Managed care is increasingly subject to political micromanagement and to attacks in the press. Managed care is undergoing the kind of bureaucrat bashing familiar to government employees, because managed care plans are being asked to perform the same type of allocation of social resources (in this case, access to health care) typically conducted by government employees. In so-doing, managed care has run afoul of two deeply ingrained American traditions: bureaucrat bashing and overhead democracy. This article uses a case study of managed care bashing to argue that private interests who perform a role in allocating social resources will be subject to the same type of criticism government employees face in allocating social resources (bureaucrat bashing), as well as political leaders' impulses toward control (overhead democracy). The ombudsman model of governing managed care is advanced as an alternative to managed care bashing and overhead democracy.

NOT JUST FOR BUREAUCRATS ANYMORE
Bureaucrat Bashing, Overhead Democracy, and Managed Care

RENE McELDOWNEY
Auburn University
WILLIAM L. MURRAY
Virginia Tech

Why has managed care, once viewed as the private sector solution to the health insurance crisis, become the object of political micromanagement and press attacks? This article argues that managed care is undergoing the kind of bureaucrat bashing familiar to government employees, because managed care plans are being asked to perform the same type of allocation of social resources (in this case, access to health care) typically conducted by government employees. In so doing, managed care has run afoul of two deeply ingrained American traditions: bureaucrat bashing and overhead democracy. This article uses a case study of managed care bashing to argue that private interests who perform a role in allocating social

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resources will be subject to the same type of criticism government employees face in allocating social resources (bureaucrat bashing), as well as political leaders' impulses toward control (overhead democracy).

This article is a case study, as defined by Yin (1989), of public criticism and attempts at political control of managed care, popularly termed managed care bashing, and its implications for public policy and public administration. The evidence for the article includes secondary literature, primarily survey research by Blendon et al. (1998), and content analysis by Brodie, Brady, and Altman (1998). The purpose of the article is not to document managed care bashing, which is already documented in the health policy literature. Rather, the article draws a theoretical connection to bureaucrat bashing and overhead democracy, both time-worn public administration concepts. The article examines lessons managed care bashing has for the making of public policy and a more effective option, the ombudsman model, for governing managed care.

The article is divided into four primary sections. The first section provides brief background on the rise of managed care after the failure of President Clinton's health insurance plan. The second section discusses the backlash against managed care in the context of bureaucrat bashing. The third section discusses the backlash against managed care in the context of overhead democracy. The final section sketches out a new potential model for government in dealing with managed care that potentially avoids both managed care bashing and overhead democracy.

THE RISE OF MANAGED CARE AND THE RESULTING BACKLASH

National health insurance proposals have traditionally been defeated by labeling them "socialized medicine" (Kingdon, 1995; McEldowney, 1994). However, with the end of the cold war, the charge of socialism had lost much of its rhetorical power. Therefore, the Clinton health care plan, which failed in 1994, was attacked through bureaucrat bashing. Goodsell (1990) characterizes bureaucrat bashing as gratuitous criticism of government or bureaucrats. A popular slogan in 1994 held that the Clinton health care plan was assailed as creating a government entity that would "have all the efficiency of the postal service and all of the compassion of the I.R.S."

With the defeat of the Clinton health care plan, the focus on controlling health care cost shifted to the private sector and the increasing move toward managed care. Ironically, during the past 2 years managed care

plans have faced a public backlash (Blendon et al., 1998; Brodie et al., 1998; Hilzenrath, 1997; Iglehart, 1998). Indeed, press and political criticism of insurance company bureaucrats is reminiscent of the attacks on the Clinton health care plan.

Managed care can be generally defined as an approach to health insurance that seeks to comprehensively provide care for a patient while controlling costs through promoting good health among health plan members, denying care that is not medically necessary or appropriate, and having care provided, when possible, by primary care providers, not more expensive specialists. In contrast, traditional indemnity insurance did not attempt to manage care or promote member wellness; rather, it paid a fixed percentage (typically 80% after the annual deductible was met) for care provided when a member became ill. Rather than paying physicians only when patients are sick to perform a particular procedure or treatment (fee-for-service reimbursement), managed care plans typically pay primary care providers through capitation, where providers receive a fixed amount per member, per month, and do not receive additional payments for seeing patients when they are sick. Providers therefore have a financial incentive to keep patients well rather than to deny them care. To further promote the health of members, managed care plans typically pay for a variety of preventative services such as well baby visits, breast cancer screenings, and periodic physical examinations.

To varying degrees, managed care health plans also direct patients toward a limited number of providers. Staff model health maintenance organizations provide care using employees of the health plan. More typically, managed care health plans require patients to see providers with whom the health plan has a contractual arrangement (network or participating providers). These contractual arrangements typically include discounted rates for treating the health plan's members, protocols for approving certain expensive care (such as hospitalization, certain diagnostic tests, or experimental treatments) in advance, and limitations on the type of services covered by the health plan. Patients that do not see a participating provider may have to pay a higher copayment or deductible. In some cases (a closed panel health plan), no payment is made for services provided by an out-of-network provider.

The move toward managed care has been driven by employer-sponsored health insurance plans. The percentage of Americans in employer-sponsored health insurance plans who are in some type of managed care plan has increased from 29% in 1988 to 82% in 1998 (KPMG Surveys of Employer Sponsored Health Benefits, 1988, 1998).

The impetus for the move toward managed care was the business community's desire to control the spiraling cost of health insurance premiums. For a time at least, managed care appeared successful in reducing premium increases. Health insurance premium increases for employer-sponsored health plans decreased from 11.5% in 1991 to 2.1% in 1997 (KPMG Surveys of Employer Sponsored Health Benefits, 1991-1997). However, it appears that health insurance premiums increased at a faster rate in 1998. Notwithstanding managed care's apparent role in controlling (at least for a time) health insurance premium increases, the managed care industry has been under attack during the past 2 years by the press and political leaders.

MANAGED CARE BASHING: BUREAUCRAT BASHING FINDS A NEW TARGET

In a recent article, the president of the American Association of Health Plans bemoans what she deems to be unfair and anecdotally based criticism of managed care in the media (Ignani, 1998). The popular press has also highlighted managed care bashing (Church, 1997; Hilzenrath, 1997). Brodie et al. (1998) found that there is an anti–managed care bias in the most visible media sources (such as television). In addition, Brodie et al. (1998) found that managed care coverage by the press has become more negative over time:

> In 1990 positive managed care stories (27 percent) appeared twice as often as critical stories (12 percent). . . . While the majority of coverage remained neutral over the study period, beginning in 1993 the coverage with any tone was more critical of managed care and consistently outpaced the positive coverage over the rest of the period. By 1997, 28 percent of all stories were critical of managed care, while only 4 percent were positive. (p. 19)

A typical example of anti–managed care journalism was found in *Time* magazine's 1997 cover story, "The Backlash Against HMOs" (press accounts often use Health Maintenance Organizations [HMOs], a particular type of managed care, as synonymous with managed care in general). The article began with rolling prose indicting managed care in general:

> By now, nearly anybody who has come into contact with the system can recite a litany of horror stories: nit-picking "utilization review" of doctor's

> bills by insurance company bureaucrats; patients hustled out of the hospital within hours, even after surgery as traumatic as breast removal; gag orders forbidding doctors to tell a patient about an expensive treatment. A recent addition: a patient rushes to the emergency room with what feels like a heart attack but turns out to be only gas pains—and gets zapped by a huge bill because his HMO will reimburse only for a "real emergency." (Church, 1997)

Similarly, the *Washington Post* writers group distributed a cartoon strip, "Stitches," which includes a character named Hugh Lyon Sack. This name is what literary critics refer to as a canting name, because when pronounced it makes the character's last name appear to be "Lying Sack." And no account of managed care bashing would be complete without noting actress Helen Hunt's profane denunciation of HMOs in the movie *As Good as It Gets*. Reviews of this movie invariably noted that the audience would offer raucous applause during this scene.

In the editorial in the *Health Affairs* special issue on the media and managed care, Iglehart (1998) calls on the press to fulfill a higher civic calling and opines that "journalists have an obligation to inform their readers, not just provoke them, to reach beyond the individual anecdote to report the entire story of managed care" (pp. 7-8). In this statement, Iglehart (1998) echoes Goodsell's (1990) call for an end to bureaucrat bashing and a more fact-based, less anecdote-driven style of public discourse. Likewise, Ignani (1998) echoes Goodsell's *Case for Bureaucracy* and its call for an empirical rebuttal of bureaucrat bashing in stating that

> time after time, the media as a whole have been susceptible to critics' charges that health plans are able to contain costs only by denying referrals, limiting access to high cost treatments, or by otherwise stinting on care. The result is to give credence to claims that eventually are proved unwarranted by the preponderance of the evidence but in the meantime do no end of damage to public confidence. Examples abound: "drive-through" deliveries; outpatient mastectomies; "gag rules" for physicians. (p. 28)

Just as Goodsell's (1990) public administration polemic had limited success in curbing the tendency to bureaucrat bash, so is it unlikely that Iglehart (1998) or Ignani's (1998) appeals will be successful. Just as Goodsell (1990) offered empirical evidence to show that much of the criticism of government and government bureaucrats is unwarranted, so Ignani (1998) offers empirical evidence that much of the criticism managed care plans have endured is unwarranted. One of the most striking

examples is the U.S. General Accounting Office's (GAO) 1997 report *Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, but Physician Concerns Remain.*

In preparing the GAO report on gag clauses, GAO staff examined 1,150 contracts from 592 HMO contracts. None contained explicit gag clauses. Moreover, 60% of the contracts examined by GAO staff contained explicit statements, dubbed "anti-gag clause" provisions by GAO staff, asserting "that the contract or a specific business clause does not seek to limit communication between physicians and patients concerning all treatment options" (GAO, 1997, p. 9). Other managed care horror stories, such as denials of needed care, appear to be relatively rare when examined empirically. As Blendon et al. (1998) find, whereas some consumers have experienced significant problems with managed care, "the public backlash is also being driven by rare events that seem threatening and dramatic but have been experienced by few consumers" (p. 90). The history of bureaucrat bashing suggests that managed care will be the target of sharp media criticism whether such criticism is empirically justified.

There is a strong tradition in American civic culture to attack what former Virginia Lieutenant Governor Henry Howell referred to as "the big boys." This runs from the Antifederalists to Andrew Jackson to the Progressive era. However, the criticism of managed care extends beyond the type of criticism directed at any large institution. The criticism emphasizes the social allocation function played by managed care organizations in rationing health care, a role that would be played by government in most other countries.

Blendon et al. (1998) express surprise at their contradictory finding that most Americans are satisfied with their health plan yet most support increased regulation by government of managed care. The way to answering this contradiction is framed in the prologue to Daniels and Sabin's 1998 article "The Ethics of Accountability in Managed Care Reform," which observes that

> no country in the world can afford all of the medical care that providers can render to consumers. Thus, in every nation governments and private-sector organizations design mechanisms that ration resources . . . For the most part, governments establish these mechanisms . . . but in the United States, the purchasers of medical care have increasingly favored the allocation of resources through market-like mechanisms rather than government regulations. Consumers and providers have found many of these strictures

objectionable and have argued that private sector health plans must be called to greater accountability for their allocation decisions. (p. 50)

It is this demand for accountability that puzzles the health policy community. Moran (1997) terms federal regulation of managed care "An Impulse in Search of a Theory" in his lead article in *Health Affairs*. The answer for this public demand for accountability is the hoary theory of overhead democracy. As Daniels and Sabin (1998) observe, managed care plans play the same role that government does in most countries of allocating health care. Therefore, managed care health plans are subject not only to bureaucrat bashing but also to the impulse of political leaders to exert control. This impulse flows from the theory and practice of overhead democracy.

MICROMANAGING MANAGED CARE AND THE LIMITS OF OVERHEAD DEMOCRACY

In addition to the increasing trend toward press criticism of managed care, political leaders have become increasingly active in enacting legislation to address the perceived shortcomings or abuses of managed care. Congress has been grappling with legislation for the past two sessions, establishing a Managed Care Consumer's Bill of Rights. Though Congress has been deliberating the matter, 39 state legislatures have enacted either patient protection acts or consumer bills of rights for managed care consumers (Cauchi, 1999, p. 15). The remaining 11 states are all considering such legislation (Cauchi, 1999). Specific components of this state legislation include the following:

- provisions mandating coverage of certain procedures (e.g., breast cancer screening);
- requiring health plans to pay for at least 2 days in the hospital for mothers after the normal vaginal delivery of an infant;
- mandating more direct access to certain specialists without requiring patients to first see a primary care physician (particularly obstetrician/gynecologists);
- adopting a prudent layperson standard for emergency room visits that holds that health plans may not deny payment for emergency room visits when a patient had a good faith, reasonable belief that emergency care was

required (even if subsequent examination reveals emergency care was not medically necessary);
- banning so-called "gag clauses" in managed care contracts that anecdotally are reported to prohibit providers from discussing certain expensive treatment options with patients; and
- requiring an independent external review of denials of care above a certain dollar threshold.

The increasing move to regulate and otherwise control through legislative action perceived excesses of managed care plans is a manifestation of overhead democracy. Overhead democracy is a belief that government bureaucrats are subordinate actors in a hierarchy beginning with the legislature and the chief executive, descending though various levels of the chief executive's political appointees, and ending in the lowly bureaucrat who is viewed as a mere instrument of the will of his or her political superiors. Redford (1969) explained the concept of overhead democracy as the traditional view of public administration and political science. According to Redford,

> Traditional literature on administration and politics gave us a model of how the administrative state ought to operate—a model that acquired orthodoxy in both administrative and democratic theory. It was a simple model of overhead democracy. It asserted that democratic control should run through a single line from the representatives of the people to all those who exercised power in the name of the government. The line ran from the people to their representatives in the Presidency and Congress, and from there to the President as chief executive, then to lesser units, and so on to the fingertips of administration. (p. 71)

Redford views overhead democracy as an important part of the American regime, but he criticizes the concept as overly simplistic, suggesting that the influences on bureaucratic action are more web-like than linear (pp. 72-80).

Notwithstanding Redford's (1969) attempt to sketch a more sophisticated model, overhead democracy's power as a normative theory remained potent enough so that two decades later Lane and Wolf (1990) could state that

> [overhead democracy] is a powerful normative theory which satisfies the need for establishing political control over the bureaucratic administrative establishment. The fact that the theory takes an overly simplistic view does not diminish its significance as a powerful influence on public organizational cultures. (p. 100)

The theory of overhead democracy is not without its critics. Rohr (1986) implicitly rejects the contention that the administrative (and regulatory) state can be legitimated only by tight political control exercised from the top by chief executives and their partisan appointees. Rohr finds considerable support for the administrative state in the Constitution, particularly in Publius's argument for the adoption of the Constitution. Rohr continues his argument for the constitutional legitimacy of public administration in Wamsley et al. (1990), arguing that important aspects of the administrative state fulfill the political vision of the Constitution's framers as originally manifested in the U.S. Senate. In particular, Rohr argues that

> the image of a balance wheel best captures the distinctive contribution of the Public Administration. The Senate originally intended by the framers (as opposed to the Senate of history) is the constitutional model for public administration because the Senate, like the Public Administration, was intended to exercise all three powers of government. Unlike the Senate of the framers intent, however, the Public Administration exercises all three powers in a subordinate capacity and must make its peculiar contribution in conformity with that subordination. It does this by choosing which of its constitutional masters it will favor at a given time on a given issue in the continual struggle between the three branches as they act out the script of *Federalist 51*. (Rohr, 1990, p. 81)

Rohr's argument assumes, as does *Federalist 51*, that no one branch of government will control the practice of administration to the exclusion of the legitimate role of the other branches. This assumption has been resisted by American presidents and governors for most of this century, as chief executives have sought to establish themselves as the sole masters of administration. Like Rohr, Wamsley (1990) argues that the role of the administrator in the American polity should not be limited to loyalty to the chief executive. Wamsley views the public administrator as an agent for mediating the public interest in the service of democracy (the agency perspective).

Although Wamsley et al. (1990), Rohr (1986), and Wamsley (1990) offer partial critiques of overhead democracy, it continues to exert a powerful influence on the theory and practice of public administration. The appeal of executive supremacy has been demonstrated by the support public administration scholars have offered to efforts to provide chief executives more control over administration. Efforts to provide chief executives more control include the creation of the institutional chief executive,

regular calls for government reorganization, civil service reform to make career administrators more responsive, and a proliferation of political appointees to control career administrators (Murray, 1996). Despite significant reductions in the number of career staff, administrative agencies now have more layers of political appointees to constrain their autonomy, not fewer (Light, 1995).

As bureaucrat bashing has become part of our language to the point that the term *bureaucrat* is used as a mild epithet, the impulse toward control of bureaucrats by political leaders has only strengthened. Similarly, bashing of managed care in the media only accelerates the desire of the public to have political leaders do something about the perceived abuses of managed care.

The problem for health policy and public administration is that it is even harder for political leaders to control private interests (such as managed care health plans) than it is to control government bureaucrats. Much of the 20th century public administration has been occupied by the project of increasing political leaders' control over government bureaucrats. Public administration literature is replete with examples of political leaders expressing frustration at the limits of their ability to control the administrative discretion of career government bureaucrats (Aberbach & Rockman, 1990, p. 40; Butler, Senara, & Weinrod, 1984, pp. 449-452, 461-480; Colvard, 1995, p. 34; Durant, 1990, p. 321; Heclo, 1977, 1984; Ingraham, 1987, pp. 425-426; Lorentzen, 1985, pp. 411-412; Pak, 1984).

In attempting to govern private interests, political leaders lack many of the tools that they can wield (rightly or wrongly) in their efforts to control career government bureaucrats. These include the budget process, oversight hearings, personnel rules, political appointments, the confirmation process, and informal pressure. Most of these options are either inapplicable (the confirmation and appointment powers) or less effective (the budget, oversight, and informal hearings processes), with respect to private interests. In fact, private interests such as managed care health plans are potentially important sources of campaign contributions for political leaders. Private interests can also mount mass media campaigns to ward off political control, such as the Health Insurance Association of America's "Harry and Louise" campaign that helped derail the Clinton health care plan.

Despite these advantages private interests have with respect to attempted micromanagement by political leaders, this impulse toward overhead democracy has resulted in a series of regulatory reforms aimed

at managed care plans. However, many of these reforms have been limited in their effectiveness. For example, in 1996 Congress passed with much fanfare the Kennedy-Kassebaum Health Insurance Portability and Accountability Act (HIPAA). The main objectives of this legislation were to make health insurance more portable for employees switching employers and to limit denials of care for preexisting conditions. However, in 1998 GAO released a report finding that the HIPAA legislation had been largely ineffective in achieving its goals. Part of the difficulty was in tailoring a blunt instrument, legislation, to the multifarious situations regarding health insurance coverage in which individuals find themselves.

At the state level, 20 states have now adopted legislation mandating an independent, external appeal of denials of coverage by health plans (typically these appeals are limited to treatment above a certain dollar threshold and are applicable only after internal appeals have been exhausted and the health plan has issued what is termed a final adverse decision). Whereas external appeals mechanisms are usually the centerpiece of patient bills of rights, they are very limited in their applicability. For example, Florida's current system for external appeals has been in place since 1993, when responsibility for the program was transferred from the Florida Department of Insurance to the Agency for Health Care Administration. During the 5-year period from 1993 to 1997, 270 cases were initiated in Florida that had been resolved by the end of 1997. Of these cases, 118 were deemed ineligible, 100 were settled by mutual agreement of the parties involved, and 52 were heard by an external appeals mechanism. Of these cases, 65% were resolved in favor of the consumer. Similarly, New Jersey's external appeals system received only 82 appeals during its first 16 months (out of 3.5 million managed care enrollees in the state).

Irrespective of its normative appeal (or lack thereof for some), overhead democracy is difficult to operationalize with regard to government actors. It is all the more difficult to operationalize with respect to private interests. So, given the public demand for political leaders to somehow govern managed care, what is to be done?

In *Responsive Regulation*, Ayres and Braithwaite (1992) propose that effective regulation is regulation that fits the character of a particular industry. With this proposition in mind, the next section of this article suggests an ombudsman model for government managed care. This approach potentially avoids both the overheated rhetoric of bureaucrat bashing and the often ineffective blunt legislative instruments employed by political leaders trying to micromanage managed care.

AN OMBUDSMAN MODEL FOR GOVERNING MANAGED CARE

Merriam Webster's Collegiate Dictionary defines an ombudsman as "one that investigates reported complaints (as from consumers), reports findings, and helps achieve equitable settlements." Though this approach has long been established in certain industries (e.g., newspapers and hospitals), it is a relatively new concept with regard to governance of managed care. In the public sector, the best established ombudsman program is the Long-Term Care ombudsman program established by the Older Americans Act.

The long-term care ombudsman program began with five demonstration projects in 1972 and was expanded nationally through amendments to the Older Americans Act in 1975 and 1978. The 1981 amendments to the Older Americans Act extended the program to include board and care facilities, in addition to nursing homes. The long-term care ombudsman program is a nonregulatory approach where an ombudsman acts as an honest broker between the consumer and the provider. The program is nonregulatory and does not rise even to the level of binding arbitration. Neither the provider nor the consumer is required to use an ombudsman program's services, which are aimed at resolving disputes amicably (Diz, 1995).

The Patients Bill of Rights, introduced by Senator Daschle and Congressman Dingell (H.R. 3605/S. 1890) during the 105th Congress, would have provided an estimated $60 million to fund grants from the U.S. Department of Health and Human Services to states to establish a health insurance ombudsman (Congressional Budget Office, 1998). According to the Congressional Budget Office, "the ombudsman would be directed to assist consumers in choosing health insurance coverage and to help dissatisfied enrollees with appeals and grievances." The legislation directed the Secretary of Health and Human Services to provide an ombudsman program for citizens of any state that chose not to implement an ombudsman program. Although this proposal was not enacted by Congress, several states and at least one locality have examined or even implemented an ombudsman approach for health insurance.

Florida appears to be the first state to explore the concept of an ombudsman for health insurance disputes related to managed care. In 1996, the Florida Agency for Health Care Administration was directed by the state legislature to establish District Managed Care Ombudsman

Committees statewide. This program has been slow to be implemented, partially due to difficulties in appointing and defining the role of the district committees.

In 1997, Arlington County, Virginia received a grant from the Arlington Health Foundation to establish a managed care ombudsman program. The Arlington project began in March 1998. The 1999 session of the Virginia legislature approved legislation setting up a statewide ombudsman program for health insurance, partially based on the Arlington project. This legislation establishes the Office of the Managed Care Consumer Ombudsman within the Bureau of Insurance. The office is charged with

> promoting and protecting the interests of covered persons under health insurance plans in Virginia. The duties of the Managed Care Ombudsman include assisting persons in understanding their rights and processes available to them under their managed care plan, developing information on the types of managed health insurance plans available in Virginia, and monitoring and providing information to the General Assembly on managed care issues. (Virginia Code Commission, 1999, chap. 643, Senate Bill 1235)

At least two New England states have established similar ombudsman programs. Vermont's legislature created an ombudsman program in 1998. The same year, Massachusetts also implemented a managed care ombudsman program. However, rather than through legislative action, this program was initiated through an executive order by Governor Cellucci. The Massachusetts program is focused on helping consumers pursue their health plan's existing internal grievance procedures.

Other states have explored establishment of an ombudsman program but not yet established one. In 1998, the Illinois House passed legislation that would have created an ombudsman program for health insurance in the Department of Insurance, but this legislation was defeated in the Senate (Illinois Manufacturer's Association, 1998). Also in 1998, the New Mexico legislature passed legislation establishing a managed care ombudsman; this provision was vetoed by the governor (National Conference of State Legislatures, 1998). During the 1999 session of its legislature, Oklahoma and Nevada explored establishing a managed care ombudsman (State of Oklahoma, 1999). Neither had passed legislation on this topic as of this writing.

In addition to ombudsman plans aimed at all managed care consumers, several states have implemented ombudsman programs for Medicaid

recipients enrolled in managed care (Lee, 1996). Examples include Colorado, North Carolina, Oregon, and Hawaii.

One key advantage of an ombudsman program is that it avoids the major limitation on state regulation of managed care plans: the Employee Retirement Income Security Act (ERISA) of 1974. As Brennan and Berwick (1995, pp. 246-258) explain, federal courts have interpreted the statute as preempting most (if not all) state regulation of employer-self funded health plans, including managed care plans. Most working adults are in employer self-funded plans, where the employer—not the health plan—assumes the financial risk for medical losses in excess of premium revenue. Under an employer-self funded arrangement, the health plan plays the role of plan administrator, for example, conducting utilization review, processing claims, and reimbursing providers. The employer bears financial risk for the health plan. Although ERISA preempts most traditional kinds of state regulation, it does not prevent the state from playing the role of ombudsman.

The key advantage of an ombudsman program, however, is that it allows political leaders to meet the public demand to do something in an area largely ceded to the private sector. A political calculation that a given activity be ceded to the private sector does not equate to an absence of public pressure for political leaders to correct perceived market failures. As Blendon et al. (1998) find, there is a clear public demand for political leaders to address perceived problems with managed care health insurance plans. Similarly, in 1997, the governor's race in New Jersey hinged on automobile insurance rates, never a core function of state government and traditionally the province of private insurers. What is clear from the example of managed care is that even if political leaders have never acknowledged responsibility for a function such as providing health insurance, political leaders will not be immune from public pressure to intervene in the case of perceived market failures, irrespective of the accuracy of those perceptions (Ignani, 1998, pp. 29, 33-34; Moran, 1997, pp. 14-15). Just as privatizing a traditional function such as trash collection to private contractors does not inoculate political leaders from criticism if the contractor fails to perform (or is perceived as failing to perform), so choosing to cede by default a socially important function such as providing access to health care to the private sector does not exempt political leaders from being expected to do something about the private sector's perceived shortcomings.

The question is how to do something in a positive way and, in the spirit of Hippocrates, to avoid doing harm to anyone (to the extent possible). One answer is the ombudsman approach rather than, or in tandem with, more traditional command and control regulation. An ombudsman approach allows government response to be tailored to individual situations and focuses on resolving concerns, not procedural correctness (the traditional concern of administrative law).

CONCLUSION

This article proposes a new model for governing managed care—government in the role of ombudsman rather than the command and control model envisioned by overhead democracy. This model for governing managed care is meant as a practical policy solution for political leaders interested in effectively responding to their constituents' demands to do something about managed care. However, these constituent demands to do something about managed care also have something to say to public administration literature.

As this article demonstrates, it is time for public administration to take off our hair shirt that we have proudly worn in assuming that bureaucrat bashing is a unique burden that must be undergone by those in the employ of the government. Managed care has undergone its share of anecdotally based criticism that is reminiscent of bureaucrat bashing. Managed care has also found itself subject to the same impulses of control from political leaders that we term overhead democracy.

The logic of overhead democracy extends to private interests assuming a social allocation function, such as managed care health plans, in that political leaders will attempt to control the private interests' exercise of discretion, just as they try to control administrative discretion exercised by government bureaucrats. However, the already difficult task of trying to effectively control government bureaucrats is all the more difficult with regard to private interests. The tools that political leaders have available to control private interests, principally law and regulation, are blunt instruments at best in dealing with the multifarious situations that individuals face in their dealings with health plans. It is difficult to craft any legislation or rule that can be tailored to meet all or even most situations. Therefore, in heeding Ayres and Braithwaite's (1992) caution to design a regulatory

system that fits the nature of a given industry, the best solution for governing managed care might well be an ombudsman approach as described in this article.

President Clinton famously remarked that the era of big government is over. With increased moves toward privatization of government services, deregulation, and ceding certain areas of our social life (such as health care) to the private sector, political leaders and public administration and policy scholars will be increasingly challenged to identify solutions that allow government to allay citizen concerns about the unfettered exercise of discretion by private interests. The difficulty is in how to address public concerns without embarking on fruitless attempts to control private interests. With regard to managed care, this article proposes one potential model.

REFERENCES

Aberbach, J., & Rockman, B. (1990). What has happened to the U.S. Senior Civil Service? *Brookings Review, 8*(4), 35-41.

Ayres, I., & Braithwaite, J. (1992). *Responsive regulation: Transcending the deregulation debate*. New York: Oxford University Press.

Blendon, R., Brodie, M., Benson, J. M., Altman, D. E., Levitt, L., Hoff, T., & Hugick, L. (1998). Understanding the managed care backlash. *Health Affairs, 17*(4), 80-94.

Brennan, T., & Berwick, D. (1995). *The new rules: Regulation, markets, and the quality of American health care*. New York: Jossey-Bass.

Brodie, M., Brady, L., & Altman, D. (1998). Media coverage of managed care: Is there a negative bias? *Health Affairs, 17*(1), 9-25.

Butler, S., Senara, & Weinrod. (1984). *Mandate for change II*. Washington, DC: Heritage Foundation.

Cauchi, R. (1999). Managed care: Where do we go from here? *State Legislatures, 25*(3), 14-23.

Church, G. (1997, April 14). Backlash against HMOs. *Time, 114*(15).

Colvard, J. (1995). Clear air turbulence in the careerist/political appointee zone. *Public Manager: The New Bureaucrat, 24*(1), 34-36.

Congressional Budget Office. (1998, July 16). *Cost estimate for H.R. 36605/S. 1890 as modified by the sponsors* (105th Congress). Washington, DC: Author.

Daniels, N., & Sabin, J. (1998). The ethics of accountability in managed care reform. *Health Affairs, 17*(5), 50-64.

Diz, V. (1995). *What's it all about: Ombudsman program primer for state aging directors and executive staff*. Washington, DC: National Long-Term Care Ombudsman Resource Center.

Durant, R. (1990). Beyond fear or favor: Appointee-careerist relationships in the post-Reagan era. *Public Administration Review, 50*(3), 319-330.

General Accounting Office. (1997). *Managed care: Explicit gag clauses not found in HMO contracts, but physician concerns remain* (GAO/HEHS-97-175). Washington, DC: Author.

General Accounting Office. (1998). *Health insurance standards: New federal law creates challenges for consumers, insurers, and regulators* (GAO/HEHS-98-67). Washington, DC: Author.

Goodsell, C. (1990). *The case for bureaucracy: A public administration polemic* (2nd ed.). Chatham, NM: Chatham House.

Heclo, H. (1977). *A government of strangers: Executive politics in Washington*. Washington, DC: The Brookings Institution.

Heclo, H. (1984). A government of enemies. *Bureaucrat, 13*(3), 12-14.

Hilzenrath, D. (1997, June 30). Managed care backlash builds. *Washington Post*, p. A1.

Iglehart, J. (1998). The media as messenger. *Health Affairs, 17*(1), 7-8.

Ignani, K. (1998). Covering a breaking revolution: The media and managed care. *Health Affairs, 17*(1), 26-34.

Illinois Manufacturer's Association. (1998, June 9). *Spring legislative session wrap-up*. Springfield, IL: Author.

Ingraham, P. (1987). Building bridges or burning them? The president, the appointees, and the bureaucracy. *Public Administration Review, 47*(5), 425-435.

Kingdon, J. (1995). *Agendas, alternatives, and public policy* (2nd ed.). New York: HarperCollins.

Lane, L., & Wolf, J. (1990). *The human resource crisis in the public sector: Rebuilding the capacity to govern*. New York: Quorum Books.

Lee, P. (1996). *Managed care ombudsman programs: New approaches to assist consumers and improve the health care system*. Los Angeles: Center for Health Care Rights.

Light, P. (1995). *Thickening government: Federal hierarchy and the diffusion of accountability*. Washington, DC: The Brookings Institution.

Lorentzen, P. (1985). Stress in political-career relationships. *Public Administration Review, 45*(3), 411-414.

McEldowney, R. (1994). *A century of democratic deliberation over American and British health care*. Unpublished doctoral dissertation, Center for Public Administration and Policy, Virginia Polytechnic Institute and State University.

Moran, D. (1997). Regulating managed care: An impulse in search of a theory. *Health Affairs, 16*(6), 7-21.

Murray, W. (1996). *The effects of politicization on the regime, policy subsystem, and agency level: A case study of the commonwealth of Virginia*. Unpublished doctoral dissertation, Center for Public Administration and Policy, Virginia Polytechnic Institute and State University.

National Conference of State Legislatures. (1998). *Managed care insurer liability: Major actions on 1998 state bills*. Denver, CO: Author.

Pak, C. (1984). Political executives can't. *Bureaucrat, 13*(2), 19-22.

Redford, E. (1969). *Democracy in the administrative state*. New York: Oxford University Press.

Rohr, J. (1986). *To run a constitution: The legitimacy of the administrative state*. Lawrence: University of Kansas Press.

State of Oklahoma. (1999). *Senate managed care task force recommendations*. Oklahoma City: State of Oklahoma.

Virginia Code Commission. (1999). *1999 acts of assembly.* Charlottesville, VA: Michie.
Wamsley, G. (1990). *The agency perspective: Refounding public administration.* Newbury Park, CA: Sage.
Wamsley, G., et al. (Eds.). (1990). *Refounding public administration.* Newbury Park, CA: Sage.
Yin, R. (1989). *Case study research design and methods* (rev. ed.). Newbury Park, CA: Sage.

Rene McEldowney is an associate professor of Health Administration and Political Science at Auburn University in Auburn, Alabama. Her research interests lie in comparative health care reform policy, the British National Health Service, and managed care. Her latest work focuses on the use of managed care in mental health and substance abuse programs and health care policy implementation within the British National Health Service.

William L. Murray is an adjunct professor at Virginia Tech in Blacksburg, Virginia. His research interests include managed care regulation and health care financing.