CQ Review

Readers are invited to contact Greg S. Loeben in writing at Midwestern University, Glendale Campus, Bioethics Program, 19555 N. 59th Ave., Glendale, AZ 85308 (gloebe@arizona.midwestern.edu) regarding books they would like to see reviewed or books they are interested in reviewing.

The Managed Care Blues and How to Cure Them, by Walter A. Zelman and Robert A. Berenson. Washington, D.C.: Georgetown University Press, 1998. 240 pp.

In a new and important book entitled *The Managed Care Blues and How to Cure Them*, a lifetime consumer advocate and a surgeon who witnessed the excesses and unaccountable errors of his colleagues under fee for service explain with deft hands the promise of managed care, its problems, and solutions to them. Walter Zelman and Robert Berenson show empathy for the consumer backlash, provider resentment, and the patients' rights movement that has spawned a thousand bills to prevent possibly unethical actions. Yet they believe these efforts to regulate managed care are misdirected and will prevent it from realizing its potential.

Ironically, however, their own recommendations for how managed care can realize its vision of better quality care at lower cost are undermined by the structure and trends of American-style managed care. This is important, because since its inception Zelman has been a leading force in creating today's managed care system, and he now heads the industry association in California.

Divided into 10 chapters, *The Managed Care Blues* explains how the traditional insurance system failed (Chapters 1–2), describes the development of managed care from early HMOs (Chapter 3), explains the tools of managed care (Chapters 4–5), reviews the charges of the consumer backlash against the record (Chapters 6–7), worries about the way things are going (Chapter 8), explains the problems with consumer protectionism (Chapter 9), and concludes with "Thirteen Steps to Raising Quality."

The authors' assessment of "the old insurance system" is on the mark with one telling exception: they blame government for much of the health cost problem. This is the popular claim among the managed care crowd and is commonly found on the pages of *Health Affairs*; but in almost every case it is private parties that use government to protect or fund their interests, especially the AMA and the AHA.[1] To then blame "the government" is to blind oneself to the real drivers of runaway cost, and to miss the ways in which private providers use government to bankroll their services and their private markets. Researchers have documented, for example, how that "old insurance system" was crafted by the providers precisely to pay for their ser-

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vices, with as little interference as possible, and with providers dominating the committees that determined how high the reimbursements would be.[2] When Medicare and Medicaid came along, the providers' lobbies worked ferociously to be sure they too would reimburse fees and much more, such as all equipment and capital costs, by building them into the hospital day rates. In other words, a hospital could build or buy what it wanted (including underused or unnecessary equipment) and get it all paid back. Blaming the government for runaway costs is a way to keep Americans blissfully ignorant of how governmental oversight has kept the costs of most advanced healthcare systems in Europe to about 8–9% of GNP for more than 20 years while providing excellent, prompt care to everyone.

Quality is Zelman and Berenson's chief concern, and they conclude that quality in allegedly "the best health care system in the world," when fee for service reigned, was uneven and based "on a pillar of faith" with no data. The authors tell their story with just the right details, about the profound implications of large practice variations for professionalism and autonomy, about the explosion in technology and information that makes it impossible for physicians in the splendid isolation of their autonomy to keep competent, and about the focus on treating disease that keeps one from figuring out how to keep people healthy in the first place. This leads them to describe the tools of managed care, including case management and disease management, that are not compatible with fee-for-service.

With these and other tools for making healthcare better coordinated, evidence-based, and cheaper, why is there a managed care backlash? The authors sympathetically explain. Yes, billions have been saved, but it all seems to go into the pockets of the plans, the insurance companies, and the employers. Meanwhile, employees are paying out more and more in copremiums and copayments, at the same time that their coverage and access to specialty care become more limited.[3] No wonder they are angry. Moreover, every other business thrives by giving you more for your money and bending over backwards to serve its loyal customers, while managed care profits more by doing less and serving less. The last thing managed care wants, it seems, are "loyal customers," i.e., patients who need a lot of care.

On top of this, the authors write, is "The Greed Factor" of investors taking over managed care and redirecting HMOs from their early days of nonprofit and social mission, while paying themselves millions. No wonder there is backlash and distrust! But the authors remind us that the preceding quarter century shows that doctors cannot be trusted either. Today, both physicians and the press exaggerate their problems. Contrary to screaming headlines, the authors cite evidence that almost all physicians report they *can* get referrals for patients who need them, that on the whole they are *not* at significant financial risk for doing what is clinically best, and that quality is *not* lower except for those who are chronically or mentally ill.

Even though the authors think managed care has gotten a bad rap, they are admirably tough on managed care and believe it has failed to improve quality. Yet this is what attracted both Zelman and Berenson to managed care. In a way this book is their effort to work through their disappointment in a delivery system on which they pinned their hopes and to which they have devoted the past 20 years of their lives. In the final chapter, they come up with recommendations for how managed care can turn things around and real-

ize its potential. Their recommendations reflect Enthoven's original vision[4]: provide good comparative information on quality, performance, and price, and then let individuals choose plans (not providers). Unleash consumer power. Organize choice of plans into fair, orderly markets that prohibit risk selection and other kinds of market manipulations. Have consumers pay the difference for costlier plans, if they think they provide better value. After all, employees can choose better than employers (who don't know much about managed care anyway). Instead of having employers choose an insurer, who then chooses provider systems, have consumers purchase provider systems directly. Protect consumers from being "taken," not by hog-tying plans with regulations, but by empowering consumers with solid information. Make plans liable to lawsuits. Meantime, get more physicians involved in running plans.

The authors fail to mention what Enthoven and others concluded is needed to overcome market manipulations and forms of market failure: universal health insurance with a uniform package of benefits.[5]

But haunting this effort to save their dreams and managed care are three characteristics the authors identify earlier in the book as "rule of price," "cult of choice," and "cost of quality." Zelman and Berenson correctly observe that the promise of high quality through managed care rests on stable teams working with stable populations of patients to manage their health risks and problems. Yet these conditions would not be the outcomes of their proposed reforms. Rather, there would be a lot of shopping and switching by people whom research has shown usually do not understand their policy or know what an HMO is. Nor are they the conditions of current trends in managed care, which make the prerequisites for quality impossible. As the authors note, price rules. Insurers rule. Employers switch insurer plans, and plans switch the provider groups with whom they contract. Thus teams and relationships cannot develop. Moreover, "quality" is hard to define and measure; so consumers defend themselves in the only way left: they demand more choice over providers and procedures. But this too stymies good clinically managed care.

Thus the cult of choice has led to larger and larger networks, point of service type HMOs with buyout choice, and the growth of PPS (preferred provider systems)—in sum, a managed care version of the old system that could not reward quality. As Zelman and Berenson explain, so-called plans are actually combinations of the same sets of providers, so plans "end up as little more than sales organizations for providers," and comparisons of quality become impossible. Finally, even if a plan actually attains higher quality (as Berenson's former plan did), it attracts sicker patients, and then the cost of quality goes up and the plan goes under. In plain economic sociology, it is the structure of the market that undermines the pursuit of quality. In these ways, the middle of the book haunts its conclusions.

How, then, can plans contain costs? Their main options are to limit access, reduce services, increase copayments, and drive out patients with "sinkhole" problems by serving them poorly. This amounts to covert de-insurance, which discriminates heavily against minorities, women, the working classes, and people of any background with chronic conditions. Thus, the tragic structure of American healthcare markets leads to the managed care vision of better quality for less cost coming unraveled. This is the system the authors helped to create and now want to repair. As the authors write, the

"logic of managed care [for quality] is compelling"; but in a competitive "market for lemons," the logic of managed care markets rewards selling used cars that run poorly but have a shiny exterior, like the billboard ads for managed care featuring happy, healthy customers in the prime of life.

This is what Margaret Thatcher and the Conservatives concluded five years into the most comprehensive application of managed competition in the world, when they transformed the National Health Service from an administered welfare service to an internal market of buyers and sellers.[6] They found that competition raised costs, fostered distrust, and increased disruptions of service. They concluded that what good managed care needs are partnerships and cooperation, which became their new policy and is the heart of the Blair reforms. But that is another story, one that holds important lessons for the United States.

——Donald W. Light

Notes

1. Starr P. *The Social Transformation of American Medicine*. New York: Basic, 1982: Book 2.
2. Light DW. The restructuring of the American health care system. In Litman TJ, Robbins LS, eds. *Health Politics and Policy*. Albany, N.Y.: Delmar Press, 1997.
3. Light DW. Good managed care needs university health insurance. *Annals of Internal Medicine* 1999;130:686–9.
4. Enthoven A. *Theory and Practice of Managed Competition in Health Care Finance*. Amsterdam: North-Holland, 1988.
5. See note 3, Light 1999.
6. Light DW. From managed competition to managed cooperation: theory and lessons from the British experience. *The Milbank Quarterly* 1997;75:297–291.