Editorial Column

Managed Care: Achieving the Benefits, Negating the Harm

Managed care has enormous potential for both benefit *and* harm. It can improve the quality and outcomes of care while constraining the rate of increase in costs. It can also lead to the withholding of needed services and the erosion of confidence and trust between and among physicians, nurses, other health professionals, and patients. What makes managed care controversial is the fact that clinical decision making continues to rely primarily on good judgment made in the gray zone of relatively indeterminate cause and effect relationships regarding the most cost-effective treatment practices. We don't trust a system that relies on financial incentives to deliver fewer services given that the determination of what is "appropriate" and "needed" is often a matter of subjective judgment.

It is vitally important for all in the health services research community to understand that whether managed care does more good than harm will depend as much on the "navigational" qualities of timely, well-executed research as it does on the managed care arrangements and initiatives themselves. To promote that understanding, this issue features four articles and introductory comments that are the result of an invitational meeting on "Health Care Markets and Managed Care: A Discussion of Emerging Research Priorities," sponsored by the Agency for Health Care Policy and Research in February of this past year. The articles have been independently reviewed, and as a set they challenge researchers to address the issues posed by managed care with new concepts, measures, study designs, and a renewed sense of urgency and timeliness.

The term "managed care" has become so routine in the health care lexicon that one assumes shared understanding among users. It is important to remind ourselves that this is not necessarily the case. For some, managed care means cost containment and reduction at the expense of needed services and, thus, represents compromises in quality of care. For others, managed care means "actively managing clinical care." This involves patient care restructuring through the use of guidelines, protocols, pathways, case management, continuous quality improvement techniques, and related approaches. I would like to propose a third definition that combines the emphasis on judicious use of resources with preserving and even improving the quality and outcomes of care. The new definition emphasizes the concept of *value* defined as cost relative to benefits received. The goal of managed care is to improve the overall value of health services delivered to the American public.

Based on this definition, I want to highlight a number of points that cut across the managed care research agenda–setting papers. The first is the need for new measurement and new methods of classification. "Managed care" organizations are an extremely heterogeneous group about which relatively little is known of even a descriptive nature. As Fraser and Wagner note, there is need to study the specific details of these organizations from the individual physician level to the clinic site, to the group level, to the larger integrated health system level. Hurley would add the purchasing organizations as well. Many of these entities are not pure physician, hospital, or insurance models, but rather represent *hybrids* of various forms. There is need to measure and describe the various forms of hybrid relationships.

There is also need for cross-level or "Meso" research that examines individual provider behavior within the context of the clinic or group that, in turn, may be embedded within a larger integrated health system. For example, at what level of physician group size should financial incentives for bearing risk be placed? It can be argued that placing incentives at the level of five or six physicians in a group would likely result in perverse behavior. On the other hand, placing incentives at the level of a 300-person multi-specialty physician group practice may be too large in terms of diluting a sense of personal responsibility for one's practice behavior.

Aside from the issue of levels of measurement, managed care's use of new communication technologies are also forcing us to think differently about traditional measures of access. For example, what does access to a personal physician or a regular source of care mean when more "care" is being provided over the phone or on the Internet? Is it important to have a regular source of care who is a specific physician or other provider, or does one merely need regular contact with a designated group practice or integrated health system? How many Americans are coming to view themselves as their own "regular source of care?"

A second theme involves the need to study the outcomes of provider-patient interactions within managed care systems across the continuum of care and across time. As Wagner notes, this is particularly important for examining issues of chronic illness, and Binstock and Spector address the long-term care implications of such assessment. Lurie develops the concept of "secondary access," referring to the ease with which patients can navigate their way through the continuum of care having made initial contact with the system.

A third theme, particularly evident in Hurley's article, is the need to focus on the extent to which managed care affects the way in which services are actually delivered, that is, patient care delivery redesign. This involves the use of guidelines, protocols, pathways, continuous quality improvement practices, and information systems to streamline care delivery and reduce harmful or unneeded variation. The ultimate value of managed care initiatives will be determined by what happens to patients and not by the financial, legal, or organizational restructurings that may be involved. It is important to remember that these restructurings are the means to the end—important, but only to the extent that they result in something different happening to patients and the communities in which they reside.

We also need to give greater attention to the *group* and *community* levels in our analyses. Wagner emphasizes the need to examine the shift away from one-on-one individual patient care delivery to the delivery of care to groups, for example, asthma patients, diabetic patients, and hypertension patients. Lurie calls for research that examines the impact of access at the community level and not just for an organization's enrolled population. Is there any evidence that managed care organizations and/or integrated health systems are reaching out to their communities to improve access to health services beyond the individual enrollees of the system's health plan?

Although not directly addressed by these articles, it is important to note that managed care also presents a challenge of *accountability*. Patients appear to be moving away from the almost naive form of trust they have historically placed in their personal physician to a new demand for "evidence-based" accountability. Health care report cards and patient protection legislation are but two manifestations of this phenomenon. There is great need for research on these new forms of accountability and on their ability to curb the potentially negative impact of managed care and to help promote the potentially positive outcomes.

The relevance of these managed care research agenda–setting papers is underscored by the remaining presentations in this volume. Each of these articles, ranging from Schlesinger et al., "The Determinants of Dumping: A National Study of Economically Motivated Transfers Involving Mental Health Care" to Schlenker et al., "Rehabilitation Costs: Implications for Prospective Payment," deal with some aspect of "managed care." Significantly, they deal with populations that are most vulnerable to the potential negative aspects of managed care, namely, the mentally ill, those suffering from substance abuse, and those in need of intensive rehabilitation. It is hoped that the findings that emerge will serve as a foundation for future research that examines the impact of managed care policies and practices on individuals, groups, and communities across the United States and other countries. Through the timely examination of these questions and issues, health services research can help guide all parties toward the realization of greater value from our growing involvement with managed care.

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