California, the nation’s most populous state, offers fertile ground for examining social and health system trends that often presage those of the rest of the nation. The state has served as the proving ground for managed care, beginning with the influence of Kaiser as early as the 1930s; it also has a long, notable history of state and county cooperation in public health activities. California has something to show for its history of innovation: population health measures that exceed those of the nation as a whole.1

In this Perspective I examine the development of public health and managed care in California, based on my long tenure as an observer of and a participant in the state’s public health arena. I pin my observations on the Institute of Medicine’s definition of public health’s role as “fulfilling society’s interest in assuring conditions in which people can be healthy.”2 Given the state’s emphasis on managed care, it is useful to examine how well managed care interacts with the stated goals of public health.

Public health. Since one of the “conditions in which people can stay healthy” is access to effective medical services, California has included attention to access as part of its public health effort. During the 1950s and 1960s it provided state funds to match the federal funds in the Hill-Burton hospital construction program. At the outset of the Medi-Cal (California Medicaid) program in 1965, State Department of Public Health (SDPH) investigators initiated a statistical system to identify physicians who were giving excessive numbers of injections (so-called shot doctors).3 This was

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one of the earliest efforts to do something about quality in a major public health care program.

Although states carry the major governmental responsibility for health, they typically delegate much of the operations to local health departments. Recognizing the latter's fundamental importance, the SDPH motivated legislative action during the early 1950s to establish a highly effective system for nurturing full-time local health departments. A state subsidy for these departments was made contingent upon their each meeting standards that were adopted by the State Board of Health after the SDPH and the California Conference of Local Health Officers (CCLHO) agreed on them.

California's progressiveness in public health has been manifest in other ways, such as development of the first automobile emission standards for air pollution control in 1960, later adopted nationally; and passage of a 1988 voter initiative (Proposition 99) to increase the tax on cigarettes and commit a portion of the funds to what has become a successful tobacco control program.4

Managed care. Several physician group practices emerged in California in the early part of this century, in response to the need for comprehensive medical services to be provided under unified management.5 One striking innovation in California’s group practice movement was the prepaid (capitation) arrangement developed by the Ross-Loos Clinic with the Los Angeles Department of Water and Power. Undertaken in 1929 as the Great Depression set in, the plan was one of the earliest prepaid group practices in the country and continued until it was taken over recently by CIGNA, a large nationwide insurer.

Henry J. Kaiser launched another model by converting his World War II industrial medical service into a three-part, vertically integrated system: (1) the Kaiser Health Plan, which contracts on the one hand with subscribers and on the other with providers; (2) the Permanente physician group; and (3) the nonprofit Kaiser Foundation, which owns and operates hospitals.6 Along with the Health Insurance Plan of Greater New York, the Group Health Cooperative of Puget Sound, and a few others, Kaiser Permanente became the prototype of what came to be called health maintenance organizations (HMOs).

Since the 1960s several proprietary groups also have established health plans, which collected premiums from subscribers (or payers on their behalf) and in turn contracted with individual physicians or groups of physicians and with hospitals to provide services. Their environment statewide was characterized by excessive numbers of physicians (although maldistributed by specialty and geography) and hospital beds.7 For health plans with little incentive to control costs, the difference between the amounts that these new proprietary health plans could collect and the contractual pay
ments necessary to obtain physician and hospital services proved to be highly lucrative. Meanwhile, various kinds of physician practice groups emerged as a defensive measure against nonphysician forces that seemed to be directing medical services to a growing extent. These so-called individual practice associations (IPAs), however, did not check the growth of the more strongly financed proprietary health plans that have steadily out-competed-and often taken over-the IPAs. Proprietary plans not only attracted substantial amounts of venture capital but also have followed the general economic trend toward mergers. By 1995, the largest eight of these organizations had enrolled 5.7 million subscribers, compared with Kaiser Permanente's 4.6 million.

Many of the older and well-established physician group practices have joined the consolidation rush and have entered into contracts with the increasingly dominant proprietary health plans to provide medical services to the latter's subscribers. In general, however, these arrangements have differed from Kaiser's, in that the medical groups contract with several health plans and the latter contract with several medical groups.

Large employers in both the private and public sectors have become increasingly restive as their medical care costs have spiraled upward. In an effort to control those costs, large California employers have been forming coalitions to achieve leverage in negotiating with health plans. These groups have slowed, and in some instances actually reversed, previously rising costs. They also have initiated efforts to improve the quality of medical services by including preventive services in their benefit packages.

The management of medical services in California thus is evolving on multiple levels: (1) large purchasers, which are forming coalitions to influence the nature and costs of the services provided and ultimately may merge into the “single-payer” idea; (2) larger and larger health plans, which receive funds from huge numbers of subscribers, mostly in employee groups, and then contract with providers (replacing the commercial insurance companies and the nonprofit Blue Cross and Blue Shield organizations that dominated the private medical care scene for several decades with more aggressively managed care); (3) management of the physicians, hospitals, and other agencies that actually provide the services; and (4) primary care physicians who manage individual patients’ care.

Managed Care: A Part Of Public Health

Managed care’s remarkable recent growth in California has encouraged some enthusiasts to consider absorbing certain public health functions into it. This could mean that private managed care organizations would take
over medical services for those now receiving them in public programs, thus eliminating the need for the latter. Certain health data could be collected under private auspices. Health education would be conducted largely by physicians.

In that connection, however, it may be useful to consider some fundamental differences between managed care and public health and how these affect the interface between the two.

**Nature of population served.** The underlying distinction is that public health focuses on the entire population, as a societal obligation, whereas managed care focuses on one segment of the population: the people enrolled in a particular agency (or agencies) for medical care. While managed care may seek to expand coverage, for example, by seeking government contracts for payment to provide services to additional segments of the population, it carries no responsibility for the uninsured. Public health, on the other hand, does not and cannot escape its responsibility for the entire population, including the 6.3 million uninsured Californians. In 1992 more than two-thirds of the uninsured in California were full- or part-time workers and their families. In the same year state and local governments spent an estimated $795 million for their medical services; that sum does not include the unreimbursed costs incurred by private hospitals and other private agencies.

**Approach to health problems.** Managed care relies on what physicians and their allies can do to protect and advance health. Public health looks at all conditions that affect health and all of the ways of protecting it. Besides access to medical services, the latter include attention to the environmental conditions and the behavioral influences that have an impact on health.

To illustrate this difference, consider the important health matter of excessive alcohol use. Managed care provides treatment services for the diseases and injuries that result from alcohol abuse. It also may offer referral to services to groups of or individual enrollees with alcohol problems, or it may provide these services directly. In educational bulletins to enrollees, managed care plans may publish information aimed at prevention. The modality for managed care is the medical setting, however, not the entire set of circumstances that may be involved in alcohol problems.

Public health, on the other hand, besides ensuring that treatment is available to all people, extends its efforts to the factors that lead people into alcohol problems. These factors include liquor advertising, low taxes on liquor, sales to minors, minimal enforcement of laws against driving while intoxicated, lack of education about alcohol’s effects, and excessive retail liquor outlets where especially vulnerable persons live. Facilitating conditions that will lessen alcohol problems obviously involves not only official
govermental public health agencies but also a wide variety of other agencies such as voluntary health groups, state and local legislative bodies, tax authorities, police departments and courts, schools, and retail licensing authorities. Governmental public health bodies, however, are responsible for motivating and coordinating efforts by these several groups.

History and background divergence. Public health began in early societies as a collective effort to protect the health of the individuals who make up a community. Public health has embraced education on personal hygiene and good nutrition, safe water supplies, maternal and child health services, epidemiological investigations, immunization, screening for cancer, and myriad other actions. During the nascent industrial revolution, communicable disease control became essential, and more recently non-communicable conditions have required greater effort. With the emergence of modern medicine, public health has undertaken to extend effective and critical medical services to those elements of the population that mainstream medical practice does not reach. Managed care, on the other hand, has emerged in recent years as a new arrangement of services for persons who are covered by well-established payment mechanisms, as a means of achieving efficiency and thereby cost control in those services.

Convergence. To the extent that managed care as a societal thrust brings health services to people, it constitutes an aspect of public health. Governmental and organized private-sector efforts to promote managed care as a means of providing effective medical services to many people efficiently are clearly part of establishing “conditions in which people can be healthy.” The governmental public health role in that regard is to assure that managed care performs its function as a means of fulfilling society’s interest. Government’s role includes collecting, analyzing, and publicizing data about managed care’s operations and results; formulating and advocating policies that favor managed care’s emphasis on health improvement; and assuring managed care’s quality through licensing and other regulations.

### Potential For The Future

In view of the tremendous health advances in the twentieth century, how much more can be achieved, and what can public health and managed care contribute to that achievement?

Longevity (average life expectancy at birth) has increased from about forty-seven years in 1900 to more than seventy-five years in the 1990s. Infant mortality has declined from more than 100 per thousand live births at the beginning of the century to fewer than eight per thousand in the 1990s. Although the greatest increase in longevity is now occurring
among older persons, the biological limit appears to be ages eighty-five to one hundred, with extremely few people living beyond 110 years. Thus, the aim of health is shifting from preserving life to preserving functioning, especially among the elderly.

Far too many preventable deaths, of course, still occur to persons under age eighty-five, and substantial effort is needed to overcome that situation. But health improvement in the next few decades will come increasingly from the “compression of morbidity,” especially in the later years of life. The aim will be “to maintain and expand function generally and to build reserves against forces adverse to health.”

Both public health as a whole and managed care as an element of it can help to achieve these expanding health objectives. Managed care as a way of providing medical services is still mainly concerned with the biological aspects of health, seeking to influence directly what happens in the body and the mind by treating or preventing pathology. Since behavior now appears largely responsible for a great deal of current pathology (along with microorganisms, toxic substances, and physical hazards in the environment), managed care may pay greater attention to patients’ nutritional, alcohol, tobacco, and exercise habits. This would add to physicians’ typical approach to pathology through biomedical science, such as by immunization and screening for the early detection of disease. In fact, the term health maintenance organization arose because of that potential. HMOs are evidently taking that approach seriously, although the extent to which this is merely “marketing” is not clear. Nevertheless, the expansion of monitoring health throughout life may actually materialize in managed care.

Managed care also must deal with the other end of the spectrum—care of the dying. Technological advances in medical services frequently “arouse hope among terminally ill persons (and often among their relatives) that some miraculous new therapy will extend their lives significantly. Systems of payment for the services and competition among providers to have the “latest” technology have exacerbated such problems. Too frequently the services involved not only are expensive but also merely prolong suffering rather than providing a favorable health impact. Medical ethicists are intensively examining this issue, and popular views concerning it seem to be in flux. Meanwhile, managed care organizations must deal with it in the absence of consensus, sometimes with errors of commission that are very costly.

However much managed care can help to extend life, prevent disease, and promote health, the additional aspects of public health as outlined here no doubt will continue to have the greater influence, as they have in the past. The IOM statement that “this nation . . . has allowed the system of public health activities to fall into disarray” has stimulated rethinking that
system and seems to be leading to a reconstitution of the field. The gap in a coherent public health approach to prevent some of today’s major problems has resulted in large part from several factors: (1) a change in the nature of health problems, from those on which public health efforts were previously focused to a new set, mainly noncommunicable conditions; (2) public health system delay in tackling this new set of problems; (3) formation of new agencies outside of the regular public health system to deal with these new problems, especially in the environmental health field; and (4) a growing antigovernment mood, which is undercutting performance of the core public health functions of assessment, policy development, and health assurance.

Focusing on the minutiae of the current “disarray,” however, may divert attention from society’s enduring commitment to public health. Positive signs are appearing. Recently in California these include vigorous measures to control tobacco use, excessive alcohol consumption, lead exposure, domestic violence, and other major “vectors.”

Relationships in California between public health and managed care are growing. For example, the Los Angeles County government is negotiating with managed care organizations for operation of primary medical care facilities that were previously managed directly by the county’s Department of Health Services. Pressures on HMOs to increase the levels of preventive services for larger and larger segments of the population are helping the state to reach its public health objectives.

However, public health still has yet to have a major influence on managed care developments, and thus to assure that managed care has the most favorable influence possible on the public’s health.
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