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Why Liberals Should Embrace Managed Care

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I

After years of remarkable growth, managed care today faces a powerful political backlash. Critics have successfully fostered the public perception that managed care threatens the quality of health care, putting profit before people, corporate greed before human needs. Ironically, managed care's most vocal critics are on the political left—ironically, since, in origin and in essence, managed care is a deeply progressive approach to health care, with great potential to realize in practice liberal ideals of social justice and community solidarity.

The traditional fee-for-service system emphasized one-on-one relationships between individual physicians and individual patients to the exclusion of any larger social mission. Managed care, by contrast, places such relationships within the context of a more inclusive collective relationship between a coordinated team of health care workers and a whole population of health plan members. Thus it naturally ought to encourage, first, cooperation among medical professionals and, second, a shared commitment on their part to maintaining the health of the entire community they serve, rather than just caring for those who are ill, when they are ill.

The first of these two tendencies, professional cooperation, should, in turn, enhance the possibilities for oversight, accountability, and quality control. The second, commitment to community health, should refocus attention on preventive efforts that address the long run needs of the

many rather than the acute care needs of a few. Both together should lead to a fairer, more cost-effective distribution of medical resources and to a stronger bond between health care professionals and their member populations. This would well serve values of justice and community that are important to all—and especially to liberals.

In its earliest forms, managed care in America mostly emphasized the first tendency: professional cooperation. Paul Starr has traced managed care's origins in America to various initiatives that arose in the early years of the twentieth century. In *contract practice*, companies, fraternal societies and employee associations directly hired physicians to provide low-cost medical care for workers (Starr 1982: 198–199). In *corporate practice*, employers hired physicians through the intermediary of profit making firms (ibid.: 199). In *private group practice*, physicians formed their own organizations, together with business managers and technical assistants (ibid.: 209). As Starr notes,

Reformers . . . viewed these organized health services, particularly the private multispecialty clinics, as harbingers of a new order in medical care. The virtues of “cooperative teamwork” and “group medicine,” they believed, would soon become apparent to all. Individualism in medical care had had its day, and now the development of technology and specialization would require the same coordinated organization in medicine that was emerging throughout the society. (ibid.: 199)

This new enthusiasm for cooperation swept up even those who did not think of themselves as “reformers.” For example, William Mayo of the Mayo Clinic, the archetype for private group practice in America, came to believe “that medical care had become a ‘cooperative science’ and ‘individualism in medicine’ could no longer continue” (ibid.: 213).

Later, other pioneers of managed care increasingly emphasized the second tendency: commitment to the community. For example, Michael Shadid was inspired by democratic socialist ideals in his struggles to organize a medical cooperative in western Oklahoma in the 1930s. The cooperative movement sought to take power out of the hands of producers and to place it instead in those of the consumer; Shadid sought to achieve this goal in medicine through a form of managed care organization (ibid.: 303).

H. Jack Geiger and Count D. Gibson Jr. took a similar approach in their fight to establish neighborhood health centers in the Boston housing projects and in rural Mississippi in the 1960s (ibid.: 371). Among the goals of neighborhood health centers, Geiger (1984: 12–13) singled out

not only “establishing new patterns of professional organization, with emphasis on multidisciplinary teams” but also “serving defined communities and populations.”

The focus on community service had profound implications for the day-to-day practice of medicine, since the kind of health care that whole populations needed most was not limited to what individual patients had traditionally asked of their physicians. As Geiger observed, community-based medicine involved “shifting . . . the emphasis from complex tertiary care to primary care” (*ibid.*: 12). Whereas the one-on-one, fee-for-service system catered first and foremost to individual demands for acute and emergency care, population-based programs sought to head off the need for such reactive intervention through proactive, preventive measures that addressed the whole community. Ultimately, the reformers believed, such an approach might lead well beyond the bounds of medicine as traditionally conceived to include changes in education, employment, and the environment. Geiger hoped that “an emphasis on the health of communities, beyond the traditional patient-by-patient focus of clinical medicine, might promote community development and permit intervention in social and environmental causes of ill health” (*ibid.*: 16).

By better serving the long-term health care needs of entire communities, rather than focusing on immediate acute care, population-based medicine promised to remedy deep moral shortcomings of the traditional system. Because it emphasized individual physician-patient bonds to the exclusion of larger social commitments, fee-for-service (third-party payer medicine) had encouraged last-minute, high-tech intervention at the expense of alternative allocations of medical resources that could have done more good for more people. Thus, while it gave a central place to the value of beneficence, it unintentionally slighted values of social justice and community solidarity by comparison. By reversing these traditional priorities, population-based medicine sought to realize those values of justice and community. That is why radical reformers like Victor W. and Ruth Sidel (1984: 283) insisted that “the goals for a nation’s health care system include . . . making health care community based.”

II

At least in theory, the same progressive approach ought to come naturally to present-day managed care organizations. Not only are community outreach and prevention programs a part of managed care’s historical heritage, but such efforts are also in its interests: in the long run managed

care saves money by keeping its members healthy. As Stephen M. Shortell et al. (1998: 1104) have observed, "The incentive is to intervene as early as possible in the underlying causes of [community health] problems. This will require working with schools, religious organizations, health departments, social welfare agencies, business and community organizations, and others with the required expertise, resources, and commitment to deal with these challenges." This ought to translate into both a fairer distribution of health care resources and a stronger bond between health care worker and community—two goals that liberals can wholeheartedly endorse.

Why, then, is managed care today coming in for such vehement attack, especially from the left? The fact that many *physicians* oppose the growth of managed care and would prefer to go back to the traditional system comes as no surprise. They have rarely welcomed changes that threatened their own autonomy and authority by introducing independent oversight, whether in the name of social welfare or in that of business interests. So their opposition to managed care is neither mysterious nor unexpected. But why have liberals turned on their own ideological offspring and joined in the attack?

The problem is that managed care organizations have become identified, not with their progressive essence, but with incidental features which have been allowed to obscure that essence.

To begin with, it is managed care's capacity for cost control, rather than its emphasis on cooperation and community, that has driven its rapid growth in recent years. Managed care was embraced as the escape route from an impasse in the development of America's health care marketplace. Accelerating technological advance had spurred a seemingly endless spiral of rising costs that the fee-for-service system, with its incentives for excess and its compliant insurers, seemed unable to control (Schwartz 1987). Employers demanded that the costs of their employee's health benefits be contained, and these costs were among the things managed care promised it could manage. Its capacity to manage other things as well—like quality, community outreach, and prevention programs—simply didn't figure into the equation for employers in search of reduced expenditures, however central such things might have been to the original vision and mission of managed care.

Inevitably, this emphasis on managed care's cost-cutting role has led to denials of highly expensive and/or doubtfully efficacious care that the fee-for-service system had previously rubber-stamped. But every such denial, reasonable or not, can be transformed into a horror story by a

journalist with an eye for drama (Anders 1996). The situation becomes all the more explosive in the case of managed care organizations that are run for profit. “Human needs sacrificed on the altar of corporate greed” is a story line that makes up in surefire human interest whatever it may lack in fairness or accuracy.

Unfortunately, such a story line is not always unfair or inaccurate. Journalists have good reason to be suspicious, for there’s no denying that managed care as currently practiced employs some morally dubious incentives. Capitation, for example, encourages physicians to withhold care indiscriminately, irrespective of their patients’ actual medical needs. Similarly, some bonus systems reward physicians for not ordering costly tests and procedures, again, regardless of whether or not they are necessary.

Such incentives look particularly morally unattractive when they are instituted by profit-making corporations with an eye to the bottom line. The problem is not the limitation of benefits as such. Many would be prepared to accept some limitations, if it meant being able to cover more people, or to make more services available to those already covered, or to promote health-related initiatives in education, employment, and the environment. But the interests of corporate shareholders hardly inspire the same willingness to sacrifice.

So the negative public perception of managed care is not without foundation. Yet it represents at best a half-truth.

III

Consider managed care’s emphasis on cost containment. This is, in itself, unobjectionable. The problem of spiraling costs is one that any viable approach to meeting America’s health care needs must tackle. Indeed, controlling rising health care costs is not only a practical necessity but a moral imperative. In a world of limited resources, not every medical expenditure produces enough good in return for what it costs to be ethically justified.

On the one hand, there are competing alternatives within the realm of health care itself. It makes no ethical sense to indulge every demand of each individual patient. This drives up the costs of coverage for all and may even deprive some of any coverage whatsoever. It may also divert scarce resources away from other alternative expenditures that may be more cost effective or may benefit a broader range of patients.

On the other hand, there are many competing values in life that health

care does not automatically trump. It would be possible for Americans to spend an even higher percentage of the gross national product on health care than they already do, purchasing ever smaller increments of life and health at ever greater expense; that is the direction in which past trends have gone. But sooner or later the odd extra day of life support must yield to other valuable goals, like education, the arts, and any number of other important personal and social goods.

So it makes good sense for society as a whole—not just cost-conscious employers and managed care organizations—to contain health care spending within reasonable limits. The pressure to control costs ultimately stems not just from corporate greed, but from legitimate evaluative priorities of the entire community. It should not be part of any progressive policy—or, indeed, any policy concerned with values of justice and community—to oppose intelligent management of the costs of health care.

Consider also that not all horror stories represent horrific realities. Some of the tales one hears of allegedly unreasonable denials of care may reflect not so much greedy indifference to patient welfare as legitimate disagreement over proper standards of care. Medicine is far from a completed science. Customary standards are often quite unsupported by scientific evidence. In many cases there may simply be no good scientific evidence available that unambiguously tells medical professionals what to do. In other cases, relevant scientific evidence may be difficult or impossible to apply, given the unique circumstances and complications that are inevitable in real-world medical situations (Rosenbaum et al. 1999). Sometimes available scientific evidence may even contradict common standards of practice. Such standards are, after all, less than absolutely reliable: they may sometimes be based on practical wisdom born of experience, but at other times they may rest on no more than prejudice, misinformation, or sheer habit. They may also differ widely from place to place and time to time—sometimes in quite arbitrary ways (Wennberg, Freeman, and Culp 1987; Ashton et al. 1999).

Thus in situations of conflict or confusion concerning scientific evidence and traditional standards of care, one should not rush to judgment or be too quick to condemn medical directors for refusing coverage. One should also recognize that judges and juries—to say nothing of journalists—may suffer from their own limitations and biases in making such evaluations.

The profit-making orientation of some managed care organizations is

more problematic. The pursuit of profit need not necessarily benefit shareholders at the expense of consumers: in ideally competitive markets, the only way for companies to make a profit is to maximize the value of the goods and services they offer, which means both improving quality and controlling cost. Unfortunately, the health care marketplace is far from ideally competitive. Most consumers have no real choice of health care plan at all (Bodenheimer 1999: 490). Only employers truly enjoy that freedom, when they select the plan or plans that they will make available to their employees—and they have strong incentives to sacrifice quality for the sake of economy, since they are paying the bills but not directly suffering the consequences. While they have some reason to offer a high quality plan in order to attract prospective employees, this is probably more effective in theory than in practice. Job seekers may well prefer companies that offer health care plans to those that don't, but when faced with a job offer they are hardly likely to inquire into the details of particular plans, let alone make their decision on that basis.

This, then, is a genuine and troubling problem, and will remain so unless and until employers wholeheartedly embrace the welfare of their employees as being among the goals of doing business, and/or give their employees a real voice in corporate decisions that deeply effect their lives—like the choice of health care options.

IV

Despite this stumbling block, liberals ought to rethink their attitude toward managed care. The perceived faults that drive the ongoing backlash against it may not run so deep as might at first appear. Indeed, the worst of those faults—that is, the overemphasis on cost containment—cannot, in fairness, be blamed on managed care as such, but are an inevitable legacy of the burdensome costs imposed by the fee-for-service system and the refusal of employers to go on bearing those costs. In effect, managed care is shouldering responsibility for painful but necessary measures that must be taken as part of any serious attempt to come to grips with the ongoing crisis of American health care—measures that it has shown itself better able to undertake than any alternative system.

Still more to the point, liberals, and for that matter, all who share a concern for values of justice and community, must not forget managed care's potential for contributing to community solidarity by creating a fairer allocation of health care resources. They should recognize that the

rise of population-based medicine brings not only moral risks, but significant moral opportunities as well. They should do what they can to minimize the risks, while also taking advantage of the opportunities.

The greatest risk, I have suggested, arises out of the fact that health care options are chosen by employers rather than employees. Liberals should insist that these decisions be made by those most affected by them. Instead of choosing health care plans themselves, employers could negotiate a budget with employees, whose representatives could decide how to spend it. If managed care organizations had to compete for employees' favor with everything from traditional indemnity plans to medical savings accounts, they would have no choice but to respond to people's concerns about such problems as inappropriate incentives for withholding care regardless of medical necessity.

Managed care's greatest moral opportunity lies in community outreach and prevention programs. Liberals should celebrate managed care's preventive efforts and encourage more of them. A recent study showed managed care outperforming fee-for-service in screenings for and early detection of breast cancer (Riley et al. 1999). Managed care organizations should receive as much credit for such successes as they receive blame for their failures. If they screen for breast cancer out of a self-interested desire for publicity, then so much the better for self-interest, and by all means give them their publicity. Moral progress is never so likely as when it serves people's interests to do the right thing.

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