

The End of Managed Care

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THE UNITED STATES FACES AN ACCELERATING demand for medical services due to new quality-enhancing but cost-increasing drugs and devices, an ever-broadening social definition of health, and an ever more informed and assertive consumer. Despite unprecedented prosperity, the nation lacks the economic resources to finance all services that would provide some benefit to some patient. The setting of social priorities and balancing of competing claims is imperative. The fundamental question concerns where and by whom these difficult decisions will be made. Five candidates present themselves: government, employers, insurers, physicians, and consumers. Each has serious limitations as arbitrator of who should get what, yet of necessity one must be assigned the role.

Most industrialized nations rely on public sector institutions to allocate scarce resources through a combination of capacity limits and price controls, but the United States appears no closer to embracing this approach today than in the past. The indelible political lesson of the past decade has been that initiatives to control health care costs lose votes, while initiatives that increase costs, through expansions of coverage, benefits, and access, win votes. During the same decade, employers, insurers, and some physician organizations developed managed care as a private sector alternative to governmental regulation. The managed care system has achieved considerable economic success but has proven itself a cultural and political failure, un-

Managed care embodies an effort by employers, the insurance industry, and some elements of the medical profession to establish priorities and decide who gets what from the health care system. After a turbulent decade of trial and error, that experiment can be characterized as an economic success but a political failure. The strategy of giving with one hand while taking away with the other, of offering comprehensive benefits while restricting access through utilization review, has infuriated everyone involved. The protagonists of managed care now are in full retreat, broadening physician panels, removing restrictions, and reverting to fee-for-service payment. Governmental entities are avoiding politically volatile initiatives to balance limited resources and unlimited expectations. By default, if not by design, the consumer is emerging as the locus of priority setting in health care. The shift to consumerism is driven by a widespread skepticism of governmental, corporate, and professional dominance; unprecedented economic prosperity that reduces social tolerance for interference with individual autonomy; and the Internet technology revolution, which broadens access to information and facilitates the mass customization of insurance and delivery.

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leashing a reaction against narrow physician panels, "gatekeeping," utilization review, and capitation. Employers, insurers, and physician organizations now are renouncing managed care functions and seeking new missions as entities that inform, structure, and support consumer choice.

This article examines the retreat of employers, insurers, and physicians and the emergence of the consumer as the central decision maker in US health care. A consumer-centered health care system will have incomplete information on quality, inadequate spreading of insurance risk, and insufficient financial subsidies for the poor. Some observers thus argue that the resurgence of health care inflation, coupled with an economic recession, will bring the public and the private sectors back into the central role they now abandon. But the transition to health care consumerism builds on deeper social trends, including the widespread distrust of big

government and big business, the increasing diversity in health-related attitudes and preferences, and the emergence of Internet technology as a source of information, entropy, and accelerating change.

RETREAT OF THE CARE MANAGERS

Employers

Employers entered into the financing of health benefits by historical accident and remained to purchase employee loyalty with pretax dollars.¹ When confronted with the explosion in insurance premiums, they shifted their contracts and herded their employees into managed care. This strategy achieved short-term gains, with an unprecedented slowdown in cost infla-

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tion during the 1990s,² but has caused deep damage to the workplace social compact. Although economists maintain that employer contributions to health insurance would have been added to wages and salaries,³ employees view insurance contributions as a supplement to, rather than a substitute for, cash compensation. The advantages produced by managed care, in the form of lower medical inflation, were perceived as accruing to employers, while the disadvantages, in the form of restricted access, accrued to employees. Employers now purchase ever less employee satisfaction at an ever-growing price and face a threatening wave of litigation if corporate benefit programs, as well as the insurance firms that administer them, are judged liable for the adverse health consequences of cost-cutting initiatives.

A tight labor market promotes caution and impedes initiative among corporate health benefit managers, but the trend in attitudes is clear. Employers are retreating from managed care constraints while simultaneously restricting coverage and benefits. Enrollment is shifting from tightly managed health maintenance organization (HMO) products to lightly managed alternatives, and even HMOs are relaxing gatekeeper, utilization review, and other hallmark functions under pressure from their customers. Employees are being asked to pay a greater share of the health insurance premium, with the consequent rise in the number of individuals who are offered but decline employment-based coverage.⁴ The increase in co-payments and benefit exclusions was muffled by the imperative to retain employees, but many firms are waiting for a loosening of labor market conditions to increase cost-sharing and reduce benefits.

More important than any short-term restructuring of premiums or copayments is the change from a paternalistic corporate culture to one that defines itself as supporting rather than restricting employee choice. This shift has been most visible in the evolution from defined benefit to defined contri-

bution pension plans, where most private corporations now contribute a specified monthly sum to tax-favored retirement accounts that are controlled by individual employees rather than by the firm.⁵ The advent of Internet technology has accelerated a move toward the contracting of human resources functions to other companies, consistent with the business mantra to focus on core competencies and outsource everything else. Investment analysts and human resource managers now are abuzz with discussions on how and when, rather than whether, to apply similar principles to health insurance benefits.⁶⁻⁸ While many employees remain committed to funding health insurance, as they remain committed to funding pensions, the trend is to offer information, options, and partial financial support, but to otherwise get out of the decision-making position in health care.

Insurers

The managed care industry is the confluence of several distinct sectors, including commercial indemnity carriers, prepaid group practices, and the BlueCross/BlueShield plans. Years of mergers and acquisitions have churned these once distinct entities into large and diversified conglomerates that offer multiple products across multiple states to multiple customer segments.⁹ Some embraced the role of managing care, accepting a predefined capitation budget for a predefined enrollee population and establishing criteria for allocating resources and evaluating medical necessity. Plans that could not develop physician networks, negotiate prices, and review utilization either sold out or lost market share to those that could. For a moment it seemed that insurer-based managed care was the US route to establishing priorities and balancing trade-offs in health care.

The market success of managed care, measured most commonly through the rising enrollment in HMO products, ultimately proved to be its undoing. Once the consumer and physician backlash against managed care began, it quickly

swirled into an unstoppable political tornado, reaching its peak perhaps in the recent presidential campaign, during which one candidate accused his opponent of herding elderly persons into private HMOs while the other countered that his opponent was herding them into public HMOs. The fundamental flaw of managed care, in retrospect, was that it sought to navigate the tensions between limited resources and unlimited expectations without explaining exactly how it was so doing. Enrollees were offered comprehensive benefit coverage with only minimal co-payments, which they interpreted as a promise of unrestrained access to all relevant services. Managed care proposed to control costs behind the scenes, through volume price discounts from physicians, gatekeeper restraints on specialty consultations, drug formularies, prior authorization of tests and admissions, and retrospective denial of payment for unnecessary services.¹⁰ Consumers experienced managed care's cost-control strategy in the form of barriers to access, administrative complexity, and the well-articulated frustration of their caregivers. Controlling health care costs behind the scenes is difficult even in the most propitious circumstances; it became volatile in the context of reports of excessive profits, bureaucratic hassle, and exorbitant executive earnings.

Proponents of managed care may win some of the legislative and judicial battles, but clearly they have lost the war. The largest firms in the health insurance industry, and especially the investor-owned corporations, have lost the will to fight against US popular culture and political institutions. Investment analysts are downgrading stocks of firms that persist with narrow networks and capitation, while promoting stocks of those that offer the broadest panels with the least utilization review.¹¹⁻¹³ They note that the core function of an insurance firm is to predict cost trends and establish premiums accordingly, not to accept the prices offered by purchasers and seek to hold expenditures beneath

those limits. In the short run, health plans are outrunning costs by raising premiums. In the long run, they are hoping to redefine themselves as entities that structure and support choices for individuals, offering information on coverage and quality, Web-enabled decision support tools, and actuarially fair prices for each choice.¹⁴ Heretofore, managed care organizations rarely have managed care but mostly have managed costs. Henceforth, they will not even manage costs but only analyze, explain, and pass those costs on to the consumer.

Physicians

Historically, physicians and hospitals have served as social agents for the increase in health care expenditures, adding capacity, technology, and services in pursuit of higher incomes and better clinical outcomes. During the past decade, a variety of medical groups, hospital systems, and physician-hospital entities emerged with a goal of managing the cost as well as the quality of care.^{15,16} They have combined primary, specialty, hospital, and ancillary services; have been paid through global or professional services capitation; and have been delegated authority for managed care functions, such as credentialing, utilization review, and claims processing. Many have interpreted themselves as the natural locus for clinical and financial responsibility, in marked contrast with governmental, employer, or insurance entities.

Some physician and hospital organizations have gained prominent positions in their local communities, but many others have foundered under the difficulties inherent in governing complex organizations and managing capitation payment. Attempts to expand patient volume through price cutting pulled revenues below costs; the conversion of self-employed physicians into salaried employees undermined productivity; the amalgamation of primary, specialty, and institutional physicians stimulated factionalism; the mix of professional, administrative, and

community cultures enfeebled governance. The once rising tide of integrated health care now is ebbing; as medical groups retrench, the physician practice management firms are declaring bankruptcy, and physician-hospital organizations are breaking into their component pieces.^{17,18} Physician organizations are retreating from global capitation to partial capitation, case rates, or fee-for-service; are renouncing or losing authority for utilization review and claims processing; and are quietly abandoning the rhetoric of disintermediating the health insurance plans.¹⁹

No one can predict the future organizational and payment structures for physicians and hospitals, but it appears probable that the structures will lie on some point intermediate between vertical integration and global capitation, on the one hand, and solo practice and fee-for-service, on the other. The key point for current purposes is that most physicians and hospitals no longer aspire to the dual role of agent for society and for the individual patient, for managing costs as well as quality. Physicians want to be on the side of their patients, advocating for more resources and better quality, rather than taking on the social responsibility for comparing costs and benefits in a complex and volatile environment.

POLITICAL RISK AVERSION

Enthusiasm in political circles for disciplining the health care system has waxed and waned over the years, but now is at nadir. Control over health care costs requires 1 or more of 3 equally unattractive initiatives. Elected politicians and their administrative appointees must impose limits on the professional, institutional, and technological capacity of the delivery system, limits on the prices paid to physicians, hospitals, and pharmaceutical manufacturers, or limits on which specific services physicians can offer to which specific patients. Each of these strategies requires saying no to socially influential interests.

The first strategy would require explicit reductions in how many medical specialists are trained, how many inpatient facilities are authorized, and how many clinical devices are diffused into the community. A sustained underfunding of operating expenses could achieve this goal over time, albeit in a very unattractive manner, but no meaningful short-term victories against costs are to be expected, and the political backlash against a deteriorating infrastructure likely would reverse the process.

The second public sector approach to cost control, a direct attack on physician fees, hospital payments, and drug prices, could achieve short-term political support if the targeted groups first were demonized through media exposes, fraud investigations, and liberal use of the presidential bully pulpit. But the economic beneficiaries of cost-control initiatives are quiescent while the opponents are passionate in their own defense. Physicians will argue that quality of care is threatened and that the best and brightest young people are avoiding the profession; hospitals will argue that jobs and community institutions are at stake; drug and device manufacturers will argue that the pace of innovation is slackening.

The third strategy, setting priorities and queuing for particular patients and services, is a relatively common practice in some nations and has been subject to experiments in the United States.^{20,21} But without a doubt, this is the least attractive strategy for politicians and regulators facing voters who want to have their cake and eat it too, who consider as their birthright the unlimited access to services without payment of the requisite taxes.

The risk-averse governmental strategy now is bipartisan and beyond real debate. When budgetary surpluses are available, the public sector expands coverage, benefits, research subsidies, physician payments, and patients' rights. When budgetary deficits loom, the public sector defends itself by cutting payments to physicians; the voting public is reassured that no sacrifices on its part

will be necessary. In neither the fat nor the lean years does the government place itself at the center of a discussion over which services are appropriate for which patients, what constitutes adequate quality at what price, and who should get less so that others can get more.

CONSUMERISM

The health care system is becoming increasingly consumer driven, not by design but by default. Some group must decide who gets what from a limited pool of economic resources. The United States has experimented with professional, governmental, and, most recently, corporate mechanisms for allocating resources and apparently found none to its liking. The proximate cause of the shift to consumerism is the widespread backlash against managed care's instruments of cost control, including integrated delivery systems, capitation, and utilization review. This backlash, however, is merely the tip of an iceberg of hostility toward any entity that would substitute its own priorities for those of the individual citizen. The new culture of health care consumerism is the volatile confluence of 3 central features of US society: a deeply rooted political culture, an extended period of economic prosperity, and the phenomenal growth of Internet technology.

POLITICAL CULTURE

The uproar over managed care will not be mollified by half-hearted compromises over specialty access and dispute resolution. It builds on long-standing traditions of individual autonomy and skepticism with respect to professional, governmental, and corporate dominance in health care. Historical resistance to professional authority, quieted during the middle decades of the last century, reemerged during the 1960s as part of the wider questioning of the role of institutions. Its manifestations include the women's health movement, the surge of complementary medicine, the application of antitrust law to medicine, the doctrine of informed consent,

the explosion of malpractice litigation, and the erosion of the traditional physician-patient relationship.²²⁻²⁵ The contemporary flood of health-related information from the Internet, direct-to-consumer pharmaceutical advertising, and the proliferation of patient support groups is hastening the displacement of the physician as the principal source of decision-making authority in health care.

Employees place a high value on employment-based health insurance and protest every effort by employers to cut coverage or benefits. The inexorable trend in the contemporary economy, however, is toward a more transient and less paternalistic employment relationship. Firms are interested in structuring compensation packages to reward performance and strengthen incentives, as evidenced most graphically in the replacement of traditional pension programs with employer-subsidized but employee-managed individual retirement accounts. The culture of business today is one of focusing on core competencies while exiting from peripheral activities, such as defining benefit packages, physician networks, and appropriate care. For the past decade employers have outsourced health care cost control to the managed care industry, and they felt lucky that these contractual agents stood between them and their angry employees. Now, as the insurers decline the role of buffering employers from employees, firms are looking for a new approach. Some seek to use their leverage to identify the best physicians and practices but are loath to force employees to act in their own best interest. Rather, the trend is toward providing data, decision-support tools, and financial subsidies that permit employees to make better choices for themselves.

Popular attitudes toward governmental control over health care have moved in tandem with attitudes concerning the governmental role more broadly, but the resistance toward public sector dominance has never lain far beneath the surface. Subsidy programs, such as Medicare, enjoy universal popularity but only as long as the administrative agencies re-

frain from visible incursions into and restrictions of individual choices. The politically viable range of cost-control measures available to public programs has been limited to cutbacks in payments to physicians rather than limits on the demand for clinical services. The failure of former President Clinton's Health Security Act, despite polls suggesting wide support for extension of insurance coverage, provides eloquent testimony to the liabilities of any proposal that may be characterized as a governmental takeover of individual decision-making authority.²⁶ Politicians of both parties have learned the lesson well and now restrict themselves to always-popular promises to extend coverage, enrich benefits, and ensure access. None even whispers that public resources are limited, that budget surpluses cannot be spent twice, and that costs cannot be controlled indefinitely by cutting payments to physicians, hospitals, and drug manufacturers.

ECONOMIC PROSPERITY

Economic prosperity provides the personal incomes and governmental budget surpluses to support more and better health care. But good times heighten rather than attenuate the strains between the demand and supply for services due to their effect on expectations and the social definition of health and health care. United States citizens increasingly believe they have a right to unrestricted access to ever more convenient, personalized, and high-quality services. Needless to say, the benefits of the economic expansion have been unevenly distributed and many citizens feel thankful for those health care services they can obtain. The recent economic downturn will have little immediate impact on the wave of legislation, regulation, and litigation that attack every cost-reducing instrument in the managed care toolkit.

Business cycle fluctuations will not reverse the overall trend toward an ever more demanding and impatient patient population. Whereas once health care and health insurance were understood as activities related to acute in-

juries and illnesses, they have expanded to include preventive and mental health services, long-term care, complementary medicine, and, more broadly, the ability to maintain psychological, social, spiritual, and sexual performance far into the golden years. The revolution of rising expectations, coupled with the elastic definition of health, accentuates the sentiment that health care is a matter of satisfying diverse individual preferences rather than providing a one-size-fits-all solution to collective needs. Information, decision support, and subsidies are welcomed; channeling, prior authorizations, and retrospective denials are not.

THE INTERNET REVOLUTION

Internet technology enhances and amplifies the cultural changes unleashed by prosperity, individualism, and rising social expectations. Each of the 4 key Internet health sectors, including content, commerce, connectivity, and care, accelerates the move away from managed care and toward a health care system based on individual choice. The core of the Internet is the rapid, costless, and increasingly universal dissemination of text, graphic, and audio content on a scale heretofore inconceivable. Despite the economic problems facing the content-oriented “e-health” companies, actual use of the Internet continues to grow at an exponential rate, with health and health care being among the most common subjects searched. The most radical feature of the Internet medium, however, is the opportunity it provides for users to interact with information distributors and with each other, thereby opening new channels of peer communication and community. Use of the Internet is particularly intense for individuals newly diagnosed with serious ailments and for those experiencing chronic disease.²⁷ Patients increasingly arrive in their physicians offices armed with printouts, citations, etiological theories, referral requests, and suggested interventions. Most important, the Internet stokes the culture of individual choice, the sentiment that

each person is responsible for managing his or her own health, relying on physicians as a valuable, but by no means unique, source of information and advice.

As insurance benefit packages incorporate more consumer cost sharing while offering partial coverage of a broader range of physicians, the individual patient will take on an ever more important role as direct purchaser of health care services. The rise of consumer as purchaser will be accelerated by any shift among employers toward “defined contribution” programs and of Medicare toward a choice framework modeled on the Federal Employees Health Benefits Program (as advocated by President Bush²⁸). The Internet commerce sector packages information with products in a way usually not available in the offline sector, including rich search and comparison shopping prior to purchase and extended information on use, servicing, and related products after purchase. The connectivity sector spawned by the Internet, including electronic links between employers, insurance plans, pharmacies, hospitals, and, eventually, physician offices, will enable consumers to track the administrative and clinical dimensions of their care in a manner that could not be done previously. Consumers will be able to check administrative matters, such as eligibility, benefits, coinsurance limits; search for and switch among plans and physicians; read up on others’ evaluations of quality; and make their own contribution to quality monitoring by reporting experiences with individual physicians, hospitals, and health plans.

CHALLENGES OF HEALTH CARE CONSUMERISM

The enhanced role for consumers not only offers numerous benefits, but also presents severe potential difficulties to the health care system. An ideal system presumably would allocate decision-making rights and responsibilities among government, employers, insurers, and physicians, as well as consumers, with the latter entrusted with

those decisions for which they are adequately informed and supported. But the headlong retreat of the public and private sectors from the thankless job of controlling costs is delegating to the consumer a very broad array of tasks for which many are not prepared. The rising informational, cultural, financial, and political challenges are by no means limited to consumerism and plague both managed care and highly regulated health systems. Nevertheless, they will contribute new forms of dissatisfaction and ultimately instigate new forms of social backlash.

Four problems will plague a consumer-driven health care system. First, despite the widespread dissemination of information, consumers will face significant obstacles in understanding the quality and even the true price of health insurance and health care services. Variations in utilization, cost, and outcomes challenge the analytic capabilities of governmental, corporate, insurer, and physician organizations and are daunting for even the most sophisticated and Internet-enabled consumer. Second, consumers vary enormously in their financial, cognitive, and cultural preparedness to navigate the complex health care system. The new paradigm fits most comfortably the educated, assertive, and prosperous and least comfortably the impoverished, meek, and poorly educated. Third, the consumer era will complicate the pooling of insurance risk between consistently healthy citizens and those who are chronically ill. Risk-adjusted subsidies by government and employers can foster risk-spreading, but the requisite actuarial methods are only embryonic. Finally, the emerging era will make transparent and render difficult the redistribution of income from rich to poor that otherwise results from the collective purchasing and administration of health insurance. The proliferation of insurance products and physician networks likely will accentuate the contemporary allocation of care based on ability to pay, partially mitigated through tax exemptions and refundable tax credits.

COMMENT

Managed care embodies an effort by employers, insurers, and some physician organizations to establish priorities, balance competing goals, and decide who should get what from the US health care system. After a turbulent decade of trial and error, that experiment can be characterized as a partial economic success and total political failure. The strategy of giving with one hand while taking away with the other, of offering consumers comprehensive benefits while restricting access through utilization review, obfuscates the workings of the system, undermines trust between patients and physicians, and has infuriated everyone involved.

The protagonists of the managed care system now are in full retreat, broadening panels, removing restrictions, reverting to fee-for-service, and generally getting out from between consumers and the services they want to consume. The retreat from managed care promotes access but also removes the brakes on health care cost inflation. The individual consumer and patient is the last candidate for the difficult but necessary role of balancing resources and expectations. Lest the prediction of a consumer-driven future seem unrealistic, it is worth reviewing briefly the roles desired by physicians, insurers, employers, and government in the brave new world after managed care.

The natural role of the physician is as the agent of the patient, offering information, advice, service, and support. Physicians want to advocate for more social resources to be devoted to health care, not for a balancing of their individual patients' needs with the other economic priorities of the nation. Beside cost-benefit analysis does not come easily to the individual physician any more than population-based care based on incomplete clinical and actuarial data comes easily to the physician organization. After the contemporary period of retrenchment has passed, medical groups are likely to reemerge as mechanisms that permit physicians to share administrative services, on-call responsibilities, information technology, and

disease management initiatives. But it is unlikely that they will again shoulder the burden of financial responsibility for populations of restive, assertive, and choice-oriented consumers.

The natural role of the insurer is to pool risks, predict cost trends, and set premiums accordingly. Insurers lack the clinical skills and the ethical authority to distinguish the experimental from the accepted therapy, the appropriate from the inappropriate procedure, the qualified from the unqualified physician, or the patient who is truly ill from the worried well. Health insurers cannot control the major epidemiological, technological, and cultural sources of health care utilization any more than property and casualty insurers can control the major causes of fire, theft, and collision. Health plans will continue to play significant roles as entities that design, price, and market insurance products that consumers are willing to buy. But never again will they succumb to the bait-and-switch gambit used by government and employers, who exhorted them to control health care costs and then vilified them for using the marketplace mechanisms that were at their disposal. After a decade of confusion, insurers finally have identified their true customer, the individual consumer. Though subsidized by governmental programs and employment fringe benefits, the consumer is the ultimate locus of price-sensitive and quality-conscious choice. Insurers want to stop frustrating and start facilitating those choices.

The natural role of the employer is to manufacture automobiles, distribute newspapers, and sell coffee. Their central role in the financing and design of the health care system developed through a combination of historical accidents, tax loopholes, and the paternalism of a passing era of lifetime employment. No one today would design a health insurance system that places industrialists, entrepreneurs, and convenience store owners in charge of adjudicating health benefits on behalf of employees. Most large and many small employers will continue to subsidize health insurance for their employees.

Group insurance offers administrative efficiencies, risk-spreading opportunities, and volume discounts on a scale never to be matched by individual patients shopping alone in the complex health care market. But employers will no longer seek to control the costs of fringe benefits by herding employees into health plans they disdain, to physicians they distrust, or to procedures they dislike. Information and incentives will replace paternalism and control as the primary instruments of corporate health benefits policy.

The natural role for the government in a democracy is to do what the people want rather than what the people could, would, or should want. Casual empiricism and harsh political reality suggest that the people of this nation want the government to finance care for the poor, underwrite research and training, limit fraud and abuse, facilitate standards for quality measurement, ensure technology compatibility, and protect data confidentiality, but otherwise not dictate who gets what and from whom. The American people want to direct their own health care, with clinical advice from their physicians, financial subsidy from employers and public programs, information from the Internet and offline sources, and the support of their families and friends. Public health insurance initiatives will expand to the extent private initiatives contract, but the likelihood of a national, uniform, one-size-fits-all program becomes more remote with each passing year. The centralization of finance and authority would concentrate on Washington, DC, all the tensions between limited resources and unlimited expectations that today are diffused among multiple targets. While predictions in politics are as risky as in economics, the public sector strategy appears similar to its private sector counterpart, supporting and subsidizing rather than controlling and channeling the idiosyncratic choices of individual citizens.

The natural role for the consumer in a market economy is to make informed, price-sensitive choices based on

personal preferences and subject to individual budgetary constraints. This paradigm is poorly matched to the special features of health care. Individual patients often lack the information and willpower to shop effectively across the array of physicians and procedures. Differences in health and wealth require insurance mechanisms that spread actuarial risk across the population and foster cross-subsidies from rich to poor. A purely consumer-driven health care system would be grossly inefficient as well as grotesquely inequitable. Government, employers, insurers, and physicians will continue to influence health care decision making to a much greater extent that they do in most other economic sectors. But the attempt by public and private sector entities to allocate limited resources has proven itself incompatible with US cultural proclivities and institutional structures. The consumer era in health care is emerging due to the rejection of governmental, corporate, and professional dominance rather than due to a judicious evaluation of the alternative.

British Prime Minister Winston Churchill once remarked that Americans could be counted on to do the right thing, after having exhausted the alternatives. If the right thing for health care is defined as an approach without potential problems of equity, efficiency, and clinical quality, then consumer-

ism fails the test. Of course, all other candidates for setting priorities and managing care, including government, employers, insurers, and physicians, also fail the test. But if the right thing is defined as the approach most compatible with the nation's social culture and political institutions, the candidate that remains standing after other contestants are vanquished, then consumerism is not only the likely but indeed the right thing for US health care.

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