Mention managed care to a Canadian, and he may tell you that it’s one of the best reasons to stick with public medicare. Large, impersonal health maintenance organizations (HMOs) loom large in the Canadian imagination, and American-style managed care often brings to mind only the bad — reduced choice of physicians, limits on what services are covered, and delays in or denial of care being prime examples.

But it turns out managed care is getting a bit of a bad rap. While no healthcare system is perfect, some American managed care organizations have made strides in many areas, such as improving chronic and preventive care, reducing hospital use, and improving physician practice.

**Managed care 101**

Managed care refers to a wide variety of healthcare systems, some of which control costs largely by contracting with physicians for reduced fees and by restricting the patient’s choice of physicians. Managed care includes health maintenance organizations, which either directly employ doctors or contract with groups of clinicians to provide services. Patients are usually required to have one primary care physician or physician group to pre-authorize tests, visits to specialists, and other services for care to be covered by insurance. Particularly in HMOs, savings achieved through more efficient use of services like hospitals and MRI tests can be shared with the clinicians.

Managed care organizations often put a strong focus on managing chronic illnesses and providing preventive care, in the hope of avoiding costly acute care later on. For example, in 1996 Kaiser Permanente, the largest health maintenance organization in the United States, created an integrated diabetes care management program. Kaiser used the best evidence available to develop treatment guidelines and, working collaboratively with its physicians, implement a plan that improved screening and control of blood sugar levels for its diabetic patients.

Another innovation that is becoming widely used is the “chronic care model” developed by the Group Health Cooperative, a non-profit HMO based in Seattle. The model identifies six “pillars” of good chronic care, including having healthcare organizations link with community resources and teaching patients good self-management skills. Studies of healthcare organizations that have implemented components of the model show improvements in the care provided to chronic patients.

Finally, studies of the American Veterans Affairs health system have found dramatic improvements in treatment for chronic care since it reorganized itself along the lines of a managed care organization in the mid-1990s. Examples include treating diabetes and high blood pressure and screening for and treating depression.

Some managed care organizations also do well in preventive care. Studies have looked at health maintenance organizations, the Veterans Health Administration, and Medicare’s managed care option, which allows seniors to use their Medicare
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benefits to enrol in a managed care health plan and typically receive more benefits than they would under the traditional fee-for-service option. They show higher levels of preventive services, such as vaccinations, counselling to quit smoking, screening for various cancers, and regular blood pressure checks.⁶⁻¹⁰

Show me the money

Since a hospital is usually the most expensive place to treat someone, managed care organizations (and indeed all health systems) look for ways to care for patients in non-acute settings while still giving them the best care possible. While it is always difficult to compare different hospital populations, the Veterans Affairs system reduced bed-day rates by 50 percent over four years after its reorganization, with no change in patient mortality, and bed-day use in the British National Health Service is three and a half times that of Kaiser’s rate.¹¹,¹² Finally, an extensive study of the American health system found more inappropriate hospital admissions among fee-for-service patients than among patients of Group Health Cooperative.¹³

Improving performance

One final aspect of managed care that is worth noting is its focus on providing doctors with feedback on their performance. While this information is used to determine which physicians cost the system the most (in terms of ordering tests, sending patients to specialists, etc.) and for bonus payments, it is also used for quality management. Doctors know if they are meeting benchmarks for proportion of patients screened for cancer or given a flu vaccine, for example.¹⁴⁻¹⁵ Those working in managed care organizations are far more likely to receive this information than physicians in other types of practice.¹⁶

Conclusion

Managed care organizations want to get the most out of every dollar, as do purchasers in other healthcare systems. While this can sometimes result in undesirable strategies that are well-documented in the popular media, it also means managed care organizations primarily offer services that have strong evidence of effectiveness. While requirements to see only one physician or physician group and less hospital use are seen as negatives by many patients, innovative managed care organizations find creative and effective ways to prevent illness and complications, enhancing their patients’ health while at the same time being financially responsible.

References


