main options are available. First, the United States could move to a national health insurance scheme run under government auspices and partly or entirely with government funds. The polity has steadily rejected this course, and there is no evidence that it is about to change its mind. Second, the nation could adopt a sophisticated market-based strategy such as Alain Enthoven’s Consumer Choice Health Plan, but this version of “regulated competition” has little more likelihood of enactment than does national health insurance. Third, large private-sector purchasers could join increasingly assertive public-sector buyers in a new national coalition that would work to overcome buyer fragmentation.

Such a coalition has been a practical, albeit latent, possibility since the early 1980s) when observers began predicting that the “sleeping giants” would soon awaken to lead an “employer revolution” against rising health care costs. Had the large private purchasers resolved to work with government then-when the federal government, disgusted by the failures of the hospitals’ Voluntary Effort, was moving toward PPS and when California was designing the selective contracting provisions that would soon put PPOs on the map-billions of dollars might perhaps have been saved. Faced with a recession, accelerating foreign competition, declining profits, and health insurance premiums rising 20 percent or more per year, the corporate world had both motive and opportunity to collaborate in reshaping the system. The business community, however, chose the other fork in the road, the one that led to the right, so to speak, and was therefore more comfortable politically and ideologically. Business increased cost sharing for employees, talked up competition, began installing utilization review systems, and participated in community cost containment coalitions. In the late 1980s) health insurance rates were soaring again; all but the most dogmatic free marketeers and voluntarists acknowledged the failure of the stratagems tried earlier in the decade. But the cost increases of the late 1980s occurred in a generally strong economy. Purchasers grumbled at the size of their bills and the impotence of their earlier efforts but did nothing.

The critical question for the 1990s) as Lynn Etheredge has observed, is what happens when rapidly increasing health insurance premiums next
coincide with a recession. Perhaps the business community will return to community coalitions, step up cost sharing, renew its faith in competition, labor yet again to “buy right,” or invent some new policy solution as yet undreamed of. It will be surprising, however, if any of these panaceas are revived, and it is doubtful that the private purchasers can continue indefinitely to sit there and do nothing. Perhaps the 1990s will see a day of reckoning on which the large private purchasers finally swallow their ideological aversion to government regulation (which has, after all, been known to appeal to them when it promises to save or make them money) and petition Washington to join them in a national purchaser coalition that might lay down the law to providers and payers. Given the political implausibility of national health insurance and consumer choice health plans, such a coalition is probably the necessary, and possibly a sufficient, condition for significant cost containment in the United States.

That such a coalition could and should be constituted does not of course mean that it will be. For two decades, the business community, preferring detachment from government, has embraced a wide range of quixotic communitarian and privatist policy fashions. As the 1980s end, however, the intellectual capital that fueled the Twenty Years’ War between competition and regulation is largely exhausted. The resulting analytical *tabula rasa* may be, at long last, a prelude to realism.

In U.S. health policy debates, however, realism can and usually does die a thousand deaths, and a resurrection is nowhere guaranteed. Not least powerful among the threats to realism is the world view embodied in CPAHC—that communities can and should be awarded a leadership role in containing health care costs, that progress is inevitable if only the leaders of powerful local health care institutions come to the bargaining table and stay there, and that government and the market must be held at bay lest politics and profit sully the pristine professionalism of third-force, community-serving elites. The key policy lesson of CPAHC, and its major contribution to the national policy debate, is to demonstrate, with that singular vividness that comes of many trials and more errors, the bankruptcy of those notions. Yet if government and market forces separately frighten the third force, the prospect that a public/private purchaser coalition might unite to reform the system fundamentally must be terrifying indeed. The closer the public and private sectors move toward realism—and toward partnership—the more may one expect agitated reiteration of the mythology of voluntarism and community.

The third-force mythology enshrined in CPAHC is not only a world view, a collection of deeply held values, but also a set of political weapons that may devastate cost containment “reform” in the future as they have in the past. If health care is thought to be a community affair, it will
probably be thought to be none of government’s affair, nor the market’s. If it is widely believed that process matters vastly and should be allowed to run its course, it may be believed too that the system’s dismal record in containing costs matters little and should be allowed to continue undisturbed. If society is persuaded that long conversations among round-tables of local notables is progress per se, government may fear to interrupt the conversation. If business can be convinced that coalitions between itself and the local voluntary health care power structure will bring it relief from high health insurance premiums, it will not seek or accept a national coalition uniting public and private purchasers, a partnership that would call hospitals and insurers to the negotiating table only after the partners had decided how much it would permit them to spend. It is therefore no surprise that the third-force faithful continue to recite their litany in the face of the evidence of CPAHC and other failed kindred efforts. The legitimacy of that litany preserves their political power and protects their autonomy from a cost-containing realism that might at last put community and its “forces” in their proper place.

Lessons For Foundations

The costs that The Robert Wood Johnson Foundation incurred from CPAHC were considerable. About $16 million, which for a time made CPAHC the foundation’s largest national program, was spent, with meager returns. Escalating “I told you so’s” and “Why didn’t you tell me so’s” within the foundation increased organizational stress. Recriminations over the granting and implementation of local awards embarrassed the foundation in several sites and circles. Foundation staffers who came to regard CPAHC not as the source of the important policy lessons they had sought but rather as a compendium of almost every imaginable operational error can make a powerful case for their jaundiced view. What might Johnson (or other foundations) learn from the program’s many problems?

In our view, the foundation bought a bill of goods mainly because it naively accepted three faulty premises that blocked (and still block) effective intervention on behalf of cost containment. Here we briefly challenge those premises with some countervailing suggestions.

“Arenas” matter. For most of its first ten years, The Robert Wood Johnson Foundation focused on enhancing access to (and the quality of) medical care, in fruitful collaboration with such natural allies in the voluntary sector as hospitals, academic medical centers, and health clinics. When, in 1981, the foundation decided to add cost containment, with great fanfare, to its list of good causes, it did not sufficiently pause
to ponder whether those who wore the white hats (and coats) when expanding and improving the system would show comparable sartorial taste when asked to rein in the system (that is, themselves).

One can agree with proponents of voluntarism that community hospitals and nonprofit insurers are (often) benevolent and public-spirited sources of the delivery and financing of health care and still argue that the voluntary sector is the wrong place to look for leadership in cost containment. As political scientist Theodore J. Lowi once observed, “Policy determines politics.” That is, the substantive policy arena in which one would play and lead determines—or should determine—the institutional allies one seeks and the practical expectations one forms. To be sure, recurrent resort to the voluntary sector is an appealing strategic compromise for right-of-center types, suspicious of government, and left-of-center adherents, distrustful of the market. Nonetheless, turning reflexively to the “Chicago crowd” for bold new initiatives to address rising costs two years after the collapse of the Voluntary Effort was a breathtaking blunder, the fundamental error from which many others flowed in CPAHC.

Steeped in the powerful clinical, social, and public health world views that sustained its first decade of activities, some foundation staffers stammered (indeed choked) on the political, economic, and organizational lexicon required to talk sense in the very different arena of cost containment. Going Berlitz, as it were, they ended up lisping about “power structures” and “heavy hitters” without knowing whereof they spoke. Foundations that would change the real world of health policy—as distinct from that steadily shrinking sphere that lies within the autonomous reach of the voluntary sector—need to gain a better understanding of politics, economics, and organizational behavior and of how these intervening variables mediate and transmute the transition from purpose to outcome in distinct patterns in diverse policy arenas. Such variables have next to nothing to do with “science” (medical or other) and everything to do with power.

Had the foundation posed and pursued hard questions about political, economic, and organizational power at the outset, it would have concerned itself less with what local hospitals and Blue Cross and Blue Shield plans might do and more with how the big public and private purchasers of care might be united in strategies that would carry them beyond cost shifting. But addressing these concerns programmatically would have meant leaving the foundation’s familiar third-force friends on the sidelines and engaging with the daunting denizens of government and business, for whom health care is but one, and by no means the most central, product line.
“Keep your eye on the ball.” Resolved to consort and cavort with the voluntaries, superficially tutored in the peculiar institutional proclivities of the cost containment arena, and but dimly aware that containing costs could mean cutting back, which could mean sharp conflict, The Robert Wood Johnson Foundation clung to the consoling view that the natural play of process-relatively unfettered interchange among local health care elites-could not fail to yield impressive outcomes. CPAHC would provide the stimulus to bring “heavy hitters” from major health care institutions to the bargaining table, where they would devotedly sustain elevated exchanges about the public interest until consensus emerged on how their community (“as a whole,” of course) should lock horns with health care costs. Enthusiasts at the foundation and elsewhere often admiringly described the strategy as “bringing the right people together” and “getting something going in the community.”

Alas, this process-worship rested on no realistic production function that linked talk to action, process to outcome. Not surprisingly, talking and “bargaining” proved to be far more satisfying to such voluntary-sector participants as hospital and Blue Cross and Blue Shield officials, who discoursed at length on why the system is as it is and cannot be significantly changed without dire consequences, than to such purchasers as business and labor, who squirmed and resented the education their more specialized tablemates windily proffered. Worse, the price of consensus was in most cases measures that posed no great threat to anyone at the table.

The foundation that would strike a blow for cost containment must keep its eye on the ball. This means doing the reverse of CPAHC: deciding in some detail which outcomes it would accept as a fair return for a given investment and then tailoring-and prescribing-a planning process, cast of characters, and set of roles that stand some chance (however remote) of achieving those outcomes. What CPAHC’s mission required was consensus (or, at any rate, some working relationship) between public and private purchasers on how to slow the flow of money into the system, but this of course would have mightily upset the community health notables to whom the foundation gave pride of place in local CPAHC coalitions. Inattentive to policy arenas and their practical implications, the foundation’s notion of consensus in CPAHC helped reduce the program to yet another member of the densely populated set of excuses just to sit there-and talk-and do nothing about costs.

“No pain, no gain.” The belief that great things would surely happen if only a roundtable of important community figures reached agreement appealed to the foundation because it extrapolated its wishful thinking about the relation between social change and social conflict, namely, that one can achieve a lot of the former with little or none of the latter. If
CPAHC is generalizable, then RWJ implicitly subscribes to a “maximin” strategy of program selection: The prize goes to the program (and of course to the program’s staff progenitor) that produces a “major national demonstration” of generalizable results while causing as little aggravation as possible to anyone of consequence in the process. Deployed on behalf of the foundation’s core mission to enhance access, the maximin strategy worked reasonably well; adding resources that medical powers desired for worthy but underserved groups and causes won broad acclaim and stepped on nobody’s toes.

The cost containment arena differs, however. As Uwe Reinhardt, Robert Evans, and others have noted, each dollar of health care spending is a portion of someone’s income. Thus, cost containment initiatives always threaten the earnings, mission, or autonomy (or all three) of major health care interests, including of course the sainted voluntaries whose leadership was essential to CPAHC. As the program was implemented, the perils of transferring the maximin strategy from system improving to system-constraining projects grew painfully clear. “Meaningful” measures to slow the growth of costs would upset health care providers and payers whose good will the foundation valued. Meaningless measures that preserved consensus, however, nettled the foundation’s own better nature, which recognized only after expectations had been raised and millions of dollars spent that it did not know how to get from here to there. This, we surmise, helps explain why, within the foundation, the sense that CPAHC had betrayed it was so strong: The program exposed the important contradictions in the foundation’s basic world view and strategic premises.

The cost containment lessons that might have counted as national models would have explored the consequences that arise when unified purchasers put providers on constrained fiscal rations—as, for example, in Rochester, New York, or, by various means, in every Western industrial democracy save the United States. To launch and support programs capable of exploring such lessons, however, The Robert Wood Johnson Foundation would have had to weather much storm and strife; no local, multiparty roundtable honoring consensus would have generated such strategies, however effectively they might have done so when allocating new RWJ monies to expand their local operations. Foundations do best by doing good. If, as we believe, the war on costs is too important to be left to the health care system’s generals, foundations should either withdraw from a battlefield whose mayhem they cannot bear or seek coalition partners and patterns different from those to which they reflexively gravitate by organizational custom and character. Often, in health affairs, understanding what has failed is as important as—and a necessary prelude
to-discovering what might work. Having demonstrated the limits of voluntarism in the 1980s, the Robert Wood Johnson Foundation (and others) should follow the argument where it leads in the 1990s—to encouragement for public/private partnerships that unite and concert purchasers’ power in pursuit of the praiseworthy goals CPAHC lacked the means to attain.

NOTES

1. The program and its aims are well described in D.L. Gerber, “Community Programs for Affordable Health Care,” Inquiry (Summer 1983): 127-133.
3. For results of the pooled weighted regression, first difference model, and other statistical details, contact Catherine McLaughlin at the School of Public Health, University of Michigan, 1420 Washington Heights, Ann Arbor, Michigan 48109.
5. Because the data deal mainly with hospital patterns, we can say little, however, about projects such as those in Boston and Tulsa that did not principally intend to influence hospital behavior.