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We, Americans, planted the seeds of the managed care backlash in the design of the health care and insurance institutions we created.

The traditional model of health insurance based on fee-for-service, complete free choice of provider, and indemnity insurance (FFS), which was for many years the main form of insurance in this country, left providers largely unaccountable for the cost of care. When caring for insured people, providers could resolve every doubt in favor of doing more with no direct negative financial consequences for patients or themselves. When combined with rapidly expanding technology, these incentives led national health expenditures to increase rapidly through the 1980s, from 8.9 percent of gross domestic product (GDP) in 1980 to 13.6 percent in 1993 (Iglehart 1999).

Equally important, FFS failed to hold health care institutions and professionals accountable for the quality of the services they provided or for the health of the populations they served. Under FFS, there were very wide variations in medical practices. Researchers found five- and ten-fold variations in the per capita incidence of surgeries in different communities with no evidence of such differences in medical need or health produced (Wennberg and Cooper 1998; see also Iglehart 1984). Variations seemed to be determined more by "practice style" than by scientific evidence. This "cost-unconscious" milieu also produced large amounts of inappropriate treatments. Research found that 32 percent of carotid endarterectomies and 14 percent of coronary artery bypass surgeries were performed for

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inappropriate reasons, with many more for equivocal reasons (Winslow et al., Coronary Artery Bypass, 1988; Winslow et al., Carotid Endarterectomy, 1988). A study in the *New England Journal of Medicine* found 23 percent of hospital admissions to be inappropriate, another 17 percent avoidable through use of ambulatory surgery (Siu et al. 1986).

The growth rate in national health expenditures inevitably would have to be brought into approximate equality with that of the GDP. High and rapidly increasing health expenditures create serious social problems. They strain public finances; government now pays 47 percent of the health care bill (Iglehart 1999). They reduce the growth in real wages for working people. They price health insurance out of reach for families of moderate means; 43 million people in this country are now uninsured.

In these circumstances, any serious expenditure limitation strategy would need to attempt to create standards of appropriateness, to examine and curtail inappropriate use of services, and therefore to limit the autonomy and authority of health professionals. Thus any serious expenditure limitation policy would have caused a backlash among physicians.

Although many physicians in many medical groups have embraced managed care, recognized the need for quality and cost management, and accepted responsibility for it, many other physicians, especially those in solo practice, regret the demise of FFS and their transition to managed care. Outside of Kaiser Permanente and other multispecialty groups, most physicians do not contract with HMOs by choice, but rather have been driven to them for financial survival. Many of these physicians—particularly specialists—fear a loss of income due to managed care.[1] Doctors' unwillingness to accept responsibility to organize and manage care has created a vacuum into which health plans have moved. As a result, health plans are performing functions that upset physicians and patients.

Physicians could have headed off the loss of autonomy and authority and could now correct the situation by following the examples of doctors in prepaid group practice. These physicians have created a culture of conservative practice, peer utilization management and review, and a management structure that enables them to respond to demands for cost containment. As a result, they are responding to national economic pressures by reexamining and redesigning care processes, innovating in ways that reduce people's need for care, and even by taking salary

1. Recent indications suggest that doctors nationwide have not suffered an actual loss of income, but rather fear a loss of income and perceive that they must work harder to earn the same amount (see Kilborn 1998).

reductions. In exchange, no one outside their medical groups micromanages their practices.

Resolving this cause of the backlash will require that physicians accept the inevitability of cost containment and take responsibility for managing quality and cost. Physicians need to become actively involved in continuous quality improvement, including evaluation of practice variations, identification and promulgation of best practices, and monitoring of compliance in partnership with professional managers who can assist them (Berwick, Godfrey, and Roessner 1991; Ellwood 1988; Roper et al. 1988). To the extent that physicians are not willing to accept these responsibilities, someone else will have to manage costs, which will be less acceptable to physicians and patients. This may take a long time because it will require a major cultural change. Physicians generally were not selected or trained for management or teamwork.

Cost unconsciousness characterized consumers as well as providers during the FFS era. The inevitable correction also contributed to the backlash. Because employers typically paid all or most of the premium, consumers did not see themselves as personally involved in premium costs. Consumers do not commonly perceive that premiums ultimately come out of their wages (Fuchs 1993). (Employers may pay for premium increases out of profits in the short run, but not in the long run when they have had time to take them out of what would have been wage increases.) From that position of complete freedom and economic nonresponsibility, almost *any* change would have had to be a change for the worse, and bound to cause dissatisfaction.

Over the past decade, large numbers of consumers were converted—often involuntarily—from the freedom of FFS coverage to the limitations of HMOs, often without much explanation of the relationship between the limitations and cost containment.[2] Neither the employers nor the managed care organizations wanted to emphasize the limitations on choice of doctor, so people approached managed care with the expectations they had acquired under FFS. Suddenly, people found themselves under limitations they had not experienced before. In many cases, people were forced to change doctors, not permitted to go to the doctor they wanted, or were denied proposed medical procedures. Because they experienced no direct financial benefit, these differences between FFS and managed care coverage were perceived as pure "takeaway."

2. In an HMO, patients may receive covered services only from providers contracting with their HMO.

All this was made worse by the fact that large numbers of people were offered no choice of health insurance plan. A survey by Atul Gawande et al. (1998) of Harvard found that 42 percent of Americans with employer-based health insurance had no choice of plan. Even of those with choices, 20 percent complained they did not have enough variety of choice, and 31 percent of the total sample said their employer forced them to change health plans in the past five years. This and other surveys found that people without choices were much more likely to be dissatisfied with their health insurance and to have complaints about it. Indeed, dissatisfaction levels among those without choice are typically twice as high as among those with choices (Davis and Shoen 1997).

A great deal of consumer dissatisfaction could have been avoided if employers had created arrangements similar to the Federal Employees Health Benefits Program, the California Public Employees Retirement System, the University of California, Stanford University, Harvard University, and others that are models of responsible multiple choice of plan. Consumers must perceive a direct personal interest in economical medical care. Otherwise, they have no reason to accept any limitations. To accomplish this, consumers must know what their health care costs are and that higher premiums come out of their pay. Difficult as it has been for employers, employees should be required to pay the full premium difference (adjusted for the health status of enrollees if possible) for a more expensive health plan. This would encourage consumers to seek value when purchasing coverage and create pressure on health plans to offer high-quality care for the lowest possible price. A limit on tax-free employer contributions might help employers overcome employee resistance to offering a contribution set at the tax-free limit and to require employees to pay the difference in premiums. Less than 10 percent of Americans have choices of plan and full economic responsibility for premium differences (Hunt et al. 1997).

If well-informed, cost-conscious consumers were given a choice of plan, ranging from FFS to preferred provider insurance to point-of-service to various types of HMOs, people could consciously make decisions on what they thought was in their own best interest.[3] Then people would see that they could save substantial sums of money by accepting the limita-

3. Preferred provider insurance resembles FFS augmented by a list of providers who have agreed to accept the health plan's fees as payment in full and by incentives to choose those providers. A point-of-service plan is an HMO augmented by a preferred provider insurance plan for those patients who want access to a wider network of providers and are willing to pay more out-of-pocket when accessing them.

tions of managed care, and gradually most people would do so. The people who really wanted FFS and were willing to pay for it could have that, too.

While cost consciousness in consumers' choice of health plan will foster competition and reduce price, alone it is likely to be insufficient to appease the backlash. Enrollees in HMOs pay little at the point of service—usually a $5 or $10 copayment for a physician's visit and zero for hospitalization—and therefore have little or no incentive to accept less costly care. The RAND Health Insurance Experiment suggests that patients might respond differently if they were required to pay part of the cost of each of the services they receive (Newhouse et al. 1981).

These two elements, doctors angered by loss of authority, autonomy, and income, and consumers who have seen their freedoms replaced by restrictions with no apparent direct personal benefit, have made managed care a tinderbox in which incidents, real or imagined, can produce national conflagrations. For example, "early" (i.e., within twenty-four hours) hospital discharge for uncomplicated vaginal deliveries was tested in numerous studies with inconclusive medical results. Neither proponents nor opponents had good data on which to base their cases. But when HMOs and other insurers attempted to implement this as a standard for coverage—in the context of a crisis atmosphere regarding health care costs and intense pressure from government and employers to restrain premiums—in 1995 and 1996, 25 states and the federal government adopted early discharge laws generally requiring coverage of forty-eight-hour stays for uncomplicated vaginal deliveries. As Declercq and Simmes (1997) observe in a review of the history, "The legislation was politically symbolic, capturing the frustration of consumers and physicians with HMOs." A recent study reported that such legislation in Maryland, the first state to adopt it, added about $5.5 million to the annual cost for maternity stays (Udom and Betley 1998).

Of course, HMOs are not helpless victims of the managed care backlash. Rather, at times they seem to be their own worst enemies. Some health plans have resisted market-improving legislation, in part because they may benefit from market imperfections that allow them to attract healthy populations while avoiding the sick. The industry generally has not supported responsible multiple-choice arrangements. Some health plans have needlessly antagonized physicians in their cost control efforts rather than try to find ways to win their cooperation in an effort to improve quality while reducing costs. Many have done a poor job of recognizing and responding to reasonable and legitimate consumer and

patient concerns. Although this behavior is not true of all health plans and not always true of any of them, such resistance, lack of responsiveness, and antagonistic behavior reflect negatively on the industry. The industry needs to be more proactive in the early identification and resolution of problems.

Managed care as we see it today is an innovation and a work in progress. In response to demands by government and employers for cost containment, there is a great deal of trial and error as plans try to figure out new ways to control costs while not injuring or antagonizing patients. Mistakes are inevitable.

Mistakes have long been commonplace in medicine. For example, the Harvard Medical Practice Study, done for the State of New York by a multidisciplinary team of some of the most distinguished scholars in their fields, examined hospital care in New York in 1984 and estimated that in that year there were 98,609 cases of unintended injuries caused by medical management. Of these, 27,179 cases were due to negligence. Fourteen percent of the injured patients, or 13,805, died at least in part as a result of their adverse event, and about 2,500 cases of permanent total disability resulted from medical injury (Harvard Medical Practice Study 1990). Managed care was minimal in New York that year, so managed care had virtually nothing to do with these events one way or the other.

Ironically, we have not seen a medical injury backlash. Sustained public support for medical quality improvement has been hard to create. We have not seen, for example, congressional legislation to require hospitals to implement computerized drug-ordering systems that reduce errors. And yet, studies of drug dosing errors show many patients are injured by such mistakes in hospitals (Leape et al. 1991; Bates et al. 1995). In California, the legislature has not acted to prevent the forty hospitals doing coronary artery bypass surgery in volumes below the minimum recommended for patient safety by the specialty societies.

The mistakes of managed care (and some nonmistakes, such as twenty-four-hour hospital stays for uncomplicated deliveries) are being judged very differently than the mistakes of the rest of medicine. People are not fighting the mistakes; they are fighting the idea of limits on their medical care, even though limits are inevitable, and some limits—like disapproval of inappropriate surgery—may be good for their health.

There are real problems about this industry that require regulation to make the market work, such as the need for standards and disclosure of information. Among the most important is the lack of responsible con-

sumer choice from among a variety of plans. Solving these problems is an appropriate role for legislation if the industry does not do so itself. Hundreds of thousands of consumers in California alone called their elected officials about problems with their health plans (MHCTF 1998). It is thus not surprising that politicians want to be seen as responding with new legislation. Piecemeal legislation, however, won't solve the fundamental problems of the backlash.

The managed care backlash is the consequence of the inevitable introduction of financial restraint into health care. Without such restraint and even perhaps despite it, national health expenditure growth in excess of the present 13.5 percent of GDP will create costs in the form of increased numbers of uninsured, reductions in public health programs, higher taxes, and crowding out other important public expenditures on education, infrastructure, criminal justice, and so on. Doctors could have avoided the distasteful loss of authority if they had accepted responsibility to control costs themselves and surrendered their autonomy to their peers in an organized effort to manage care. Patients would have experienced much less dissatisfaction if they had gotten to managed care through informed responsible choices that they saw as in their own best interest. While managed care organizations are inevitably imperfect human institutions that sometimes make mistakes; the backlash does not stem primarily from the failings of managed care. It stems from resource constraints and the failing of many doctors to step up to the responsibility to manage the cost of care themselves.

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