

Corporatism in Question: A Note on "Managed Care"

In March of this year, the President of the United States asked thirty-four citizen-experts to draft a "bill of rights" protecting Americans from the corporations insuring their health. He appointed them all to a panel called the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, its task to reform "managed care," to domesticate it, to make it safe and as worthy of the public trust as its defenders contend it already is.

"Consumer protection"—an inauspicious term. And a telling one.

Not so long ago, reference to a patient as a "consumer" would not have been understood. Patients were consumers, of course, and also often producers, and the nature of their role in and relation to the general economy was routinely of interest to their physicians. "What do you do for a living?" was a question always asked in any comprehensive clinical evaluation of an adult, and the specifics of "consumption" and "production" were likewise often of interest. But "consumers" in the Commission's sense were then the *patients* of physicians and nurses and other professional men and women. And all these same professionals themselves *became* patients when they got sick.

Well, so what? A little linguistic evolution? A sign of change, and mostly overdue change at that? Perhaps. But what if the change now turning patients into "consumers" is exactly the change the Commission has been empaneled to reverse or, at the very least, to refine? And what if the Commission does not quite realize that? And what if it also does not realize that a sign of parallel change — the now nearly constant use of the term "provider" to mean either physician or corporation, as displayed even in the President's own charge to the Commission — suggests that the costliest piece of high ground on medicine's moral landscape has, with barely a hearing and hardly a second thought, been rezoned for commercial use?

How Did We Get Here?

We all know the headlines. "Managed-care plan denies lifesaving procedure." "Managed-care doctor withheld vital information, attorney says." "Managed-care ads targeted to low-risk groups." "Managed-care

plan leaves town; seeks 'younger, healthier' elsewhere." "Managed-care appeals process inadequate, study says." "Managed-care incentives tempt doctors, worry patients."

It used to be that American physicians acted for patients and, by extension, for families, as well as for unmet millions of the public. Most of the time, they acted honorably, sensibly, and skillfully. But sometimes they acted poorly, sometimes selfishly, sometimes wastefully, sometimes dishonestly. Physicians were widely and fairly assumed to induce patient demand to increase their own income and status, though they typically argued that prosperity was the simple consequence of conscientious practice, not its object. Only for medical pirates was prosperity a sign of plunder. Indeed, physician-induced demand—the *appropriate* variety—remains a necessary feature of any medical practice. Much of a physician's bedside "art" involves the inducement of demand, as when patients must be convinced to accept—economically, to "demand"—unwanted goods and services urged upon them for their own good: "Sir, I understand your reluctance, but you really *must* allow me to remove your appendix." And so forth.

Physician-induced demand—the *inappropriate* variety—can be a type of fraud. No doubt about it. But it has usually and most importantly been a fraud of degrees, often routinized and easy enough to square with professional self-respect. Many physicians grew rich ordering and then interpreting, as the fanciful acronym might have been written, ETKTM (for "Every Test Known To Man"). Others bypassed far more coronary and carotid arteries than was really necessary in aspirin's heroic age. Others kept treating dying patients more aggressively and far longer than hope could have required or compassion should have allowed. Others appointed their patients for office visits more frequently than needed or discharged them from hospital only in the mornings, after one last billable rounding visit. Many patients applauded such behaviors as indicative of thoroughness, and hospitals welcomed them as beneficial for budgets and building funds. Inappropriate physician-induced demand was *and is* an ineluctable feature of fee-for-service arrangements, which still obtain outside, and persist even

inside, managed-care structures, and it has long thrived in the minor-emergency business. But in the health-care economy generally its range and scope are more restricted now than they were.

If physician-induced demand had never spilled beyond the appropriate (or drifted there during years of federal rainmaking), if it had never eroded the barriers of conduct so long entrusted to collective professional maintenance (or seeped through spots thinned by hospital administrators and pharmaceutical and device promoters), if it had never undermined the international competitiveness of the American industrial economy (or made poorly crafted cars even less salable than they would otherwise have been), then *continuity*, rather than change, might be the story of our day. But history tells another tale.

In 1993, the President proposed to systematize American health care. His intentions were widely admired, but his plan proved awkward, heavy, and unconvincingly responsive to increasingly pointed questions. Among the most wounding were some of the more simplistic. Just when societies the world around were abandoning the ruins of central planning, many asked, why should the most creative of all life-sciences economies move in? Why not trust what former socialists and even former communists had now learned to trust? Why not trust the market? Why not trust capitalism?

Freer for Whom?

It is axiomatic that capitalists must please their customers to survive in a free market. It is likewise axiomatic that in the most efficient markets capitalists and customers all act in their rationally chosen, continually reassessed, and flexibly pursued interests. It is in *these* markets that customers are most likely to be pleased and capitalists are most likely to succeed or fail on the basis of customer-pleasing or customer-alienating performance.

Is the American health-care market now closer to this ideal than it used to be? Or is it, in important respects, further away? Patient satisfaction—citizen satisfaction with health care—has evidently declined in important respects in recent years in state after state. Dissatisfaction, of course, could be overreported, overestimated, overemphasized, or misunderstood. It could be a transitional phenomenon, hard even for free-market capitalism to avoid or quickly to assuage. Economists might argue that patients are actually better off or about to become better off, financially if not in other ways. Physician satisfaction has evidently also declined—precipitously. Health-care administrators and legislators correspondingly might contend that physicians abused their old freedom and are still free enough, as free as other workers and far better paid.

But, as capitalism grinds toward the putative rationalization of yet another inefficient “cottage industry,” there is no mistaking the darkened professional mood.

How could these trends exist, and how could they persist in parallel, if health care’s new market is “freer,” inherently more likely to please, than the one it supplanted?

The answer is easy. This new market *is* freer for corporations, those that *choose* insurance schemes plus those that *are* insurance schemes, but it is consciously *less* free for individuals. Yes, individuals may usually select among chosen plans, but once they have made their selections they are rather seriously stuck, for at least a year (the standard enrollment period), while plan vendors themselves compete as boldly one against another as “the market” will bear (and the government allow). Herein we find unwelcome resemblances to the voluntary-but-irrevocable life-and-death contract between citizens and sovereign and to the no-holds-barred hotter-the-better competition among sovereigns themselves that Thomas Hobbes proposed in *Leviathan*. Even with this Hobbesian shadow uncast, though, the view ahead is dark enough. Dissatisfaction may be both real and structural, as likely to worsen as to improve.

Redefining “Market Discipline”

Back when managed-care corporations were few, mostly still not-for-profit, and widely regarded as progressive health-maintaining community assets, the temptation to maximize profit (or, in not-for-profit terms, excess revenue) was dampened by the certain knowledge that alienated managed-care patients could return at will to the then still-dominant mode, fee-for-service. Now, in “major markets,” many millions of patients insured through employer-sponsored plans would have a far harder time (and costlier course) doing so. Managed-care corporations increasingly compete against *each other*, at least for pre-Medicare and non-Medicaid patients, and their competition has many more facets than most patients ever see.

Managed care has now transfigured professional incentives. Physicians employed by managed-care corporations now have no reason to induce demand inappropriately, since they might be disciplined or dismissed for doing so. Physicians contracting with managed-care corporations—many of such contractors in specialized practices—have less reason to induce demand inappropriately than they do, say, when caring for their fee-for-service Medicare Part B outpatients, since they might be dropped from corporate consulting lists. And many physicians themselves are now to varying degrees incorporated risk-holders or corporate risk-partners, and they might decrease their own net incomes by inducing demand inappropriately.



Drawing by Ed Gamble
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Unfortunately, physicians "incented" in such ways may also be less likely to induce demand *appropriately*, less likely to inform about expensive options and to urge that expensive recommendations be followed, since, again, they might lose their jobs in whole or in part or lose financially (in the short run, anyway). Managed-care physicians are now typically incented to deflect or *refuse* (rather than to induce) certain patient demands that they themselves may judge to be sensible. Most infamously, managed-care physicians may be required contractually to refrain from "any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in... the quality of... coverage." That is, they may agree to be "gagged" by their corporations. Some physicians may even come to accept the legitimacy of corporate interests in this regard.

And why would they not? Their own government did. In 1982, the Federal Trade Commission ordered the American Medical Association, likeliest meddler in whatever budget-relieving magic the market might then have been about to conjure, to mind its own business in the matter of Faustian bargains. When the AMA challenged the FTC, the United States Supreme Court upheld the order. As noted by way of disclaimer in "Ethical Issues in Managed Care," the rather anodyne 1995 report of its Council on Ethical and Judicial Affairs, the AMA is prohibited from "regulating... [or] advising on the ethical propriety of... the consideration offered or provided to any physician in any contract with any entity that offers physicians' services

to the public." Thomas Hobbes, given the means, might have sought a similar no-interference injunction against the Pope.

Can We Speak?

Much has been made of the plight of patients whose physicians are badgered by corporations straining to meet fiduciary obligations to shareholders—obligations to maximize profits, dividends, and share values. Less has been made of other risks: the moral *incorporation* of physicians and the social acceptance of corporations *themselves* not just as the "artificial persons" of realist political ethics and common law but also as the "artificial professionals" of radical socialism and, in George Orwell's 1984, black satire.

The moral incorporation of physicians is easily enough explained, though not readily forgiven. The social acceptance of corporations as "artificial professionals" is *not* easily explained, not in American culture, at any rate. How has it been accomplished?

One answer might be obfuscation, its linguistic manifestation "Carespeak." "Choice" can now mean "constraint," as when patients find they must choose "care managers," whom they hope never to meet, but may no longer choose physicians, on whom their lives may depend. "Managed," as in "managed care," can now mean "undelivered," as when a "care manager" holds a patient's money but declines to spend it in a patient's interest. "Prepaid" can no longer simply mean "paid in advance in full or in excess," as when premium-weary patients find they must "copay" for occasional medical

visits so they can "share the pain" felt by the financial institution enjoying zero-interest use of their payroll deductions, lest they "abuse the system" in future by exhibiting "infinite demand" for "free" goods and services. "More efficient" can now mean "more expensive," as when a hospital bills Medicare far more for a procedure performed more cheaply on an outpatient basis than it could have been performed on an inpatient basis, not to win more federal money, which it cannot receive, but, rather, to inflate the dollar value of the Medicare beneficiary's twenty-percent copayment obligation, inflating in turn the value of "uncompensated care" provided to the community. "Competition" can now mean "restraint of trade," as when patients and physicians *separately* are tied to a profit-seeking and cash-holding managerial corporation encouraged by regulators to become, for the time being, as much like a monopoly as fortunes will allow. "Symmetric perfect information," or the good-faith approximation of same, whose absence is among the five classic causes of market failure, can now accommodate "gagging." "Health maintenance," as in "health-maintenance organization" or "HMO," can now legally mean practically nothing, while *chief-executive-officer* maintenance in HMOs is more generous than in any other American industry. The professional and financial restriction, petty administrative interference, arbitrary bureaucratic rule-making, and confidentiality-compromise American physicians and their patients long feared from a "socialized" fee-for-service system are being *delivered* by a "private" corporate system, which promises for physicians and patients alike less and less of what used to be called "privacy." All of which, supposedly, is double-plus good.

Among the many subglossaries of "Carespeak" is one that may be proving instrumental to the social acceptance of corporations as artificial professionals, one useful in a process we might call "perceptual transitivity." This subglossary is not truly neologistic in "Carespeak," however. It has been borrowed from an older language: "Crimespeak."

When asked by a journalist to describe what her husband, then the reputed head of New York's Gambino family, did for a living, Mrs. John Gotti explained, "He provides." Here was an answer elegant and evocative, one that Émile Durkheim, father of functionalism, and Talcott Parsons, structural-functional founder of American medical sociology, would have understood. Yes, Mr. Gotti "provided" for his wife. But he was also a "crime provider" generally. Indeed, Mr. Gotti and the Mafia—professional and professional corporation—were *both* "crime providers." To contact one was to contact the other. Mr. Gotti was a functional part of a highly evolved social organism.

No physician ever swore a "provider's" oath. But a physician is, proudly, a provider of health care. In

"Carespeak," a physician's assistant and a nurse-practitioner and a clinical nurse-specialist are also "providers," though sometimes only "mid-level providers." A registered nurse, oddly, is *not* a "provider." A nurse-anesthetist and a physical therapist may or may not be. The corporate incentive to categorize high-priced professionals and their lower-priced paraprofessional substitutes together is self-evident; labor history brims with attempts to homogenize by function rather than certified skill set. The more interesting piece of "perceptual transitivity," though, homogenizes the professional and the professional-*employing* corporation.

In the "Crimespeak" example, recall that homogenization involved a professional and a corporation of professionals—a group practice, as it were. In "Carespeak," the corporation *becomes* the professional. Some of this transition has been accomplished directly—"Let our doctors care for you" becoming "We [plural] want to be your health-care provider [singular]." Some of it has been accomplished indirectly, by other agents, largely through gratuitous adoption of increasingly common usage—"Ask your doctor about NoSNEEZE" becoming "Ask your doctor or health-care provider about NoSNEEZE" and then the now-ubiquitous "Ask your health-care provider [no doctor] about NoSNEEZE." For more and more Americans, the implication is not altogether satisfactory: "Ask your managed-care corporation."

How New is "New" Now?

"New" risks often have old roots, and they certainly do in this case. The moral-incorporation and artificial-professionalism problems currently being presented to us by managed care are tenaciously perennial. Indeed, political-ethical thought in the life sciences has long centered on them exactly, has long centered on the multifarious problem of *corporatism*.

The political-ethical tradition of the life sciences is long, its sophistication at times surprising. Contributors have included the obscure, the illustrious, the underestimated, the misremembered. Yet the protagonist in this tradition—a political-ethical tradition in, of, and for the life sciences—is a set of ideas. Its product, its prescriptive core, I have systematized elsewhere as "life-sciences liberalism," a political ethic for which men and women of biology and medicine seem, usually, to show high natural affinity (while of its ontogeny they may be able to recapitulate nearly nothing). This newly assembled "ism" says much about the physician's necessarily troublesome obligation to individuals, including the medically and morally *unhomogenized* mix of individuals making up societies, states, and corporations—and health-insurance risk pools.

Life-sciences liberalism requires that any enterprise

be judged only by the good it intends and that it serve humankind by serving individuals, all of whom are held to be freeborn, rational, rights-bearing as human beings, rights-bearing across borders, rights-bearing in defeat and even in death, coequal with any physician, entitled to opinions, entitled to enter into therapeutic compacts and to withdraw from them at personal discretion, entitled to hear the truth about their own conditions and to decide autonomously about treatment, about participation in clinical trials, and, generally, about the future. Few health-care organizations, however selflessly founded, could pass muster without demerit on grounds such as these. All organizations after a while become jealous of their territory, concerned for their prospects, and intent on stability and solvency, even after their original missions may have been accomplished. Not-for-profit corporations pursuing excess revenue may do no better morally than for-profit corporations pursuing investment capital, and profiteers may behave less hypocritically. The service-to-individuals requirement is particularly difficult for big organizations to satisfy, and public-health organizations may constantly fall short as if by intent, the "public" somehow becoming more deserving than the individuals composing it.

Life-sciences liberalism further requires that all agreements be seen as made among individuals and that all acts be seen as committed by individuals, regardless of the structures into which individuals are incorporated. Physician practices may complement the interests of a corporation but must never be made subservient to such interests; professional ethical responsibilities exist beyond corporate obligation and may require the subordination of corporate interests. Thus, the dealings of physician and patient must transcend the structure in which they take place. "Gagging" and many subtler sins are by this standard inexcusable, and they are more reprehensible for the complicit physicians, whose commitments are professional, than for the imposing corporations, whose commitments are not professional.

Prospects

What, then, can we expect from the Advisory Commission on Consumer Protection and Quality in the Health Care Industry? We will presumably get something called a "bill of rights" and some suggestions for statutory reform. We could also get a draft law modulating certain behaviors of health insurers, probably by adapting rules already in force in one or more states. This output will then be praised and criticized predictably. Measures incorporating its recommendations and countermeasures with less—or even more—drastic provisions will be introduced in Congress. Composites will be negotiated. Interested

groups—including the corporations to be regulated—will make their wishes known, privately if not publicly but nonetheless effectively. One or more bills may or may not result. Even if a bill with Commission marks somewhere upon it is passed and signed and implemented, the corporations to be regulated will likely already have moved beyond the behaviors targeted. They will have arranged a way, found a way, or made a way to keep their cash flowing and their investments profitable. "Consumers" will have new protections, but almost assuredly not the protection of once again truly being *patients*.

—Robert Hunt Sprinkle

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