The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform

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PARAMOUNT AMONG THE MANY ISSUES AND PROBLEMS the American health care system faces are the failure to make progress toward universal health care coverage and the growing numbers of people who have no insurance or are underinsured (Holahan and Kim 2000). These insurance issues receive some attention in health care journals and in news media but their salience on the national agenda is overwhelmed by the inordinate attention to managed care. Even the professional literature, as reflected in Medline entries, is disproportionately focused on managed care. Between 1992 and July 2000, Medline reported a total of 808 entries for "insurance coverage" and "medically insured" and 3,647 entries for "managed care programs." This focus is even more exaggerated in the media and in political activity at the state and federal levels.

A plausible explanation is that the overwhelming attention given to managed care reflects widespread public and professional dissatisfaction while the limits of insurance coverage, in contrast, directly affect only a minority of Americans. The generality of concerns about managed care helps mobilize media coverage and political initiatives. The premise of this article is that the public focus is often misplaced—concerned with managed care issues that are peripheral to the central health care

The Milbank Quarterly, Vol. 79, No. 1, 2001
© 2001 Milbank Memorial Fund. Published by Blackwell Publishers,
350 Main Street, Malden, MA 02148, USA, and 108 Cowley Road,
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questions that need our concentrated attention. I argue that much of the discussion about managed care is based on a distorted understanding of the relation between financial constraints and the provision of accessible and competent health care. I also maintain that various factual misperceptions about managed care feed on themselves, make the public anxious, and divert attention from more central issues. These distortions contribute to an atmosphere of distrust, which channels public attention and concern. After reviewing some important misperceptions, I explore the need for public trust and better understanding of the difficult tradeoffs involved in health care and the potential for making health care reform a more central part of our national health agenda.

The Context of Managed Care Evaluation

Any fair reading of the large and increasingly growing literature on access and quality under managed care would have to conclude that the assessments are mixed (Miller and Luft 1994, 1997). Managed care organizations seem to do better on some measures and worse on others, with considerable variability among most of the indicators typically investigated. This should not be surprising, as managed care consists of many types of organizations, financial strategies, and care approaches (Robinson 1999). These arrangements are combined in varying ways, making managed care organizations different from one another and making it difficult to make informed comparisons. The same set of organizational arrangements—for example, physician incentives—may have varied effects when embedded in different organizational contexts (Pauly, Hillman, and Kerstein 1990).

Structural and financial arrangements are not fully determinative because performance depends as much on the quality of the professionals drawn to various organizational arrangements, their technical capacities and communication skills, the support infrastructure of their practices, and the culture and leadership of the group. Moreover, the demands and responses of patient populations may vary, as well—by their acuity of illness, concern for health, cooperation with treatment, and motivation to participate actively in promoting their own health.

Given the apparent uncertainties, it is puzzling that many observers have such firm views about managed care. For those who have much to lose in the way of income, autonomy, or professional status, their motivation for criticism seems transparent enough. Alternatively, the

motivation of those who have a large stake in new financial and organizational arrangements is also suspect. The large majority of the public, however, have no such predetermined interests and, thus, their overwhelming antagonism to managed care requires further explanation (Blendon, Brodie, Benson, et al. 1998; Peterson 1999).

The Managed Care Backlash

The chorus of opposition from physicians and other professionals, negative media coverage, repeated atrocity-type anecdotes, and bashing by politicians all contribute to the public's discomfort with new arrangements. Moreover, the seemingly arbitrary power of large organizations in managing one's illness and care can be disconcerting. Further, the shifting of patients among managed care organizations and the resulting discontinuities in care also contribute to distrust (Davis, Collins, Schoen, et al. 1995). But a more fundamental reason for the public perception is that most Americans are discomforted by the idea of having their care rationed and, at some level, they understand that managed care is a mechanism for doing so.

The traditional system rationed access to care through lack of insurance coverage, through required out-of-pocket costs, and through benefit design—but not usually at the time service was provided. Physicians had incentives to provide services at the margins, and patients with insurance had little reason to believe that useful services were being denied. Managed care, and particularly utilization management, makes patients acutely aware of rationing and the fact that services they may want or their physicians believe desirable are sometimes denied. The explicitness of utilization review and some other managed care strategies, which may require patients to call their health care plan or oblige their doctors to delay care until a particular procedure is reviewed and approved, makes rationing salient. The media reinforce these experiences by focusing on the instances of denial of care that allegedly resulted in harm to the patient.

The public can understand that resources are not unlimited and that having reasonable cost controls in place is prudent. While many still attribute the cost crisis to greed and overcharging by professionals and medical facilities, there is growing appreciation of the need to contain cost increases. Managed care has played an important role in containing premium growth until recently, when premiums began to rise again

(Moskowitz 2000). It remains unclear whether managed care will allow more than a one-time cost reduction but any credit it may receive for contributing to cost control in the long term hardly balances the evident hostility and mistrust it faces now. The public can agree in the abstract about the necessity of containing costs but does not want their own care or the care of their loved ones restricted. The American middle class dislikes medical care rationing at the point of service, never having had to face it. Anecdotes of harm from cost containment practices thus carry weight.

With hundreds of millions of medical transactions taking place annually, it is hardly surprising that some judgments to withhold or delay services are mistaken and some have adverse consequences (Schuster, McGlynn, and Brook 1998). One cannot assume that such incorrect judgments are more frequent than was characteristic of the traditional fee-for-service system. It is difficult, however, for patients to see any equivalence between the risks of denied care from those of too much care. In the latter case, they maintain more control and believe they have a choice.

The Patient-Physician Relationship as a Basis of Trust

The evidence about what patients seek in medical relationships has been quite consistent over many years despite massive changes in the medical information available, patient sophistication in accessing it, and a growing trend toward consumerism and patient activism (Roter and Hall 1992). Their relationships with health care plans have taken on increasing importance but most patients still view their medical care in terms of their relationships with a limited number of physicians (Mechanic and Meyer 2000). They seek both technical and interpersonal competence from physicians and they make judgments based on interactional cues. They also seek assurance that the doctor is their advocate—that is, on their side and protecting their interests.

All these important expectations, concerning competence, agency, and advocacy, are assessed substantially through doctors' interpersonal behaviors: the listening ability, caring, and compassion they demonstrate through giving patients sufficient time to tell their "story" and providing responsive feedback. Patients find technical skill the most difficult to discern, but they commonly begin with the assumption that physicians

are qualified as reflected in their reputation and training. Yet patients implicitly, if not explicitly, test their physicians (Mechanic and Meyer 2000): Do they take a reasonable history, ask meaningful questions, perform the expected physical exam, order the expected tests, show awareness of new research, and the like? Patients also judge the competence of their physicians by the course their illnesses take and the extent to which they deviate negatively from expected trajectories. Such judgments may not truly reflect quality of care. Nevertheless, many of these judgments of technical capability depend on physicians' interpersonal skills, how effectively they communicate, and how well they inform patients about their illnesses.

Trust, by its very nature, develops over time as patients discover that their doctor behaves in their interests and in expected ways (Mechanic 1996; 1998). Thus, it is not surprising that studies find that choice of physician and continuity of care are significant bases of trusting patient-physician relationships (Kao, Green, Davis, et al. 1998; Kao, Green, Zaslavsky, et al. 1998). As managed care organizations compete for enrollees, and as physicians compete among themselves for patients, they are increasingly made aware of the importance of patient satisfaction. HMOs and other managed care organizations monitor patient satisfaction and complaints through surveys and patient focus groups (Mechanic and Rosenthal 1999), and some now adjust physician remuneration to take account of performance in this area (Gold, Hurley, Lake, et al. 1995). Doctors who alienate too many patients are at risk of being dropped from physician networks, and health professionals increasingly appreciate that they cannot take patient loyalty for granted. Although the large volume of literature on the importance of psychosocial care (Roter and Hall 1992) has probably not penetrated deeply into the physician community, physicians intuitively understand the importance of having satisfied patients.

The Claims of Dissatisfied Physicians

Physicians today, particularly those trained in an earlier era of autonomy and unchallenged respect, feel bewildered. Patients are increasingly more aggressive and demanding; direct pharmaceutical advertising to consumers influence patient expectations about treatment; the news media abound with stories of physicians' errors and misdeeds; an explosion of medical news is readily available to the public but increasingly difficult for physicians to keep abreast of; more administrators and regulators are

monitoring their activities; and they feel less control over their professional lives. Surveys of physicians report increasing complaints, from loss of control and autonomy over medical decision making to insufficient time for patients (Hadley, Mitchell, Sulmasy, et al. 1999; Burdi and Baker 1999). It is difficult, however, to assess how much this chorus of complaints reflects physicians' anxieties about control over their professional lives and future incomes and how much it reflects deficiencies of current medical care. One signpost of doctor discontent was a recent editorial in the *New England Journal of Medicine*:

> Frustrations in their attempts to deliver ideal care, restrictions on their personal time, financial incentives that strain their professional principles, and loss of control over their clinical decisions are a few of the major issues. Physicians' time is increasingly consumed by paperwork that they view as intrusive and valueless, by meetings devoted to expanding clinical-reporting requirements, by the need to seek permission to use resources, by telephone calls to patients as formularies change, and by the complex business activities forced on them by the fragmented health care system. To maintain their incomes, many not only work longer hours, but also fit many more patients into their already crowded schedules. (Kassirer 1998, p. 1543)

Another example is taken from a recent important history of changes in medical education:

> Perhaps the most extraordinary development in medical practice during the age of managed care was that time, in the name of efficiency, was being squeezed out of the doctor-patient relationship. Managed care organizations, with their insistence on maximizing "throughput," were forcing physicians to churn through patients in assembly line fashion at ever-accelerating rates of speed. . . . By the late 1990s, the pressure on doctors to see more patients in less time showed no signs of abating, and many doctors were staggering under the load. (Ludmerer 1999, p. 384)

Unhappy physicians contribute to the managed care backlash, and many of their dissatisfactions reflect social change and the dissolution of medical sovereignty (Starr 1982). Physician dissatisfaction is significant because attitudes affect personal commitment and behavior and can impede effective and trusting relations with patients. Nevertheless, good social policy requires differentiating perceptions and rhetoric from the facts. Examining contentions and trends objectively, and not simply

depending on subjective reports from surveys, is essential. Thus, to illustrate, I examine three common allegations that have had a central role in the rhetoric of those attacking managed care: (1) that managed care has increasingly reduced patient-physician time; (2) that physicians are restricted in informing patients of their treatment options; (3) and that managed care closes access to needed inpatient care.

Patient Visits Are Not Getting Shorter

There seems to be a broad consensus that the time available in physician-patient relationships is greatly constricted with the growth of managed care. Doctors complain increasingly about not having sufficient time for their patients, and our understanding of managed care leads us to suspect, as stated earlier in the quote by Ken Ludmerer, that time is "being squeezed out" of the physician-patient relationship. This is highly plausible but contrary to the available evidence. Examination of yearly data between 1989 and 1998 from the National Ambulatory Medical Care Survey and independently from the American Medical Association's Physician Masterfile and Socioeconomic Monitoring System indicate a trend of longer physician-patient visits despite the significant growth of managed care penetration (Mechanic, McAlpine, and Rosenthal 2001). This trend, with an average increase of a minute or two between 1989 and 1998, occurs among prepaid and nonprepaid encounters, among primary care and specialty encounters, and among initial visits and revisits. The general trend also characterizes visits associated with the most common diagnoses and for diagnoses associated with the major causes of death. Prepaid visits are somewhat shorter than nonprepaid visits, but this was true in 1989 and also before the growth of managed care. In short, the consensus of shrinking visit time is a misperception.

Surveys of physicians about their perceptions have limited usefulness because their overall distress about the rapid changes in medical practice may lead them to respond more negatively to many conditions affecting their practice than the facts warrant. Surveys on such matters have large contextual and question-order effects, a fact well recognized by experts on surveys (Sudman and Bradburn 1982; Bradburn and Sudman 1988).

We have examined various hypotheses to explain the trend in visit time with physicians (Mechanic, McAlpine, and Rosenthal 2001) by

investigating such factors as the increase in the number of physicians, the changing gender distribution of doctors, the growing competitiveness to enlist and retain patients, changes in the complexity of care, and increased expectations of physician responsibility. Notwithstanding that the available data are incomplete, we find that no single factor explains the observed trend, although several of the factors noted make some contribution. My best guess at this point is that the growing competition for patient recruitment and retention, and physicians' expectations that time and more detailed explanations are needed to satisfy patients, inhibits reducing encounter time and also leaves physicians with a feeling that they must do more within the same time limits. Thus, they may perceive that they have less time for each patient, even when they are spending more.

A related but somewhat different confusion pertains to the extended discussion of gag rules.

Do Managed Care Organizations Gag Physicians?

In the *New England Journal of Medicine*, Steffie Woolhandler and David Himmelstein (1995) began an editorial critical of the growth of corporate medicine by quoting a confidentiality clause in their contract with U.S. Healthcare. The editorial ended with a footnote that Dr. Himmelstein's contract was terminated without cause on December 1, 1995. The implication was that corporate medicine would retaliate against critics. On December 21, 1995, Robert Pear wrote an article in the *New York Times* on gag rules and quoted a directive to physicians from an Ohio Kaiser Permanente Group that prohibited physicians from discussing proposed treatments with patients prior to authorization of the treatment. Thus was born the national debate on "gag rules" (Pear 1995).

The allegation that physicians were commonly being restricted in discussing treatment options with patients was serious because it spoke to a key obligation of physicians to their patients as advocates, to truthfulness in medical communication, and to trust (Mechanic and Schlesinger 1996). The article in the *New York Times* elicited much interest. The early response from the health plan industry was defensive but after a flurry of damaging publicity, and attacks by the American Medical Association and other physician groups, some major HMOs (e.g., U.S. Healthcare and Humana) revised their contractual language and the

American Association of Health Plans now discourages any use of gag rules. Numerous articles and discussions appeared reviewing the ethics of withholding full information from patients, and political figures, including the President of the United States, repeatedly advocated the prohibition of gag rules. Many politicians still continue to do so with powerful rhetoric. The examples cited in the press of restrictions on what doctors could say to their patients were of real concern but those anecdotes were used as if they were characteristic of everyday practice. The realities were more complex.

By 1997, Sara Rosenbaum, an attorney and well-known patient advocate, reported at various workshops that she had examined a large number of managed care contracts in an unpublished study and that gag rules were, in fact, rare. She and her colleagues subsequently published a study of contracts between managed care organizations and comprehensive providers of community-based care under the Medicaid program. Of the 50 contracts reviewed, only two contained clauses that "appear to prohibit providers from speaking to patients about coverage and treatment determinations made by the plan" (Rosenbaum, Silver, and Wehr 1997).

In August 1997, the U.S. General Accounting Office reported on a review of contracts from 529 HMOs. They found that none had provisions that specifically restricted physicians from discussing all treatment options with their patients. However, two-thirds of the HMOs had nondisparagement, nonsolicitation, or confidentiality clauses that some physicians might construe as limiting their communication options. After further study—including interviews with physicians—the GAO concluded that such clauses were not likely to have a significant impact on physicians' actions. It found that "even taking into account the prevalence of business clauses that could be interpreted by physicians as interfering with medical communications, it is unlikely that these contract clauses actually limit physicians' discussions of all treatment options with their patients" (U.S. General Accounting Office 1997, Letter 6).

By the middle of 1997, 25 states passed legislation prohibiting the use of gag rules in managed care contracts, and legislation was being considered in 23 other states. Between December 1996 and February 1997, the Health Care financing Administration (HCFA) also prohibited gag rules in the Medicare and Medicaid programs (President's Advisory Commission 1999, p. A46). Prohibition of gag rules was

recommended by the President's Advisory Commission on Consumer Protection in Quality in the Health Care Industry and is included in both the Republican and Democratic parties' proposals for a patient's bill of rights. Denouncing gag rules offers politicians a powerful sound bite that is popular with the public and carries no political risk. From the political rhetoric about gag rules, one might think that such contract clauses were a central problem in American health care. This issue is tangential and practically trivial, but it serves as a potent symbol for widespread concern about the rapid changes in health care arrangements and the high level of distrust by physicians and many patients of the motives and behavior of corporate health care (Blendon et al. 1998).

Politicians respond to these anxieties by introducing numerous legislative proposals, some more carefully conceived than others. A dispassionate consideration of the likely effects of various proposals for patient protection under managed care must conclude that their value is largely symbolic, I think, potentially helping to restore eroding trust. The right to sue one's HMO, for example—an issue of protracted controversy—may have some deterrent effect on organizational decisions and make some patients feel they have more control but, like many other proposals, it is largely peripheral to the main deficiencies in our health care system: insurance coverage, access, and quality.

"Drive-Through" Health Care

The issue of "drive-through" care provides wonderful sound bites, but holds little central importance. Some health plans and physicians may have been insensitive in their decisions, but it does not follow that legislators and the Congress should set treatment norms for specific medical procedures. Even in such highly symbolic cases as childbirth and mastectomy, the case is arguable. Hospital stays are both expensive and dangerous (Kohn, Corrigan, and Donaldson 2000), and most patients do well when they return home quickly. Clinicians require the flexibility to exercise judgment about contingencies affecting a particular case but it is questionable whether this is best promoted through governmental mandates. On this issue, many physicians and their organizations supported government intrusion into the care process itself—a position they would more typically condemn—because of their dislike of managed care.

Managed care has held costs in check mostly through substantial reductions in inpatients' length of stay, with no convincing evidence in most instances of a concomitant reduction in quality of care (Miller and Luft 1994, 1997). Indemnity insurance and fee-for-service medicine provided incentives for excessive inpatient stays and unneeded use of hospital capacity, and there was little thought given to using hospital resources efficiently. Over several decades, in one area of medicine after another, evidence mounted that shorter hospital stays and earlier ambulation and return to everyday activities was beneficial. The introduction of prospective reimbursement in Medicare accelerated an already long-term trend in reduced length of stay, and the growth of managed care has continued and reinforced this trend.

Misjudgments and purposeful unjustified denials occur, of course, and in some instances they cause harm. But what much of the political rhetoric ignores is that comparable misjudgments were common before the managed care era. Contrary to popular perception, managed care companies rarely deny hospital admission, although many carry out rigorous concurrent review that seeks to reduce the period of hospitalization. One large survey of physicians in 1995 reported that first-round denial rates for hospitalization were only 3.4 percent, and only 1 percent following appeal (Remler, Donelan, Blendon, et al. 1997). A study of utilization review of almost 50,000 privately insured patients between January 1989 and December 1993 using insurance administrative records found that only 0.4 percent of requests for inpatient care were denied (Wickizer and Lessler 1998a). These examples are characteristic of studies generally, although there may be substantial variations among managed care organizations (Schlesinger, Gray, and Perreira 1997).

Taking account of our knowledge of vast practice variations and much unnecessary and inappropriate care, the rate of denial is small. For example, Wickizer and Lessler (1998a) found that 4.2 percent of requests for hysterectomy were denied, making up half of all denials. Hysterectomy is a common operation, though rates vary a great deal from one location to another, and the procedure is often inappropriate (Broder, Kanouse, Mittman, et al. 2000). There may be errors of judgment, but such errors are not unique to managed care. Physicians come to understand the standards used by utilization review, which may affect subsequent utilization requests. Thus, the effects of initial review may be underestimated. Nevertheless, there is little evidence that utilization

review results in the disallowal of needed hospital admissions beyond the inevitable errors in judgment.

Length of stay is another matter, and reductions have been substantial under managed care. Overall, there is little evidence that shorter lengths of stay have reduced the quality of care, although they may be of special concern in the case of disorders that require extensive rehabilitation, such as stroke or serious mental illness. The challenge is to have good evidence-based standards and to monitor care processes to ensure adherence to those standards. The treatment of mental illness and of substance abuse are special concerns because they are understood less well and are stigmatized in comparison with most medical and surgical conditions (Mechanic and McAlpine 1999). Historically, psychiatric inpatient admissions have been long as compared with medical and surgical admissions, and standards of care have been less clear.

Studies of mental health and substance abuse treatment indicate that length of stay has been very sharply reduced (Mechanic, McAlpine, Olfson 1998) and that treatment days requested are much more likely to be denied than medical and surgical days (Wickizer and Lessler 1998a, 1998b). There is also an indication that care is being redistributed through utilization management in a manner that does not appropriately differentiate between patients with greater and lesser need (Mechanic and McAlpine 1999). The lack of clear, appropriate norms for inpatient care, and the relatively low status of such care within the health care system, makes mental health and substance abuse treatment a particularly vulnerable area for excessive reductions in care.

The central point is that much uncertainty in medical care remains, creating the need for a better understanding of how processes of care affect outcomes, and for evidence-based standards. Managed care practices need fine-tuning to evolve and become more sensitive to the many contingencies of people's lives. These are complex matters that will require years of thoughtful effort. Legislators should not be setting treatment standards, substituting politically popular mandates for professional judgments. Public trust is more likely to result from real accountability on the part of care providers than from political micromanagement. This would involve enhancing patient choice, facilitating continuity in medical relationships, and providing for easy, fair, and responsive ways of managing disagreements and grievances (Davis et al. 1995; Kao et al. 1998). An effective, evolving approach to managed care will have to give much attention to each of these issues.

Thoughtful Tradeoffs Are Essential

Unhappy clients can readily compartmentalize their wants from the public good, but responsible social policy cannot. Unwillingness to spend more is at the core of many issues, and once rhetoric is put aside, it is apparent that the underlying tension in many discussions of managed care derives from the legitimacy of rationing and how it is carried out.

There are those who believe that medicine is incompatible with profit and that private interests corrupt health care. But this is not the American reality, and for-profit medicine will persist. Health care is now more price-competitive than in the past, and both private and public purchasers seek to reduce insurance costs. Many of the managed care strategies that people complain about—the lack of direct access to specialists, the use of primary physicians as gatekeepers, utilization review, drug formularies—help bring costs down. In fact, managed care has been quite remarkable in developing customized insurance products (Robinson 1999), such as preferred-provider organizations and point-of-service plans, that respond constructively to concerns about restricted choices. Managed care organizations are not dictating the options; they provide whatever benefit designs and patient-care processes employers or public programs are willing to pay for.

Lack of Public Trust Fuels Backlash

Managed care organizations are highly centralized. This provides many opportunities—still unrealized—to build intelligence through effective information systems, to implement practice guidelines and management systems, and to disseminate treatment information (Millenson 1997). It also provides an easy target for opponents who would attribute any of the thousands of errors and contested judgments that occur in any medical care system to the structures and strategies of the central organization (Mechanic 1997). This obvious vulnerability makes it essential that managed care organizations have a proactive and aggressive public relations strategy. But it is not clear how they can best establish credibility.

The public has a low opinion of insurance companies, and an even lower opinion of managed care. Physicians continue to enjoy considerable public respect and credibility, and managed care's best prospects lay in forming an alliance with physicians and other health professionals.

Achieving this requires treating health professionals with respect and implementing processes that protect the professionalism of medical groups in a balanced partnership (Mechanic 2000). Managed care may set standards and put practice guidelines in place, but successful implementation calls for a cooperative effort that gives physicians needed discretion in tough cases. Maintaining physician credibility is essential, but some monetary incentives that have been increasingly used raise questions about physician agency and advocacy (Gold et al. 1995). A debased physician is no asset to managed care.

Governmental protections can provide a framework that allows patients to trust their health care providers. Such a framework can be largely informational and procedural and need not dictate the content of treatment processes or decisions. The government can ensure that reasonable choices are available and that appropriate representational and dispute processes are in place. It can also ensure that patients and the public receive the appropriate information and facilitate the flow of such information. In a broader sense, the government has overall responsibility for the health care system—for preventive medicine and public health initiatives, for ensuring that everyone receives minimally decent care, and for promoting an effective educational, research, and ethical structure to support the provision of care.

The Need to Focus Public Discussion on Universal Coverage

The United States has on several occasions reached the threshold of comprehensive health care reform only to turn away in defeat (Starr 1982; Skocpol 1997). Despite the robust economy in recent years and a significant projected surplus, the political will for universal coverage has been weak, indeed. Efforts to bring coverage to the uninsured have been slow and painful, and still face many barriers. The increased financial stakes involved make major changes extraordinarily difficult. Health reform within a paradigm of restraint seems unlikely because the politics of reform requires feathering many nests (Skocpol 1997). As Aneurin Bevan purportedly said after convincing British specialists to cooperate in the establishment of the English National Health Service, "I stuffed their mouths with gold."

Thinking about comprehensive reform now mobilizes enormous opposition, and it is increasingly apparent that in American health care,

the search for perfection is too often the enemy of the good. Reformers first sought a national health service in the 1960s, then a single-payer universal system in the early 1970s, and more recently an employer mandate in the early 1990s, and were defeated each time by their inability to negotiate an acceptable compromise. Aspirations have receded, but the politics have become no less difficult. While both presidential candidates focused on health reform as a major issue in 2000, their ambitions would impress veterans of earlier campaigns as modest, indeed.

The policymaking process itself, with its sophisticated modeling and actuarial projections, makes broad policy changes more difficult. Congress's suspension of negotiations during the Clinton health reform debate to await the projections from the Congressional Budget Office (CBO) on its latest proposals uncovered a new kind of politics. Policymakers now find it difficult to consider extending health insurance to the uninsured without worrying about long-term cost outlays, the displacement of employers' coverage of their employees, the selection of the most healthy patients by health plans, and the shifting of responsibility from sector to sector. These are all legitimate and important concerns, but the potential complexities and uncertainties of any large policy changes now appear to limit our ambitions. As Joseph White (1999) noted in examining long-term cost estimates for Medicare by the CBO and HCFA, "the effort to project solutions far into the future is itself inherently biased in favor of radical changes to the principle of entitlement to benefits, and against concrete controls on the costs of individual services. Using long-term estimates to create a sense of crisis therefore puts Americans' future ability to receive benefits from Medicare at unnecessary risk" (p. 5). Our health policy community has become extremely adept at showing how almost any initiative will be too costly, will not work, or will have undesirable unplanned consequences.

Looking back on Social Security, Medicare, and many other successful and popular initiatives, we see much that was imperfect in retrospect. These big programs were legislated by taking advantage of particular political and historical opportunities, including large legislative majorities. Yet, we might wonder whether these programs would exist had they been subjected to the same intensity of policy analysis and scrutiny supported by partisan interest groups that is inevitable today. Despite their imperfections, these programs have contributed immensely to the national good, and have been amended over time. Constructive social

policy requires taking prudent risks and fine-tuning the programs as circumstances warrant.

Achieving universal coverage not only addresses a fundamental flaw in our health care system but also provides a constructive approach to building social capital and a stronger and more cohesive community. The current strength of the U.S. economy and our continuing prosperity offer an immense opportunity to address the insurance issue in a comprehensive way. An eventual downturn of our economy is inevitable and one can anticipate a future crisis in health care. Some believe that only a crisis that affects the middle class will provide the political will for the necessary reforms. But what better time is there than now to begin to seriously address this inevitable challenge?

Much attention has been given, of course, to the issue of the uninsured, and many proposals have been made to close the gap in coverage (Glied 1999; Feder and Burke 1999). Efforts are mostly in the realm of incremental initiatives that are perceived as politically feasible, such as enrolling eligible children in Medicaid and in the Children's Health Insurance Program (CHIP), building purchasing alliances for small employers, and providing incentives to employers and employees to acquire health coverage. Although useful, these steps have difficulty keeping pace with the rate of erosion of insurance coverage (Holahan and Kim 2000). We need a broader national debate in which we think in larger terms of how we achieve the elusive goal of universal coverage. There is no dearth of models and achieving coverage is not rocket science. The core barrier is political.

Focusing Public Issues and Muddling Through

There is presently an unfortunate disconnect between the public discussion of managed care and the key challenges in providing accessible and high-quality health care. Much change has occurred in the last decade in health care arrangements, and the resulting anxieties and lack of trust have focused the most attention on troubling but often peripheral issues. Establishing some constraints on managed care so that the public can be more trusting may be useful, but the central issues are insurance coverage, quality of care, and a viable approach to chronic illness and long-term care. In the larger context of health care concerns, managed care strategies offer the potential to increase population coverage while

controlling costs, to move toward greater administrative and clinical integration of medical services, and to establish quality assurance programs and systems of accountability. Managed care remains an imperfect, unfinished, and evolving product, but its public disparagement makes it more difficult to achieve meaningful modifications and focus attention on approaches to broader and more comprehensive insurance coverage.

Medicine is a changing endeavor presenting many new challenges and opportunities. No new program, however ambitious, can offer a permanent fix. Reasonable people accept the fact that solutions are iterative and must be adapted to changing circumstances. Solutions must also respect the extraordinary social and geographic diversity of the American population. We have little alternative but to muddle through and do so as elegantly as possible. This requires a framework that sets constraints—but has sufficient flexibility to deal with the complexities in people's lives and in medical practice. The government can best contribute to this goal by establishing a universal decent minimum standard for health care and by setting the framework and criteria to implement it (Daniels and Sabin 1997).

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Acknowledgment: This work was supported in part by a Robert Wood Johnson Investigator Award in Health Policy Research. The views expressed imply no endorsement by the Robert Wood Johnson Foundation.

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