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Managing A Pluralist Health System
by Lynn Etheredge and Stanley Jones

Our pluralist health system needs a management revolution in the 1990s. Study after study depicts a deepening crisis even for Americans who have insurance coverage—rising costs and inefficiency, exclusionary underwriting and rating practices by insurers, inadequate emergency room care, unassured clinical quality, and growing public concern. A persuasive conclusion is that much of the health system is not managed well to serve the public interest.

If a pluralist health system is to be preserved, it will require a new management paradigm that manifests a social philosophy of accountability. In this new paradigm, health care institutions and professions should be organized and motivated toward economy, high quality, and improved patient health. There will need to be a “jointness” to these efforts—and, among private-sector leaders, a sense of “stewardship” for the health system as a whole—that ensures collective action for better systemic performance.

In one guise or another, of course, management of the health system as a whole is a recurring concern of health policy. Many reform ideas of the past twenty years have been built around the idea of a single health care manager, and policy debates have often centered on assigning the lead role to one actor or another, Nominees have included federal, state, and community government; hospitals; physicians; community health centers; individuals (vouchers); and, most recently, employers and insurers (“managed care”). Indeed, nearly every actor has had an advocate for giving it management authority over health care spending. So far, most of the groups involved have declined the nomination or have been vetoed (or frustrated) by others.

Short of having government manage the health system by default, we are obliged to develop a pluralist managerial system. We do not believe

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that any single health-sector actor can well manage an American health care system that, producing over $700 billion of goods and services each year, is already the eighth-largest world economy. Nor can a pluralist system operate well if only one group (such as insurers or government) is expected to manage alone while other groups abdicate responsibility and pursue contrary objectives. The public’s interest and the welfare of individual patients need attention by all parties.

What might such a pluralist paradigm mean for the health system’s major actors? A management revolution in health care purchasing, building on some of employers’ and insurers’ “managed care” debuts, will be essential for a well-managed health care system. But a management revolution in health care delivery—including an expanded commitment to medical professionalism and the development of self-managing medical organizations—will also be needed to improve the health care system, as well as to realize the potential of health care purchasing. Much better information about health care prices, service volumes, and quality and about medical efficacy will be needed to support these revolutionary changes. Also new government roles will be essential in such areas as insurance market reforms, uniform data reporting, medical training, and tax policy. An effective management paradigm for a pluralist health system, although only part of a national health policy agenda, must go well beyond incremental reform. It must go to revolution.

The U.S. Health Care System: A Management Failure

As a result of culture, evolution, and public policy, the U.S. health system is dysfunctional in some uniquely American ways. It has been, and remains, a system in which individuals and institutions have great freedom. At times, this system’s resulting innovation and excellence have set the world’s standard; in other instances, its services and performance have been a national disgrace. The effects of the American penchant for individualism—plus excess trust in physicians, technology, and nonprofit institutions—have been amplified by a “blank-check” insurance system, underwritten by tax dollars, that has paid health care providers for just about everything. In short, we have chosen to “insure” health care rather than to “manage” it. Our current system is a management failure on the part of private and public sectors alike.

The adoption of an insurance model, rather than a management model, has been at the heart of poor health system performance. In the insurance model, hospitals and physicians set fees; physicians and patients made medical care decisions; the primary functions of intermediaries were simply to collect premiums, spread risk, and pay service-by-service bills.
The traditional U.S. health insurance company was not designed to negotiate payment rates, manage medical care, foster competition among providers, restrain spending, produce useful data, assess the value of medical care, improve patient outcomes, or change physician and hospital practices. Thus, health care providers have not been effectively accountable for assuring economy, high quality, or good patient outcomes.

In this climate of ineffective accountability, health service delivery has grown as a fragmented, cottage-industry nonsystem in which a plethora of entrepreneurial specialists and independent institutions seek professional satisfaction, financial rewards, and patient service objectives. Excess supply (for example, 35 percent hospital bed vacancy) has become a hallmark. With insurers’ payments based on transactions for individual services, the health care financing system has not been an effective instrument for accountability in treating patients’ health problems or for optimal system development. In fact, individual service and insurance claims data files seldom permit the most rudimentary information to be developed for would-be managers.

To make matters worse, these fragmented transactions are divided amidst a fragmented industry. The Medicare program is the only large national payer (19 percent market share). In the private sector, most large employers self-insure (especially since the Employee Retirement Income Security Act, or ERISA, took effect in 1974). Except for Blue Cross/Blue Shield plans in a few states, individual insurers usually have less than a 5 percent market share. Most insurers (several hundred to over a thousand by different counts) have less than a 1 percent share.

The Heritage Of Minimal Management

The view that an open checkbook for health care providers, plus a laissez-faire approach by patients, payers, and government, will produce a first-rate health system seems downright foolish in retrospect. The consequences of inattention to results for which managers are normally accountable—economy, high quality, and value to the consumer—are distressing. Absent a new management paradigm, these problems will grow more severe.

Hyperinflation. Over the past ten years, national health care spending rose from $250 billion in 1980 (9.1 percent of gross national product [GNP]) to $666 billion in 1990 (12.2 percent of GNP). If not effectively managed, national health care costs, at current rates of increase, will be over $1 trillion annually by 1995 and more than $10 trillion over the 1990s. The U.S. Department of Health and Human Services recently
forecast that health spending will consume 16 percent of GNP by 2000.

**Inefficiencies.** Comparisons with other nations that manage their health care systems through a variety of public- and private-sector models show that the U.S. health care system is exceptional for its expense. U.S. per capita spending exceeds that of the Canadian system by 40 percent and that of the French and German systems by 85–90 percent. Insurers’ payment rates—recognizing wide-ranging charges for the same services—have been a key contributor. These practices distort financial incentives and encourage unnecessary services, overinvestment, and oversupply.

**Absence of data.** Nowhere has our nation’s failure to develop a viable management philosophy for our health care system been more disabling than in the absence of data that managers need to be effective. Individual employers’ and insurers’ databases are usually too small to enable reliable comparisons of hospital and physician charges for procedures and episodes of care, and aggregating data is impossible when they are not collected uniformly and are treated as proprietary information. Quality of care and patient outcomes data are collected and reported sporadically. Beyond national spending (which is partially estimated), there are sparse national, state, or local data for expenditures, price and volume trends by service, or clinical practice variations.

**Nonvalidated clinical practices.** An assumption that medical schools, medical professionals, or insurers systematically and rigorously evaluate medical practices to advance the “state of the art” and norms of clinical practice is in error. Without a managed clinical assessment process, much of the 12 percent of GNP spent on health care has not been evaluated through such scientific studies, and few clinicians are even trained in skills to make such evaluations or contribute to them.

**Ineffective quality assurance.** Quality management in the health care system—often relying on paperwork compliance, external “policemen,” and malpractice litigation—now lags several generations behind the state of the art in the rest of the private sector. In their clumsy efforts to manage health spending when clinicians refuse to do so, employers and insurers treat most hospitals as though they were in Chapter 11 oversight by outside reviewers, patient by patient. Well-managed organizations would not require such day-to-day intrusions into their internal operations.

**Defective competition.** Unmanaged competition among today’s insurers, health maintenance organizations (HMOs), and providers has clearly not been the answer for dealing with health cost inflation. Many factors contribute, including the inability to compare premiums because of adverse selection and the lack of comparable data on quality. In the small-group market, unmanaged insurance competition has led to exclusionary medical underwriting and rating practices and disintegration of
risk pools. And there is little evidence that insurers have reduced health care costs by prompting providers to compete. Physicians especially have been annoyed and angered by competition but have not noticeably lowered their prices or changed their practice patterns to contain costs.

**Deficient health professions education.** Health professional schools should be leading the development of professionalism, in the vanguard of evaluating effectiveness of clinical practices in ways that meet statistically rigorous standards, and reshaping curricula to reflect these findings, rapid changes in biomedical sciences, and emerging professional management roles. With decades of excess applications and rising tides of funding, plus feudal internal organization, health professional schools show little motivation to be agents of change. Indeed, the basic structure of the medical school curriculum has changed little since 1910.\(^3\)

**Inadequate attention to patient welfare.** Management of patient services in hospital emergency rooms and outpatient departments, and excess mortality for the uninsured even when hospitalized, are a professional disgrace. More generally, an interesting test for whether the health care system is doing well enough by its patients is to ask physicians or insurers whether they would be willing to have family members treated for a major illness by randomly selected physicians from their own specialties or networks. (So far, we have found no takers of this offer.) At bottom, the health care system now lacks the organization, motivation, and tools for uncompromising management on behalf of patients.

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**Insurers In A Management Paradigm**

Against this background, a number of insurance companies, employers, HMOs, and others pioneered a “managed care” movement in the 1980s. Several general observations and caveats about this evolving management system are in order.

First, much of purchasers’ efforts to “manage” care have been necessary because providers have declined to attempt effective management. Purchasers have often had to build the organizations to manage care and to contract with primary care “gatekeepers” as individual managers. Data for comparing price, quality, and patient satisfaction also had to be developed by purchasers. The same is true for medical review standards. Thus, management of health care purchasing has been far more difficult than purchasing in other markets and less effective in encouraging cost-effective management by providers. It has intruded into provider/patient relations, driven up administrative costs, and provoked intense hostility between payers and providers. But, absent self-managing medical care organizations, such purchaser actions have often been necessary.
Second, many of the elements necessary for effective management of health care purchasing still do not exist systemwide. In fact, they are more the exception than the rule. These elements include well-managed delivery systems; reliable comparative data on price, quantity, quality, and patient outcomes; scientifically validated practice standards; and well-managed insurance markets. Staff- and group-model HMOs cover only a small percentage of the population.

Third, most insurers still operate from the traditional insurance paradigm, with the addition of just a few new elements (primarily hospital admission and length-of-stay review); the same is true of many new provider-organized “network” preferred provider organizations (PPOs) and HMOs. Indeed, most insurers, which are primarily in property, casualty, and life insurance and have tiny health market shares, do not have the technical resources to manage health care or the market leverage to use these resources if they had them. These insurers, PPOs, and HMOs market as “managed care” techniques now considered outmoded and inadequate by industry leaders. Meanwhile, the handful of industry leaders—which still must operate usually in a “transactions-based” mode–seldom have been able to realize substantial savings for their new managed care efforts that can be supported by the evidence.

Among leadership companies, basic elements for managing health care purchasing do exist. These include contractual relationships with an organized group of providers, prospective payment rates, use and quality review procedures, data reports, and other features for continuously improving these aspects of medical care. Why, then, is it so difficult for such purchasing arrangements to show results? The fundamental reason is that effective “management” of health care by third-party purchasers alone is (or ought to be) largely a misnomer. Insurers seem well suited to purchase services, but providers are the more appropriate managers for health care delivery. A second reason is that new management technologies must be developed for health insurers to be more effective. So much of what is needed to make their management more effective now lies outside insurers’ immediate ability to deliver.

**Two credible models.** At this point, only two credible models have evolved for insurers and providers to work jointly to manage care: (1) the group- or staff-model HMO; and (2) the highly leveraged selective purchaser of health services, such as business coalition purchasing of mental health care.

Insurers have been extremely slow to join with providers to form group- and staff-model HMOs, demonstrably the most efficient form of health care delivery. Most of the thousand-plus insurers have been constrained from such joint efforts by tremendous inertia growing out of their view of
their core business as primarily financial and claims service, their culture of dealing at “arm’s length” with health professionals, and their huge investment in claims processing computers and expertise. For leadership insurers willing to attempt these ventures, capital requirements have been substantial and development processes, time-consuming.

Rather than developing “jointness” with providers, such as in staff- and group-model HMOs, insurers have formed PPOs, loose individual practice association (IPA)-type HMOs, and other managed care arrangements that cannot demonstrate comparable efficiencies and that seldom effectively share accountability and responsibility for managing health care. In fact, these models have generated high distrust and hostility levels between insurers and providers—clearly a major barrier to any joint effort to manage the health care system.

We have a long way to go. Insurers’ “arm’s-length,” strategies for dealing with providers are hopelessly complicated and blocked by the sheer number of insurers in each locality and each insurer’s lack of leverage for selective purchasing. Providers complain legitimately about scores of separate contracts with different insurers with different requirements and conditions of payment. They feel no “jointness,” nor do they realize clear business or clinical advantages from working with these many insurers, each of whom represents only a fraction of their business. For a better-managed system, the number of insurers has to be radically reduced, the size of each insurer’s market share must be increased, and insurers and providers must recognize more clearly the mutual importance of successful working relationships.

New management technologies. What new management technologies will be needed to bolster these relationships? Needed technologies fall into the categories of data and data analyses, clinical practice standards, quality measures, and selection. In these areas, development of viable technologies will require collaborative efforts by insurers with health care providers, employers, and/or government.

First, insurers need a nationally uniform, mandatory claims form and data standard, so that comprehensive information is routinely available to the public and payers for assessing provider pricing, volume trends, and patterns of care. This data standard is also needed to take advantage of electronic claims processing and reduce administrative costs. Second, for assessing appropriateness of care, insurers need to work with medical professionals to develop scientifically valid clinical review standards for procedures that account for area-to-area cost differences and cost inflation. Third, for development of quality measures, insurers need to work with medical professionals to identify a set of indicators, such as patient outcomes data, that will be required reporting to assure public account-
ability and improve clinical practices. Fourth, for selection management, insurers need to work with employers to develop better ways to assess and cope with the (perhaps intractable) problem of adverse selection.\(^4\)

We also suggest it will prove useful for private insurers to change their current payment practices to strengthen the ability of payers and providers to manage care. These measures include adopting physician payment schedules based on a resource-based relative value scale (RBRVS) to strengthen incentives for appropriate care and packaging of services. Although these basic organizational characteristics needed to manage the purchasing of health care and new insurer technologies may appear simple, their development would bring a revolution in health care purchasing—a revolution that has barely begun.

Making Management Work

What else is needed for a pluralist health care sector to be successfully managed in the 1990s? The earlier concatenation of problems suggests major complementary roles and accountabilities for medical professionals, medical care organizations, employers, government, and patients, along with stewardship of the health system by private-sector leaders.

**Medical professionalism.** At the core of the problem of developing a viable management paradigm is that the medical care system will not work well for patients unless it is focused on patient welfare through high professional standards and an overriding sense of mission. No less an economic theorist than Adam Smith stated that physicians, like judges, ought to be governed by professional norms rather than by financial gain.\(^5\) No less a management theorist than Peter Drucker stated that hospitals and other nonprofit institutions must be managed from their sense of mission rather than from profit-and-loss statements.\(^6\)

With “monetarization” of medical care, the strength of professional norms has eroded markedly over the past several decades.\(^7\) This is particularly regrettable because physicians have a key role in an estimated 70 to 80 percent of medical care decisions. The trends should be reversed. It is up to medical professionals, to the extent they wish to claim the prerogative of professionals to be self-managing, to put the house of medicine in order. The responsibilities of professionalism need to be expanded beyond the bounds of individual technical competence to include an ecumenical responsibility for institutional performance, the profession’s clinical practices, and the health system, including objective assessments and accountabilities for continuous improvement.

Specifically, medical professional societies and medical schools could lead new nationwide efforts to evaluate medical procedures and practices,
both to advance clinical care and to eliminate unnecessary expense. Each specialty society could regularly review its national, regional, and local patterns of care, plus patient outcomes data, to develop a "report to the profession;" improved clinical standards, medical protocols, and review guidelines; and continuing education programs at all levels. Absent such professional efforts, insurance companies and courts have little recourse but to evolve their own views on how medicine should be practiced and to engage in patient-by-patient questioning of medical practice.

A similarly renewed professionalism is needed to construct a broader paradigm for health professions education. Although an agenda for health professions education reform goes well beyond the scope of this essay, two elements seem important, particularly in residency training, to develop a new professional role for increasingly outcome-oriented practice of medicine and for improved institutional performance. The first goal could involve each medical school physician in the automatic reporting of selected clinical and outcomes data to develop clinical knowledge and practice standards. Patient outcomes studies, a logical requirement for scientific advance of clinical practice, could be an integral part of medical schools' clinical services and training. The second goal could involve training in team care accountability (particularly for patients with chronic conditions) and physician roles in assessing and continuously improving institutional performance. Medical training thus would include professional training in evaluating institutional, as well as medical staff, performance (particularly including patients' views) and devising and implementing ways to improve it.

**Self-managing medical organizations.** The fragmented health service delivery system needs to evolve into organizations that can manage for economy, high quality, and patient satisfaction. A generic name would be "self-managing medical organizations," which emphasizes the core idea that society should want medical organizations (and professionals) to manage themselves and will hold them accountable for their performance. With such organizations, purchasers could do a better (and less intrusive) job of managing health care.

Many specific organizational forms might meet this objective, including staff- and group-model HMOs and well-managed hospital and/or physician organizations (for example, Kaiser's Permanente groups) that are able to contract with insurers. Today, only a small fraction of health care providers are well managed in terms of economy, high quality, and patient satisfaction. Beyond broader organization, the health care delivery system is also missing many of the same "management technologies" that were suggested earlier for insurer/provider cooperation: uniform claims form data, science-based clinical standards for managing care, and
quality indicators, including patient outcomes data. New professional/institutional relations are needed, particularly those that hold medical staffs and employees accountable for improving all aspects of institutional performance. Most importantly, health care organizations need to develop management approaches, such as continuous quality improvement procedures, that can generate enthusiastic commitment to the organization’s mission of patient welfare. As key personnel, nurses should have strong professional and institutional roles in all of these efforts.

**Employers.** From a management perspective, it is difficult to see a useful role for most employers in the health care system. With the exception of the nation’s largest corporations, few employers can expect to develop the expertise, data, and market clout to make managing their own health benefits programs an intelligent choice. Multiemployer organizations are thus needed to manage employer spending effectively. These might be insurers who enroll many employer groups and manage employee choice among their own sponsored plans, or employer-organized managers of competition among insurers or providers.

A particularly attractive model of the second type is the “health insurance purchasing corporation,” proposed by Alain Enthoven for the small-group market to manage competition among insurers on behalf of employers and workers. In this approach, the individual employer’s requirements (and administrative burdens) would be simplified as much as possible, amounting primarily to writing a check to the health insurance purchasing corporation. The corporation would assume all other management functions: evaluating insurers’ bids for service, qualifying plans, overseeing marketing, and managing competition. The health insurance purchasing corporation would also handle federal requirements for continuing coverage of those who lose employment and coordination among Medicaid, multiple insurance coverage, and the new health insurance tax credit. The purchasing corporation would hold insurers accountable for their costs, quality of care, and patient outcomes. In turn, health insurers would manage health care purchasing, and health care providers would manage the delivery of care. If negotiated health spending targets are enacted by federal, state, or local governments, then such a structure could be useful in managing such limits.

**Government’s role.** To facilitate private-sector management of a pluralist health system, several new government roles will be useful. First, the managers of health insurance competition, health care purchasing, and health care delivery will need basic health system data. Only the federal government has the span of control to mandate nationwide reporting and availability of data for public use. A new government role in assuring uniform data would be philosophically consistent with Presi-
dent Bush’s recent national testing proposals for education reform. Being assured that there are comparative data, states, communities, private payers, and intermediaries can begin to establish effective accountability, a prerequisite for improved performance. Public funding may also be desirable for medical efficacy assessments, although professional organizations and clinicians may conduct this research. It may also be necessary to insist on an overall national assessment plan.

Government action is needed to set up the new health insurance purchasing corporations for small-group markets. Additional research on management of insurance competition and adverse selection in such environments will be critical. The federal government could set health care provider standards (for example, data reporting), which could be made a condition for Medicare program participation. Similarly, federal financial support for graduate medical education through Medicare might be conditioned on such initiatives as patient outcomes studies.

The federal government could use the tax code to speed development of effective health care purchasing organizations by restricting the tax exclusion of employer premiums to “qualified medical plans” that meet basic requirements for effectively managing care, and phasing out these subsidies for insurance plans that lack such management capabilities and whose blank-check payment policies are making the health cost inflation problem worse. These tax subsidies now amount to $48 billion, rising to $73 billion by 1995. This would follow the precedent of limiting the tax deferral of employer retirement contributions to “qualified pension plans” that meet basic management and other standards. A limit on tax-free employer contributions might also be useful, if it could be adjusted to reflect area variations in charges for delivering uniform benefits.

Patients. It is essential that the health system’s managers be ultimately accountable for serving the public. A well-managed system needs to include well-informed patients, who make decisions about their own medical care. To do this, individuals need state-of-the-art knowledge about health care options and patient outcomes, as well as about health insurer and provider performance. To make responsible choices for managing their own medical care, individuals must also have freedom of choice among insurance plans and providers. And finally, if they lack insurance coverage altogether, individuals have a severely restricted ability to exercise freedom of choice about health care matters.

Management As National Policy

The challenge to insurers and other health care industry leaders today is to manage. Failure to manage our health system now threatens our
economic future and our society’s health. Will the private sector rise to this challenge? In this essay, we have outlined a number of steps that we believe would be useful for managing a pluralist health system. But to bring about such reforms will require health-sector leaders to accept a social philosophy of accountability to society for their stewardship of the health system as a whole and commitment to collaborative action.

First, it is unrealistic to expect health insurance companies (or anyone else) to “manage” the health care system alone, absent the contributions of health professionals, providers, employers, governments, and patients. If “managed care” by insurers is used as a pretext for everyone else to abdicate responsibility, our situation will grow more difficult.

Second, a role of health insurer as a “manager” of health care purchasing should be matched by health professionals and providers as “managers” of health care delivery (for continuous improvement of quality, economy, and patient satisfaction); by medical schools and professional societies as “managers” of an ongoing national process to assess medical technologies and advance clinical knowledge; by new “managers” of health insurance purchasing; by government as “manager” of national data reporting requirements, insurance market reforms, and tax policies; and by patients as “managers” of their own choices about lifestyles, health insurance, and health care. We need a new philosophy of social responsibility, agreement on management roles, and joint stewardship for the health system to bring about these changes.

Third, health policy proposals before national and state governments, as well as product development and marketing strategies in the private sector, do not go far enough to trigger the revolutionary changes society needs in the management of our health care system as a whole. The proposals reflect a willingness to get serious about problems, and many hold hints of the kinds of solutions that might work. But they are often designed more to protect shares of power and market revenues than to assure effective management of the health system.

Is this management paradigm for a pluralist health system feasible? Would it well serve the public’s interest? America’s private sector has long prided itself on an ability to manage the largest, most complex, and most innovative of the world’s economies. On the “blank canvas” of American history, progress has often involved private-sector leadership to build new institutions, define new professional and institutional roles, and enact new public policies. It would be ironic if today’s pluralist health system had to be replaced by a fully government-budgeted and -regulated system because it was unable to meet the management challenges of the 1990s.