President Barack Obama’s efforts to reform the American health care system came to fruition with Congress’s enactment of the Affordable Care Act (ACA) in March 2010. It drew a spectrum of reactions, from enthusiastic to tepid to hostile. Among the more thoughtful commentaries on the policy is *Fresh Medicine*, by former Tennessee Governor Phil Bredesen. Drawing from his time serving as a conservative Democratic governor in a red state, Bredesen criticizes the ACA and prescribe an alternative. Bredesen believes the American health care system is structurally broken, citing the increasing costs that he himself struggled with when managing Tennessee’s Medicaid program. While he commends the ACA for providing more Americans with health care coverage, he believes that it also aggravated the system’s underlying financial problems.

**Bredesen’s Alternative**

In response to the unsustainable economics of the current system, Bredesen suggests establishing a baseline for quality care grounded in evidence-based medicine, which would, in turn, be integrated into competitive systems of managed care. Americans would buy into these systems of care with vouchers that draw on a trust fund financed by progressive taxes.

According to Bredesen, the essential structural problem is the development of an insurance payment model that leaves patients disconnected from the full burden of health care prices. The system gives buyers an incentive...
to increase the amount of care they demand, because they do not have to pay full cost – while allowing sellers the liberty to set higher prices for services. This creates a “systematic disengagement within our health care system of the economic tension that creates value.” In other words, “the tension between buyer and seller that makes economics work” is gone.

In laying out his six-step response to this economic problem, Bredesen begins with the ethical principles of fairness, dignity, and universal access. He then moves to a discussion of costs, though he fails to address cost drivers like medical technology and an aging population. The third step he suggests involves a new approach to managing care that depends on the notion of managing health care delivery’s inherent “hypercomplexity.” Given the health system’s idiosyncrasies and the loose arrangement of its various actors, Bredesen feels that similarly complex models, such as market economics and evolution, are better examples to learn from. Discussions of seeking quality and of building systems of care follow. His surprising final step is to finance this new approach progressively with vouchers and a trust fund.

Bredesen bases his arguments on his own experience in developing a for-profit managed care company and serving two terms as Tennessee governor. As governor, he restored fiscal stability to Tennessee’s troubled Medicaid managed care demonstration project through a series of controversial decisions, including the disenrollment of more than 100,000 uninsured or uninsurable Medicaid enrollees. Despite having substantial professional experience in this field, Bredesen writes with little scholarly documentation. Instead, he supports his business-like argument with a mixture of personal anecdotes (for instance, discussing his physical examination), and relatable, if oversimplified, images. For example, he uses the metaphor of shopping in a grocery store without posted prices to explain the process of choosing health services.

Worn-out Ideas or Fresh Medicine?

Bredesen puts forward a detailed argument worth serious examination, but I will comment on only three issues: hypercomplexity, systems of care, and funding.

1. Managing hypercomplexity through competition only protects the “fittest”

First, managing the health care system’s hypercomplexity by identifying an underlying mechanism is at the heart of Bredesen’s proposal. He would set up competition toward rigorously determined quality as his mechanism.
However, this type of competition seems inconsistent with his values. For instance, Bredesen’s suggestion of competitive Darwinism as a management strategy could conflict with concerns for equity, dignity, or other ethical principles. In addition to the normative questions of justice that a “survival of the fittest” system of care raises, it also could attract more enemies than supporters and so merits further scrutiny.

2. Bredesen’s transformational system is still tied to managed care

Second, in advocating for systems of care grounded in evidence-based medicine, Bredesen aspires to be transformational. However, he seems to lack a clear formulation of how his alternative would work, instead remaining tied to the old world of managed care. When he describes a possible future for health care in Nashville, Bredesen imagines a framework driven by big hospital systems - but it could just as well be a big insurer. His suggestion seems counterintuitive; Bredesen could easily have incorporated the ACA’s suggestion of accountable care organizations into his framework, building upon the existing legislation. However, he claims – with little explanation – that his system is somehow different than what the ACA establishes.

Bredesen’s prescription is still managed care, relying on incentives to manage costs. In assuming the validity of the for-profit managed care model, he does not thoroughly question the applicability of managed care to high-utilizing vulnerable populations. He also insufficiently attends to instances of market failure, such as asymmetries of information or inequality of bargaining power among patients, professionals, and other participants in the system.

Bredesen does not believe that the ACA will moderate the trend of unsustainable increasing costs. He credits this belief to the influence of politics— as illustrated by Congress’ experience with Medicare physician reimbursement cuts—and the creative responses of markets to new incentives. Yet Bredesen’s own apolitical and technical framework for establishing quality in care systems may be incompatible with the powerful interests of health insurers, doctors, hospitals, and other stakeholders. In addition, some observers, such as Theda Skocpol and Lawrence Jacobs1, find the ACA’s potential for bending the cost curve to be more significant than Fresh Medicine allows – making Bredesen’s unwillingness to build on it a missed opportunity. I suspect that Bredesen and the ACA need to find a fresh way of delivering quality care in order to control

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costs, but neither one has found it.

3. Bredesen’s funding resembles the single-payer system

Finally, Bredesen’s health care trust fund approach is very reminiscent of the single-payer approach that he criticizes. Both single-payer and Bredesen’s trust fund allow for a diverse private base of providers supported by public financing. When it comes to controlling costs, Bredesen would have been better served by discussing the role of hard limits or soft targets for the total health system.

_Fresh Medicine_ provides a good description of the current health care system’s inner workings, and a somewhat overdrawn critique of reform. Proposing increased management of our complex health care economy, coupled with evidence-based medicine, presents an intriguing, but not transformational, argument for further change. To his credit, Bredesen’s work is a reminder that the health care debate – despite the ACA’s passage – is far from over. However, I suspect that American society, as the patient who would receive his prescription for a new path for health care, should ask for a second opinion. This iteration of managed care may not be as fresh or as effective as the patient may need—a little more collaboration among the would-be healers may be in order.

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**Endnotes**

2 Bredesen, 1.
3 Bredesen, 112.
4 Bredesen, 73.