In a world of sound bites and photo ops where everyone has fifteen minutes of fame, it should not be surprising that infatuation with managed care on the part of politicians, the media, and other hucksters has turned to disillusionment and assault. Overreaction to the shortcomings of real managed care plans is an almost inevitable result of the overselling of previous years. He who prospers as a result of media hype always runs the risk of being hoist with his own petard. The “managed care backlash” is the Newtonian correlate of the previous “frontlash.”

Ever since Larry Brown, a distinguished former editor of this journal, published his book on health maintenance organizations (HMOs) in 1983, we should have all accepted two basic premises: first, that operating a successful managed care plan over time is an extremely difficult thing to do, with success more likely to be the exception than the norm; and second, that the promotion of managed care as a solution to the nation’s health policy problems was a strategy grounded as much in public relations and political expediency as in a realistic assessment of managed care’s potential achievements. Since the effective institutional memory of those engaged in the public policy process in this country now appears to be measurable in days, or even minutes, the failure to heed these lessons should come as no surprise.

Thus, when purchaser-driven managed care plans succeeded at achieving some very real, if likely one-time, savings in employers’ benefit costs in the early 1990s, “New Democrats” and old Republicans alike seized on that small zygote of evidence, and surrounded it with a veritable pla-
centsa of nurturing theory, rhetoric, and promotion as the core of their respective agendas. No one thought to ask either consumers or providers how they felt about a total rearrangement of medical care provision, and for that matter many of the older and more established managed care professionals themselves just went rather uneasy along for the ride, driven by promoters' claims, rather than their own.

Some of the old-timers even remembered when prepaid group practices, as they were then called, were widely attacked by representatives of the medical profession and their allies as radical socialist experiments, which imperiled the very professional practice of medicine. Managed care, in the generic sense, is indeed a long-standing dream of many of the most idealistic medical reformers. In principle, doctors working together, sharing decision making about the best ways to provide care and seeking to insure the well-being of the whole patient over time, rather than just managing a specific illness at a specific moment, should be able to produce better care than traditional, atomistic, solo practitioners. Capitated payments should only reinforce those values, so long as the capitated amount is adequate.

In a world in which solo practice fee for service was the norm, and prepaid group practice the radical exception, it was easy for the latter to demonstrate superiority on a number of dimensions. The status quo was easy to beat; indeed, it was, by and large, pervasively mediocre. As a beleaguered minority, managed care was better in both theory and practice. But as any student of real markets understands, there's all the difference in the world between succeeding in a niche and surviving as the dominant player. The public policy process, on the other hand, at least as it is actually constituted and as it actually behaves in this country at this time, appears to have no room for such distinctions among the thirty-second television spots and political attack ads.

Managed care has fallen victim to the cycle of inflated expectations followed by exaggerated disappointments, in which some modestly successful innovation is hyped as the unique and unitary solution to some complex, persistent problem; enormous efforts are invested in trying to take that solution to scale too quickly and too carelessly; problems emerge and scandals develop; public disillusionment focuses not only on the specific intervention, which so recently was viewed so positively, but on the very capacity of society to solve its problems; and the proprietors of the previous, smaller-scale projects are lucky to escape with some semblance of the professional activities in which they were engaged before they became the answer to everyone's problems.
The only difference between that general pattern and the specific case of today’s managed care backlash is that the latter instance is, by now, our third time around. We’ve been through this before—in the Medi-Cal scandals of the early 1970s, the individual practice association (IPA) debacles in the private sector in the 1970s and Medicare in the 1980s, and now once again. The question is not why the backlash is occurring, but why we seem stuck in this recurring pattern.

I would suggest three hypotheses. The first is the political drive toward identification of the Big Fix. Real solutions to problems of cost and access in the health care system are likely to be extremely complicated, difficult to implement, expensive in the short run, infuriating to well-financed vested interests, and demanding of patience and a tolerance for ambiguity. No politician in his right mind would get anywhere near such an issue. When circumstances—generally budgetary—leave no alternative to doing something, that something is therefore likely to involve either the attachment of inflated expectations to “solutions” like prevention, portability of private health insurance benefits, or managed care, or attacks on last year’s oversold solutions. Putative solutions that can evoke such potent contemporary political symbols as “privatization,” “market forces,” or “deregulation” are likely to be especially popular.

This tendency on the part of the political system is significantly reinforced by the irresponsibility of entrepreneurial policy intellectuals, who promote their Big Fixes by demonstrating that their theoretical models work better than empirical reality. For years, HMOs could bask in the knowledge that, however mediocre their performance, they were sure to look good by comparison with the average performance of the private fee-for-service system. Now that they are under attack, they find that defending themselves with the argument that the abuses they commit are no worse than those in the fee-for-service community cuts no ice with the jury of public opinion—since that jury is applying the same double standard the analysts use by comparing contemporary problems to an idealized fantasy about the “good old days.” The theoretical always looks better than the real. But much of our contemporary policy discourse, at least in health policy, consists of assertions that are the logical equivalent of saying that unicorns are much prettier than horses.

It’s one thing for politicians or hired lobbyists or the public to make such comparisons; analysts and professors should know better. Or at least act better. But they don’t. A real-life example: I was recently engaged in an increasingly heated, private argument with one of the most vocal exponents of applying a “premium support” approach to Medicare reform
(for the unlettered, “premium support” is this year’s sophisticated euphemism for “defined contribution”). To counter one of his assertions, I adduced some evidence from the experience of Medicare+Choice. His response was that Medicare+Choice was “so badly designed” that it provided no useful evidence of any kind. I then suggested that the particular premium support proposal about which we were arguing had many of the same problems; he responded that those were “only” problems of “design.” In other words, a real system was inconsistent with the theoretical model, so reality was at fault.

Note the beauty of this position. If the analyst’s chosen Big Fix is adopted and fails (or more likely, in the real world, partially succeeds and partially fails) the analyst can always disclaim responsibility by identifying some detail in the actual implementation of the idea that constituted some sort of failure of “design.” If the theory is correct in the abstract, then its uselessness in improving the world can never be the theorist’s fault. And in theory, a systematic approach like managed care always trumps a nonsystem that grew organically from multiple, atheoretical sources.

Unfortunately, this argument is not entirely academic. But that’s the third reason why, I believe, the successive rounds of managed care backlashes are qualitatively different from those that occur in other fields: health care is serious business. When the system doesn’t work properly, people are seriously injured, or die. Of course, most managed care enrollees who die probably would have died anyway, at about the same time, if no one had ever heard of managed care. And good managed care plans undoubtedly save the lives of at least some enrollees who would have died sooner outside the plan. But that’s beside the point. Managed care is at the center of the agenda now, and so it must pay the price of public scrutiny. It is now the real to which a theoretical ideal can be invidiously compared.

The sad thing about all this, of course, is that the cycle of overselling followed by overreaction to shortcomings rarely ever stops at any rational equilibrium point. We are always at risk, when we seek to remedy problems created by last year’s solutions, of throwing the baby out with the bath water. For example, surveys of Medicare beneficiaries have shown consistently, for years, that the overwhelming majority of those enrolled in HMOs were extremely satisfied with their choices, while the overwhelming majority of those not in HMOs had no desire to go into them. Those findings make a certain amount of sense in the context of a system which gives beneficiaries free choice: those who enroll in HMOs
and like them, stay, and those who don’t, leave. During the period in which these surveys were conducted, of course, Medicare was significantly overpaying HMOs, but it always seemed to me the solution was to stop overpaying them but to continue to give beneficiaries an uncoerced choice. That way, no one ran too great a risk, and nobody got hurt.

Managed care, in other words, is almost certainly not the solution to the problems of Medicare, or our health care system more generally, but it is almost certainly a solution, to some part of the problem for some people. Perhaps more to the point, good managed care is a good thing, and bad managed care is a bad thing; there’s a lot of both around, and the principal challenge to policy makers (and analysts) should be to learn how to better distinguish the good ones from the bad, to promote the good, eliminate the bad, and to find ways to make the good ones better.

But at this juncture in our history, it’s not entirely clear to me how to get our political system or our policy intellectuals to think in those terms. Instead, we devote our finite energies and shrinking attention spans to diversions like “Patients’ Bills of Rights” or consumer protections, which are designed to regulate individual manifestations of system failures rather than to redesign the systems. In so doing, we run the very real risk of creating new bureaucratic structures that will provide consumers with only limited real protection, but which will effectively vitiate any benefits good managed care might have produced in the first place. That is, if we could tell the difference, any longer, between good managed care and lousy managed care.

As Alain Enthoven (who should know) liked to say, health care in the United States cannot be reformed by bombing from forty thousand feet. Instead, it will require a protracted infantry campaign, slogging through the mud one hill at a time, fighting many small skirmishes rather than one big battle, incurring lots of casualties and constantly challenging the morale of the combatants. But while Saving Private Ryan may earn our distant respect, Star Wars will sell more tickets.

Reference