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Managed Care, Rationing, And Quality: A Tangled Relationship

Managed care, in defending its position against the current anti–managed care backlash, must demonstrate that it does, in fact, represent the “good guys.”

by Emily Friedman

With the rapid restructuring of the U.S. health care system and a massive increase in managed care enrollment, it was probably inevitable that a backlash would occur, especially with the profound redistribution of power and money these changes are causing. Although some consumer advocates, such as Sidney Wolfe of the Public Citizen Health Research Group, have criticized emerging large health care systems and for-profit health plans and providers, the most successful barrage of criticism has been targeted at managed care, the level of access that it affords (the “rationing” question), and the quality of the care it provides and/or pays for.

The critics comprise a diverse (and often unintentional) coalition of entities with different goals and agendas. They include (1) some hospitals, physicians, and other providers, who are watching payers take over the health care system they once controlled and are not happy about it, especially given their diminishing incomes and revenues; (2) those in health care who are simply resistant to change, regardless of the nature of that change; (3) some elements of organized medicine and others, who condemn managed care for ideological reasons; (4) health care professionals and others who work in the field—many of them union members—who are worried about their futures and who are using the anti–managed care backlash to push job security demands; (5) a press that loves a scandal and that has been provided with substantial fodder, as some plans and systems have engaged in questionable behavior involving recruitment, enrollment, and access to care and providers; (6) politicians seeking to show sensitivity to press criticism and public complaints; and (7)

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persons whose ultimate goal is a national single-payer plan and who thus condemn all other approaches, fee-for-service and managed care alike.²

- **A distorted debate.** This hodgepodge of critics with their various agendas unfortunately has produced great distortion in the discussion of health care quality, especially in terms of the quality of managed care. Many critics, clearly, are operating as much from self-interest as from a concern for the quality of patient care; in some cases, patient care may place a poor second.

  On the other side, health plans, which are being put on the defensive even as their enrollment reaches record-high levels, are also given to self-interest. It obviously would be to their benefit if they could offer claims of high-quality care (empirically proven or not) as a defense against the increasing hostility they face. Also, managed care plans do not wish to be regulated heavily, and, so far, in most states they have not been subject to the same level of regulation as traditional insurers or providers have. If health plans can assure government and the public that their services are of high quality, they might be able to avoid more regulation and legislation of their activities.

  Government, of course, gets hit from both sides. Critics of managed care claim that government does not do enough; supporters of managed care fear that government will cripple the movement’s success. Furthermore, when it comes to determination of quality, government has a conflict of interest. As Trish Riley of the National Academy for State Health Policy has pointed out, the situation is especially difficult for states, which have several different tasks when it comes to managed care.³ States seek to enroll Medicaid beneficiaries and their own employees in health plans at the same time that they are charged with protection of those beneficiaries and employees as well as with oversight of managed care activities and licensing of plans. States often do not do all of these things well.

  However, that does not mean that self-regulation or unsubstantiated claims of high quality by providers and plans is sufficient or that government should just stand on the sidelines, cranking out quality standards without enforcing them, while paying nearly half the nation’s health care bill. Even in this somewhat anarchistic nation, there is a legitimate role for government in protecting the public’s health and safety. Those who truly believe in managed care should be helping government discharge that duty, rather than trying to blunt its effectiveness; good plans should not fear appropriate regulation. Geraldine Dallek of Families USA has said it best: “Just because we did a poor job of regulating fee-for-service does not mean we should do an equally poor job of regulating managed care.”⁴
When as many of the distractions as possible are stripped away, three things seem clear: First, although the debate has been heavily politicized and often distorted, there are legitimate issues of quality, access, and fairness involved in the managed care revolution. Second, part of the debate revolves around the question of whether the fee-for-service approach is superior to the managed care approach. Third, the core issues of the debate appear to be fear of lack of access, or rationing of care, on the part of groups that previously have not faced such constraints, and the quality of care afforded by health plans and managed care providers.

**Fee-for-service versus managed care.** The cost/quality trade-offs in both fee-for-service and managed care have varied enormously. Sometimes cost has won; sometimes quality has won. This does not mean that high cost implies good quality or that low cost implies good quality, for that matter. However, when the cost/quality trade-off is unbalanced, one consequence is that patients usually bear the brunt of the failure.

The ethical issues of balancing cost and quality under fee-for-service payment have to do with inappropriate care, profiteering, patient disempowerment, violation of the Hippocratic promise to do no harm, and the violent maldistribution of resources in a society that could do many other things with the money that is being misallocated or squandered. These same issues arise under managed care. The fact is that managed care is no more a magic bullet than fee-for-service incentives are inherently evil, and vice versa.

Furthermore, it is fruitless to depict either fee-for-service or managed care approaches as monolithic, implying that they do not vary internally but only from each other. Fee-for-service incentives and structures can be good or bad; managed care incentives and structures can be good or bad. It depends on the specific circumstances, including the structure of the provider, the ownership of the plan and providers, the incentives (financial and otherwise) involved, and the patient populations.

Despite the claims of those who believe that the traditional solo-practice, fragmented, fee-for-service system was the best health care system in the world, it is difficult to find any moral high ground there. Astute observers have argued persuasively for years that the greatest risks to the quality of patient care are overcare and unnecessary services. Indeed, Eli Ginzberg and colleagues, in examining the putative benefits the health care system provides to the poor, concluded that the greatest help it offers, by far, has been to employ them and get them out of poverty.

Nonetheless, this is the United States. The fact is that we Americans, culturally, are much more resistant to skimping or perceived
“A welcome initiative would be to stop overstating how much we really know about the quality of care.”

skimping than we are to gorging ourselves, even if we secretly know that lean is better than fat. Therefore, we perceive managed care—which is, after all, based on constraints of one kind or another—to be more of a threat than is a fee-for-service system.

The dichotomy, however, is false. In judging the quality of a given health care plan or provider, it is necessary to identify the particular elements—structures, ownership, incentives, practices, and even mission and values—that produce good or bad results. These factors have an enormous influence—even a determining influence—on the quality of care provided. Also, these elements are far more specific than an overall designation of “fee-for-service” or “managed care.”

Improving quality and affordability. This then leads to two questions: What should health plans, delivery systems, and public policymakers do to improve both the quality and the affordability of health care and to resolve the ethical issues? And what might be done to allay the public’s fear and suspicion of health care systems that ration services?

In answer to the first question, several actions would help. One is a commitment on the part of health plans, providers, and quality researchers to the idea that the determination of high quality (or the lack thereof) must be objective and should be based on empirical clinical and similar evidence. Although they have their place, process measures, patient satisfaction surveys (which are easily manipulated), and marketing campaigns are not proper substitutes for sufficiently adjusted empirical information.

Another welcome initiative would be to stop overstating how much we really know about the quality of care. I am not alone in this belief. At a recent meeting of a group of employers, I offered the opinion that we are only at “the dawn” of quality and outcomes research. Aaron Katz of the University of Washington responded, “I think it’s still the middle of the night.”

Although there are continuing sincere—even heroic—efforts to find better methodologies, measures, and evaluative techniques, it is also true that many claims about quality are overblown. Too often, what little we do know about quality, risk adjustment, and outcomes is ballooned into outlandish claims about quality measurement products—claims that can be invalid, or at least premature, in terms of how well the product has been tested and evaluated in real-world situations.
This type of hucksterism is a long way from the stated goal: being able to measure the quality of care received by diverse patients, with diverse diagnoses, who live in diverse locations, under diverse socio-economic conditions, and who belong to diverse health plans. A companion goal is to measure and enhance the health status of entire populations. Health services research is nowhere near attaining either goal—and, frankly, probably will never get there. It can only hope to come close and thus should not oversell what it accomplishes. The stakes are too high.

A third avenue that would help the emerging health care system to ingratiate itself with a skeptical public is for plans, providers, and quality researchers to learn to communicate better. Sadly, some of the same people who say they support patient empowerment, public education, and data sharing with patients use terms such as \textit{quality infringement sensors} and \textit{indices of service parsimony} and methodological terminology that would make a Nobel laureate pale. Instead of informing patients and purchasers, we have built a tower of Babel. Not only patients, but also many front-line physicians, nurses, and other providers do not understand the technical language of health care quality and therefore cannot do what is needed.

Theory and practice necessarily occupy different spots in quality measurement, but the gulf between them must be bridged. Out there in the real world are patients and practitioners who want to do the right thing and who want the right thing to be the priority, but who cannot stop to get a master’s degree in econometrics to find out what the right thing is.

I once knew an emergency physician who became interested in decision analysis. I loaned him many works on the subject, and he perused them diligently. Then he told me, “I really appreciate this, but I work in a Level One trauma center, and my average decision time is about three and a half minutes.”

Quality measurement will never be simple, but if it is going to work in the real world, it cannot be as complicated as we are making it. And if we cannot make it “user-friendly,” that failure will only give greater credibility to those whose criticisms of managed care and health care quality are not scientific but are stated clearly and passionately.

\textbf{The link between access and quality.} To address the question of rationing, it is necessary to understand that much of the public complaint about managed care derives from a belief that access and quality are related—that it does no good for a plan or provider to give marvelous care if members do not have access to it. Access and quality cannot be put in separate boxes on the quality measurement chart. The relationship is not linear; overcare is just as
much of a threat to patients as is undercare—perhaps more. But a relationship between good quality and good access exists. In other words, although fears of rationing are as much cultural as they are clinical, they are real fears, and the emerging health care system must address them.

Rationing was hardly born with managed care. The uninsured and many Medicaid beneficiaries have faced it for years, as have the providers working in overloaded, underfunded clinics, hospitals, and other settings that serve unpopular, underinsured, and/or unsponsored populations. The problem today seems to be that access to care is being constrained for patients who previously have not undergone the experience, other than having to wait awhile in a physician’s office or a hospital’s emergency department.

Historically, cost and quality trade-offs have not fallen equally on everyone; one person’s rationing is another person’s income. Albert Jonsen explains this with a telling metaphor. He describes a forest, in one part of which are happy, wealthy people who are living well. Say “rationing” to them, and they assume that they must give something up, so they protest—loudly. In another part of the forest are people who are just scraping by, living on next to nothing, sacrificing constantly. Say “rationing” to them, and they get excited and proclaim, “Hooray! We will get a bigger slice of the pie!”

The same is proving true in terms of the debate over quality and managed care: It is easier to ration care to poor, powerless people than to privately financed, politically powerful people. Thus there has been far more activity in attempting to demonstrate health plan quality to employers and other private payers than in doing so for the Medicaid population or the uninsured (who have virtually no access to health plans anyway). Indeed, the acronym HEDIS stands for Health Plan Employer (emphasis added) Data and Information Set. The National Committee for Quality Assurance (NCQA) is only now introducing a set of standards for Medicaid patients.

Similarly, if quality and access are indeed linked, then there is likely a significant quality issue embedded in the fact that according to U.S. Census Bureau figures, on any given day in this country, sixty-one million people have no health insurance. Approximately forty million have coverage rarely, if ever.

Where are the researchers monitoring the quality of the care received by the uninsured—when they receive it at all? Are managed care plans using the money they are saving to enroll the medically indigent? Is government wringing its hands over their access and quality problems? No. Instead, Congress furrows its brow over maternal lengths-of-stay, while through the new welfare law, it blithely consigns a million children to poverty and destitution because it
does not approve of their mothers.

Quality concerns and patient protection are disproportionately focused on more visible, politically powerful, and vocal populations—including the publicly sponsored Medicare population. The problem is that the emerging health care system must be able to demonstrate a reasonable standard of care for all patients—even the mostlowly—if it is to earn lasting public trust.

The alternative is not appetizing. If the development and enforcement of quality standards and appropriate access continue to vary by patient population, this country could end up with a reconfigured, restructured, reengineered, right-sized, shiny, brand-new health care system, fully converted to capitation and organized health plans, with the finest possible quality measurement systems—and few patients, because most of them would be back in the other part of the forest, dying of measles.

**Equity and social justice.** It is reasonable to ask, of course, if it is the responsibility of those who seek to measure and provide good-quality health care to address issues of equity and social justice. I argue that they do have such a duty, for two reasons. First, as long as massive inequities in access, scope of services, and choice exist among different patient populations, the quality of their care undoubtedly will also vary, and, therefore, accusations of poor quality throughout the health care system will continue.

Second, if managed care is the way of the future, and if the counter-revolution seeking to block managed care is rooted in complaints about access and rationing, then the public, patients, the press, and government must be convinced that it is possible to have a certain degree of rationing without sacrificing good quality.

The best means of achieving that goal is to be honest about the need or desire for constraints but also to appeal to people’s sense of fairness. As Norman Daniels observes, people are more willing to accept the rationing of care if, first, they perceive that the process that brings them to the point of sacrifice is fair and, second, if they know that their sacrifices will benefit someone else.\(^\text{10}\)

Unfortunately, in U.S. health care, neither criterion is being satisfied. In terms of the process of selecting those upon whom rationing will fall hardest, as is true elsewhere in society, the poor, the powerless, the non-squeaky wheels, and the “bad risks” are the ones who most likely will end up doing the sacrificing.

For example, there have been scandals in several states involving illegal and unethical health plan recruitment and enrollment practices and improper limits on access to care for the Medicaid population, usually with delayed and lukewarm state government response.\(^\text{11}\) It is difficult to believe that if the same abuses occurred
when the population at risk was, say, members of the U.S. House of Representatives, the practices would be allowed to continue. Indeed, were Congress to be subject to these abuses, they would be stamped out in a matter of hours.

In the process of rationing, the health care system does not play fair. And the public knows that. Little wonder, then, that people are skeptical about being asked to give up free choice and access.

As for the beneficiaries of rationing, fairness is also at issue. It is difficult enough to convince patients to give up perceived access or quality in a society that has long believed that more is better, including how much money is spent on health services. Ours is a monetized health care system. Therefore, patients measure quality by expense: The more something costs, the better it must be.

If Americans define better health care as more spending, more access, and more services, what reaction can we expect to managed care’s perceived skinflint nature other than public suspicion? If health care is a financial transaction, we want the most money possible spent on us because that ensures that we are getting the best possible care. When money is used as a surrogate for quality, such an attitude is neither irrational nor illogical.

It is not easy to overcome this view. But two approaches could help: First, demonstrate that less access does not translate into lower quality. Second, be scrupulously honest about how the savings achieved through rationing will be used. After all, patients have demonstrated that they will rebel if they believe that they are being asked to reduce their demand for services to increase the value of stock options or to subsidize a new airplane for a billionaire health plan executive. On the other hand, it is entirely possible that expanding access for the uninsured working poor and their children is something many people would be willing to sacrifice for, either through paying more taxes or reining in their health care appetites.

Thus, to allay public skepticism about managed care, it is necessary to come clean. If rationing of care is to occur, it is necessary to explain publicly why care is being rationed, to what end, to whose benefit, and at whose expense—financial or otherwise.

Managed care, group practice, integrated health care, capitation, and conservative patterns of care—even the rationing of some care—can and should serve as the basis of a finer health care system than even this fortunate nation has seen, a system that is also universally available and whose ethical quality, to use Uwe Reinhardt’s term, is as demonstrable as its technical quality. But these innovations could also fall into disrepute, and the energetic reconfiguring of the health care system could falter.
The battle is far from over, and there is no guarantee that the good guys will win. It will aid the cause of managed care no end if it can demonstrate that it does, in fact, represent the good guys.

NOTES


