

The Rise and Fall of Managed Care*

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The managed care backlash is analyzed as a collective behavioral response led by attacks from threatened professional, provider, and special interest communities. Central to the backlash was the middle class's repudiation of explicit rationing at the point of service adopted by Health Maintenance Organizations (HMOs) and other managed care plans. Americans are accustomed to choice and autonomy in their health care utilization and reacted negatively to restrictions. Assisted by negative anecdotes in the media and allegations of the denial of needed services, opponents built a negative picture of managed care often inconsistent with the empirical evidence. They succeeded in arousing public anxiety that appropriate health care might not be available when people most needed it. The private centralization of large health plans made them an easy target for the media, politicians, and provider groups in opposition. These attacks and regulatory initiatives succeeded in diluting strong utilization management controls contributing to current difficulties of containing large health cost increases.

In a recent paper in the *Journal of the American Medical Association*, James Robinson (2001) proclaimed the death of managed care, a verdict widely shared in the health policy community. At the very least, managed care has been transformed into what some analysts call “managed care lite.” There are few health images in American life that elicit displeasure comparable to managed care. Managed care companies and cigarette companies share the lowest levels of public confidence in social surveys. A Harris poll in May 2000 found that respondents’ reports of industries doing a good job ranged from a high of 80 percent to a low of 28 percent. Tobacco companies defined the floor at 28 percent with managed care companies next at 29 percent (Blendon and Benson 2001). Although tobacco companies had low ratings for each of the prior three years as well, managed care was on a falling trajectory in public confidence over the four years covered by the report from 51 percent in 1997 to 29 percent in 2000. Repeated

surveys in recent years also report that a majority of the public have unfavorable views of Health Maintenance Organizations (HMOs) (kaisernetwork.org 2002). Managed care also has been a source of derision in movies, television dramas, and in late show comedy routines.

Although satisfaction in more recent years has been less than in traditional practice (Miller and Luft 1997, 2002), most enrollees in managed care health plans report reasonable levels of satisfaction. Nevertheless, managed care has been the object of thousands of legislative proposals in Congress and state legislatures and an object of criticism by many politicians who find it an easy target (Mechanic 1997). The negative managed care symbolism is suggested by President Bush’s 2003 State of the Union address, where after asserting to applause that “Instead of bureaucrats and trial lawyers and HMOs, we must put doctors and nurses and patients back in charge of American medicine,” he proposed financial incentives to push the elderly into HMOs.

Managed care encompasses many organizational forms, strategies, and approaches, but any overall evaluation of the performance of this hybrid industry would have to conclude that there has been little performance difference between managed care and traditional

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fee-for-service medicine in access or quality (Miller and Luft 1994, 1997, 2002). Evaluation is complicated by the fact that significant proportions of respondents to surveys are confused as to whether they are in managed care (Nelson et al. 2000). Most surveys of managed care enrollees find that while they have a variety of complaints, as do members of traditional plans, most are reasonably satisfied with their plans and the medical care they have received. Those in managed care have generally preferred the cost advantages, while those in fee-for-service were more satisfied with choice and interpersonal amenities (Miller and Luft 2002). The restriction of choice clearly has a negative effect on satisfaction (Gawande et al. 1998; Ullman et al. 1997). Nevertheless, it is difficult to account for the large gap between reported personal experience with managed care and public perception and response.

Managed care is credited with containing health care costs over the period of its growth. Many of the cost reductions came by negotiating, some would say dictating, lower rates of reimbursement for hospitals, doctors, other professionals, and a variety of ancillary services. Some significant cost reductions have come from utilization review and utilization management, particularly substantial reductions in length of hospital stays and some more prudent use of expensive diagnostic modalities. However, in fact, managed care approaches, while varying from one company to another, have not to any large degree limited access to hospital admission or to general medical care (Remler et al. 1997). The impact of its strategies have been more to constrain reimbursement than access to services. This hasn't made many friends and supporters in the health provider community. One important strategy for hospitals and providers has been to consolidate to achieve more market dominance and strengthen bargaining position in negotiations with large managed care organizations (Burns and Pauly 2002). Whatever uncertainty there might be about objective experience, there is little disagreement that managed care practices now have been substantially eroded, that costs are rising significantly, and that health care premiums are increasing substantially (Strunk, Ginsburg, and Gabel 2001; Center for Studying Health System Change 2002; Draper et al. 2002; Kaiser Health Poll Report 2003). Other factors, of course, con-

tribute to cost increases, such as new medical technologies and drugs, aggressive direct advertising of pharmaceuticals and new medical services, and growing public awareness of treatable conditions and the value of medical care (Cutler 2001).

In this paper I suggest that the failure of managed care speaks as much to American culture, the nature of mass communications, and the character of the medical marketplace as it does to the intrinsic qualities and performance of managed care (Mechanic 2002a). While many errors are rightfully attributed to managed care practices, errors are common in all medical activities (Institute of Medicine 2001; Kohn, Corrigan, and Donaldson 2000). In the pre-managed care era, such errors were attributed to the individual failures of hospitals, physicians, and other health care personnel. With the centralization of medical care into a more limited number of large health insurance companies and managed care providers, errors are more readily generalized to the now more visible centralized target (Mechanic 1997). Thus, the organization of medicine itself, and its increasing centralization, contributed to the public relations problems experienced by managed care plans and providers.

Basic to the backlash against managed care is the underlying American cultural preference for independence, autonomy, choice, and activism, and the view shared by many Americans that there should be no barriers to their access and choices in seeking and receiving medical care. Interest groups understand that the idea of "rationing" is unacceptable in the American context, and there is a long history of attacks on health reform by professional medicine and other health interests through assertions that it would "ration health care." Unlike in the United Kingdom, for example, health policy makers in the United States understand that they cannot have serious discussions about rationing in a political context. The intense interest by academics in Oregon's rationing scheme for its Medicaid program is an exception that helps prove the rule. Oregon went through an elaborate process of evaluating the value of medical and surgical interventions so that reductions in the Medicaid program would be limited to less valuable services. A major motivation was to extend valuable coverage to more people. What really happened in Oregon, however, is often misun-

derstood (Jacobs, Marmor, and Oberlander 1999).

I suggest further that the rejection of managed care was not simply that it rationed. There is much implicit rationing in health care programs (Mechanic 1995). However, utilization management and other strategies used by managed care providers were clearly explicit, making both patients and their doctors aware at the time of service that their choices and autonomy were being restricted. In popular parlance, it was "in your face" rationing. It was the constraints on preferred choice and managed care's inclination to temper the activism characteristic of American physicians that contributed to its negative reputation. Physicians complained bitterly that managed care was restricting their decisions (Kassirer 1998). The American patient has been socialized to value having all health care options and opportunities. They may endorse the rationality of cost containment measures in a general sense but resist any limitations when they believe that their health or the health of their loved ones might be at stake.

The public's unhappiness with rationing was an important factor, but it was not the only factor that led to the collective outburst perhaps best illustrated by movie audiences around the country cheering when actress Helen Hunt denounced HMOs in the 1997 movie hit, "As Good As It Gets." The tensions can be traced back to the failure of the Clinton health plan and the broad opposition it aroused from conservatives, businesses, health plans, physicians, hospitals, and the broader health care community. As Skocpol (1997) has noted, Clinton's efforts to be a new fiscally responsible Democrat led him to propose National Health Insurance that was cheap, substituting tight new cost-constraining regulations for large new expenditure commitments. Threatened by the potential loss of profits and autonomy, interest groups unleashed their public relations campaigns in opposition, such as the "Harry and Louise" ads that became famous after Hillary Clinton attacked them.

Managed care ultimately attempted what Clinton was unable to achieve: constraints that threatened the reimbursement and autonomy of health institutions and providers. Health organizations mobilized their media resources against managed care, as did many advocacy groups who feared restrictions on services. Public trust in medical institutions and leaders

had been falling for some time, as was the case with leaders in many other social sectors, but patients still retained high trust in their personal physicians. Physicians' hostile responses to managed care reinforced patients' worries that health plans would put profits ahead of their welfare.

THE RISE OF MANAGED CARE

Managed care is the rubric applied to a range of organizational forms that emerged in the last couple of decades in which a variety of structures, mechanisms, and utilization strategies are used to allocate care so as to reduce unneeded services and constrain cost (Luft 1987; Zelman and Berenson 1998). The origins date back more than a century to industrial health programs where companies contracted with physicians to provide basic medical care for their employees through a capitation arrangement (Starr 1982). Some unions early in the last century organized similar plans for their members at modest cost. The more contemporary prototype was the prepaid group practice model such as the one organized by Sidney Garfield to provide medical care to workers for the Kaiser industries during World War II, later to evolve into Kaiser-Permanente, now the largest prepaid group practice plan in the United States (Hendricks 1993). A related model of prepaid group practice was organized by the City of New York for municipal workers, the Health Insurance Plan of New York, which was later extended to other city populations (Silver, Cherkasky, and Axelrod 1957). Other noteworthy plans included consumer organized prepaid group practices such as Group Health Cooperative of Puget Sound and the Group Health Association in Washington, DC (Berkowitz and Wolff 1988; Starr 1982). These group structures differed as to whether physicians were employees (the staff model) or contractors (the group model), whether the plan owned hospitals or contracted for hospital care, and on a variety of other dimensions, but the central fact for patients was that care was prepaid and there were no uncertainties about cost at the point of service.

The early pioneers of prepaid group practice believed that prepaid group practice was a superior way to meet patient care needs and promote the population's health (Committee on the Costs of Medical Care 1932; Falk,

Roem, and Ring 1933). For example, Ernest Saward, a leader in prepaid group practice and medical director of the Permanente Clinic in Portland, Oregon, described the philosophical basis of the Kaiser concept as having six elements in which prepaid group practice was the "genetic code:" prepayment, group practice, an integrated medical center, voluntary enrollment where employers offer patients choices, capitation payment, and comprehensive coverage (Saward 1969). Many of the early pioneers believed passionately in the concept and encouraged some of the most outstanding early health services research and development of practice information systems (Saward, Blank, and Greenlick 1968).

Research on prepaid group practice in the decades 1950–1970 generally found that prepaid practice performed as well as or better than fee-for-service practice and could provide care at lesser cost (Donabedian 1965, 1969; Luft 1987). Much of the cost reductions resulted from less use of hospital care. Studies also showed that prepaid group practice programs to manage care for special populations—such as poor pregnant women and the frail elderly—and enhance preventive care were associated with improved patient outcomes (Shapiro et al. 1960; Shapiro et al. 1967). Throughout much of its early history, however, prepaid group practice was attacked as "socialized medicine," and physicians associated with such groups were harassed by organized medicine and often excluded from local medical societies (Starr 1982). Over time, through litigation, court judgments, and changing attitudes, prepaid group practice gained modest acceptability (Starr 1982), but with the exception of California and some Midwestern communities it had little penetration. Recruitment and retention of the best doctors were difficult and the limited panel of doctors available to choose from was a disincentive for patient enrollment.

With advances in scientific knowledge and medical technology in the post World War II era, medical care increasingly offered more value than before, and employers increasingly provided health insurance to employees and their families. During the war there were government controls on wage increases, so in lieu of wages unions bargained for health insurance benefits, which were not limited similarly. This trend of bargaining over benefits continued after the war and was the basis for the American pattern of providing health insur-

ance through employment. From the end of the war, when medical expenditures were about 4 percent of Gross National Product (GNP), expenditures grew over several decades at a rate greater than the economy as a whole. Between 1965 and 1980 medical expenditures as a proportion of GNP increased from 6 to 9.4 percent (U.S. Department of Health and Human Services 1981, page 195). Cost inflation greatly accelerated following the introduction of Medicare and Medicaid in 1965 and put increasing pressure on federal finance.

By the early 1970s the growth in medical care costs were perceived as a national problem with few acceptable alternatives for constraining them. Although there had been repeated calls for a national health care scheme over the century, and many plans were submitted to the Congress, a political consensus never emerged, and each of these proposals was eventually defeated, including one supported by Nixon in 1974 (Rivlin 1974; Starr 1982). The Nixon administration in the early 1970s was searching for some way of containing costs and rationalizing care and focused on the growing evidence over the decades of the cost effectiveness of prepaid group practice. Repackaged as "health maintenance organizations" by advisor Paul Elwood, and enlarged as a concept encouraging prepaid forms other than group practice, such as independent practice associations, the Federal government began encouraging and subsidizing the growth of HMOs.

New prepaid group practices required considerable organizational know-how and capital, and they were difficult to bring to a point of economic viability. Instead, much of the growth occurred through the emergence of new organizational forms such as practice associations and networks which allowed doctors to provide medical care to prepaid patients in their private offices. Over time, these new largely financial structures overshadowed the nonprofit HMO group model on which most of the early research had been based. By 1994, 69 percent of HMO membership was in independent practice associations or network plans and only 31 percent was in more traditional staff and group practice models (Gabel 1997). Fifty-eight percent of members by 1994 were enrolled in for-profit organizations, a sizeable change from earlier years when nonprofit organizations predominated. Also, as the backlash against restrictions on choice grew, non-

HMO forms of managed care, namely so-called "preferred provider organizations," grew most quickly, gaining an increased share of the managed care market. Many prepaid group practices added a point-of-service (POS) option that allowed enrollees to get care outside the group at the point of service but at greater out-of-pocket expense. These POS plans were essentially preferred provider options that gave patients financial incentives for using plan doctors and facilities but did not directly restrict choice. Hybrid plans developed rapidly (Gabel 1997), combining different types of HMOs and preferred provider arrangements. Between 1990 and 1994 HMOs offering POS plans increased from 36 to 61 percent, and PPO offerings increased from 35 to 50 percent (Gabel 1997).

During the period 1970–1990 the public became increasingly aware of the importance of mental health and substance abuse problems, and increasingly private health insurance covered at least some such services. Large private corporations such as Xerox, General Electric, and IBM provided comprehensive benefit coverage and experienced large increases in mental health and substance abuse treatment expenditures, a situation of growing concern for employers. Some entrepreneurs from the prepaid group practice industry and from public mental health programs developed private companies that managed mental health and substance abuse care for employers. As concern mounted about mental health and substance abuse costs, private industry turned to these managed behavioral health care companies to administer their mental health and substance abuse benefits on an administrative or "carveout" risk basis. It was soon clear that utilization review could substantially reduce these types of expenditures, and the managed behavioral health care industry developed very rapidly, first serving the private sector but then expanding into public sector behavioral health care management (Mechanic 1998b, 1999; Mechanic, Schlesinger, and McAlpine 1995). As states struggled to manage their mounting Medicaid costs, they too turned to managed care but initially kept out the disabled population. Over time, however, states extended managed care to its most disabled populations as well.

The managed behavioral health industry now manages the mental health and substance abuse benefits of a majority of the American

population. Although available evidence indicates that, overall, behavioral health management has increased access and reduced cost for the employed population as a whole, data on the intensity and quality of care for the most seriously mentally ill suggests that management of care may be problematic (Mechanic 1999; Mechanic and McAlpine 1999). Studies of state Medicaid managed behavioral health programs report mixed results depending on the care for which the programs are designed and administered, and probably on payment rates, which vary among states (Mechanic 2003).

Although there is debate and uncertainty as to the overall effects of managed care, performance failures cannot explain the strong public backlash. Neither objective studies of access and quality nor surveys of enrollee satisfaction in such programs justify the public and political response (Miller and Luft 1994, 1997, 2002). Careful reviews of the available studies document failures and difficulties, but they also show that they are generally comparable to those found in traditional practice. The number of studies that document better performance of managed care structures match those that show greater deficiencies, and most comparative studies find few significant differences. Thus, the backlash might be seen more usefully as a collective behavior phenomenon connected with American assumptions and values which were challenged by the strategies of managed care.

The media and opponents of managed care had no need to present a balanced picture of the empirical evidence. Opponents and advocates, of course, are selective and seek to make a persuasive case. Journalists may not have similar motivation, but they seek good, compelling stories, and powerful health plans motivated by profit allegedly denying services to a sick child or a cancer patient is a more compelling story than one that reports few differences in overall performance. There were enough irritations with managed care, as there are with medical care in general, to encourage peoples' anxiety about whether their care would be there when they really needed it (Blendon et al. 1993).

Another difficult issue in health care reform is that what is rational overall, cost aside, may not be optimal for each individual. It may be irrational to fund costly, untested, "last chance" therapies, but those affected may see

such therapies in their interests. Systems of care require trade-offs. Universal and equitable systems expose all to comparable constraints. European systems of universal access depend substantially on concepts of solidarity that make the population more accepting of limitations. Solidarity plays a smaller role in the American context, which makes it difficult to achieve acceptance of reform with limits. As Skocpol (1997) noted, when more privileged Americans saw that the Clinton health reforms might reduce their advantages, they turned against it.

CORE VALUES CHALLENGED BY MANAGED CARE

Surveys in the United States have long indicated that most Americans see medical care as different than other products and services and believe it should be available to those who need it regardless of socioeconomic status or geography (Blendon et al. 1994; Lewis et al. 1976). Moreover, academic experts have noted the numerous ways that medical care has deviated from a traditional market environment (Arrow 1963; Mechanic 1978; Rice 1998). Nevertheless, many economists have argued that health care is most efficiently produced and distributed through a market approach, a view that resonates with conservative policy makers philosophically wedded to competitive markets and the belief that markets are more efficient than planned programs. This value assumption is widely shared by the general public, who distrust government and government regulation (Nye, Zelikow, and King 1997; Skocpol 1997). This eases the path for those who advocate a minimum of government intervention and oppose centralized reforms such as national health insurance. The popular conception of the marketplace also reinforces other strongly held public values such as consumer autonomy, choice, activism, and technical progress.

Perhaps most surprising about the final decades of the 20th century was that the enhanced rhetoric about market competition and choice accompanied an extraordinary degree of market consolidation in what were substantially decentralized and local markets (Burns and Pauly 2002). Hospitals, nursing homes, and other facilities were brought into national chains, and even medical groups—the

last bastion of proclaimed independence—were organized into larger collectivities and parts of larger networks. These developments limited patients' options, their choices among health plans, and even their choices of doctors. Although choice of care and community rating had previously been strong community values, these were now superseded by reduced choice and risk rating. Many employers, and most small ones, now offer employees only HMO options, and decreasing numbers offer a choice of both HMOs and indemnity plans (Rice et al. 2002). Many employees in low paid employment receive no health benefits at all, while others have coverage for themselves but not for their families.

The growth of managed care, and what were perceived publicly as its most onerous practices, followed the failures of government intervention. After the demise of the Clinton health plan in the early 1990s (Mechanic 1996a), the business sector endorsed a managed care approach, private regulation of health care choice, and provisions that went well beyond anything government could or would have done. Managed care, and its implicit challenge to consumer choice and physician autonomy, was a product of big business, privatization, and a quest for larger profits. Profit has always played a significant part in health care, but in the 1990s the tide turned demonstrably from small entrepreneurs and localized cottage industries to equity capitalism and the large corporation.

The American experiment in managed care was substantially built on a set of strategies of managerial capitalism and not one motivated by philosophical commitments comparable to those of the early managed care innovators. As employee complaints increased and the public expressed dissatisfaction with restrictions on choice, both employers and health plans retreated by relaxing the utilization controls that gave managed care advantages in constraining costs. On the positive side, private plans and provider groups showed ingenuity in devising new types of practice arrangements that adapted to changing circumstances (Robinson 1999). By the new century, health providers were increasingly successful at consolidating and strengthening their bargaining position as well, making it more difficult for health plans to demand low reimbursement rates. This new equilibrium has again brought us into a cost spiral with little sense of what

countervailing forces will restrain it (Heffler et al. 2002).

HOW EXPLICIT RATIONING HELPED UNDERMINE STRONG MANAGED CARE

In American medicine almost any service a patient might want is available at a price. Instances of full exclusion by rationing as mandated by scarcity—such as in the transplantation of kidneys, hearts, livers, and lungs—are relatively rare. Most rationing that occurs is implicit and less recognizable, such as barriers to care resulting from inability to pay, distance to sites of care, difficulty in scheduling appointments, limited personnel in certain specialties, and waiting times (Klein, Day, and Redmayne 1996; Mechanic 1995). Most patients experience many of these barriers as inconveniences and “facts of life” but not as rationing. Utilization management, in contrast, introduces a third party into the medical transaction at the point of service; this third party must grant permission for certain procedures or expenditures. In some instances it is the patient who must call a telephone number and seek permission or a referral; in other instances this requirement falls on physicians. Neither like going through such gatekeepers, and explicit denials of preferred treatments are often a source of frustration and anger. It is little wonder that the explicitness of rationing makes patients open to negative media coverage and the professional campaigns against management of care.

Most managed care practices have been used conservatively and most enrollees, while inconvenienced, have not been explicitly denied an important service. Instances of denying access to hospital care or a life-saving course of treatment have been rare (Remler et al. 1997), although most of the public know about such instances from media coverage. Explicit rationing, however, weakens the trust that individuals have in their health care plans, and it also weakens their confidence that their health plans will put their health care needs ahead of cost containment and profit (Blendon et al. 1993). Studies have consistently found that patients particularly value being able to trust that their health care systems, and particularly their physicians, put their health and welfare first (Mechanic 1996b, 1998a; Mechanic and Meyer 2000; Mechanic and

Schlesinger 1996). Explicit rationing and related media coverage have contributed to eroding trust, especially in health care plans.

Physicians also resent the explicitness of many managed care practices, particularly utilization review (Hadley and Mitchell 2002; Kassirer 1998). Asking permission is an affront to physician autonomy and sense of professionalism. They also resent the manner in which managed care companies have used their relative power to bargain down reimbursement and capitation rates. Physicians are more oriented to their own clinical experience than theoretical knowledge and prefer to err on the side of intervening (Freidson 1970; Scheff 1963). These are not orientations compatible with explicit rationing.

FUTURE UNCERTAINTIES

Managed care has not been the disaster the media portrays, but neither has it fulfilled its promise. The optimistic claim that managed care would bring improved clinical practices, higher quality of care, and maintain the public's health, and all at reduced cost, has been an illusion. There have been significant innovations in some of the established prepaid group practices (Hurtado, Greenlick, and Saward 1969; Wagner, Austin, and von Korff 1996) which offer guidance for putting in place good disease management programs and quality assurance practices, but such group structures are a shrinking part of the health care sector. The forms of managed care that have prevailed have been virtual networks rather than group structures, for-profit in contrast to not-for-profit organizations, and systems that manage costs more than care. Non-profit plans have performed better than profit organizations (Tu and Reschovsky 2002), and they are more likely than for-profit ones to put in place service arrangements that more broadly enhance care (Mechanic and Rosenthal 1999).

As we proceed further into this century there is a renewed focus on quality, on reducing hospital and medical error, and on managing disability and chronic disease more effectively (Institute of Medicine 2001). Although much has been written on the clinical integration of services, there are many barriers, and clinical integration rarely has occurred (Burns and Pauly 2002; Shortell et al. 2000). Advances in information technology, however, make dis-

ease management approaches more possible in virtual systems, and many companies now offer high risk and high cost patient management services, as well as the ability to usefully process massive claims data to improve patient population management (Mechanic 2002). The barriers are more human and organizational than technical; developing appropriate incentives and redirecting physician and other professional behavior toward these new approaches and systems is difficult and slow (Mechanic 2002b).

There is growing realization that the high prevalence of error and injury and the failure to provide high quality care are structural challenges and not simply individual problems. Spurred on by two influential Institute of Medicine reports (Institute of Medicine 2001; Kohn et al. 2000) and a collaboration of major business groups in the Leapfrog Group (2001), efforts are being made to use purchasing power to correct some deficiencies of health care systems. There appears to be a significant, wide spread realization that, despite our vast expenditures for health care, quality is often poor and simple errors abound. It remains to be seen whether remedial efforts are sustained and grow or whether this is another example of adaptation and co-optation to just one more passing challenge.

The fact remains that the American health care system is disorganized and irrational. The interest groups who have a stake in its size and operations are powerful, making significant changes challenging their interests exceedingly difficult. The spiral of cost and premium increases accompanying the dilution of managed care will exacerbate the problems of insurance coverage and maintenance of the safety net for those who lack coverage. As employers and government face increased costs and budget constraints they will transfer more cost to patients. Medicine has more to offer than in the past, and the gaps in coverage for prescription drugs, preventive services, long-term care, and even the most basic services will be felt more strongly. The course of health care in America remains uncertain, and prediction is always hazardous. However, one thing is certain: If managed care is truly dead, a proposition I believe is doubtful, a functional substitute will be required. More likely, we will see managed care take iterative forms that dispense with gatekeepers and limited choices, that force patients into more self-conscious

frugality, and that reintroduce rationing more implicitly. This is what experience should lead us to anticipate (Klein et al. 1996; Mechanic 1995).

In the final analysis, the underlying fault is in the failure of the United States to introduce a rational system of universal health care. While 60 percent of all health expenditures are from government through health programs, tax subsidies, and coverage of health benefits for government employees (Woolhandler and Himmelstein 2002), we maintain the illusion of a private health care system and pay a high price for it. Experience suggests that converting from our present system to a more rational insurance program is not politically possible without payoffs to established interests. Whether the failure is an example of American exceptionalism or a product of other cultural expectations and values, the likely prognosis under the current arrangement is one of greater inequalities in access and treatment and growth in the uninsured and under-insured, among other problems. There certainly will be efforts to muddle through and patch the cracks, but fundamental changes are unlikely until a significant proportion of the population is threatened and personally dissatisfied. Unfortunately, things are likely to get much worse before getting much better.

A NOTE ON MEDICAL SOCIOLOGY AND MANAGED CARE RESEARCH

With some notable exceptions, sociologists have not been central in either research or analysis of managed care or the transformation of health care more generally. Several decades ago sociological analysis was central to understanding medical practice and health care dynamics (Bloom 2002), and medicine was a fertile ground for developing and testing sociological conceptions. In more recent decades sociologists have ceded dominance to health economics, health administration, and health services research (Mechanic 1993), and more recently to political science and law. Although just a single example, the interdisciplinary journal, *Journal of Health Politics, Policy and Law*, brought together almost 50 scholars to analyze the managed care backlash (*Journal of Health Politics, Policy and Law* 1999). Since the journal is strongly oriented to political science, it is not surprising that 12 of the contrib-

utors were from that field, but 15 were from economics, 7 were from management and business, 5 were from law, and the remaining 10 or so were spread across a range of fields with only one sociologist among them.

A range of sociological fields potentially speak to managed care and newly emerging structures and patterns of health care: economic sociology, political sociology, collective behavior, organizations, the professions, public opinion, and social psychology, among others. However, sociologists in these fields have not made their analyses felt in the larger interdisciplinary discussions and research. Medical sociology traditionally has had its deepest roots in mental health, and more recently in development of the stress model, but while sociologists are more evident in mental health research literature, and especially in psychiatric epidemiology, they have had little to say about how managed behavioral health has transformed the mental health sector or about its profound effects on patients and mental health professionals.

The re-emergence of interest in population health, and especially in socioeconomic and ethnic disparities, should engage more sociologists for whom this is natural terrain. Moreover, there is also a need to apply sociological theories and methods to understand the restructuring of health care institutions, the growth of consumerism, and the changing dynamics between patients and health providers, as well as how the media and social and cultural trends affect illness attribution, self-care, help-seeking processes, and health and illness outcomes. In recent years, economics has so dominated public discussion and social policy that many of the important social factors affecting disease processes and care have been neglected. The medical arena offers even more opportunity for the sociological imagination and for important and useful contributions to promoting health and welfare. It is time for the next generation of sociologists to seize the day.

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