

Power and Purchasing: Why Strategic Purchasing Fails

SCOTT L. GREER,* KATARZYNA KLASA,*
and EWOUT VAN GINNEKEN†

**University of Michigan, School of Public Health*; †*European Observatory on Health Systems and Policies, Berlin University of Technology*

Policy Points:

- Strategically purchasing health care has been and continues to be a popular policy idea around the world.
- Key asymmetries in information, market power, political power, and financial power hinder the effective implementation of strategic purchasing.
- Strategic purchasing has consistently failed to live up to its promises for these reasons. Future strategies based on strategic purchasing should tailor their expectations to its real effectiveness.

Context: Strategic purchasing of health care has been a popular policy idea around the world for decades, with advocates claiming that it can lead to improved quality, patient satisfaction, efficiency, accountability, and even population health. In this article, we report the results of an inquiry into the implementation and effects of strategic purchasing.

Methods: We conducted three in-depth case studies of England, the Netherlands, and the United States. We reviewed definitions of purchasing, including its slow acquisition of adjectives such as *strategic*, and settled on a definition of purchasing that distinguishes it from the mere use of contracts to regulate stable interorganizational relationships. The case studies review the career of

The Milbank Quarterly, Vol. 98, No. 3, 2020 (pp. 975-1020)

© 2020 The Authors. *The Milbank Quarterly* published by Wiley Periodicals LLC on behalf of The Millbank Memorial Fund

This is an open access article under the terms of the Creative Commons Attribution-Non-Commercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

strategic purchasing in three different systems where its installation and use have been a policy priority for years.

Findings: No existing health care system has effective strategic purchasing because of four key asymmetries: market power asymmetry, information asymmetry, financial asymmetry, and political power asymmetry.

Conclusions: Further investment in policies that are premised on the effectiveness of strategic purchasing, or efforts to promote it, may not be worthwhile. Instead, policymakers may need to focus on the real sources of power in a health care system. Policy for systems with existing purchasing relationships should take into account the asymmetries, ways to work with them, and the constraints that they create.

Keywords: strategic purchasing, contracting, purchasing, health systems.

STRATEGIC PURCHASING OF HEALTH CARE HAS BEEN A POPULAR policy idea around the world for almost two decades now. Many health systems, including the social insurance countries and the United States, have a long history of transactions in which a health service is purchased by some agent that pools funds, such as an insurer. But strategic purchasing, part of a family of concepts including commissioning and managed competition, is an idea that dates to the mid-1980s and involves adding a list of attributes to the basic act of purchasing. Strategic purchasing promises to achieve affordable access to high-quality care and maximize health system efficiency through financing mechanisms and purchasing tools that promote provider competition, pool risks, prioritize effectively, and ensure equity through citizen engagement. It has been put forth in several versions, with more or less well developed frameworks intended to specify conditions for its success. It is a key component of the World Health Organization's universal health coverage framework and is also being promoted internationally by United States government programs,^{1,2} a level of institutional support that ensures continuing conversation about it.

Most definitions of purchasing roughly agree with the World Health Organization that purchasing means the allocation of pooled funds to providers that deliver health care goods and services to the covered population, as per the defined benefit package. *Strategic purchasing* means "active, evidence-based engagement in defining the service mix and volume, and selecting the provider mix in order to maximize societal

objectives.”¹ The appeal of strategic purchasing as a tool to improve health system performance seems to span different types of health systems, with reforms premised on or intended to promise strategic purchasing found in Bismarckian, Beveridgean, and hybrid systems, as well as the very different institutional environment of the United States.³⁻¹⁰

Although many countries have adopted the name and elements of strategic purchasing, reviews find that no country has systematically and successfully incorporated all elements.^{3,4,11-13} However, few of these reviews analyzed the implementation of strategic purchasing or tried to develop an understanding of why it had the effects it did.^{3-7,9,10,12,14} Why does the idea of strategic purchasing keep disappointing in implementation?

In this article, we argue that the failure is not for want of trying. Rather, it is because there are fundamental asymmetries between purchaser and provider that make purchasing unlikely to be strategic in any definition.

In the next section, we review definitions of purchasing, including its slow acquisition of adjectives such as *strategic*, and settle on a definition of purchasing that distinguishes it from the mere use of contracts to regulate interorganizational relationships. We then present a theory of why strategic purchasing, as a health care policy tool, is unlikely to actually take place. The remainder of the paper reviews the evolution of strategic purchasing in three different systems where its installation and use (under different names, such as commissioning, selective purchasing, prudent purchasing, or active purchasing) have been a policy priority for years.^{3,11,15-28}

We chose England, the Netherlands, and the United States as our three case health systems because they are internationally known, high-income countries, have been substantially evaluated, and have attempted to promote strategic purchasing through legislation and varying levels of implementation. In other words, we are maximizing the seriousness of the policy intent and the quality of the literature, as well as the diversity of health systems. These three cases represent both different purchasing systems and different styles of health care policy reform (see Table 1).^{29,30} They constitute a fortuitous “most different systems” design.³¹ The three systems that have the most extensive and well-documented attempts to introduce strategic purchasing have very different health systems, politics, and public-private divisions of labor. If we see the same results in such different systems, united only by powerful forces advocating for

Table 1. Case Country Selection Overview

Country	Market Structure	Choice of Purchaser	UHC?	Type of Purchaser	Purchaser Coverage	For Profit
United Kingdom (England)	Single payer	No	Yes	Government (CCGs)	NHSE: national, geographically delimited CCGs: local, geographically delimited	No
The Netherlands	Multipayer competing	Yes	Yes	Private insurance companies	National, not geographically delimited	Allowed (only one insurer is for profit)
United States	Hybrid model: mixture of payers	Mixed ^a	No ^b	Government and private insurance companies	Employer-based/insurance exchanges/Medicare Advantage: state-based, not geographically delimited Medicare: national, not geographically delimited Medicaid: state-based, geographically delimited VA: national, geographically delimited	Allowed, common

Abbreviations: CCG, clinical commissioning group; NHSE, National Health Service England; UHC, universal health coverage; VA, Veterans Affairs.

^aMedicare beneficiaries can opt out of traditional Medicare and choose a Medicare Advantage plan. Employer-based insurance typically has a choice of purchaser, but this is dependent upon the employer. Plans on the marketplaces provide consumers with a choice of purchaser. Medicaid and the VA do not provide a choice of purchaser.

^bMedicare only provides UHC for individuals ≥ 65 years old, younger people with disabilities, and people with end-stage renal disease.

strategic purchasing, then we can say something about strategic purchasing's utility beyond evaluations of individual countries.

What Is Strategic Purchasing?

Although the act of buying health care services is hardly a recent invention, the theory of strategic purchasing in its current form is often traced back to Alain Enthoven's concept of managed competition:

[A] purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from microeconomic principles. A sponsor (either an employer, a governmental entity, or a purchasing cooperative), acting on behalf of a large group of subscribers, structures and adjusts the market to overcome attempts by insurers to avoid price competition. The sponsor establishes rules of equity, selects participating plans, manages the enrollment process, creates price-elastic demand, and manages risk selection.³²

Enthoven's concept was influential in England,³³ where, along with the theories of Alan Maynard, it was said to be a major influence over Margaret Thatcher's government. Thatcher's government introduced a "purchaser-provider split" and an "internal market" into the National Health Service (NHS) systems of the United Kingdom with the 1989 Working for Patients program.³⁴ The implementation of Working for Patients contributed to the language of purchasing, identifying an internal market as a market with a split between purchasers and providers. At the time, the Dutch system was seen as the first health system to consistently implement Enthoven's model and, unlike the United Kingdom, also implement insurance competition.³⁵

In principle, the logic of purchasing, as an alternative to hierarchical decisions about resource use, is that it allows market-based coordination of decisions. Rather than allocating resources through hierarchies, it allows decentralized actors to allocate (at least some) resources in order to better reflect efficiency, priorities, and local tastes.³⁶ In Hirschman's terms, it mobilizes the purchaser's exit option to shape policy at least on the margins, since purchasers who do not like a given provider's offering are able to replace it.³⁷ Reliance on group purchasers—what Enthoven envisaged—allows both risk pooling and the possibility that the purchasers will develop expertise, policy capacity, and data that allow them to make better decisions.

This means that strategic purchasing excludes policies in which individual patients have full free choice of providers, as this may be constrained by a limited network created through the strategic purchasing system. There are a variety of systems that combine strategic purchasing policies with patient choice policies, but the two mechanisms are different and may contradict each other. Patients are usually not asked to purchase strategically because they lack the expertise to gauge quality and might not prioritize overall efficiency. Instead, we can expect them to focus on observable issues such as waiting times, convenience, and the particular procedures they require. Judging by the English experiences described in this paper, patient choice has a better record of actually affecting providers than strategic purchasing does, possibly for that reason.

Since Enthoven and Working for Patients, the purchaser-provider split, internal markets (another name for the purchaser-provider split), purchasing, contracting, and various forms of competition between providers have all become common health policies. Some social insurance systems have adopted some of the logic of purchasing, asking their funds to take a more direct role in prospectively contracting and deciding on care (rather than merely retrospectively reimbursing whatever patients choose), and private insurance companies, in contexts as different as the United States and the Netherlands, have likewise been asked to take on, or tried to take on, a role that looks beyond price and quantity.

Purchasing has also acquired adjectives, most of all *strategic*. It is a case of what Theodore Marmor has noted, namely, the use of adjectives as a rhetorical device to make a concept attractive.^{8,38} “Managed care” is one example. Just as nobody would want unmanaged uncaring health services, nobody would prefer that their purchasing be unstrategic.

The use of adjectives allows authors to expand the range of characteristics that they attribute to their desired form of purchasing, defining it by what *they want* it to be and do. For example, Enthoven specifies that purchasers shall seek “maximum value,” that the rules shall be “derived from microeconomic principles,” and that the market shall be structured by sponsors to prevent anticompetitive behavior, promote equity and elasticity, and manage risk selection. That will elevate mere purchasing to managed competition, and the sponsor will certainly do a great deal of management—in an enlightened and informed fashion—if it is to work.

It is an intimidating list of requirements for a policymaker. Intellectually, it sets up what philosophers call no-true-Scotsman fallacies. A

“no-true-Scotsman” fallacy is one that tries to preserve generalizations (eg, “strategic purchasing promotes efficiency”) by adding ad hoc qualifications that rule out a counterexample (eg, a given country with an apparently failed implementation of strategic purchasing did not really have strategic purchasing because the legal framework did not incorporate “adherence to microeconomic principles”).³⁹ Thus, any failure of strategic purchasing can be attributed to its not really being strategic purchasing and should not be held against the concept.

The problem compounds if a policy cannot actually be implemented. In that case, proponents can always argue that it failed because of its implementation, even if they really should be held accountable for advocating for an idea that cannot be implemented. It is less a no-true-Scotsman fallacy than a no-true-unicorn fallacy, since at least Scottish people exist.

We want to underline the scale of definitional expansion here, visible in Table 2. Simple “purchasing” or “contracting” happens in many ways and holds little obvious promise for reforming health systems. Each author, in definitions and in frameworks, has added a range of additional desiderata to differentiate strategic purchasing and make it attractive or at least something that can be evaluated. We also want to underline another definitional slippage, between frameworks and definitions. Some authors clearly define strategic purchasing, and others provide frameworks for it to work, which look like definitions but whose status is not quite clear (eg, if a framework identifies what is necessary for strategic purchasing to work, what is a policy that fulfills few or none of the requirements but that has been called strategic purchasing?). The synthetic definition at the bottom of Table 2 tries to distill the commonalities by defining strategic purchasing as “an evidence-based process that sculpts health care systems by prioritizing the financing of certain goods and services over others through collaborative planning across various healthcare stakeholders while incorporating the needs and priorities of citizens in the distribution of health care and promoting equity, quality of care, efficiency, and responsiveness in the provision of health services.” Some recent policies have also tried to incorporate population health (eg, “social determinants” such as unsafe living conditions, lack of exercise, or poor diet). We expect that the challenges facing strategic purchasing would be found in population health initiatives, but they might be more serious due to the complexity of trying to address broad social determinants of health.

Table 2. Existing Strategic Purchasing Definitions

Author/Organization	Definitions
European Observatory (2007:45) ³	Strategic purchasing is a "systemic approach . . . [that] aims to increase health systems' performance by effectively allocating financial resources to providers, by deciding the following: <i>which</i> interventions to purchase in response to population needs, national health priorities, and evidence-based cost-effectiveness; <i>how</i> to purchase these interventions, including contractual mechanisms and payment systems; and <i>from whom</i> to purchase, taking into account quality and efficiency of providers."
World Health Organization (2000:97, 104-107) ⁵	<p>Purchasing organizations should "continuously search for the best interventions to purchase, the best providers to purchase from, and using the best payment mechanisms and contracting arrangements possible to achieve the highest, equitable health outcomes possible." The following are key elements of strategic purchasing:</p> <ol style="list-style-type: none"> 1. Use public health to determine priorities for public financing, enforce stewardship, and use population health data in choosing which interventions to buy. 2. Prioritize units in purchasing in order to promote the creation of more long-term contracts. 3. Avoid micro-purchasing and micro-managing, which prevent the pooling of health services and populations and prevent risk-sharing. 4. Through budgeting and contracting, establish an environment in which there are appropriate incentives for providers to (1) prevent health problems of pool members, (2) provide services and solve health problems of members, (3) be responsive to people's legitimate expectations, and (4) contain costs. 5. Establish appropriate political capacity and governance to promote flexible provider resource management, promote accountability, and prevent negative consequences of financing reforms.

Continued

Table 2. *Continued*

Author/Organization	Definitions
World Bank (2007:3-4) ⁶	<p>The World Bank uses a normative approach toward its strategic purchasing framework. Implementing a proper strategic purchasing policy framework requires addressing the following sets of issues in order to ensure improved health system efficiency and equity.</p> <ol style="list-style-type: none"> 1. Political Economy <ol style="list-style-type: none"> a. The political choice about the appropriate role of the state, government failure, market failure, and stakeholders 2. Policy Design <ol style="list-style-type: none"> a. Resource allocation and the purchasing arrangement, which determine for whom to buy, what to buy, from whom to buy, how much to pay, and how to pay b. Revenue collection mechanisms, which include the level of prepayment, degree of progressivity, earmarking, choice, and enrollment c. Pooling of revenues and risk sharing, which consider the size, number, risk equalization, coverage, and risk rating 3. Organizational Structure <ol style="list-style-type: none"> a. The organizational forms (including contractual relationships), structural configuration, and incentive regimes at play 4. Institutional Environment <ol style="list-style-type: none"> a. The legal frameworks, regulatory instruments, administrative procedures, and customs and practices 5. Management Capacity <ol style="list-style-type: none"> a. The management levels, skills, incentives, and tools available

Continued

Table 2. *Continued*

Author/Organization	Definitions
UK Department of Health (2007:3-6) ⁹	<p>The United Kingdom, which arguably started the whole purchasing conversation with its 1980s purchaser-provider split, incorporated strategic purchasing into the commissioning cycle for health services ("commissioning" has been the term for strategic purchasing in England since 1997). The cycle is centered on the patient/public and attempts to meet national health targets. While the English NHS has since been reorganized so as to leave the context of this particular document irrelevant, the model it contains is worth noting:</p> <ol style="list-style-type: none"> 1. "Assessing needs 2. Reviewing service provision 3. Deciding priorities 4. Designing services 5. Shaping the structure of supply 6. Managing demand 7. Referrals, individual needs assessment, advice on choices, and treatment/activity 8. Managing performance (quality, performance, outcomes) 9. Seeking public and patient views"

Continued

Table 2. *Continued*

Author/Organization	Definitions
Honda et al. (RESYST consortium) for WHO-WPRO (2015:4) ⁴	<p>“In strategic purchasing, a purchaser is an organization that buys health services, using pooled funds, for certain groups or the entire population. The purchaser can use levers to influence the behavior of providers to improve quality and efficiency in health service provision and facilitate equity in the distribution of healthcare providers. However, purchasing mechanisms operate within each country’s policy framework and, in strategic purchasing, government is required to play a stewardship role by providing a clear policy framework and appropriate guidance to ensure that resource allocation and purchasing decisions are linked to public health priorities. As the purchaser buys health services for people, it is important for the purchaser to ensure that there are effective mechanisms in place to determine and reflect people’s needs, preferences and values in purchasing, and hold healthcare providers accountable to the people.”</p>
Synthesized definition	<p>An evidence-based process that sculpts health care systems by prioritizing the financing of certain goods and services over others through collaborative planning across various health care stakeholders while incorporating the needs and priorities of citizens in the distribution of health care and promoting equity, quality of care, efficiency, and responsiveness in the provision of health services.</p>

Adapted from Klasa K, Greer SL, van Ginneken E. Strategic purchasing in practice: comparing ten European countries. *Health Policy*. 2018;122(5):457-472.

Why Strategic Purchasing Fails

Researchers have failed to find examples of effective strategic purchasing, including those whose papers are cited in this section.¹³ Most of these views focus on misaligned incentives.^{1,4,6,9,40-45} But finding repeated negative evaluations of a policy is not the same thing as finding a reason why the policy systematically fails. Attempting the latter, we argue that the absence of strategic purchasing by any definition is the result of four key asymmetries (see Table 3) that lead to power imbalances between purchaser and provider (or patient), which are difficult or unlikely to change.

Information Asymmetries

Information asymmetries are the first problem. Arrow's classic analysis of health care economics points to the problem.^{46,47} Purchasers suffer from information asymmetries relative to the providers they seek to contract with or individual patients. This means that effective needs assessment or utilization reviews, as well as purchasing decisions, will be very costly and often require more information and time than can be had within existing financial, technical, and organizational capacity to collect and use data. The temptation will be to simply continue purchasing more or less what was purchased last year, or use crude approaches that can lead to backlash.

Political Power Asymmetries

Literature about strategic purchasing is often framed in terms of exogenous incentives, but what if some actors can deploy political power to change the incentive structure or prevent it from having the expected effects? Strategic purchasers are intervening with purely financial instruments in decisions about patient care, professionalism, and the behavior of large community institutions such as hospitals and universities. We posit that strategic purchasers, whether insurance companies or special purpose organizations such as England's clinical commissioning groups (CCGs), will always be politically weaker than patients, professionals, or hospitals. As a result, any serious efforts by a payer to discipline a provider by pushing patients elsewhere will be undercut by medical

Table 3. Definitions of Four Asymmetries

Asymmetry	Definition
Information	When one actor has more information than the other in purchasing decisions. This occurs when the patient or provider has more information than the purchaser, which prevents effective needs assessment or utilization reviews and leads to inefficient purchasing contracts.
Political power	When one actor has more political power than the other; in purchasing, this occurs when the purchaser has less power than patients, providers, or politicians, which prevents its ability to intentionally affect and influence the behaviors of providers, limiting its ability to discipline, ensure compliance, and uphold accountability.
Market power	When there is a lack of competition and/or imbalance in the marketplace; in purchasing, this occurs when a purchaser has no exit option or capacity to negotiate effectively due to geographic limitations or powerful strategic “sellers” (ie, monopoly or oligopoly providers and hospitals).
Financial	When one actor in a transaction lacks the financial leverage required to receive more than the marginal cost of the transaction. In purchasing, this occurs when a purchaser does not have enough future income, funds, or power to finance capital investment compared to other health care actors.

and patient noncompliance and risks political backlash when politicians choose to intervene to save a hospital or treat patients differently. It also means that purchasers are expendable, as seen in their constant reorganization in the UK systems (and their unproblematic abolition in Scotland, discussed later in the paper).

Market Power Asymmetries

Market power asymmetry refers to competitive structures, and geographical constraints, that lead to a lack of competition and imbalances such as between monopoly providers and purchasers. It is not universal but is certainly common in remote and rural areas and some entire countries. A purchaser has power—an exit option—only if there are competing providers with spare capacity. The assumption of competing options with spare capacity is not always operative, for reasons of population density, geography, or investment in health care facilities. For example, if hospitals are all run at high rates of bed occupancy and there is no capital funding for expansion, then there is no reason to seek more patients. Often, providers attempt to strategically increase their own market power by merging.⁴⁸ Such asymmetric market power is a common situation in historically tightly budgeted countries that have not sought to create spare capacity (eg, the UK systems); but it can also happen in markets such as the United States and the Netherlands, where hospitals have merged into local monopolies and oligopolies.⁴⁹

Financial Asymmetries

Finally, existing strategic purchasing involves, at best, routing patients to one provider over another (assuming that information and power asymmetries mean purchasers can actually do that). For this to discipline providers, the amount of money purchasers have and can redirect must suffice to make providers responsive to purchasers. In general, purchasers do not have enough money to influence providers, especially capital investment, and when they do it is at the margins. Even if payers did have enough money to shape capital investments, political difficulties would still hinder their ability to threaten disinvestment.

The money associated with each patient episode, however calculated, is usually closer to the marginal cost of the procedure than to a cost including enough profit to finance capital investment. In the United States, hospital capital investment is substantially funded by fee-for-service payments and bond markets, which take future income from all sources (public and private payers) into account. Some systems have tariffs that include future capital expenditure needs. In other systems, the government (national, regional, or local) is almost always responsible for capital expenditure. As a result, a hospital that benefits from strategic purchasing might be able to build up a useful financial cushion, hire some marginal staff, or buy some equipment, but it is highly unlikely to actually be able to access the kind of money needed for real capital investment through that route. As a result, the capital investments that form the skeleton of the health care system are often decided by governments, not strategic purchasers. This is the same reason why classic Bismarckian systems, for all their emphasis on insurance funds and organized professions, had capital come from the state, local governments, or churches in almost every case, and therefore had delivery systems shaped by politics rather than social insurance. Last, this financial asymmetry also affects the purchaser's ability to selectively contract, as governments will generally not allow institutions that received substantial government funding to go bankrupt. In principle, this is the easiest asymmetry to address, since all it requires is that capital expenditure budgets be given to the payers and incorporated into the strategic purchasing process. But it is vulnerable to cost containment efforts that allow the capital component of the payment to drop over time, as might have happened in England. Moreover, as the Dutch case study shows, even where insurers control the money, including capital, and contract selectively, they may still lack the tools necessary to steer patients to preferred providers.

These four asymmetries amount to saying that purchasers are the least informed and economically or politically powerful players in the system. Further, in many cases they will lack the financial ability to determine capital expenditures in any purposeful way. Their strategies are accordingly going to have limited impact on health care. We explore these dynamics in the fate of three ambitious strategic purchasing initiatives: England, the Netherlands, and the United States.

The United Kingdom and England

England is the homeland of purchasing as a key policy instrument. It is where the theory that purchasing should be adopted and be made strategic was introduced into national health service systems, and where we have had by far the longest experience of efforts to build a health system around strategic purchasing.

Working for Patients, the 1989 NHS reform, was the first explicit effort to turn purchasing into a policy instrument as part of a package of reforms that sought to introduce competition as a force in a national health service system. Essentially, it split apart purchasers and providers and set up purchasing of care as the action that linked them and would give power to the purchasers. The purchaser-provider split meant two things. One was that health authorities, which previously managed providers, would become purchasers of care. This was the core of the purchaser-provider split: hospitals, organized into autonomous trusts, would compete for the custom of the territorial purchasers. The second was that individual general practitioners could also choose to become purchasers (“fundholders”), purchasing care from trusts on behalf of their patients. The government, after enacting the reform, almost immediately sought to reduce its potentially destabilizing effects by, for example, discouraging price competition and major shifts in patient flows that might shut down uncompetitive trusts. There was one major evaluation, which found small-scale improvements in NHS efficiency and quality.⁵⁰ Enthoven soon made it clear that the United Kingdom did not implement his ideas sufficiently, so what might appear to be the premier test of his concept of managed competition was not so.⁵¹

The Labour Party under Tony Blair initially abolished fundholding in England, grouping fundholders with non-fundholding general practitioners (GPs) into Primary Care Groups to advise health authorities on what to purchase. Within just a few years, the Labour Party shifted back toward a focus on strategic purchasing as a key part of the system. First, it turned Primary Care Groups into Primary Care Trusts and made them responsible for purchasing. Then it introduced a standard diagnosis-related group (DRG) tariff system for England, called Payment by Results, and set out to invite new providers from the private sector into the NHS as competition for the incumbent NHS trusts. It also introduced the term *commissioning*, which was a case of purchasing-with-adjectives,

incorporating issues such as attention to equity, data, and community health into the definition of the action. Developments in commissioning came alongside a focus on individual patient choice, which included letting patients choose their hospitals when they required treatment. Late in the Blair government, the administration began to experiment with “practice-based commissioning,” which was much like GP fundholding.

The best (but still hotly contested) evaluations of competition in these years were focused on the influence of patient choice, rather than the strategic purchasers.^{45,52,53} They found that competition among hospitals for patients improved efficiency and, in some cases, quality, presumably because the gains or losses of patients on the margin was enough to improve management of the hospital overall. Notably, the mechanism of strategic purchasing, as against patient choice affecting hospitals at the margins, barely appeared in these studies.

Under David Cameron’s coalition government, a highly contentious health reform led by Secretary of State Andrew Lansley swept away the existing infrastructure of commissioning in England. It transferred most of the budget to a multiplicity of CCGs of GPs, who were to be the strategic purchasers for their patients, and left the rest in the hands of NHS England, which purchased key national services and would be responsible for the overall direction of commissioning. Whether or not this project, with its small CCGs, would have been workable, the simultaneous arrival of austerity meant that policy shifted toward care integration. Integration, rather than competition, was to maximize efficiency even at the price of leaving no spare resources for innovation or competition. From the perspective of individual patients, their ability to choose providers remained the same, though probably with fewer providers to choose from as budget constraints bit. The sheer difficulty of characterizing NHS policy and operations since these reforms, and the simultaneous impact of austerity, has made them difficult to evaluate.⁵⁴

Meanwhile, there was something of a rebellion against the concept in Scotland and Wales after they gained political autonomy in 1998. Both systems eliminated the purchaser-provider split and purchasing mechanisms, instead choosing to build their health systems around territorially integrated boards,⁵⁵ and suffered no apparent loss of efficiency, equity, or effectiveness as a result. Although the systems in Scotland and Wales can be criticized in a variety of ways, there has been no demonstration that their failures can be attributed to abandoning the purchaser-provider split, and the Commonwealth Fund found that Scotland had the lowest

administrative costs of any of the health systems it studied (Wales was not in the study).⁵⁶⁻⁵⁸

Why Strategic Purchasing Did Not Happen

The United Kingdom made different attempts to impose strategic purchasing in England, often at the same time as attempts to expand individual patient choice and top-down target setting or regulatory initiatives. There were some clearly implemented patient choice policies that had effects on the margins, in hospital quality and efficiency. Each of our four asymmetries was at work and helped to explain why there is not much evidence that purchasing was in any way strategic or led to identifiable outcomes.

Information Asymmetries. At the dawn of the internal market, public health officers were often focused on purchasing because they had the best data skills.⁵⁹ Despite extensive efforts to improve commissioning and data use skills since then, there are recurrent complaints about the quality and quantity of data available to commissioners as well as a clear tendency for the CCGs to have even less data, and analysis skill, than the Primary Care Trusts they replaced.

Political Power Asymmetries. As one article studying efforts to close services noted, the management structures of the English NHS change constantly, but the structure of the services and their locations change extremely slowly.⁶⁰ The focus of debates about closures is on individual services such as maternity units, because an overt attempt to close an entire hospital in England is essentially unknown. Any proposal to close a service, however economically marginal or poor quality the service may be, tends to be met by an opposition campaign, and higher-level authorities encourage managers to desist. At most, problematic trusts are merged with other trusts. The basic threat of competition—that failing organizations will be forced to exit the market—does not appear to matter.

Market Power Asymmetries. Market power was clearly identified as an issue in the evaluations of patient choice, with greater local competition associated with greater improvements in hospital efficiency under patient choice policies.⁶¹ It appears that the problem was more severe for purchasers, which were usually stuck with their dominant local providers.⁶² Their ability to move enough patients to threaten a provider

was limited, as was the scale of any single purchaser relative to the trusts. They also had to work with trusts to shape the health economy, which demanded long-term reciprocity and trust that made it hard to comparison shop for services. As a result, in interviews, managers used the language of the market but showed a “preference for cooperative approaches.”⁶³

Financial Asymmetries. Financial asymmetries incorporated the same problem as seen with market power asymmetries. The bulk of the literature on NHS capital investment focuses on analyzing the use of public-private partnerships (PPP, which in the NHS systems is best known as Private Finance Initiative, PFI). This literature can be very critical.⁶⁴ But the core problem is that no District Health Authority, Primary Care Group, Primary Care Trust, or CCG has had enough money to shape trusts’ decisions because the tariff, despite efforts, does not cover enough capital expenditure.^{54,65} The tariff scheme Payment by Results incorporates capital expenditures related to policies named in the NHS Mandate (the mission statement given to the NHS by the government) that are specified to be paid through the tariff and incorporates adjustments for depreciation and purchasing power parity. In practice, efficiency relative to the tariff might allow trusts to build a cushion against emergencies but will not allow them to finance new services or infrastructure. Purchasers, meanwhile, are fragmented enough that even if the tariff did reliably cover capital costs, it is unlikely that any one or two CCGs would be big enough to shape capital investment with their decisions.

Lessons Learned

In short, efforts to use strategic purchasing (whether called the internal market, purchasing, or commissioning) have been a constant in English health policy since 1989 despite fluctuating regulatory frameworks and reorganizations of the purchasing side. Much of English health policy since Working for Patients amounts to churning through different kinds of commissioners in the search for a strategic purchaser that will deliver benefits. There is no real evidence that this churn has produced any useful lessons about how to make strategic purchasing work better. And what is striking is that there is very little evidence that the different efforts to create strategic purchasing have been effectively implemented or are responsible for the changing outcomes of the NHS. Meanwhile, Scotland and Wales abandoned the entire purchaser-provider split,

which reduced administrative costs in Scotland and had no clear effect on either country's system's efficiency or quality.

The Netherlands

In the Netherlands, purchasing became a central tenet of the health system after a major health reform in 2006, happening after 30 years of failed attempts to integrate the social health insurance system and the private health insurance system. Earlier attempts failed after strong opposition from key stakeholders (ie, private health insurers, employers, and physicians), but several smaller and incremental market-oriented reforms brought the public system in line with the private system, making unification of the schemes a commonsense next step supported by key stakeholders.⁶⁶

The new system aimed to reduce the emphasis on government regulation of health care supply, increase efficiency through strategic purchasing, and increase fairness through the reduction of fragmentation to ultimately offer more affordable and patient-driven health care.^{66,67} In 2006, a single private insurance scheme following the principles of managed competition was established. In this system, the insurer plays a key role as a strategic purchaser—allowed to selectively contract and expected to negotiate on the basis of price, volume, and quality of care. However, more than a decade into this reform, purchasing fails to incorporate quality measures on a large scale.^{15,68,69} Most contracts seek to control costs and run for only one year, often lacking agreements on quality of care or patient outcomes.⁷⁰ Moreover, no health needs assessments are made, and contracting is predominantly based on historical data. This purchasing setup has not led to the desired macro-level cost containment, forcing the government to intervene on numerous occasions. Examples include concluding multistakeholder agreements about spending limits to rein in growth in hospital care and nurturing the development of quality measures.

Why Strategic Purchasing Did Not Happen

Insurers generally lack the incentives, tools, expertise, and meaningful quality data to control costs and have a direct effect on care quality. Evidence is growing to illustrate this further. For example, Douven et al.

hypothesized that effective insurer-hospital negotiations would result in limited price variation across hospitals for the same service, but their results showed that the opposite is true.⁷¹ Another study hypothesized that the Dutch hospital market governed under managed competition would lead to substantial budget reallocations between providers.⁷² Also here, the hypothesis was rejected, as yearly budget reallocations were remarkably stable over long periods of time. In fact, much higher yearly budget reallocations were found for municipalities, which act as noncompeting purchasers of social care. Each of the four asymmetries helps explain why purchasing has not delivered its envisaged outcomes.

Information Asymmetries. At the inception of the reforms, the government assumed that competing insurers would have sufficient incentives to purchase based on prices and volume but also on quality, in order to achieve an advantage over competitors and attract more customers. However, the insurers have been—and still are—reluctant to use quality information for contracting policies. This is partly because the government and insurers have been unable to develop, provide, or nurture enough meaningful information to make health markets more transparent.

However, there have been attempts to change this situation through a new quality institute, which imposed a mandatory framework for the development of care standards, clinical guidelines, and performance measures. Moreover, a new policy goal attempts to make treatments of 50% of the disease burden transparent with outcome indicators by 2022. Insurers increasingly claim to have collected data on quality and cost, but how valid and reliable such information is has been left open to question due to past provider criticisms.⁷³ Therefore, some insurers are experimenting with new approaches to shift purchasing from a price-and-volume focus to a best-value-based focus.^{69,74} But these developments are still only accounting for a small share of total purchasing volume.

Additionally, evidence suggests that the decision to switch insurers is rarely motivated by the quality of contracted care providers but rather by price.^{75,76} This undermines the effectiveness of a comprehensive quality strategy to attract customers and perhaps takes away the incentive to use it in purchasing.⁷⁷

Political Power Asymmetries. Maarse and colleagues framed the relationship between insurers and providers as a power conflict in which providers find that the power shift has gone too far and GPs perceive the offered contracts as a diktat.⁶⁸ However, others have argued that

the bargaining position of health insurers vis-à-vis GPs and hospitals remains relatively weak.^{69,78} In the Netherlands, GPs are represented in a strong professional organization called the National Association of General Practitioners (LHV). They have effectively used their long-standing relationship with their patients to mobilize public support against contracting practices and enforcement of competition policies. Perhaps unsurprisingly, insurers hardly use selective contracting in GP care and generally pay the maximum prices as set by the Dutch Healthcare Authority.⁶⁹ A similar picture is evident among hospitals, where insurers have been reluctant to engage in selective contracting, fearing an outcry from politicians, the public, and the media, as Dutch patients generally do not like to travel for their care. Furthermore, consumers seem to question whether insurers with restrictive networks are committed to providing good quality care.^{75,79} In addition, evidence is growing that trust in Dutch insurers is eroding. This may further hamper the ability of insurers to use selective purchasing and steer patients to preferred providers.^{80,81}

Lastly, there has been deep political division over the direction of the reforms. Depending on the coalition in charge, market reforms—which take years to establish—have been slowed down or accelerated, allowing proponents of market reform to argue that it does not work as envisaged because key preconditions (eg, quality, transparency) have not been met.⁸²⁻⁸⁵

Market Power Asymmetries. The Dutch insurance market has been aggressively consolidating, resulting in 4 large insurers having about 90% of the market.⁸⁶ One would think that this would greatly enhance the bargaining position of the insurers. But even though GPs work in small independent practices, they are well organized in the LHV, and not contracting with some could imply a forced breaking up of long-standing relationships between the GP and the patient. The introduction of bundled payments for certain chronic patients in GP care, which are likely to be rolled out in other areas, has led to a rapid proliferation of new care groups that consist of several practices, further strengthening their negotiation position. This provides a good example of the bad fit between market mechanisms and the international trend for better coordination and integration between providers.¹⁵ We can interpret the transparency push (eg, a new quality institute, making part of the disease burden transparent with outcome indicators), bundled payment schemes, and spending agreements as efforts by the government to supplement the

private insurers, since their strategic purchasing was not apparently effective on its own. The market was failing to deliver the overall strategic purchasing without additional policy tools from the state.

Furthermore, hospitals, supported by lenient competition policy enforcement, have been merging and consolidating their position in the Dutch health provision market. The number of hospitals has gone down from 90 in 2014 to 79 in 2016. In 2014, general hospitals had a market share of about 58% in their catchment area.⁸⁵ The regional dominance of the hospitals helps explain the difficulty insurers have in selectively contracting. In the few cases where insurers decided to deny contracts to underperforming hospitals, leading to their forced closure, it mostly led to full or partial acquisition by another hospital (eg, Ruwaard van Putten and Sionsberg, Slotervaart and IJsselmeer hospitals). This, perhaps ironically, further strengthens the regional dominance of hospitals.⁸⁷ The 2018 Slotervaart bankruptcy provides a case in point. Although the Netherlands Authority for Consumers and Markets (ACM) acknowledged that its partial acquisition would lead to a stronger position of the buying hospital (OLVG), it allowed the acquisition on the ground that “patients of the Slotervaart hospital would have gone to the OLVG anyway, even without this acquisition.”⁸⁸

Financial Asymmetries. In the Dutch system, the insurers are regionally dominant and their reimbursements must cover capital investment. In theory, they have the financial clout to discipline providers. Yet, the Dutch case shows that this does not weigh up against their disadvantage in political and market power. Even if a patient decides to visit a noncontracted provider, the insurers still have to reimburse to a level (generally 75% to 80% of total cost) that makes it affordable for the patient to pay the rest out of pocket. This limits purchasers’ ability to steer patients and may mitigate the financial threat of selective contracting. In 2014, a bill to restrict choice to contracted providers failed in the senate after criticism that it undermined solidarity and gave insurers too much power to decide what care is “good enough.”

Lessons Learned

Efforts to strengthen strategic purchasing are severely hampered due to these four asymmetries. In 2008, the Netherlands Council for Health and Society (RVS), an independent advisory body to the government and

parliament, called selective contracting the best instrument to adapt to the growing and changing care needs of the population. However, in 2017, the RVS published a report offering a damning verdict on purchasing, stating that it has not been able to deliver added value for the population and that the expectation that it would has been, in hindsight, unrealistic. Purchasing in its current form leads to uniformity, decreased trust, and high administrative costs, and it hampers future innovations and prevention initiatives. The RVS recommended discontinuation of selective contracting and detailed contracts that specify structural and process indicators. It favored an approach where the relationship between the patient and the provider leads the process of defining health care needs. It also recommended having longer-term contracts that focus on increasing efficiency in administration, facilitating innovation and prevention, and sharing data to improve care. The minister chose to ignore the essence of the report (ie, its calls for abolishing selective contracting and restrictions in patient choice), but supported the idea of using long-term contracts to facilitate a partnership between insurers and providers.

The United States

Because of the famous complexity of the US health care sector, it is not possible to characterize the United States as having any single dominant form of purchasing in the same way as can be done for the English or Dutch systems. Nonetheless, the United States is home to a huge volume of theory and practice on purchasing. Its government has repeatedly enacted policies premised on the effectiveness of strategic purchasing, such as accountable care organizations, Medicare Advantage, and the introduction of “population health” into firms’ insurance decisions.

Providing an in-depth analysis of the many kinds of purchasers in the United States is beyond the scope of this paper. Where important, we highlight aspects of the private insurance market (including employer-sponsored coverage) to help further explain certain asymmetries. But, to improve comparability with the other cases, we focus on one well-established component of the US health system: the publicly funded traditional Medicare program, highlighting Medicare Advantage plans. Medicare Advantage is a type of health plan offered by a private insurance company that contracts to provide Medicare Part A (hospitalization) and Part B (medical) benefits as well as, in most cases, Part D

(drug coverage). MA allows private plan participation in the Medicare program. Since MA plans receive a fixed amount of money per month for each enrollee, based on the characteristics (eg, demographics, medical diagnoses) of the particular enrollees in their plan, they have much stronger financial incentives to be strategic purchasers and seek efficiency relative to traditional Medicare through mechanisms such as care integration and alternative payment models.⁸⁹ Further, commercial insurers in the MA market can balance risks and negotiate with providers across MA and other products they offer. In 2018, more than 2,300 different MA plans were available nationwide, with the average Medicare beneficiary able to choose from 21 different plans.⁹⁰ MA currently enrolls more than one-third of all Medicare beneficiaries.⁹¹

Why Strategic Purchasing Did Not Happen

Although the current adjective attached to purchasing in the United States is more commonly “value-based” than “strategic,” the basic goal of prioritizing the financing of certain goods and services over others to promote equity, quality of care, efficiency, and responsiveness in the provision of health services remains true to the theoretical goals of strategic purchasing. However, the transformation from “volume to value” in the US health care system has had limited success,⁹²⁻¹¹⁷ being “driven more by ideology and aspiration than by evidence.”¹¹⁸ In the following sections, we show how the four asymmetries help explain the difficulty of implementing strategic purchasing in the United States. Our discussion includes some experience beyond Medicare Advantage that sets the context for MA, but we highlight experience within MA.

Information Asymmetries. Massive initiatives to collect data through implementation of electronic medical records (EMRs), as well as extensive measurement requirements for “quality-based” payments, have led to a situation in which US medical payers are data rich but information poor. While private health insurers, including MA insurers, have access to all of their individual patient claims data (often this data is kept proprietary and rarely shared), they remain plagued by a lack of pricing transparency. Private insurers often know about care utilization across different providers and hospitals, especially those within their networks, but they do not know actual hospital costs, patient information if they change insurers, and how much pharmaceutical drugs should cost

(or which ones are necessary and should be covered). Additionally, hospital and pharmaceutical contracting lacks transparency. These negotiations often involve “secret clauses” such as anticompetitive demands, antisteering clauses, claim limits, and proprietary price information that cannot be shared.¹¹⁹⁻¹²³ Here, private insurers fail to be effective “strategic purchasers” for employers and employer-sponsored coverage, as well as for MA plans. The result is that private insurers (and their respective beneficiaries) continue to face high price markups from hospitals seeking to maximize their profits.¹²⁴⁻¹²⁷

Many private insurers attempt to pass on health care decisions to patients, who are supposed to make their own, hopefully well-informed, choices on what care to seek and how to save costs. Insurers cannot threaten market exit to negotiate prices, so patients are forced to make these “exit” choices. Thus, in the private insurance market, employers (as purchasers) are unable, and possibly unwilling, to “purchase for value.”

Moreover, the Centers for Medicare and Medicaid Services (CMS) struggles to adapt data collection initiatives to ever-changing health policies. Most analysis of policy efficacy, effectiveness, and impact is conducted by independent researchers using limited publicly available data. CMS has made more data publicly available, but the process is slow and there are constant complaints of its poor quality. The behavior of MA plans, the quality of care that they provide, and their benefits to the public payer are consequently poorly understood.^{128,129} For all but a few people who can access Medicare earlier (eg, people with end-stage renal failure), CMS does not know a patient’s medical history prior to the age of 65.

Data fragmented across payers (MA providers, traditional Medicare, and others), opaque contracts, and a continued lack of strong regulatory and price transparency policies make it difficult for privately insured patients or their employers to compare prices or value and for the federal government to regulate deviant hospital, provider, or private corporate (ie, pharmaceutical) behaviors. Last, the cost burden of information is high. Collecting data, analyzing it, storing it, and then disseminating it to the general populace is an expensive task that might never produce satisfactory results, might never be worth the resources, increases administrative burdens, and requires an incredible amount of coordination between various actors and stakeholders.

Political Asymmetries. The political asymmetry that we focus on is the purchaser’s political power compared to patients, providers,

hospitals, and other key actors. A lack of purchaser political power can hinder the development of strategic purchasing, since other actors could use the political system to circumvent strategic purchasers. In the case of the United States, this would mean other groups such as providers modifying the regulation or purchasing decisions of purchasers. Research on the politics of employer and provider power suggests that such opportunistic behavior has happened.¹³⁰⁻¹³²

Despite traditional Medicare's power as the largest single purchaser of health care in the United States, Congress has imposed serious limits on its power over providers or its ability to use its power strategically.^{133,134} Lobbying groups are numerous and powerful in health care, and providers, including provider lobbies, are better regarded by the public than politicians, technocrats, or insurance companies.¹³⁴ Members of Congress also fear that cutting even the lowest-value services could lead to a backlash from older voters.^{135,136} The result is that Medicare is legally constrained from even the most obvious and internationally common ways to contain costs and purchase strategically. Famously, it cannot conduct price negotiations on medicines backed up by a single formulary. For another example, Medicare is unable to increase its administrative costs unless Congress appropriates additional funds to the program for this specific purpose—even if robust administration could result in greater efficiency (eg, disease management, coordination of care) and customer satisfaction (eg, more customer support lines and services).

Although Medicare reimbursement rates are its principal tool for cost containment, the process of deciding those rates fits no definition of strategic purchasing. CMS heavily relies on physician specialty societies to update its rates, as well as recommendations from the American Medical Association and the Specialty Society Relative Value Scale Update Committee (RUC).¹³¹ Most RUC members are appointed by major physician specialty societies. CMS continues to accept the majority of RUC recommendations for the fee schedule.^{131,137,138} There is no guarantee that prices will be set fairly, as factionalism among specialty groups could impact decision making.¹³⁹ Here, no explicit negotiation between purchaser and provider (or health system) is occurring. Despite Medicare's strong market power in price setting, it still acts as a passive, relatively unstrategic purchaser. Moreover, Medicare (like CMS) is a government entity. Although reports and testimonies from CMS are taken seriously among policymakers and other purchasers, CMS is formally and informally restricted in lobbying Congress or using its expertise to

make policy decisions. For example, in Provision 6301, the Affordable Care Act prevented Medicare's Patient-Centered Outcomes Research Institute from using cost-effectiveness analysis.

MA was to be a solution to the problem of political limitations on traditional Medicare's ability to engage in strategic purchasing by allowing private insurers, chosen by the beneficiaries, to find ways to save costs and provide high-quality care, using the private sector to circumvent legislative restrictions on the government's ability to purchase strategically. However, MA faces similar challenges to traditional Medicare.

Although MA plans can negotiate "narrow networks," which can allow them to avoid lower-quality or higher-cost providers, federal legislation means that providers cannot charge more than standard traditional Medicare rates to out-of-network MA patients.^{111,140} MA plans use the same Medicare fee schedules and, therefore, face the same political limitations in determining the value of physicians' work (and resulting reimbursement payments) because of the power of physicians in the RUC.¹³¹ Additionally, MA plans don't have enough market power on their own in the private insurance market to negotiate lower prices, making traditional Medicare's fee schedule the default pricing choice. Relative to doctors, hospitals, and patients, managed care plans are low profile, unpopular, and politically weak.¹⁴¹⁻¹⁴⁶

Market Power Asymmetries. The market power asymmetry affects prices and occurs when there is a lack of market competition, hindering the ability of purchasers to effectively negotiate with providers, hospitals, and health systems. US purchasers face varying degrees of market power asymmetry. MA plans, like any insurers who seek to actively purchase, face resistance from strategic sellers—providers and health care systems that have merged and vertically integrated across the United States to increase their negotiating leverage.

Hospital and health system mergers have created behemoths that sharply limit competition in many markets, increasing prices and loading more risk on insurers.^{147,148} Physician practices in urban and suburban areas have seen an increase in mergers that are slowly resulting in price increases.^{149,150} Initial research has found such vertical integration to have mixed impacts on quality of care while leading to increases in prices instead of cost savings.¹⁴⁷ Meanwhile, horizontal integration can have anticompetitive effects, weakening private insurers' bargaining power.^{147,151}

Insurers have responded with consolidation. Most states have approximately three private insurers collectively claiming at least 80% of the state's total enrollments.¹⁵² US insurance companies slowly consolidated between 2005 and 2013, with many national commercial insurers purchasing local and regional health plans. In 2016, the five largest private insurers covered 43% of the total insured population.¹⁵²

However, private insurers are faced with a declining employer-based health insurance market and a growing Medicare population. Thus, the incentives to capture Medicare payments are high, with the "big 5" insurers collectively serving 52% of the Medicare Advantage market.¹⁵² Relatively few barriers to entry into or exit from the market exist for the five biggest private insurers.¹⁵² But, the MA sector is not large enough to have significant market power that can shape overall health care markets, and the market power wielded by private insurers across multiple lines of business that include MA could be greater than any given MA plan alone. Thus, for the most part, MA plans passively accept the Medicare fee schedule and do not renegotiate with hospitals and providers for better prices. However, for a select few services (eg, cataract removal) and physician reimbursements, MA plans are able to leverage the commercial market's favorable rates and pay lower prices than traditional Medicare.¹⁴⁰

During the Aetna and Humana merger court case, traditional Medicare and MA were found to be in different product markets, suggesting that they do not directly compete with each other.^{153,154} Instead, MA plans compete with other MA plans only in highly concentrated markets with minimal overall competition.^{155,156} Furthermore, bonus payments and rebate incentives for four- or five-star-rated MA plans incentivized the creation of narrow networks. While narrow networks can lead to cost savings (lower total costs, not price discounts) and efficiency,¹⁵⁷ they can also lead to negative outcomes when they have insufficient capacity to serve their enrollees or geographically dispersed providers that are difficult to access.¹⁵⁸ The lack of need to compete for market share may lead to variance between urban and rural access to different MA or private plan options, and to physicians and hospitals that accept Medicare, MA plans, or private insurers with narrow networks. Many rural areas have access to only one provider and one MA plan. Network adequacy is difficult to measure and determine, with many current standards and regulations failing to monitor compliance and ensure appropriate access.¹⁵⁹⁻¹⁶¹ The Trump administration has further complicated

matters by decreasing enforcement and ceding network adequacy regulation to the states.¹⁶²

Last, insurers' power is weakened due to physician consolidations. The race between insurer and provider amalgamation has not shown any signs of empowering insurers or making them more strategic purchasers. Physicians, specifically specialists, have the ability to negotiate with purchasers and exploit their market power. In theory, their power is supposed to check the powers of private insurers, but the fragmented health care system has led to perverse incentives and opportunistic behavior. Certain specialists—notably anesthesiologists, emergency department physicians, and radiologists—face limited competition and deal with episodic, urgent, and unplanned patient demand for care. This has incentivized them to use their power to reject network contracts in order to maximize reimbursements, leading to surprise billing charges.

Ultimately, MA in the United States and separate strategic purchasers in other systems are simply agents for the real payer (governmental or quasi-governmental). This will always create agency problems that range from abusing or extorting risk adjustment to passive behavior and an inability to affect the real sources of power in the system.

Financial Asymmetries. Although Medicare is the dominant price setter in its own market, hospital profits from it are often far less than from private insurers (which are often also the MA payers). Traditional Medicare also directly subsidizes physician residency programs (eg, approximately \$140,000 per resident is paid directly to the hospital through the Direct Graduate Medical Education program) and caps the number of subsidized residency slots, moderating (and more recently limiting) the supply of physicians in the United States. However, it is otherwise not directly involved in any major health care capital investments. For purchasers providing Medicare Advantage, the same methodological problem holds for interpreting the ability of MA to affect capital investment and allocation as for gauging its market power.

Even when considering the role of MA plans in broader strategies adopted by the big insurers, it is unrealistic to expect that MA would control enough of a given provider's revenue to change its capital strategies. Moreover, raising capital for health care facilities in the United States is quite unlike raising capital in England. Funds can come from a mixture of debt issuance, loans, private capital, and vendor financing, with lenders making judgments about the likelihood of future repayment based on the providers' business (ie, future income and revenue)

across multiple purchasers. In other words, capital markets, rather than any purchaser, allocate capital. This means that any strategic purchasing would only work indirectly by effectively reallocating resources in a way that capital markets understand, price in, and use to affect providers' decisions.

Lessons Learned

The United States might lack a coherent health care system, but there is a great deal of purchasing in its health care sector and a consistently high level of interest in policies that promise to use purchasing strategically to improve care and contain costs. Overall, it does not appear that an internationally distinctive role for insurers and elaborate purchasing schemes has led to cost containment or superior quality in American health care, which might lead us to question the added value of its large and unpopular insurance industry. We focused on Medicare Advantage, which on paper promises to combine the power of Medicare's size with freedom for insurers to escape the rules that constrain Medicare in its relationships with providers. Even in MA, though, the four asymmetries that we find in other systems mean that the effect falls short of any advocates' claims for what strategic purchasing might do.

Conclusion: Impact at the Margins?

Purchasing of some sort is ubiquitous in health systems. Many health systems, including the social insurance countries and the United States, have a long history of transactions in which a health service is purchased by some agent that pools funds, such as an insurer. But strategic purchasing, part of a family of concepts including commissioning and managed competition, is an idea that dates to the mid-1980s and involves adding a list of attributes to the basic act of purchasing. It resembles other concepts that seem practical but are actually very aspirational—and might turn out to be completely impractical.

As was found in Burns and Pauly's discussion of the "volume to value" transformation in the United States, or White's discussion of the practice variations crusade, strategic purchasing is an unrealistic, albeit persistent, solution that promises both everything and nothing.^{118,163} As we noted above, strategic purchasing promises to ensure affordable access to

high-quality care, maximize health system efficiency, reduce fragmentation, pool risks, and ensure equity through citizen engagement. It fails on all counts.

We found, in three case studies, that in each case four asymmetries limited the impact of purchasing by agents such as insurers: information asymmetry, political power asymmetry, market power asymmetry, and financial asymmetry. Given such weaknesses, it should not be surprising that strategic purchasing and its kin concepts have been more attractive on paper than consequential in practice.

Elaborate purchasing initiatives can increase, or create, transaction costs, as they were added to systems based on some simpler form of planning and organizational coordination. Their effects are at best marginal and difficult to distinguish from patient flows driven by the preferences of patients and providers that payers might not have influenced or even known about. In the English case, for example, it seems that there might have been benefits on the margins in terms of quality and efficiency, though it is difficult to separate such benefits from the simultaneous increase in patient choice and funding under Labour governments.

Greater transparency, increased accountability, good governance, and subtlety about implementation are critical to turn any policy, strategic or not, into a successful initiative. But health care is not immune to politics and opportunistic behaviors. Strategic purchasing is, like most policies, a blunt tool under the guise of a silver bullet solution. Our scholarly recommendation is to focus future research on understanding why strategic purchasing as a policy has persisted for so long. Our policy recommendation is that further investment in thought about strategic purchasing, and further policies that are premised on it or promote it, would not be worthwhile. Strategic purchasing might be a harmless label for planning or other policies, or it might be a repository for misplaced hopes, but it is not a valuable approach to adopt. Focusing on the real sources of power in a health care system—information, political power, and capital—would direct us away from misguided faith in insurers and the alphabet soup of purchasers, and back to the long-standing foci of health care policy studies: professionals, hospitals, voters, and politicians.

References

1. Mathauer I, Dale E, Meessen B; World Health Organization. *Strategic Purchasing for Universal Health Coverage: Key*

- Policy Issues and Questions; A Summary From Expert and Practitioners' Discussions.* Geneva, Switzerland: World Health Organization; 2017. https://www.who.int/health_financing/documents/strategic-purchasing-discussion-summary/en/. Accessed May 14, 2020.
2. Cashin C, Eichler R, Hartel L. *Unleashing the Potential of Strategic Purchasing.* Washington, DC: USAID, Health Finance and Governance; 2019. <https://www.hfgproject.org/unleashing-potential-strategic-purchasing/>. Accessed May 22, 2020.
 3. Busse R, Figueras J, Robinson R, Jakubowski E. Strategic purchasing to improve health system performance: key issues and international trends. *Healthc Pap.* 2007;8(Spec No):62-76.
 4. Figueras J, Robinson R, Jakubowski E, eds. *Purchasing to Improve Health Systems Performance.* Berkshire, England: Open University Press; 2005. http://www.euro.who.int/__data/assets/pdf_file/0004/98428/E86300.pdf. Accessed May 14, 2020.
 5. World Health Organization. *The World Health Report 2000: Health Systems: Improving Performance.* Geneva, Switzerland: World Health Organization; 2000. <https://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=24&codcch=2000>. Accessed May 14, 2020.
 6. Preker AS, Liu X, Velenyi EV, Baris E. *Public Ends, Private Means: Strategic Purchasing of Health Services.* Washington, DC: World Bank; 2007. <https://openknowledge.worldbank.org/handle/10986/6683>. Accessed May 19, 2020.
 7. Carter JR, Narasimhan R. Is purchasing really strategic? *Int J Purch Mater Manag.* 1996;32(4):20-28. <https://doi.org/10.1111/j.1745-493X.1996.tb00216.x>.
 8. Marmor TR. Fads in medical care policy and politics: the rhetoric and reality of managerialism. In: Marmor TR, ed. *Fads, Fallacies and Foolishness in Medical Care Management and Policy.* Hackensack, NJ: World Scientific Publishing; 2007:1-25.
 9. McSorley G. Strategic purchasing: the experience in England. *Healthc Pap.* 2007;8(Spec No):77-92. <https://doi.org/10.12927/hcpap.2007.19222>.
 10. Honda A. *What Is Strategic Purchasing for Health?* London, England: Department of Global Health and Development, London School of Hygiene and Tropical Medicine; 2014. <https://doi.org/10.17037/PUBS.02760470>.
 11. European Observatory on Health Systems and Policies. Health Systems and Policy Monitor. <http://www.hspm.org/mainpage.aspx>. Accessed May 19, 2020.

12. Habicht T, Habicht J, van Ginneken E. Strategic purchasing reform in Estonia: reducing inequalities in access while improving care concentration and quality. *Health Policy*. 2015;119(8):1011-1016. <https://doi.org/10.1016/j.healthpol.2015.06.002>.
13. Klasa K, Greer SL, van Ginneken E. Strategic purchasing in practice: comparing ten European countries. *Health Policy*. 2018;122(5):457-472.
14. Honda A, Hanson K, Tangcharoensathien V, Huntington D, McIntyre D. "Strategic purchasing"—definition and analytical framework used in the multi-country study. In: Regional Office for the Western Pacific, World Health Organization. *Strategic Purchasing in China, Indonesia and the Philippines*. Comparative Country Studies. Vol 2. No. 1. Geneva, Switzerland: World Health Organization; 2016:2-19.
15. Kroneman M, Boerma W, van den Berg M, Groenewegen P, de Jong J, van Ginneken E. Netherlands: health system review. *Health Syst Transit*. 2016;18(2):1-240.
16. De Pietro C, Camenzind P, Sturny I, et al. Switzerland: health system review. *Health Syst Transit*. 2015;17(4):1-288, xix.
17. Ferre F, de Belvis AG, Valerio L, et al. Italy: health system review. *Health Syst Transit*. 2014;16(4):1-168.
18. Smatana M, Pazitny P, Kandilaki D, et al. Slovakia: health system review. *Health Syst Transit*. 2016;18(6):1-210.
19. Boyle S. United Kingdom (England): health system review. *Health Syst Transit*. 2011;13(1):1-483, xix-xx.
20. Cylus J, Richardson E, Findley L, Longley M, O'Neill C, Steel D. United Kingdom: health system review. *Health Syst Transit*. 2015;17(5):1-126.
21. García-Armesto S, Begoña Abadía-Taira M, Durán A, Hernández-Quevedo C, Bernal-Delgado E. Spain: health system review. *Health Syst Transit*. 2010;12(4):1-295, xix-xx.
22. Bernal-Delgado E, García-Armesto S, Oliva J, et al. Spain: health system review. *Health Syst Transit*. 2018;20(2):1-179.
23. Olejaz M, Juul Nielsen A, Rudkjoberg A, Okkels Birk H, Krasnik A, Hernandez-Quevedo C. Denmark: health system review. *Health Syst Transit*. 2012;14(2):i-xxii, 1-192.
24. Lai T, Habicht T, Kahur K, Reinap M, Kiiivet R, van Ginneken E. Estonia: health system review. *Health Syst Transit*. 2013;15(6):1-196.
25. Habicht T, Reinap M, Kasekamp K, Sikkut R, Aaben L, van Ginneken E. Estonia: health system review. *Health Syst Transit*. 2018;20(1):1-189.

26. Chevreul K, Berg Brigham K, Durand-Zaleski I, Hernandez-Quevedo C. France: health system review. *Health Syst Transit*. 2015;17(3):1-218, xvii.
27. Busse R, Blumel M. Germany: health system review. *Health Syst Transit*. 2014;16(2):1-296, xxi.
28. Toniolo F, Mantoan D, Maresso A. Veneto Region, Italy: health system review. *Health Syst Transit*. 2012;14(1):i-xix, 1-138.
29. Tuohy CH. *Remaking Policy: Scale, Pace, and Political Strategy in Health Care Reform*. Vol 54. Toronto, ON: University of Toronto Press; 2018.
30. Mossialos E, Wenzl M, Osborn R, Sarnak D. *2015 International Profiles of Health Care Systems*. Ottawa, ON: Canadian Agency for Drugs and Technologies in Health; 2016.
31. Teune H, Przeworski A. *The Logic of Comparative Social Inquiry*. New York, NY: Wiley-Interscience; 1970.
32. Enthoven AC. The history and principles of managed competition. *Health Aff (Millwood)*. 1993;12(Suppl):24-48.
33. Enthoven AC. *Reflections on the Management of the National Health Service: An American Looks at Incentives to Efficiency in Health Services Management in the UK*. London, England: Nuffield Trust; 1985.
34. Her Majesty's Stationery Office. *Working for Patients: Presented to Parliament by the Secretaries of State for Health, Wales, Northern Ireland and Scotland by Command of Her Majesty, January 1989*. London, England: HMSO; 1989.
35. van de Ven WPMM, Schut FT. Universal mandatory health insurance in the Netherlands: a model for the United States? *Health Aff (Millwood)*. 2008;27(3):771-781.
36. Le Grand J. *The Other Invisible Hand: Delivering Public Services Through Choice and Competition*. Princeton, NJ: Princeton University Press; 2009.
37. Hirschman AO. *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States*. Boston, MA: Harvard University Press; 1970.
38. Marmor T. The rage for reform: sense and nonsense in health policy. In: Drache D, Sullivan T, eds. *Health Reform: Public Success, Private Failure*. London, England: Routledge; 1999:260-271.
39. Flew A. *Thinking About Thinking: Or, Do I Sincerely Want to Be Right?* Fontana/Collins; 1975.
40. Cashin C, Chi Y-L, Smith P, Borowitz M, Thomson S. Health provider P4P and strategic health purchasing. In: Cashin C, Chi Y-L, Smith P, Borowitz M, Thomson S, eds. *Paying for Performance in Health Care: Implications for Health System Performance and*

- Accountability*. Berkshire, England: Open University Press; 2014:3-21.
41. Tangcharoensathien V, Limwattananon S, Patcharanarumol W, Thammatacharee J, Jongudomsuk P, Sirilak S. Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy Plan*. 2015;30(9):1152-1161. <https://doi.org/10.1093/heapol/czu120>.
 42. Robinson JC. Value-based purchasing for medical devices. *Health Aff (Millwood)*. 2008;27(6):1523-1531.
 43. Langenbrunner JC, Orosz E, Kutzin J, Wiley MM. Purchasing and paying providers. In: Figueras J, Robinson R, eds. *Purchasing to Improve Health System Performance*. New York, NY: Open University Press; 2005:236-265.
 44. Propper C. Agency and incentives in the NHS internal market. *Soc Sci Med*. 1995;40(12):1683-1690.
 45. Propper C, Burgess SM, Gossage D. Competition and quality: evidence from the NHS internal market, 1991-9. *Econ J*. 2008;118(525):138-170.
 46. Arrow KJ. Uncertainty and the welfare economics of medical care. *Am Econ Rev*. 1963;53(5):941-973.
 47. Hammer PJ, Haas-Wilson D, Peterson MA, Sage WM. *Uncertain Times: Kenneth Arrow and the Changing Economics of Health Care*. Chapel Hill, NC: Duke University Press; 2003.
 48. Baker LC, Bundorf MK, Kessler DP. Does multispecialty practice enhance physician market power? <https://www.nber.org/papers/w23871>. National Bureau of Economic Research working paper 23871. Published September 2017. Accessed May 19, 2020.
 49. Rosenthal E. *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back*. New York, NY: Penguin Press; 2017.
 50. Robinson R, Le Grand J, eds. *Evaluating the NHS Reforms*. London, England: Kings Fund; 1993.
 51. Enthoven AC. In pursuit of an improving National Health Service. *Health Aff (Millwood)*. 2000;19(3):102-119.
 52. Cooper Z, Gibbons S, Jones S, McGuire A. Does hospital competition save lives? Evidence from the English NHS patient choice reforms. *Econ J*. 2011;121(554):F228-F260.
 53. Bloom N, Propper C, Seiler S, Van Reenen J. The impact of competition on management quality: evidence from public hospitals. *Rev Econ Stud*. 2015;82(2):457-489.
 54. Exworthy M, Mannion R, Powell M. *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol, UK: Policy Press; 2016.

55. Greer SL. Devolution and health in the UK: policy and its lessons since 1998. *Br Med Bull*. 2016;118(1):16-24.
56. Greer SL, Wilson I, Donnelly PD. The wages of continuity: Health Policy under the SNP. *Scott Aff*. 2016;25(1):28-44.
57. Organisation for Economic Co-operation and Development. *OECD Reviews of Health Care Quality: United Kingdom; Raising Standards*. Paris, France: OECD Publishing; 2016. <https://doi.org/10.1787/9789264239487-en>.
58. Himmelstein DU, Jun M, Busse R, et al. A comparison of hospital administrative costs in eight nations: US costs exceed all others by far. *Health Aff (Millwood)*. 2014;33(9):1586-1594.
59. Tuohy CH. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. Oxford, England: Oxford University Press; 1999.
60. Stewart E, Greer SL, Ercia A, Donnelly PD. Transforming health care: the policy and politics of service reconfiguration in the UK's four health systems. *Health Econ Policy Law*. 2020;15(3):289-307. <https://doi.org/10.1017/S1744133119000148>.
61. Gaynor M, Moreno-Serra R, Propper C. Death by market power: reform, competition, and patient outcomes in the National Health Service. *Am Econ J Econ Policy*. 2013;5(4):134-166.
62. Paton C. NHS confidential: implementation, or ... how great expectations in Whitehall are dashed in Stoke-on-Trent. In: Exworthy M, Peckham S, Powell M, Hann A. *Shaping Health Policy: Case Study Methods and Analysis*. Chicago, IL: University of Chicago Press; 2011:249-266.
63. Osipovič D, Allen P, Shepherd E, et al. Interrogating institutional change: actors' attitudes to competition and cooperation in commissioning health services in England. *Public Adm*. 2016;94(3):823-838.
64. Mizell L. Public-private partnerships at the subnational level of government: the case of PFI in the United Kingdom. In: Organisation for Economic Co-operation and Development. *Subnational Public Private Partnerships*. Paris, France: OECD Publishing; 2018:75-105. <https://doi.org/10.1787/9789264304864-5-en>.
65. Powell M, Exworthy M. Never again? a retrospective and prospective view of English health reforms. In: Exworthy M, Mannion R, Powell M, eds. *Dismantling the NHS? Evaluating the Impact of Health Reforms*. Bristol, UK: Policy Press; 2016:256.
66. van Ginneken E, Busse R, Gericke CA. Universal private health insurance in the Netherlands: the first year. *J Manag Mark Health Care*. 2008;1(2):139-153. <https://doi.org/10.1179/mmh.2008.1.2.139>.

67. Thomson S, Busse R, Crivelli L, van de Ven W, de Voorde C. Statutory health insurance competition in Europe: a four-country comparison. *Health Policy*. 2013;109(3):209-225.
68. Maarse H, Jeurissen P, Ruwaard D. Results of the market-oriented reform in the Netherlands: a review. *Health Econ Policy Law*. 2016;11(2):161-178.
69. Schut FT, Varkevisser M. Competition policy for health care provision in the Netherlands. *Health Policy*. 2017;121(2):126-133.
70. Dohmen PJG, van Raaij EM. A new approach to preferred provider selection in health care. *Health Policy*. 2018;123(3):300-305.
71. Douven R, Burger M, Schut F. Does managed competition constrain hospitals' contract prices? evidence from the Netherlands. *Health Econ Policy Law*. 2020;15(3):341-354.
72. Stadhouders N, Maarse H, Koolman X, Tanke M, Jeurissen P. Do managed competition and active purchasing go hand in hand? analyzing provider budget reallocations in the Netherlands. In: Stadhouders N, ed., *Effective Healthcare Cost Containment Policies* [PhD thesis]. <https://repository.ubn.ru.nl/bitstream/handle/2066/201892/201892.pdf?sequence=1>. Accessed July 7, 2020.
73. Zuiderent-Jerak T, Grit KJ, van der Grinten T. *Markets and Public Values in Health Care*. <https://pdfs.semanticscholar.org/b178/72a1ec6c91d8bb5af5139b86da2562608a36.pdf>. iBMG working paper W2010.01. Published June 2011. Accessed May 19, 2020.
74. van Leersum N, Bennemeer P, Otten M, Visser S, Klink A, Kremer JAM. Cure for increasing health care costs: the Bernhoven case as driver of new standards of appropriate care. *Health Policy*. 2019;123(3):306-311.
75. Boonen LHHM, Laske-Aldershof T, Schut FT. Switching health insurers: the role of price, quality and consumer information search. *Eur J Health Econ*. 2016;17(3):339-353.
76. Reitsma-van Rooijen M, de Jong JD, Rijken M. Regulated competition in health care: switching and barriers to switching in the Dutch health insurance system. *BMC Health Serv Res*. 2011;11:95.
77. Stolper KCF, Boonen LHHM, Schut FT, Varkevisser M. Managed competition in the Netherlands: do insurers have incentives to steer on quality? *Health Policy*. 2019;123(3):293-299.
78. Loozen E, Varkevisser M, Schut E. *Goede Zorginkoop Vergt Gezonde Machtsverhoudingen: Het Belang van Markt- En Mededingingstoezicht Binnen Het Nederlandse Zorgstelsel*. Rotterdam, The Netherlands: Erasmus University Rotterdam; 2016.

79. Boonen LHHM, Schut FT. Preferred providers and the credible commitment problem in health insurance: first experiences with the implementation of managed competition in the Dutch health care system. *Health Econ Policy Law*. 2011;6(2): 219-235.
80. Groenewegen PP, Hansen J, de Jong JD. Trust in times of health reform. *Health Policy*. 2019;123(3):281-287.
81. Maarse H, Jeurissen P. Low institutional trust in health insurers in Dutch health care. *Health Policy*. 2019;123(3):288-292.
82. van Ginneken E, Swartz K. Implementing insurance exchanges—lessons from Europe. *N Engl J Med*. 2012;367(8):691-693. <http://www.nejm.org/doi/full/10.1056/NEJMp1205832>. Accessed May 19, 2020.
83. Maarse H, Paulus A. The politics of health-care reform in the Netherlands since 2006. *Health Econ Policy Law*. 2011;6(1):125-134.
84. Schut FT, van de Ven WPMM. Effects of purchaser competition in the Dutch health system: is the glass half full or half empty? *Health Econ Policy Law*. 2011;6(1):109-123.
85. Bal R, Zuiderent-Jerak T. The practice of markets in Dutch health care: are we drinking from the same glass? *Health Econ Policy Law*. 2011;6(1):139-145.
86. Nederlandse Zorgautoriteit (NZa). *Marketscan: Medisch-Specialistische Zorg 2016*. https://puc.overheid.nl/nza/doc/PUC_3601_22/1/. Published January 6, 2017. Accessed May 19, 2020.
87. Netherlands Authority for Consumers and Markets (ACM). *Prijs-En Volume-Effecten van Ziekenhuisfusies Onderzoek Naar Effecten van Ziekenhuisfusies, 2007–2014*. The Hague, Netherlands: ACM; 2017. <https://www.acm.nl/sites/default/files/documents/2017-12/rapport-prijs-en-volume-effecten-van-ziekenhuisfusies-van-2007-2014-2017-12-05.pdf>. Accessed May 19, 2020.
88. Authority for Consumers and Markets (ACM). *OLVG Hospital Allowed to Acquire Parts of Slotervaart Hospital*. The Hague, Netherlands: ACM; 2019. <https://www.acm.nl/en/publications/olvg-hospital-allowed-acquire-parts-slotervaart-hospital>. Accessed May 2, 2019.
89. Rice T, Rosenau P, Unruh LY, Barnes AJ, Saltman RB, van Ginneken E. United States of America: health system review. *Health Syst Transit*. 2013;15(3):1-431.
90. Jacobson G, Damico A, Neuman T. *Medicare Advantage 2018 Data Spotlight: First Look*. Menlo Park, CA: Henry J. Kaiser

- Family Foundation; October 2017. <http://files.kff.org/attachment/Issue-Brief-Medicare-Advantage-2018-Data-Spotlight-First-Look>. Accessed May 19, 2020.
91. Moffit RE, Numerof RE, Buseman CM. Let the market compete: learning from Medicare Advantage to move toward value-based care. *Health Affairs Blog*. January 25, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20180122.210298/full/>. Accessed May 19, 2020.
 92. Hackbarth GM, Berenson RA, Miller ME, et al. *Report to the Congress: Medicare payment policy*. Testimony on behalf of MedPAC. Washington, DC: MedPAC; 2009. <http://www.medpac.gov/docs/default-source/reports/march-2009-report-to-congress-medicare-payment-policy.pdf>. Accessed May 19, 2020.
 93. Marmor TR. *The Politics of Medicare*. Hawthorne, NY: Aldine de Gruyter; 2000.
 94. Chee TT, Ryan AM, Wasfy JH, Borden WB. Current state of value-based purchasing programs. *Circulation*. 2016;133(22):2197-2205.
 95. Tanenbaum SJ. What is the value of value-based purchasing? *J Health Polit Policy Law*. 2016;41(5):1033-1045.
 96. Tanenbaum SJ. Pay for performance in Medicare: evidentiary irony and the politics of value. *J Health Polit Policy Law*. 2009;34(5):717-746.
 97. Ryan A. Hospital-based pay-for-performance in the United States. *Health Econ*. 2009;18(10):1109-1113.
 98. Berwick DM, Hackbarth AD. Eliminating waste in US health care. *JAMA*. 2012;307(14):1513-1516.
 99. Marmor T, From HMOs to ACOs: the quest for the Holy Grail in US health policy. *J Gen Intern Med*. 2012;27(9):1215-1218.
 100. Maio V, Goldfarb NI, Carter C, Nash DB. *Value-Based Purchasing: A Review of the Literature*. New York, NY: The Commonwealth Fund; 2003.
 101. Werner RM, Dudley RA. Medicare's new hospital value-based purchasing program is likely to have only a small impact on hospital payments. *Health Aff (Millwood)*. 2012;31(9):1932-1940.
 102. Porter ME, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition on Results*. Boston, MA: Harvard Business Press; 2006.
 103. Kandel ZK, Rittenhouse DR, Bibi S, Frazee TK, Shortell SM, Rodriguez HP. The CMS State Innovation Models initiative and improved health information technology and care management capabilities of physician practices. *Med Care Res Rev*. 2020:1077558719901217.

104. Oberlander J. *The Political Life of Medicare*. Chicago, IL: University of Chicago Press; 2003.
105. Olson A, Viverette N, Campbell H, McKethan A, Buntin M. Value-based payment reform in a managed care environment: innovator states' experiences with episodes of care. *N C Med J*. 2019;80(5):297-299.
106. Kissam SM, Beil H, Cousart C, Greenwald LM, Lloyd JT. States encouraging value-based payment: lessons from CMS's State Innovation Models Initiative. *Milbank Q*. 2019;97(2):506-542.
107. Centers for Medicare and Medicaid Services (CMS); Department of Health and Human Services. Medicare program; payment policies under the physician fee schedule, five-year review of work relative value units, clinical laboratory fee schedule: signature on requisition, and other revisions to part B for CY 2012. Final rule with comment period. *Fed Regist*. 2011;76(228):73026.
108. Donabedian A. Evaluating the quality of medical care. *Milbank Q*. 1966;44(3):166-206.
109. Luce JM, Bindman AB, Lee PR. A brief history of health care quality assessment and improvement in the United States. *West J Med*. 1994;160(3):263.
110. Brook RH. The end of the quality improvement movement: long live improving value. *JAMA*. 2010;304(16):1831-1832.
111. Berenson RA, Sunshine JH, Helms D, Lawton E. Why Medicare Advantage plans pay hospitals traditional Medicare prices. *Health Aff (Millwood)*. 2015;34(8):1289-1295.
112. Berenson RA, Goodson JD. Finding value in unexpected places—fixing the Medicare physician fee schedule. *N Engl J Med*. 2016;374(14):1306-1309.
113. Willink A, DuGoff EH. Integrating medical and nonmedical services: the promise and pitfalls of the CHRONIC Care Act. *N Engl J Med*. 2018;378(23):2153-2155.
114. Marjoua Y, Bozic KJ. Brief history of quality movement in US healthcare. *Curr Rev Musculoskelet Med*. 2012;5(4):265-273.
115. Damberg CL, Sorbero ME, Lovejoy SL, Martsolf GR, Raaen L, Mandel D. Measuring success in health care value-based purchasing programs: findings from an environmental scan, literature review, and expert panel discussions. *Rand Health Q*. 2014;4(3).
116. Eldridge GN, Korda H. Value-based purchasing: the evidence. *Am J Manag Care*. 2011;17(8):e310-e313.
117. Burke LA, Ryan AM. The complex relationship between cost and quality in US health care. *AMA J Ethics*. 2014;16(2):124-130.

118. Burns LR, Pauly MV. Transformation of the health care industry: curb your enthusiasm? *Milbank Q*. 2018;96(1):57-109.
119. Gudiksen KL, Chang SM, King JS. *The Secret of Health Care Prices: Why Transparency Is in the Public Interest*. San Francisco, CA: California Health Care Foundation; 2019. <https://www.chcf.org/wp-content/uploads/2019/06/SecretHealthCarePrices.pdf>. Accessed May 20, 2020.
120. Azar AM II, Mnuchin ST, Acosta A. *Reforming America's Health-care System Through Choice and Competition*. Washington, DC: Department of Health and Human Services; 2019. <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>. Accessed May 22, 2020.
121. Mathews AW. Behind your rising health-care bills: secret hospital deals that squelch competition. *Wall Street Journal*. September 18, 2018. <https://www.wsj.com/articles/behind-your-rising-health-care-bills-secret-hospital-deals-that-squelch-competition-1537281963>. Accessed May 20, 2020.
122. Berenson RA, King JS, Gudiksen KL, Murray R, Shartz A. *Addressing Health Care Market Consolidation and High Prices*. Washington, DC: Urban Institute; 2020. https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf. Accessed May 20, 2020.
123. Nation GA III. Contracting for healthcare: price terms in hospital admission agreements. *Dickinson L Rev*. 2019;124:91.
124. Bai G, Anderson GF. US hospitals are still using charge-master markups to maximize revenues. *Health Aff (Millwood)*. 2016;35(9):1658-1664.
125. Maeda J, Nelson L. An analysis of hospital prices for commercial and Medicare Advantage plans. Congressional Budget Office. Presented at: 2017 Annual Research Meeting AcademyHealth; June 26, 2017; Washington, DC.
126. Selden TM, Karaca Z, Keenan P, White C, Kronick R. The growing difference between public and private payment rates for inpatient hospital care. *Health Aff (Millwood)*. 2015;34(12):2147-2150.
127. White C, Whaley C. Prices paid to hospitals by private health plans are high relative to Medicare and vary widely: findings from an employer-led transparency initiative. Arlington, VA: Rand; 2019. https://www.rand.org/pubs/research_reports/RR3033.html. Accessed May 20, 2020.

128. Fact sheet: data driven patient care strategy. Centers for Medicare and Medicaid Services website. <https://www.cms.gov/newsroom/fact-sheets/data-driven-patient-care-strategy>. Published April 26, 2018. Accessed May 20, 2020.
129. CMS administrator Verma unveils new strategy to fuel data-driven patient care, transparency [press release]. Centers for Medicare and Medicaid Services website. <https://www.cms.gov/newsroom/press-releases/cms-administrator-verma-unveils-new-strategy-fuel-data-driven-patient-care-transparency>. Published April 26, 2018. Accessed May 20, 2020.
130. Patashnik EM, Gerber AS, Dowling CM. *Unhealthy Politics: The Battle Over Evidence-Based Medicine*. Princeton, NJ: Princeton University Press; 2017.
131. Laugesen M. *Fixing Medical Prices*. Cambridge, MA: Harvard University Press; 2016.
132. Martin CJ. Employers: passive purchasers or provocateurs? *J Health Polit Policy Law*. 2003;28(2-3):317-340.
133. Gray BH, Gusmano MK, Collins SR. AHCPR and the changing politics of health services research. *Health Aff (Millwood)*. 2003;22(Suppl.1):w3. <https://doi.org/10.1377/hlthaff.w3.283>.
134. Patashnik EM. *Reforms at Risk: What Happens After Major Policy Changes Are Enacted*. Princeton, NJ: Princeton University Press; 2014.
135. Fry R. Millennials approach Baby Boomers as America's largest generation in electorate. Pew Research Center website. <https://www.pewresearch.org/fact-tank/2018/04/03/millennials-approach-baby-boomers-as-largest-generation-in-u-s-electorate/>. Published April 3, 2018. Accessed May 20, 2020.
136. Fry R. Will Millennial, GenX voters match older generations in 2018 turnout? Pew Research Center website. 2018.
137. National Health Policy Forum. *The Basics: Relative Value Units (RVUs)*. Washington, DC: National Health Policy Forum; 2015. https://www.nhpf.org/library/the-basics/Basics_RVUs_01-12-15.pdf. Accessed May 20, 2020.
138. RVS Update Committee (RUC). American Medical Association website. <https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc>. Published 2019. Accessed May 19, 2020.
139. Chan DC, Dickstein MJ. Industry input in policy making: evidence from Medicare. *QJ Econ*. 2019;134(3):1299-1342.
140. Trish E, Ginsburg P, Gascue L, Joyce G. Physician reimbursement in Medicare Advantage compared with traditional

- Medicare and commercial health insurance. *JAMA Intern Med.* 2017;177(9):1287-1295.
141. Patashnik E, Zelizer J. Paying for Medicare: benefits, budgets, and Wilbur Mills's policy legacy. *J Health Polit Policy Law.* 2001;26(1):7-36.
 142. Patashnik EM, Zelizer JE. The struggle to remake politics: liberal reform and the limits of policy feedback in the contemporary American state. *Perspect Polit.* 2013;11(4):1071-1087.
 143. Laugesen MJ. Siren song: physicians, Congress, and Medicare fees. *J Health Polit Policy Law.* 2009;34(2):157-179.
 144. Enthoven AC, Singer SJ. The managed care backlash and the task force in California: lessons for consumers, physicians, health care workers, health plans, and politicians from California's task force on managed care. *Health Aff (Millwood).* 1998;17(4):95-110.
 145. Hall MA. The death of managed care: a regulatory autopsy. *J Health Polit Policy Law.* 2005;30(3):427-452.
 146. Oberlander JB. Managed care and Medicare reform. *J Health Polit Policy Law.* 1997;22(2):595-631.
 147. Post B, Buchmueller T, Ryan AM. Vertical integration of hospitals and physicians: economic theory and empirical evidence on spending and quality. *Med Care Res Rev.* 2018;75(4):399-433.
 148. Cooper Z, Craig SV, Gaynor M, Van Reenen J. The price ain't right? hospital prices and health spending on the privately insured. *Q J Econ.* 2019;134(1):51-107.
 149. Kleiner SA, White WD, Lyons S. Market power and provider consolidation in physician markets. *Int J Health Econ Manag.* 2015;15(1):99-126.
 150. Casalino LP, Saiani R, Bhidya S, Khullar D, O'Donnell E. Private equity acquisition of physician practices. *Ann Intern Med.* 2019;171(1):78.
 151. Peters CT. *Bargaining Power and the Effects of Joint Negotiation: The "Recapture Effect."* Washington, DC: Economic Analysis Group; 2014. <https://www.justice.gov/sites/default/files/atr/legacy/2014/09/26/308877.pdf>. Accessed May 22, 2020.
 152. Schoen C, Collins SR. The big five health insurers' membership and revenue trends: implications for public policy. *Health Aff (Millwood).* 2017;36(12):2185-2194.
 153. Berenson RA. When is competition not competition: the curious case of Medicare Advantage. *St Louis U J Health Law Policy.* 2017;11(1):141. <https://scholarship.law.slu.edu/jhlp/vol11/iss1/8>. Accessed May 19, 2020.
 154. *United States v. Aetna Inc.*, 240 F. Supp. 3d 1, 21 (2017).

155. Frank RG, McGuire TG. *Market Concentration and Potential Competition in Medicare Advantage*. New York, NY: Commonwealth Fund; 2019:1-8.
156. Frank RG, McGuire TG. Regulated Medicare Advantage and marketplace individual health insurance markets rely on insurer competition. *Health Aff (Millwood)*. 2017;36(9):1578-1584.
157. Skopec L, Berenson RA, Feder J. *Why Do Medicare Advantage Plans Have Narrow Networks?* Washington, DC: Urban Institute; 2018. https://www.urban.org/sites/default/files/publication/99414/why_do_medicare_advantage_plans_have_narrow_networks.pdf. Accessed May 22, 2020.
158. Hall MA, Ginsburg PB. A better approach to regulating provider network adequacy. Brookings Institute website. <https://www.brookings.edu/research/a-better-approach-to-regulating-provider-network-adequacy/>. Published September 14, 2017. Accessed May 19, 2020.
159. Haeder SF, Weimer DL, Mukamel DB. A knotty problem: consumer access and the regulation of provider networks. *J Health Polit Policy Law*. 2019;44(6):937-954.
160. Haeder SF, Weimer DL, Mukamel DB. Surprise billing: no surprise in view of network complexity. *Health Affairs Blog*. June 5, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20190603.704918/full/>. Accessed May 19, 2020.
161. Adler L, Fiedler M, Ginsburg PB, et al. *State Approaches to Mitigating Surprise Out-of-Network Billing*. Washington, DC: Brookings Institute; 2019.
162. Hall MA, Brandt C. Network adequacy under the Trump administration. *Health Affairs Blog*. September 14, 2017. <https://www.healthaffairs.org/doi/10.1377/hblog20170914.061958/full/>. Accessed May 19, 2020.
163. White J. Prices, volume, and the perverse effects of the variations crusade. *J Health Polit Policy Law*. 2011;36(4):775-790.

Funding/Support: None.

Conflict of Interest Disclosure: All authors declare that they have no conflicts of interest.

Acknowledgments: We would like to thank Sheelagh Kennedy, Jeff McCullough, Minakshi Raj, and participants in a panel at the International Health Economics Association 2017 meeting in Boston for their helpful comments. We would also like to thank Joseph White and an anonymous reviewer for their comments.

Address correspondence to: Scott L. Greer, PhD, University of Michigan School of Public Health, Department of Health Management and Policy, 1415 Washington Heights, Ann Arbor, MI 48109 (email: slgreer@umich.edu).