

Managed Care with a Mission

BY GREG VAN PELT

Managed care is not a new concept. Chronicles of the Sisters of Providence describe prepaid healthcare provided by Mother Joseph to early settlers in the Oregon Territory. Kaiser Permanente in the Northwest and Providence Good Health Plan have decades of experience in prepaid managed care, as do many other healthcare organizations in the United States. However, managed care is much more prevalent than before. To understand the role of managed care in our system, we first must understand why managed care has evolved.

PRINCIPLES OF A SERVICE MARKET

Any service provided to any market has to meet three criteria to be successful: The service must be accessible, of affordable cost, and of acceptable quality. Whenever any one of these market forces is out of balance, the market condition changes and the service faces certain failure. This is not a question of mission or ethics. Even "free" social service agencies will fail if they perform a service that is cost prohibitive (computed as dollars, time, or opportunity), that is inaccessible, or that its users see as inferior.

The healthcare system as we have known it, and for the most part as it was built, continued for decades without change because it was *affordable*. Employers and insurance companies paid the bills, and uninsured people either received charity care or were invisible to our society. The system continued without change because it was *accessible*—people could receive care

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wherever they wanted it—and because it had perceived *quality* as measured by technology and access. Like all markets, however, the healthcare system has changed, and we who deliver healthcare services have found ourselves out of balance.

SYSTEM OUT OF BALANCE

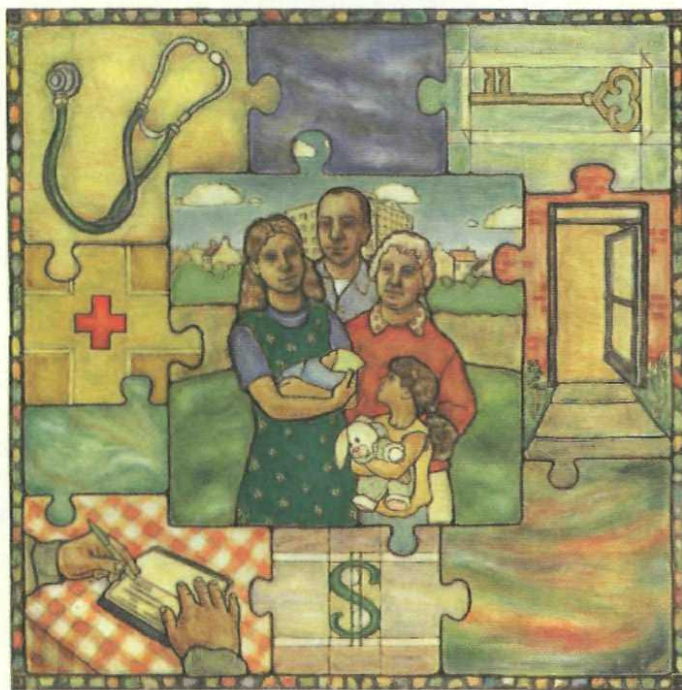
Employers and most individuals can no longer afford the cost of the existing system, too many people do not have access to care, and quality is difficult to measure.

In a recent survey conducted for Providence Health System in Portland—a market of high HMO penetration—we asked if people thought healthcare was on the right or wrong track. A disappointing 61 percent of respondents said healthcare was on the wrong track. They were not disappointed in HMOs. In fact, Medicare beneficiaries represented the most favorable

opinions in the survey, this in a market with more than a 55 percent Medicare HMO presence.

Most respondents who said healthcare was on the wrong track expressed concerns about cost and access. Other surveys reveal similar findings in terms of what people want from the healthcare system. Communities look to their local healthcare system to be accountable for prevention, coordinated services and information, quality in terms of service and health outcomes, and fair price relative to other goods and services. The challenge for leaders today is engineering our system to meet those expectations.

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Katherine Berney

THE REAL CHALLENGE

Our real challenge is not finding a role for managed care in "our" system, but changing the system itself. Managed care offers the opportunity to experiment with new models. Changing the system itself requires an understanding of the results the system is expected to achieve. As a nation, we have failed to specify those performance goals, but I believe Catholic healthcare organizations have been able to articulate the balance of cost, access, and quality that we hope to achieve and to express the value of managed care in meeting those goals.

Cost Healthcare must be balanced with other needs, including food, shelter, and other social services that have a direct impact on healthcare cost. Because managed care plans provide appropriate services for a defined population or community, they are able to allocate resources where they can do the most good, not where they generate the most income to providers.

In many respects, the debate on resource allocation becomes one of justice. Which services do the most good for the most people in an environment of fixed resources? For example, prenatal care to reduce low birthweight can be more cost-effective than reacting to problems associated with low birthweight. Early breast cancer screening and interventions are less expensive and have a greater impact on survival rate than expensive technological intervention in late-stage cancer. Hospice care can be less expensive and more responsive to human dignity than futile technological solutions at the end of life.

We need to design a system to manage cost increases similar to those in place for other components of our economy. Managed care allows us to provide services that avoid long-term costs and reward providers for prevention as well as for performing procedures. We move from "Did we do it right?" to "Did we do the right thing?"

Access As Catholic healthcare providers, we recognize that all individuals have a right to appropriate care. The goal of universal access calls us to design systems that can meet the needs of the uninsured. Managed care provides a mechanism to plan resources for the special needs of the poor and vulnerable through such programs as Medicaid risk contracts. Initiatives in which healthcare providers work with Catholic Charities

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represent another example of the "larger view" of healthcare.

Managed care can facilitate our ability to finance, arrange, and deliver services to meet people's needs, many of which are met outside of institutions. Parish nursing and nurse advice lines are two examples of innovative outreach programs. Using the "membership model" of managed care—that is, knowing our members and having the flexibility to allocate premium dollars—we can provide better access to more people and design specific services to meet their needs.

Quality Closely related to access is the criterion of quality. Historically, quality focused on procedural outcomes and access to technology. Managed care emphasizes the measurement of health indicators of a population. This view of quality requires a different approach to measuring success as a healthcare system and is almost impossible to gauge without managed care tools, such as population health risk assessment and disease management. Epidemiology, immunization rates, and birthweight rates, for example, all require a population "denominator" to measure progress in improving health. The "membership" model allows us to understand our populations, experiment with intervention, and measure our progress, as we do in public health programs. Managed care does not mean a lack of attention to the individual; rather, it provides the individual with the best intervention based on knowledge of the best outcome for people of similar needs or interests. This approach to care also reflects the Sisters of Providence's core values: respect for the individual and excellence based on empirical evidence.

RETHINKING THE SYSTEM

The future of Catholic healthcare is managed care with a mission. Managed care involves all the components of healthcare delivery, not just financing. It requires Catholic healthcare leaders to make a substantial effort to rethink our ethical principles, rethink our systems of care, and rethink our mechanisms of measuring accomplishments and the value that Catholic healthcare brings to our communities. Our leadership challenge is to promote change and build the best managed care systems possible. □