



Policy Brief

Stanford Institute for Economic Policy Research

The Future of Managed Care

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The 1990s was the decade of managed care. In 1990, most insured patients could choose freely among available providers, physician decisions were rarely questioned by insurers, most physicians practiced solo or in small groups and were reimbursed fee-for-service. Today, under managed care, purchasers (insurance companies and HMOs) selectively contract with providers (medical care groups, hospitals, and doctors), patients face financial penalties if they seek care “out of plan,” fees and prices are negotiated in advance, physician decisions are subject to outside review, and hospitals and physicians often share in the insurance risk. This restructuring of health care was less revolutionary on the West Coast, where Kaiser Permanente, the Group Health Cooperative of Puget Sound, and other forms of managed care had been around for decades; for most of the country, however, the organization of medical care was dramatically transformed.

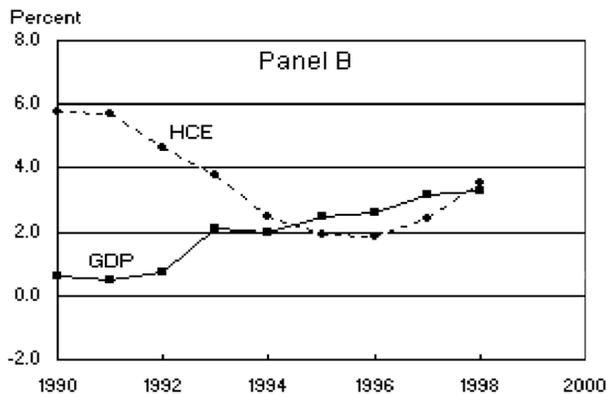
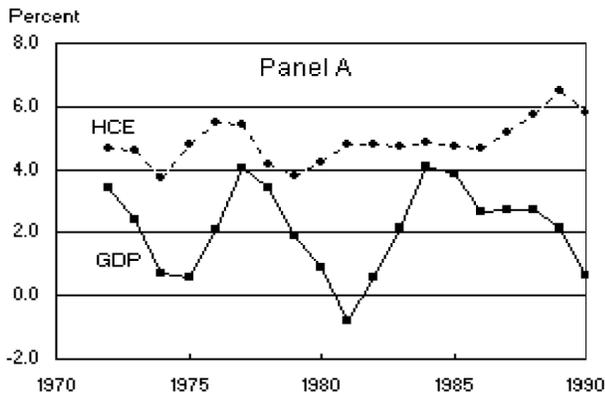
Now the future of managed care seems uncertain. Talk of “backlash” is widespread; mention of HMOs in a movie elicits boos and hisses from the audience; Congress debates legislation to curb managed care and promote a Patient’s Bill of Rights; and even managed care proponents have lost much of their enthusiasm.

What went wrong? No doubt some managed care organizations have behaved badly. But long before managed care, some physicians also behaved badly. No doubt some patients have experienced bad outcomes, while others have been disadvantaged or inconvenienced. But long before managed care, some patients had bad outcomes while others were disadvantaged or inconvenienced. Despite the buzz about the evils of managed care, there has not been any systematic evidence showing an adverse effect on the health of the U.S. population during the 1990s. To understand why there is such widespread dissatisfaction, it is necessary to look at trends in health care expenditures (HCE) and the gross domestic product (GDP) over the past 30 years.

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Annual Rate of Change of HCE and GDP

(Deflated, per capita, 3 year moving average)



Panel A shows annual rates of change of HCE and GDP (real per capita) for 1970-90. We see that between 1970 and the mid-1980s, real HCE per capita grew by 4 to 5 percent per annum. Annual changes in real GDP per capita showed more variation (reflecting the business cycle), with an average growth of about 2 percent per annum. In response to this excess growth of HCE over GDP of 2 to 3 percent per annum, pressure began to build to contain the growth of HCE. Then, in the second half of the 1980s, the pressure became intense as the change in HCE climbed to over 6 percent per annum at the same time that GDP growth was slowing. Both private and public payers demanded restraint of HCE.

Panel B shows that managed care dramatically answered that call. The rate of growth in HCE fell sharply, reaching about 2 percent per annum by the middle of the decade. At the same time, GDP growth accelerated. By the mid-1990s, HCE was

growing less rapidly than GDP, a situation unprecedented in living memory.

With profits, wages, and incomes all soaring, it is hardly surprising the public is unhappy with a health care system whose prime objective is to hold down expenditures. In 1990 the health care industry was instructed to produce “Volkswagen” medical care, but by the end of the decade the public was buying SUVs and BMWs. Health care was not the only industry to get whipsawed by the booming economy of the 1990s. At the beginning of the decade, airlines were putting in as many rows of seats as the fire marshal would allow. By the end of the decade, they were pulling rows out of economy to provide more legroom, and serving vintage wine in the first-class cabin.

In my judgement, reports of the demise of managed care are greatly exaggerated. A return to the previous unconstrained, cost-unconscious system would trigger an acceleration in health care expenditures. Should this occur when the economy is less robust than it was in the late 1990s, there will be renewed calls to curb expenditures. Moreover, the passage of time means that more and more physicians and patients have become familiar with managed care and are less likely than older generations to see it as an abrupt departure from traditional forms of health insurance and medical care. Finally, and most important, managed care is likely to survive because there is no good alternative on the horizon.

If managed care were abandoned, what would take its place? A return to the premanaged care system is no more likely than basketball’s return to the center jump after every basket. A move to a system such as the British National Health Service or the Canadian single payer universal insurance seems equally unlikely in the present political climate. Health care along the British or Canadian lines requires compulsory insurance with subsidization for the poor and sick. The American public is not likely to embrace cross-subsidization and compulsion except in the wake of a war, a depression, or large scale civil unrest. A small fraction of the population may use a new alternative based on the Internet, with individuals researching and choosing physicians on the basis of price and

other information. This approach, however, will not provide most people with an effective, equitable approach to health insurance and health care.

Short of a major change in the political climate, managed care is likely to survive, but it will (and should) take new directions. To enlarge choice for those willing and able to pay for more than a basic plan, employers will offer several plans starting with a defined contribution geared to a low-cost plan. If people want more or better coverage, they will have to increase their contribution to pay for that. Moreover, even a single plan may offer multiple options with higher co-payment for the less restrictive options. More effort will be devoted to devising per-patient reimbursement methods that reduce incentives for health plans to insure only healthy patients (“cherry pick”) and deny coverage to people with high expected medical costs (“lemon drop”).

As the stock market induced “merger mania” of the 1990s subsides, more attention will be paid to finding truly efficient scale. For health care, the proposition that bigger is always better is very dubious. Smaller health plans, led by health professionals rather than executives bent on beating last quarter’s profits, will need to focus on restoring trust between patients and physicians, on improving the quality of service, and on reducing litigation by imaginative use of mediation and arbitration.

The future of managed care will be decided primarily in private markets, but public policy can play an important role. First, only government can create a system to cover the uninsured. Second, public policy should try to preserve professional norms as an instrument of control through encouragement of physician-led managed care. Third, the government should view with suspicion mergers and acquisitions that are undertaken primarily to achieve market power.

Managed care, even at its best, is far from a panacea. Advances in medical technology will continue to exert upward pressure on total health care expenditures, even when those advances lower the price of treating an individual case. No other system, however, does a better job of reconciling the competing demands of Americans for efficiency, innovation, equity, and freedom.

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About the author



Victor R. Fuchs received his Ph.D. from Columbia University and his B.S. from New York University. He is the Henry J. Kaiser, Jr. Professor (Emeritus) at Stanford University. He was a professor in the Economics Department as well as the School of Medicine’s Department of Health Research and Policy from 1974 to 1995.

Professor Fuchs was elected president of the American Economic Association in 1995. His contributions have been recognized by his election to the American Philosophical Society, the American Academy of Arts and Sciences and the Institute of Medicine, National Academy of Arts and Sciences. He was the first economist to receive the Distinguished Investigator Award of the Association for Health Services Research and has also received the Baxter Foundation Health Services Research Prize.

Fuchs is the author of nine books and has published over one hundred articles. His current research topics include mortality and healthcare utilization of the elderly, the future of American healthcare and the relation between empirical results, values and economic policy.

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