Introduction

Learning to Manage

The tick-tack of high heels echoed on the polished tile floor. The health plan's employees had straightened up their desks, turned off their computers, and clocked out. They joked and gossiped as they hurried toward the lobby. It was 4:30 and the elevators descended through the modern glass office building packed with customer service representatives, authorization nurses, and claims processors who filed out to the parking lot. Cars already clogged the side streets; they lunged forward and stopped in the irregular rhythm of San Juan's rush-hour traffic. Many employees would drive for more than an hour before reaching homes in the more affordable municipalities of Bayamón and Carolina.

Inside, the steamy late afternoon heat was neutralized by central air conditioning set just above arctic. I longed to leave, too, but instead hunched over a management training book. The pod of cubicles that made up the Compliance Department sat outside my doorway. Six months ago, I worked in one of those cubicles. Now my name was etched on the plastic plate beside my office door.

I was a fledgling manager, behind on several projects and cramming before a meeting. On that day, as so many others, learning to manage overshadowed my other reason for being at this health maintenance organization (HMO): I was also an anthropologist studying daily life at the company, observing how the health plan managed patient care, and

interviewing health plan members in their homes. To my knowledge, I was the first anthropologist to carry out fieldwork inside an HMO.

I reluctantly opened the thin, hardcover book entitled *Fish!* and skimmed the large type. The book's jacket described it as "a remarkable way to boost morale and improve results" (Lundin, Paul, and Christensen 2000). The reading was part of a new company initiative designed to coach managers—to provide the skills and tools necessary to supervise employees and meet production goals. Managers were required to complete online coursework in English on topics such as how to create objectives, evaluate employees, and motivate staff. For a previous session, we had filled out psychological profiles that revealed if our management styles were "intuitive, rational, sensitive, or active." Though I hated reading primers on being a better manager, I also craved some advice. Just the day before, the president of the company had brought up my management style. He was delicate about it, but the bottom line was that I needed to be more diplomatic. I should go for an educational, not punishing approach. Employees should feel as though they were part of a family, and family members do not always agree with one another. The company president assured me that one's management style was something that required constant self-reflection and could always be improved. I left his office with the acute sense that I had been managed.

The reading assignment was another in a long series of opportunities to learn how to manage others and, in so doing, to be managed oneself. *Fish!* tells the story of Mary Jane Ramirez, who stumbles upon the Pike Place fish market in Seattle and learns from a fishmonger named Lonnie how to energize her staff. She is beset by doubts about her own job security and that of her staff. She muses, "Does my staff know that the security they cherish might be just an illusion? Do they realize the extent to which market forces are reshaping this industry?" (Lundin, Paul, and Christensen 2000, 23). The central message of the book is that every employee should adopt a positive attitude in order to ease the fear, lack of morale, and insecurity generated in a flexible economy.

As an anthropologist, I bristled at how the focus on a positive individual attitude obscured larger social forces like uneven access to quality education and widening rates of income inequality that limit economic possibilities for most people, no matter how positive their

dispositions.[1] But after reading these texts and discussing them at companywide management meetings, I saw that the other supervisors and managers took the advice on what I have come to think of as "learning to manage" quite seriously. In these books they found a road map (endorsed by their bosses) for navigating the day-to-day challenges of working at a rapidly changing company. During the meeting at which we discussed *Fish!*, managers formulated plans for how they intended to use the book's ideas to develop incentive programs and revitalize the work in their departments. Shortly after the group discussion, posters appeared throughout the office building with short motivational quotes from the book: *Make their day! Be present. This is an adult playground. Watch out for adult children.*

The positive-thinking message conveyed in management primers like *Fish!* shared much in common with the optimistic rhetoric of the health policies that created and funded this health plan—policies that trumpeted privatized managed care as the market-based cure for an ailing health care system. In retrospect, these trainings were new and exciting to my fellow managers at a particular moment when the company was growing precipitously, offering the possibility of steady employment, the acquisition of business know-how, and the potential to attain the lifestyle of a professional. The management training initiatives tapped into the personal aspirations of newly minted managers and created a sense of future possibility, a future that for most never arrived.

Eighteen months later, the company I worked for was sold in a transaction that resulted in tens of millions of dollars in profit for the founders. By that time, many of these same managers either had been fired or had quit. The lucky ones who were still around signed contracts promising that they would not work for a competitor. In return for their loyalty pledge, they received a bonus but no such promise that their own jobs would be secure.

Managing Care, Managing People: Market Reforms to the Health System

This company, which I hereafter call "Acme," rode a wave of anticipation, exuberant expansion, and then turbulent and stressful

transformation in the wake of new legislation that extended the role of private contractors in the federal Medicare program. The legislation, popularly known as the Medicare Modernization Act, was signed into law by President Bush in December 2003. It vastly expanded the managed care program in Medicare by changing its funding structure, adding additional managed care plan types, and creating prescription-drug coverage that would be administered by private companies. I worked and researched at Acme at the peak of excitement, as managed care in Medicare first came to Puerto Rico, enrolling record numbers of beneficiaries and making profits that far surpassed what was possible on the mainland.

The Commonwealth of Puerto Rico (known as the Estado Libre Asociado in Spanish, literally, the Free Associated State) is a territory of the United States and, as such, is unevenly incorporated into the U.S. health care system. Since the 1950s, health care had been available to all, regardless of the ability to pay in Puerto Rico (Arbona and Ramírez de Arellano 1978). But following a pattern that was already well established in international development circles (Harvey 2005; Pfeiffer and Chapman 2010), in the 1990s, the health system in Puerto Rico underwent a series of market-based—or neoliberal—reforms.[2] First, the publicly funded regional health system was privatized by closing public health facilities and by enrolling eligible beneficiaries in private managed care health plans. During the next decade, privatization intensified due to market-based reforms in the Medicare program.[3]

Together these two waves of privatization radically remade the health system on the island. Puerto Rican citizens became consumers of private insurance coverage. The federal and Puerto Rican governments contracted with private corporations like Acme to deliver public services. Regulators employed new oversight strategies such as compliance auditing, performance monitoring, and quality measurement. Private health plans launched new technologies such as customer service and enrollment databases, electronic claims systems, and risk-management software to track how much consumers spent on medical care and to shape utilization patterns. These new technologies and oversight strategies sought to increase efficiency, improve the standard of care, allow data to be exchanged more quickly, and, importantly, generate profit. These technological transformations in how health care is organized

and distributed represent novel attempts to mold and manage people according to market imperatives.[4]

Under a market-based health system, patients are increasingly called upon by public health officials and insurance companies to make healthy choices, become more knowledgeable about their own health care, and apply cost-benefit criteria to treatment and insurance coverage decisions (Lemke 2001; Rose 2007). For patients in Puerto Rico, this often entails following middle-class or American cultural norms like avoiding rice and beans or fried foods; conducting health research on the Internet; and putting more "skin in the game" (paying out of pocket for some care). Likewise, providers are urged by the managed care organizations with whom they contract to become more entrepreneurial and businesslike in how they administer their practices and treat patients. Providers are encouraged to switch to computerized payment systems, implement appointment schedules, and monitor their quality ratings. Health plan workers, in turn, not only must manage the care of plan members, but also must conduct themselves in a manner that is professional, efficient, and informed by management principles like those described in *Fish!* Though others have observed that managed care and health insurance seek to transform people into more responsible self-regulating subjects (Rose 2007), scholars know relatively little about how people actually respond to these efforts to mold them into subjects who value health, self-care, and economic forms of decision making.[5] Through the process of implementing health reform in Puerto Rico, did poor, elderly, and disabled patients grow into responsible, calculating consumers? Did physicians become cooperative contracted providers? Did employees learn how to manage? In short, did Puerto Rico realize the market promise of a more-efficient, higher-quality, and less-costly health system? On all accounts, the answer is "not quite."

This book is at heart an ethnographic work that asks how people made sense of market-based health reform, and it explores the daily practices through which reforms were implemented, including Acme's attempts to cultivate responsible health care consumers, alter the behavior of contracted providers, and train its managers. I begin by analyzing the reform projects, legislation, and policy documents that sought to transform the health system into a managed care model. But then the story turns to the everyday contexts in which market reforms were

actually enacted—to the compliance department of a managed care organization, to the visits of federal auditors to a health plan, and to the homes of health plan members who recount their experiences trying to navigate the new managed care system.

This book analyzes market-based health reform projects in a bifocal perspective: the near lens is for reading up close the elaborate plans of market reformers while the distance lens focuses on the complex social transformations that took place when reform projects actually "touched down" in Puerto Rico (Kingfisher and Maskovsky 2008). Viewed in this way, health reform policies may be seen as messy, complex, and contradictory. As the inclusion of the word "unmanageable" in this book's title suggests, neoliberal health policies never quite remade the world in their image. Essentially, I argue that market-based health reforms failed to reorganize the health system in a way that promoted efficiency, cost-effectiveness, and high-quality care. The system became more expensive (not more efficient); patients rarely behaved as health-maximizing, information-processing consumers; care was more chaotic and difficult to access; and citizens continued to look to the state to provide health services for the poor, disabled, and elderly. The health system *was* dramatically transformed, just not according to plan.

The Managed Care Model

Managing was both a central feature of the daily work I carried out at Acme and the term given to what the company did at large. Acme was a managed care organization, commonly referred to as an HMO.[6] In order to understand how the health system was remade in Puerto Rico, it is crucial to examine the project of managing health care in its broader historical and political context, particularly the adoption of a for-profit business model focused on controlling costs.

When I refer to managed care, I mean a model for prepaying for health and medical services in which individuals access care through a network of contracted providers, according to certain predetermined rules. "Managing" occurs through activities like utilization review, which can include requiring preauthorization for some services, denying payment for services not deemed to be medically necessary, tracking the services that members are accessing, and monitoring the length

of members' hospital stays. Managing health care also takes place by employing certain standardized treatment protocols, providing health education, and enrolling health plan members in care and disease-management programs. The premise and promise of managed care is that through the rational application of management principles to the organization and distribution of medical services, health care can be coordinated, more efficient, focused on prevention, less costly, and more profitable.

The rise of HMOs and managed care in the United States in the 1970s signaled a shift in U.S. health care policy objectives away from the goal of extending coverage to more people and toward the goal of making medical care more efficient and cost-effective (Katz 2008, 263; Starr 1982, 379–380). Factors such as rising costs (especially in Medicare and Medicaid), the perception of a crisis in health care financing, and the eclipsing prestige of the medical profession challenged the premise that more care was needed and that customary delivery arrangements were the best method for distributing it. HMOs provided prepaid (as opposed to fee-for-service) care to enrolled members and focused on prevention—for these reasons, HMOs were thought to create incentives to keep patients healthy and costs low.

The number of HMOs in the United States did not grow significantly until the 1980s. At that time, a combination of factors made HMOs more attractive to health care buyers, including "an economic recession [that] forced employers, who pay for most of the private health care in the United States, to reduce the cost of their workers' health care and other benefits" (Coombs 2005, xi–xii). The rapid expansion of HMOs in the 1980s was also accompanied by a trend toward for-profit, rather than nonprofit, status (Gray 2006, 326–327). For-profit plans tended to be organized differently from their nonprofit counterparts.[7] Rather than an integrated, local model where physicians and other providers were salaried employees of a particular HMO, many of the new for-profit plans served more members, covered a larger service area, offered multiple plan types, and contracted with a network of physicians who accepted patients from multiple HMOs and health insurance plans (Gabel 1997). These for-profit plans began "thinking in terms of the health of populations (rather than solely of individuals)" and in turn developed "methods to measure the performance of individuals and

organizations in the health-care system" (Gray 2006, 332). This time period also saw increases in patient cost sharing through premiums and copays (Gabel 1997, 139).

By the late 1990s, HMOs began to provoke consumer criticism as they implemented more drastic cost-control mechanisms, including extremely brief maternity stays, denials of care often for technical reasons like not following plan rules, the shortening of doctor visit times, and confusing or nonexistent appeal procedures. In the mainland U.S. market, there was a "virulent and effective anti-managed-care backlash" that "led organizations that used utilization management methods to abandon them and to increase the size of their provider networks" (Gray 2006, 331). In 1996, 35 states passed laws to regulate HMOs, increase consumer protections, and weaken managed care (Bodenheimer 1996, 1601). The era of aggressive managed care did coincide with declines in health care inflation; however, analysts dispute whether HMOs caused this decline.[8]

Despite the backlash, perhaps the true mark of the success of HMOs is that managed care principles have been absorbed into almost all forms of health insurance in the United States through practices like (a slightly less aggressive version of) utilization review, care management, and trying to reduce the length of hospital stays.[9] In 2010, about half of the U.S. population received health care through an employer-sponsored plan where some form of managed care is the norm. In the public sector, which covers 29% of the U.S. population, a growing number of beneficiaries also belong to private managed care plans (KFF 2011a).[10] In 2011, U.S. managed care penetration (excluding Puerto Rico) was 71% in Medicaid (MACPAC 2011) and 25.6% in Medicare (KFF 2011b). As Puerto Rico and the states implement the Affordable Care Act and expand Medicaid, it is crucial that we better understand the financial and health-related implications of relying on privatized managed care for service delivery.[11]

Managed Care in Puerto Rico: Privatizing the Public Health System

The history of managed care in Puerto Rico is distinct from but related to the development of managed care in the mainland United States. The

next chapter describes the introduction of managed care in Puerto Rico in detail, illuminating how a century's worth of reforms have produced the contemporary health system. Here, a brief overview situates the arguments of this book.

Since the late 1950s, medical care had been available in Puerto Rico through a regional system of government-run facilities and clinics that were once held up as a model to be emulated in the developing world (Arbona and Ramírez de Arellano 1978). In the public system, care was provided largely free of charge with no enrollment restrictions. In many community clinics, mental and physical health care were available at the same facility together with a dispensary for pharmaceuticals. There was also a parallel private system of care for those who had employer-based insurance benefits or were wealthy enough to pay for care out-of-pocket.

In 1993, the pro-statehood governor who was also a physician, Pedro Rosselló, spearheaded a campaign to modernize the health system and bring it in line with the managed care model then current on the mainland. The new program, which was based on President Clinton's health reform agenda, came to be known simply as La Reforma (Alegría, McGuire, Vera, Canino, Freeman et al. 2001, 383). Funding for La Reforma derives in part from Medicaid and other federal monies, but the majority of the financing comes from local taxes.[12] Significant differences exist between mainland Medicaid programs and La Reforma. For example, Puerto Rico's health programs serve a population with much higher poverty rates than the mainland (around 50%) and colonial relations of rule often limit the autonomy of local health policy makers. La Reforma transformed the government from a direct health care provider to a regulator of private insurance companies contracted to deliver covered services to eligible beneficiaries in exchange for a monthly insurance premium.[13] Eligibility was restricted to those living at or below 200% of the federal poverty line, which created a class of uninsured people in Puerto Rico for the first time. The published goals of the program were to eliminate the unequal, two-tiered system already in place, control costs, downsize the health care bureaucracy, and deliver high-quality care to the medically indigent (Commonwealth of Puerto Rico 1993, 1–2).

Because of its small size and colonial status, the island of Puerto Rico has repeatedly been treated as a laboratory by mainland investigators

and insular policy makers alike for projects that have included providing an alternative to Communist development models during the Cold War (Grosfoguel 2003; Lapp 1995), implementing population-control measures, and experimenting on Puerto Rican bodies during the development of the oral contraception pill (Briggs 2003; I. Lopez 2008). More recently, the transformation of the island into a hub for the biotech and pharmaceutical industries has revived the laboratory metaphor (Dietrich 2013; Duprey 2010). Though La Reforma can be interpreted as another iteration of this laboratory—in that it was a staging ground for the implementation of President Clinton's health reform agenda—I do not want to push the metaphor too far. The implementation of La Reforma was made possible by the shifting political landscape on the island, with the statehood party growing in importance, and it addressed a set of uniquely Puerto Rican concerns even as it borrowed from neoliberal health reform models that were in vogue internationally. This book offers a complex and grounded understanding of La Reforma that acknowledges, but goes beyond, the laboratory metaphor that is employed in so much of the scholarship on Puerto Rico.

The other major government-funded health program available on the island is Medicare, which is health insurance for people over 65 or with certain disabilities under 65. There are two ways to receive Medicare benefits. The first is fee-for-service, or "Original Medicare," in which a beneficiary can visit any provider who accepts Medicare. In Original Medicare, beneficiaries have few restrictions in provider selection, but they often face high out-of-pocket costs in the form of copayments and an annual deductible. The second way to receive Medicare is through a managed care organization, currently known as the Medicare Advantage program.[14] Payment to managed care organizations under Medicare has existed in the mainland in one form or another since 1972 (Zarabozo 2000, 62), but the first Medicare managed care plan operating in Puerto Rico opened in 2000. Enrollment in Medicare managed care grew very quickly on the island; 68% of the Medicare-eligible population was enrolled in a private for-profit Medicare Advantage plan in 2011, which is much higher than the 25.6% enrolled in Medicare Advantage in the United States (KFF 2011b). The higher rates of Medicare Advantage penetration (to use the industry's language) in Puerto Rico are due to a variety of reasons, one of the most important being that

Medicare Advantage plans offer enrollees more generous benefits with lower out-of-pocket costs than Original Medicare.

Medicare managed care organizations like Acme receive a capitation (payment) per member per month (PMPM) from the federal government to offer Medicare services through a network of contracted providers. By assuming the financial risk for a large-enough group of beneficiaries, the premise is that managed care organizations can provide benefits in addition to what is covered by Medicare, focus medical management efforts on prevention, control fraud by reviewing claims, and administer health care in a more efficient and businesslike manner, which will result in cost savings for the government and profits for the managed care organization.[15] The reality, however, has been that Medicare Advantage costs more, not less, than Original Medicare. Medicare Advantage plans on the island receive much higher payments relative to Original (fee-for-service) Medicare; in 2009, the Medicare Advantage rates were close to 180% of fee-for-service Medicare (MedPac 2009, 179). Many Medicare Advantage plans have flocked to the island to profit from these high premiums.

In a relatively short period of time, the health system in Puerto Rico underwent radical restructuring through two waves of privatization—the first to the public health system and the second in the Medicare program. I hoped that working at Acme would help me to understand how these two waves of privatization transformed the experience of accessing and providing care on the island.

Working and Researching at Acme

In researching this book, I employed a variety of qualitative, anthropological methods that enabled me to explore the complex social, political, and economic phenomenon that is privatization. Participant observation was key. I worked at Acme—a private insurance company under contract with the federal government to provide Medicare services—as a paid employee (initially as an editor of policies and procedures and eventually as a compliance manager) for an average of 35 hours a week for 31 months in the mid-2000s. At Acme, I was first and foremost an employee in the compliance department, not a researcher. During the workday, being a participant trumped being an observer. So I recorded

my observations in fieldnotes at night, on the weekend, and often while I took my lunch breaks. As part of the research agreement that I negotiated with the company, I was permitted to gather company documents like meeting minutes, emails, and the manuals, policies, and procedures created within the HMO for complying with federal regulations. These documents—often scribbled with my to-do lists and impromptu observations—form a kind of bureaucratic archive that records the language, reporting structures, and regulatory changes that were prominent at the company during this time period. I returned again and again to these bureaucratic documents while writing this book. On subsequent research trips to the island in 2007 and 2009, I added to this archive by conducting open-ended interviews with some of my former coworkers at Acme.

Though I was primarily known as an employee at Acme, my research was not undercover or secret. I obtained permission from Acme's CEO to research at the company, and I submitted my project for human subjects review at Harvard University, where I was a graduate student. I disclosed my research activities to my immediate colleagues, who were aware that I was an anthropologist and taught at the local university. I told my colleagues and the CEO that I was researching quality of care on the island and wanted to understand how managed care in Medicare and La Reforma impacted quality (which was how I understood my research at the time). In order to protect the privacy of research subjects, the name of the company as well as the names of health plan members, individual doctors, and health care workers have all been changed. Public figures such as government representatives are presented with their own names unless otherwise indicated. For interested readers, I describe how I gained access to Acme and some of the ethical issues raised by this research in greater detail later in this chapter and also in appendix 1.

This book is about more than what it was like to work at Acme. I wanted to understand the interrelationships among regulators, the corporation, and plan members as part of a larger effort to transform the experience and organization of health care on the island. Privatization involved multiple actors and played out across spatially and temporally dispersed sites. So I used a multimethod and multisited approach that others have termed "studying through."[16] "Studying through" is an adaptation of the anthropologist Laura Nader's (1972) term "studying up," which refers to

anthropological accounts that investigate institutions or individuals who marshal considerable financial resources, political influence, or symbolic importance. Whereas anthropological methods like participant observation were initially developed for the study of small-scale societies or villages, Nader argued that we should use the same tools to study actors like chemical companies, government institutions, and economic elites. What makes studying through different from studying up is that it also involves studying down and sideways (Nader 1972, 292). Instead of just looking at well-paid health care executives, I also examine midlevel managers and bureaucrats as well as health plan members. In other words, studying through is a methodological approach for examining systemwide change that takes place at multiple levels and among multiple differentially situated actors (Shore and Wright 1997, 14; see also Reinhold 1994).

An essential part of my research was to interview health plan members about how their experiences with the health system had transformed as a result of the two waves of privatization that hit the island during the 1990s and the first decade of the 2000s. To this end, I conducted 35 semistructured, open-ended life history interviews with Medicare beneficiaries. Appendix 2 contains a brief description of each of the interviewees.[17] While living in San Juan, I also interviewed physicians and government officials, analyzed press coverage of health care reform, and performed archival research on the formation of Puerto Rico's health care system.

This combination of participant observation, discourse analysis, and qualitative interviewing allowed me to understand privatization from multiple perspectives. Over and over again, I saw how the goal of managing care (a goal that many Acme employees genuinely believed in and thought would improve members' health) was never completely achieved. The following story, of the first two members whom I interviewed, illustrates some of the most significant gaps between the project of rational care management as imagined at Acme and the often disjointed, not quite rational, care experienced by Acme's plan members.

Unmanageable: Life Histories and Corporate (In)efficiencies

Driving back into Hato Rey, I was struck by the trees lining the streets, well-lit white leather sofas in the windows of furniture stores, and a

dozen restaurants filling up on a Friday evening. I never realized how opulent the banking district of San Juan could look.

I always thought of it as dusty, baking in the sun, somehow unfinished. Construction of the Tren Urbano, a commuter train system, had splintered open the city streets, leaving the district with constant detours and aggravating the already-clogged traffic. Car pollution and mildew stained the paint on the middle-class apartment buildings, but the balconies teemed with plants and the views extended over the city with distant glimpses of the bay or even the ocean. The street vendors, who at noon sold lunch outside the government buildings, now peddled snacks or canned beers to the office workers enjoying the *viernes social* (social Friday).

I was returning to San Juan from Río Grande, a small town on the northeast coast of the island located close to *el Yunque*, the rain forest and tourist attraction. I had just interviewed two brothers—Don Enrique and Don Ignacio—about their experiences with the health care system. It was jarring to see Hato Rey after having sat on the brothers' porch watching a very different viernes social unfold. In their neighborhood, the concrete houses were tightly packed on small lots. The original two-room, barracks-style home provided by the government had been modified by some with a second floor, a new shade of paint, or religious ornaments. Other houses were not aging so well and showed cracks in the cement walls or appeared to be abandoned. The brothers lived behind a cemetery.

The small porch where we sat wrapped around the house and led to the backyard. Don Ignacio said his son came out once to help them take care of the yard, but it would be better if he did not come back. Don Enrique liked to fix things so the yard was littered with extra parts and half-repaired fans. His son worked an office job and lived in a gated neighborhood in San Juan. He said that all of the plastic and metal pieces were garbage and threw them away. But Don Enrique would rather have the fan parts back so he could work on them. We talked over the hum of Mexican ballads interrupted by *reggaetón* from passing cars. The brothers called out to neighbors, joked about lost loves, and showed me pictures of their children on the mainland and on the island.

Don Ignacio was far more jovial than his brother, Don Enrique, who sat in a wheelchair, shirtless in a pair of shorts with a bandage on his

left foot. The white gauze covered the toes up to his ankle. He explained that he was to have his foot amputated on Monday.

A small cut had developed into gangrene. In the house, they showed me several blood glucose monitors that Acme had sent. They were frustrated with the company and could not understand why it kept sending the wrong machine. They wanted the old one with the large-print display, but that machine had stopped working. The brothers both had Type 2 diabetes and neither was able to monitor his glucose levels regularly.

The brothers did not know it, but Acme had contracted with a new durable medical equipment provider as a cost-saving strategy and the transition to the new provider was fraught with complications: orders were botched or never delivered and customer complaints were flowing into the Acme offices.

Don Enrique said he was thinking about the impending operation. His pensiveness contrasted markedly with Don Ignacio, who fried up seafood-stuffed empanadas and insisted that I sample his homemade hot sauce. He showed me big cans of processed bulk food purchased at the new Sam's Club. He said the small amount of money he received from Social Security goes much farther at Sam's.

Don Enrique said he had known something was not right with his foot, but he let it go. He put off seeing the doctor for too long. He winced occasionally and mentioned the pain. He blamed himself.

As this fragment of the brothers' story illustrates, management—whether of one's diabetes, a patient's care, or the delivery of medical equipment—can go wrong. When Acme sent Don Ignacio and Don Enrique multiple glucose monitors that they could not read, the unused machines gathered dust in their living room. Acme's attempts to streamline its order and delivery process did not materialize into an effective and efficient system. Instead, the new durable medical equipment company substituted a less expensive, but harder-to-read model for the machine that the brothers had become accustomed to, and their care, in turn, suffered.

Clearly, the brothers were not efficiently managed by the health plan, and neither were they effectively remade into self-regulating, health care consumers. The brothers expressed interest in managing their diabetes but ate a diet full of starchy foods, enjoyed a few beers now and again,

and were less than vigilant in attending to minor ailments. They visited their physicians regularly, but still their diabetes was uncontrolled and leading to serious complications like gangrene and amputation. The self-management model trumpeted by market-based reformers failed to improve their health; in its implementation, the model confronted both material and cultural barriers. The brothers' story reveals some of the fissures between what market-based reforms set out to accomplish and what actually transpires in the complicated contexts of people's lives.

Government Goes Entrepreneurial: From the Great Society to Privatizing Medicare

By the time that I showed up for my first day of work at Acme, more than 30 years of market-based public-policy programs had considerably changed the Medicare program since its inception under the auspices of President Johnson's Great Society and the War on Poverty. The Medicare and Medicaid programs were intended to fill gaps in the existing medical system by providing health insurance for the elderly, the poor, and disabled. At the time, government was seen by the Johnson administration as the solution to social problems like poverty, inequality, and racial discrimination in the nation's health facilities (Engel 2006). When Medicare was initially implemented, it was framed as a right and as an alternative to charity. President Johnson called on all Americans to participate in making the public program successful:

> Medicare begins tomorrow. Tomorrow, for the first time, nearly every older American will receive hospital care—not as an act of charity, but as the insured right of a senior citizen. Since I signed the historic Medicare Act last summer, we have made more extensive preparation to launch this program than for any other peaceful undertaking in our Nation's history. Now we need your help to make Medicare succeed. . . . This program is not just a blessing for older Americans. It is a test for all Americans—a test of our willingness to work together. In the past, we have always passed that test. I have no doubt about the future. I believe that July 1, 1966, marks a new day of freedom for our people. (Johnson 1966)

Johnson described Medicare as the result of a massive collective undertaking led by government that would enhance "freedom for our people." In contrast, the Bush administration framed the role of government quite differently at the signing of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (commonly called the Medicare Modernization Act, or MMA):

> These reforms are the act of a vibrant and compassionate government. We show are [*sic*] concern for the dignity of our seniors by giving them quality health care. We show our respect for seniors by giving them more choices and more control over their decision-making. We're putting individuals in charge of their health care decisions. And as we move to modernize and reform other programs of this government, we will always trust individuals and their decisions, and put personal choice at the heart of our efforts. (Bush 2003)

Whereas Johnson presented Medicare as a right, Bush emphasized "compassion" on the part of the government and framed the new legislation as a "gift." Further, Johnson referred to collective responsibility and spoke of Medicare as a national project. Bush emphasized individual choice and decision making. "Personal choice," not collective responsibility, was placed "at the heart of our efforts."

This distinction between Medicare as implemented in 1965 and as reformed in 2003 illustrates a crucial shift in the objectives of public policy over the same period, from a policy that promoted collective responsibility for social welfare to one that valorized personal responsibility and consumer choice. Though the Bush reforms of 2003 did not completely privatize Medicare (beneficiaries can still opt to receive their Medicare services through the original program), the reform represents a significant move to structure Medicare according to business models based on consumer choice. For example, the new prescription-drug benefit must be administered by private companies called pharmacy benefit managers, the government is prohibited from negotiating prescription-drug prices, and the types of managed care plans that beneficiaries can choose to join under the Medicare program are significantly expanded.

Public-policy shifts toward making the delivery and administration of public services conform to business models did not just occur in health care. The Clinton welfare reforms and the Bush administration's No Child Left Behind Act in education are two additional examples of public-policy reforms that attempt to downsize and privatize public service provision, make government more efficient, and transform recipients of public services as well as public employees into more responsible, accountable individuals. These policies have been widely discussed as "neoliberal reforms" (Giroux 2008; Harvey 2005); however, I find the more narrow term "entrepreneurial governance" (Holland et al. 2007) useful for articulating what was unique about how neoliberal policies developed in the United States and Puerto Rico during the 1990s and the first decade of the 21st century.

"Entrepreneurial governance" seeks to transform government into an efficient and streamlined enterprise in partnership with the private sector (Holland et al. 2007). On the whole, the United States has not advocated the same kind of radical dismantling of public institutions at home that USAID and other development institutions have proscribed abroad.[18] The focus domestically has been on the more politically palatable projects of cultivating partnerships with the private sector, lowering taxes, contracting out public services, minimizing regulation, and creating a more business-friendly and businesslike environment in public administration. When public services have been significantly cut or restructured according to entrepreneurial principles (as with welfare), these reforms have been disproportionately targeted at the poor, women, immigrants, and racial minorities (Katz 2008).

It is important to note that privatization does not eliminate government, but rather it changes its form (Barry et al. 1996, 14; Ferguson and Gupta 2002; Shore and Wright 1997, 28). When health programs were privatized in Puerto Rico and the United States, the government was still concerned with how patients were cared for and how public money was spent. So regulatory agencies employed techniques for "governing from afar" like audits and performance measurement (Clarke 2004; Rose 1996, 43) that allowed oversight to continue in an altered form. A social policy researcher, John Clarke (2004), has termed this the "performance-evaluation nexus," and others refer to it as "audit culture" (Shore and Wright 2000; Strathern 2000) or "audit society" (Power

1997). As a result of contracting out a wide swath of public programs and services (education, health care, war, etc.), the government increasingly functions as a contract administrator while corporations deliver public services and open themselves to government scrutiny and regulation. In the process, citizens become hybridized citizen consumers who receive public services from and whose rights are ostensibly protected by corporations.

In health care, entrepreneurial governance is supposed to work when regulators hold insurance companies to a minimum level of accountability, companies optimize the efficiency of health care delivery in a competitive marketplace, and informed consumers engage in rational decision making about their health options. But this *model* for how relationships among the state, corporations, and citizen consumers are redrawn by entrepreneurial governance is far more tidy on paper than in the complex social contexts where policies are actually enacted. Drawing this distinction between a model and its enactment makes it possible to understand how and why policy justifications for managed care are often incongruous with how privatization unfolds in the world. For example, proponents of market-based economic policies oppose state involvement in the provision of many kinds of basic services (trash collection, water treatment, road construction, education, health care, etc.), but contracting out these same services to private corporations can actually expand government expenditures (Holland et al. 2007, 124). The 2003 Medicare legislation discussed above that extended the use of managed care plans and added a prescription-drug benefit vastly increased the cost of the Medicare program and in turn resulted in a larger federal bureaucracy to oversee the new plans. Furthermore, managed care in Medicare costs 13% more to provide than traditional fee-for-service Medicare (Zarabozo and Harrison 2009, W55). The irony is that programs that were aimed at streamlining and downsizing government involvement in the provision of health care had the opposite effect.

As various anthropological studies have shown (see, for example, Horton et al. 2001; Lamphere 2005; Stan 2007; Waitzkin et al. 2002), the process of privatizing health care is often fraught with contradiction and unintended consequences. For example, when the Medicaid system in New Mexico was subjected to a privatized managed care model, access to care through the use of primary care physicians initially improved.

However, privatization also resulted in enrollment difficulties, more bureaucracy and rules for providers, an added burden on safety-net providers, access barriers for rural clients, and decreased access to mental health care (Lamphere 2005, 13). Across the globe, market-based reforms to health systems have created access difficulties for the poor, even when these reforms were designed to extend coverage (Abadía and Oviedo 2009; Armada and Muntaner 2004; Foley 2010; Horton et al. 2012 and 2014; Kim 2000; Pfeiffer and Chapman 2010). In Senegal, for example, one anthropologist found that "recent health reforms fail to accomplish their stated objectives, and they aggravate social inequalities in ways that have important implications for vulnerability to disease" (Foley 2010, 3). When it comes to market-based reforms to health systems, failure may be the rule, not the exception.[19]

Understanding public policy *anthropologically* necessarily entails putting the contradictions and messiness of policy creation and implementation at the center of analysis (Li 2007). Therefore, I engage here in close readings of policy documents and programs, but I also explore the complex social processes through which policies were implemented and, in their implementation, transformed. Market-based policy programs set out to redraw relationships between government, private enterprise, and citizen consumers, but, in their implementation, policy programs are themselves transformed by prior practices, social relations, power dynamics, institutional constraints, and unpredictable subjects. In this book, I contend that market reforms to the health system became "unmanageable" in Puerto Rico because of colonial relations of rule and a political culture that continued to see a strong role for government in the provision of health services. Privatized for-profit managed care is also far better at making and managing money than managing health (or people), especially in the context of high poverty rates that leave many "consumers" outside of the market. Most important, market-based public policies vastly overestimated their own ability both to remake the world and to understand the people in it.

Up to this point, I have treated managing (be it care or people) as an organizational principle, a rationalizing and economizing method for conducting oneself and directing the conduct of others. By participating in and observing daily life at Acme, it became clear to me that managing was also a moral and ethical project.

The Moral Project of Market-Based Care

Critics of privatized managed care have tended to cast it as immoral or opposed to the common good:

> Health care as a right is not compatible with health care as commodity; the former is grounded in principles of justice and social good, whereas the latter is rooted in profit motives that pay lip service to the "laws" of supply and demand. Continuing to allow market forces to unilaterally dictate the policy agenda and shape of health care delivery in this country ensures that profound inequalities will continue to grow. By default, modern medicine will have to become increasingly adept at managing inequality rather than managing (providing) care. (Rylko-Bauer and Farmer 2002, 477)

While this critique usefully points to the role privatization can play in exacerbating inequality and placing cutting costs above patient care, it ignores how market-based reforms like the one implemented in Puerto Rico are themselves moral projects. "Moral" here is taken in its sociological sense to mean "what a society, or a group, defines as good or bad, legitimate or inappropriate" (Fourcade and Healy 2007, 301). Market reforms in health care are moral in the sense that they are invested in naturalizing market solutions to social problems, promoting competition, creating more consumer choice, and fostering calculative, economic forms of decision making on the part of consumers.

The managers with whom I worked at Acme did not see a stark opposition between the market on the one hand and social good on the other. They, too, were worried about inequality. In fact, they felt that they were alleviating some of the inequalities in the Puerto Rican health system by providing managed care to the Medicare population. They pushed physicians to improve their documentation, conducted quality inspections of offices, and enrolled beneficiaries in disease-management programs. They ran Acme to make money, certainly, but also gained moral satisfaction from the work. Managed care in Medicare was not just another business: for them it was the right thing to do. Through working in managed care, my coworkers understood that they were modernizing the health system in Puerto Rico.

Privatization and managed care cannot be fully understood as a bureaucratic or technical enterprise aimed at reorganizing how health care is delivered. This book argues that managed care is also a moral project—one in which new notions of responsible patients are developed and one in which efficiency and economization become not just economically expedient but also morally imperative. This project is communicated in policy statements and politicians' speeches, but it is also transmitted in the everyday practices through which privatized managed care is organized and administered.

The moral aspects of managed care became clear to me through the process of working at Acme. When I first began my job editing policies and procedures, I had no intention of writing a book about it; I planned to work part time for a few months while I got established in Puerto Rico and started a research project on reproductive health. But at Acme, I observed how my coworkers struggled to master the lingo of managed care, support their families, and please their bosses. Managers, in turn, distilled lessons about how to dress, show up on time, comply with regulations, and exhibit the right attitude. I saw elderly and disabled beneficiaries patiently waiting in the Customer Service department to speak with someone face-to-face, often flanked by several family members. And I wondered what the "managed" in managed care meant. As time went on, I found the rows of cubicles and reams of insurance regulations increasingly compelling so I began to concoct a new research project. I approached my direct boss, who already knew I was in the middle of a doctoral program, and pitched a study on managed care and quality, which was how I saw my research taking shape at the time. She encouraged me to approach the CEO for permission. I was nervous to speak with him, because I thought he would balk at my request. Who would allow an anthropologist unfettered access to their company? Instead, he enthusiastically supported my idea. Shortly thereafter, I obtained human subject approval to work at the corporation, observe daily life, and interview Acme members. The CEO signed the research agreement without even asking me to change the language (language that stated that whatever information I collected would be my property).

Within 6 months, I was promoted to Compliance supervisor. Shortly thereafter, I became a manager in the department. After 9 months at

Acme, my fieldnotes showed I was trying to make sense of managed care and chart out some sort of ethical terrain from which to assess it. In short, I found the moral discourse of managed care both compelling and insidious—I spoke in its language. I wrote,

> FIELDWORK MONTH 10. What I'm doing now feels so compromised, so closely linked to the government, to a corporation, to the privatization of Medicare. But somehow it feels honest. There is no way to feign innocence as the compliance manager of a largely U.S.-run company. I'm entangled. But the access is an anthropologist's dream.
>
> FIELDWORK MONTH 11. When I first started at Acme, a coworker mentioned off-handedly, "We make money as long as the members are healthy." What a strange confluence of the public good and capitalism. There's almost something utopian to the notion that the application of sound scientific methods in medicine and managed care will produce a healthier population, create profits, and allow us to distribute a limited good more widely. Always lurking in the background of this discussion (at least here in Puerto Rico) is the possibility of universal health care. But then the profit motive brings us back to reality. For me, part of this is an ethical issue: is it moral to let private corporations profit off of Medicare and Medicaid? Are limits on their profits a sufficient controlling factor? (What the hell does "controlling factor" mean? I find myself more and more using this techno jargon, becoming what I describe.)
>
> FIELDWORK MONTH 12. I would rather get my care through an HMO. I want my care to be managed. I want someone auditing the provider and making sure that I can appeal. I want disease and diabetes management programs. I am buying into the life-and-death stakes. I want order—rational delivery of health care. But I still have a problem with profit. Medicare is going bankrupt and the CEO is buying a yacht. I'm not sure if he is what's wrong or the answer. How did my position get so muddled?

Muddled indeed. I was remade through working at Acme by participating in the daily routines of managing care and reading scores of management primers, regulatory manuals, and company policies and procedures. However, I was also already amenable to the language of neoliberalism from growing up in the United States, attending

university, and having worked previously. There was a playfulness in my musings derived from knowing that this was fieldwork, in part a performance, and that it would at some point end. But there was also a real consternation when I realized that I knew how to do things like run a business meeting, describe how insurance worked, and monitor employees even though I could not pinpoint how I came to possess such knowledge. Part of the problem was that I needed to be able to work everyday and thereby had to learn to operate within this corporate world even as I tried to reflect on what it meant.

While working at Acme, I became caught up in competing moral discourses about managed care; I found some of its promises genuinely compelling. Recall Bush's framing of more managed care in Medicare as the act of "a vibrant and compassionate government" that was concerned with dignity and quality health care. He characterized the reform as part of efforts to "modernize" government that would "always trust individuals and their decisions, and put personal choice at the heart of our efforts" (Bush 2003). Who wouldn't want modern care, high quality, more choice, and dignity? From within, surrounded by its language, managed care seemed rational, beneficent, and modernizing. And yet I constantly saw the ways in which it went awry—initiatives designed to protect consumers' rights created layers of inscrutable bureaucracy; efficiency and cost-saving schemes produced new problems with the delivery of medical equipment; unmanageable employees were routinely fired. Managed care was itself a moral project invested in creating certain kinds of subjects (rational, calculating, health seeking) and instilling certain values (efficiency is good, efficiency coupled with cost-saving is better). But as a moral project, it was contested from within and without.

Acme as a Contact Zone

Over the course of my research, I began to think of Acme as a "contact zone" (Pratt 1992) where diverse organizational forms (corporate health care, federal bureaucracy, and a "Puerto Rican" workplace) rubbed up against one another in the process of creating a private health plan with a federal contract in a colonial context. Conceptualizing Acme as a contact zone foregrounds "copresence, interaction, interlocking

understandings and practices, often within radically asymmetrical relations of power" (Pratt 1992, 7). The corporation itself, and especially the Compliance Department where I worked, formed a crossroads where a group of diverse actors—federal government regulators, mainland health care entrepreneurs, Puerto Rican workers (from highly experienced and educated health care professionals to entry-level office workers), and elderly and disabled plan members—all interacted with one another and in so doing actively shaped the course of health care privatization on the island.

When Acme is understood as a contact zone, rather than as a blank slate on which governmental or managerial rationalities can inscribe themselves unopposed, then one can begin to appreciate some of the moral complexities of life at this managed care organization. The moral project of managed care was just one project among others directed at shaping employees' actions and their ethical orientation toward their work.

Workers at Acme already had political and moral ideas about privatization before they became part of the organization. One important source of these ideas was electoral politics. The three main political parties in Puerto Rico are organized around political status, and elections are interpreted as referendums on the island's future relationship with the United States. The Popular Democratic Party advocates for maintaining the current relationship with the United States. The New Progressive Party is pro-statehood and favors ending Puerto Rico's colonial status by becoming the 51st state of the union. The Independence Party supports complete political separation from the United States. *Independentistas* and *populares* tend to oppose privatization; they see privatization as a loss of political and cultural patrimony, and managed care in particular has come under criticism for being corrupt and too invested in profit making. Statehooders have led most privatization campaigns and support downsizing the Puerto Rican government in order to make it more modern, efficient, and more likely to become a state (Colón Reyes 2005, 301). For the purposes of understanding privatization as a contested moral domain, it is important to point out that employees came from all of the parties—an *independentista* led at least one department while many employees openly supported statehood.

Many employees were highly religious (both Catholic and various Protestant denominations) and hence understood "care" in a broader moral sense having to do with one's obligations to others and a duty to behave piously rather than the purely medical-technical and bureaucratic notion of care implied in "managed care" (I was once asked incredulously if the CEO was really an atheist). Employees often greeted one another and plan members with "*Dios te bendinga*" or "*bendición*" (God bless you, or blessing) indicating an ethical-religious orientation toward one another that exceeded their roles as rationalized health care workers.

Cultural expectations about how one should behave were also a frequent topic of conversation at the company with multiple opinions about "American" and "Puerto Rican" management styles. Almost all of the Puerto Rican–born employees at least partially spoke English, though most preferred to communicate in Spanish. Some managers were ridiculed behind their backs for being "too Puerto Rican" and not American enough in their management style (for example, if they were late to meetings or permissive with employees they were friendly with). Some American managers were derided for being too cold and businesslike (occasionally that person was me). The American executives took Spanish classes and tried to learn about the island (albeit returning to homes and apartments in exclusive, gated neighborhoods in the evenings). Finally, health care practitioners like the registered nurses (RNs) who worked in utilization review or case management came to Acme with competing ethical notions from the Hippocratic oath and their professional training in which letting financial considerations enter into medical decision making was seen as ethically wrong. These are the employees who probably struggled the most with their new workselves at a managed care organization. In short, thinking about Acme as a contact zone allows one to contextualize the moral project of managed care as it unfolded in an intercultural milieu that was already saturated with moral practices.

Organization of the Book

Even if management did not always work as planned, new market-based public-policy programs *did* reshape the health system on the

island and *did* draw citizens, corporations, and government into new kinds of relationships. Market-based public-policy programs radically reconfigured the provision of care when private managed care organizations contracted with the federal and Puerto Rican governments to provide publicly financed health services to poor, elderly, and disabled beneficiaries on the island. Privatization was also a moral project that cast market intervention as good, right, and natural while it set about trying to remake patients into responsible consumers, health care workers into managers of themselves and others, and health care providers into medical entrepreneurs. Each of the chapters that follow explores both the managerial and moral projects of implementing market reforms to health care.

In part 1, "Elements of a System," I examine the constituent parts that make up the health system in Puerto Rico. Chapter 1 retraces a 100-year history of reforms to the health system on the island beginning with the U.S. occupation in 1898. The shifting organizing principles of health planners and regulators are highlighted in this chapter and include sanitation and controlling communicable diseases during the first half of the 20th century, public health goals and ensuring universal access to care at midcentury, and efficiency and the free market beginning in the 1990s. Chapter 2 depicts the everyday nature of regulation through audit, performance management, and corrective action plans. It also shows the unstable side of private enterprise by retelling the stories of Acme employees who were fired, quit, or downsized. Chapter 3 tells the life histories of particular citizen consumers who struggled to obtain care in the privatized health system. This chapter also argues that the subject-making aspirations of neoliberal health policies never quite managed to remake patients into calculating, health-seeking consumers.

Part 2, "The Business of Care: Market Values and Management Strategies," consists of shorter chapters focused on specific technologies for managing care. In a sense, it shows the system in motion—it relates how the actors (health planners and regulators, HMO administrators, citizen consumers, and health care providers) come into contact with one another through the contradictory project of managing care. Chapters 4, 5, and 6 explore specific technologies and practices that are essential to managed care: quality measurement, complaints processing, the

role of choice, and partnering efforts between the federal government and managed care organizations. In each chapter, management sets out on an ambitious project of remaking the organization of care and the behavior of individuals who work in and are served by the health care system. Yet, in each chapter, management never quite achieves its aims. In the conclusion, I argue that failure and the unmanageable are central components of market reform. The conclusion revisits the moral implications of market reform, the legacy of U.S. colonialism in Puerto Rico, and the future of health reform on the island and the U.S. mainland.

Following research on the anthropology of policy (Shore and Wright 1997) and answering calls to study managed care and market medicine ethnographically (Horton and Lamphere 2006; Rylko-Bauer and Farmer 2002), this book explores "the growing influence of market ideology and corporate structures that are shaping medicine and health care delivery" (Rylko-Bauer and Farmer 2002, 476). I combine this critical approach to the privatization of health care with a set of concerns that are influenced by the work of Michel Foucault and others on governmentality and practices of self-regulation that are characteristic of neoliberal society (Foucault 1991; Lemke 2001; Rose 2007). But though I find these ideas compelling, they tend to cast the neoliberal person as a fait accompli. In my search for neoliberal consumers, few people responded as the system predicted. Instead, I saw Acme as a contact zone where managed care and market-based public-policy programs were one moral project among others that were invested in shaping how people behaved. Likewise, many of the patients who were enrolled in neoliberal self-management projects (like the brothers mentioned earlier) did not behave first and foremost as cost-benefit-calculating health care consumers. And so the workings of managed care, the moral project of market reform programs, and the promotion of self-care became ethnographic problems.