TAKING ISSUE

Profit and Quality in Managed Care

As a recovering academic who became employed in managed care, I take issue with Dr. Fuller Torrey's claim in this column in April 1998 that profit and quality managed care are incompatible. His thesis is supported by selected examples of corporate excess that fail to portray more complex economic and sociopolitical realities.

Indemnity insurance was created in the 1950s by for-profit corporations to attract employees during a government-imposed wage freeze. It ultimately failed because two people– the doctor and patient– spent somebody else's money with no oversight to assure quality or fiscal accountability. Those who profited were physicians whose inflated incomes supported expensive lifestyles but whose practices revealed inexplicable geographic variances in admission rates, lengths of stay, and surgical and other invasive procedures.

The community mental health center movement failed miserably to meet the needs of deinstitutionalized and disenfranchised people with serious mental illness. Professionals courted the worried well, while governments pocketed profits derived from closing hospitals but not diverting money to community programs.

Managed care was ushered in by out-of-control fee-for-service inflation. Managed care stole its basic principles from public health and did it better– delivering continuous, coordinated, and cost-effective care at the least restrictive level. Assuring quality is a second-generation concern that is now being incrementally addressed by legislation, litigation, and accreditation. How very American! The National Committee for Quality Assurance now seeks to impose dozens of objective standards on a previously unmanaged health care system. This endeavor will be paid for by increased corporate and government costs, decreased shareholder profits, or industry consolidation and efficiency.

After Clinton's proposed health care reform failed in Congress, the public, via the ballot box, showed it preferred the profit motive to government control. This preference has created a backlash and vigorous debate over what taxpayers can afford and what individuals are willing to do without in health care. Only Oregon has come close to addressing this conundrum. Elsewhere, professional guilds and public crybabies lament their loss of control while politicians capitalize on anecdote-driven angst to promote their own oxymoron– that capitation is compatible with unrestricted access and unlimited choice.

As an immigrant, I embrace the reality that America is both an entreprenurial and a democratic society that vacillates toward an ideal that attempts to combine the profit motive with a high standard of living. I believe profit and quality are as compatible in health care as in any other product.– BARRY BLACKWELL, M.D., *clinical professor of psychiatry, University of Wisconsin School of Medicine*

Psychiatric Services (formerly *Hospital and Community Psychiatry* [*H&CP*]) was established in 1950 by Daniel Blain, M.D. It is published monthly by the American Psychiatric Association for mental health professionals and others concerned with treatment and services for persons with mental illnesses and mental disabilities, in keeping with APA's objectives to improve care and treatment, to promote research and professional education in psychiatric and related fields, and to advance the standards of all psychiatric services and facilities.