Simply stated, containing healthcare cost does not automatically equate with the provision of optimal medical outcome in the mind of the provider or the consumer. Indeed, it would be surprising if it did; healthcare systems are so complex due to the conflicting roles of the provider and consumer, patient and physician. The era of limited resources is forcing us to adopt a different paradigm. We are moving from a simple system, based on structure and process, toward one that focuses, as well, if not predominantly, on outcome and accountability.

Few would disagree with the objective of using the fewest resources to produce the optimal health care. The attainment is neither simple nor easy to reach. The myriad of financing mechanisms ranging from Federal programs such as Medicare and Department of Defense, State programs such as Medicaid and their own employee health care plans, the private sector with group and individual insurance, Blue Cross and Blue Shield programs, self-funded ERISA plans, workers' compensation and automobile first- and third-party medical payments, cause the actuality of accountability and outcome measurement to be blurred in terms of the specific patient or injured party. Furthermore, while there are perverse financial incentives from some of the programs in terms of the provider, such as fee for service, there are perverse incentives for the consumer or patient in the workers' compensation programs and third-party automobile liability.

Financing itself may not be the only variable. Indeed, the Health Care Financing Administration (HCFA) is pursuing the ultimate goal of realizing maximum value for the health care dollar. This goal, HCFA believes, can only be achieved by the realization that there must be simultaneous attention to the interrelated dynamics of price, volume and quality. Both difficulty and challenge reside in how such attention is applied and who (payer, provider and/or patient), should assume the primary stewardship and responsibility.

There are candidates. The simple expedient of controlling price and process by setting and enforcing limits on prices and closely supervising the service delivery process allows the patient to retain responsibility.

HCFA, through demonstration programs, has encouraged cost effective use by offering incentives and choices to the beneficiaries. Finally, HCFA has entrusted the care and management responsibility to the providers, either in local and defined areas of diagnostic category, such as coronary artery bypass surgery, or whole population groups as in the capitation payments made to HCFA risk contracting Health Maintenance Organizations. In other words, HCFA is gradually altering the relationship of payor, provider and patient in the realization that there is a future finite amount of resource available and these programs are there to "redistribute" the available resources.

In fact, in this country we spend more than any other country in the world, per capita, on health care. Thus we should have enough to have the best health care system that money can buy in terms of access and outcome, life expectancy, perinatal mortality, and inoculation rate, if the resources were to be distributed and consumed appropriately. It is the frugal management of resources that managed care really is.

Despite that, managed care has mixed reviews. As fast as states legislate programs that manage healthcare resources (i.e., managed care enabling legislation) other legislation appears that makes it more difficult to manage care, because there is a perception that managed care causes physician "hassle" and additional and unnecessary extra administrative expense. Part of the current confusion is semantics. Although the heat generated in often acrimonious arguments makes one wonder if it is more semiotics than semantics. The term "managed care" symbolizes to some the most invasive, intrusive and interfering procedure that increases physician "hassle factor" and inevitably leads to compromise in the management of the individual patient and additional, unnecessary expenditures. To others, managed care is a panacea, a creative and caring attempt to provide the appropriate and necessary care, even if that particular care falls outside the specific contractual obligation of that healthcare benefit plan, insurance certificate or policy. For some, the term "managed care" has been changed to reflect more accurately the actions, they think: coordinated care, case management, rehabilitation and cost containment, but above all the enhancement of quality.
In the editorial, "The Essence of Managed Care," I define managed care, and for the purposes of this editorial, I am keeping fairly close to that definition. The purpose of that editorial was to try to define the concept of managed care and transmit the noumenon. It is the specific phenomena of managed care that garner advocacy or criticism, act as rallying banners or lightning rods for different factions. Again, I am suggesting a definition for the essence of managed care:

The structure: An organizational structure, opportunity for control, for measurement, for accountability and feedback. The process: Appropriate financial incentives, management control and the use of information systems to facilitate operational decision making and the outcome: Namely, the balance of healthcare resources, quality enhancement and cost containment.

In order to have a managed care program that meets the above "specification," there must be specific tools. It is these tools, and the applications of the tools, that are presented by this cluster of articles.

Perhaps the sobriquet of "tools and applications" is somewhat simplistic when talking of an area so complex as managed care. Nevertheless, the notion is that there must be an organizational structure. This structure must be identified as providing an efficient and accurate service commensurate with the investment needed for managed care. Furthermore, to achieve such a structure, the impetus must come from the top.

"Opportunity for control, for measurement, for accountability and feedback." Along with the appropriate "organizational structure," these are components of the structure portion of the definition of "managed care." In order to have a functional entity there must be something within the "organizational structure" that permits the flow of information. Indeed standard data elements, standardized billing through the predominant use of universal hospital (UB82) and physician (HCFA 1500) billing formats and standardized data set format for transmission are prerequisites. It is this area that is covered in the first of the managed care "Tools" articles. Edwards (see pp 162-166) focuses predominantly on electronic data interchange (EDI). She writes of compelling reasons to have a paperless claims system and supplies evidence that this could cut administrative cost. However, she stresses the potential of value-added services. In fact, it is the model she uses of the pharmaceutical industry that is most poignant. A certain company used to receive claims by mail, entered them into their database, and from that, paid claims. They cut the checks and mailed them individually. The company now has few, if any, traditional claims payers. The inputting is done in the local pharmacy by the pharmacist. On-line EDI results in the functions that used to be performed by the company are now being performed by the claimants and the service of the "old claims payer" are being a value-added informational source on drug side effects, cross reactions and cost. Furthermore, this system can now be relied upon to provide statistical reports "...for measurement, for accountability and feedback." Finally, Edwards reviews briefly other uses for EDI such as outcomes research, fraud detection, provider profiling, evaluation of practice parameters and utilization management.

Moving to the "Process" portion of the definition of managed care definition, Manton (see pp 166-171) covers the topic of practice parameters. By now, synonymous with quality, is the adage, "know what to do, do it and do it right the first time." This may be appropriate for an industrial manufacturing process and it is easy to calculate the "price of non-conformity," or the cost of the re-work process, but it may be even more so for medical matters. We do not necessarily know the cost of the highest quality, but we surely know that the poorest quality can be had for ultimate price - death. Poor quality, short of death, often requires longer hospital stays and more re-admissions, repeated investigatory tests and surgical procedures. Practice parameters are described in terms of development and dissemination. The potentially beneficial aspects are high-lighted. He also outlines some common concerns.

Education in general, and in specific as it applies to managed care, is extremely important. Ziegenfuss (see pp 171-176), one of the few clinical program directors of fellowship programs in quality assurance, utilization management, risk management and clinical decision making, writes from the perspective of his program at Penn State at Harrisburg, Pennsylvania. He discusses the future needs for education. He divides healthcare quality into some six major areas: organization and management, health systems, quality theory and methods, management information systems and research, governmental policy and economics and finance. Not only does Ziegenfuss outline forces that are driving the educational imperative, but he challenges us on the levels and delivery of the education tool. It would not be inappropriate to consider that these efforts are aimed at "constant improvement," "on the job training, building leadership and instituting educational self-improvement."

Three authors address the "tools":

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Implicitly, this editorial has covered the fourth "tool": total quality management (TQM) or continuous quality improvement (CQI). I chose not to have a separate article on TQM/CQI for I thought that it would necessarily send the wrong message. TQM/CQI is inherent in any managed care program; it must be. It cannot be regarded as an isolated module. In fact, as I have reviewed the other "tools" not only have I covered Deming's fourteen points:

- Organizational structure
- Impetus from the top
- Statistical controls
- Containing costs
- Constantly improving
- Established on-the-job training
- Build leadership
- Drive out fear
- Break down barriers between areas
- Eliminate slogans
- Manage through effective leadership
- Remove barriers for individuals
- Institute educational self-improvement
- Involve everyone

but I have also mentioned Crosby's "price of non-conformance."

The final three articles in this cluster are some "applications":

Outcomes Management
Physician Profiling
Technology Assessment and Control

Nash writes on "outcomes management." (see pp 176-179) He traces the movement of outcome management from the perspective of the health service researcher, the administrator or clinician executive, the clinician and the purchaser.

The Physician Payment Review Commission has examined the potential of profiling physician practice patterns within the context of cost containment and quality assurance. Dr Philip Lee, Chairman of the Commission, and colleagues review that experience. (see pp 179-182) They stress the profile of a practitioner may be practice-based or standards-based. The Commission has been particularly interested in the application of profiling in three areas: quality improvement, assessment of physician performance and utilization review. Lee raises the controversial question of having cost-effectiveness as a component in the data used to compare performance. In contradistinction to the Agency for Health Care Policy and Research, the commission believes that cost-effectiveness must be a factor in assessment of appropriateness of care. Parenthetically, one should add that the deliberative body of the American Medical Association, the House of Delegates, has debated long and hard and will only countenance profiling for education purposes.

In the final "applications article," Sennett (see pp 182-186) discusses technology assessment and control. He defines technology assessment and discusses "generation" and "synthesis" processes. At the heart of the assessment he enumerates two critical parameters, namely effectiveness and cost. Sennett points out in the second section of his article that there are opportunities to control the use of technology. These range from the development and introduction phases, to expansion, maturity and senescence.

In putting together this cluster of articles, I have tried to highlight some tools: electronic data interchange, practice parameters and education. I have indicated that to use these tools and subsequent "applications" effectively, total quality management/continuous quality improvement is necessary. I have selected as applications: outcomes management, physician profiling and technology assessment and control.

In this cluster of articles I have deliberately omitted, for space reasons, several other very important "applications," namely:

Cost Containment
Vendor Management
Case Management
Reimbursement Issues

The first of these, cost containment, comprises bill review and repricing, rebundling of unbundled services and other claims practices, and fraud and abuse detection and control. By vendor management, I mean the appropriate oversight of services such as supplying durable medical equipment, rehabilitation services, software programs for claims management that may be provided by one or more vendors.

Case management could almost rate a whole journal edition to itself, and is obviously an "application" which may be extremely complimentary to the goals of enhancement of quality and preservation of value. Finally,
I have not included an article on the development of fair reimbursement prices.

In summary, I have started from the definition of the concept of managed care and have selected a number of articles discussing the tools and applications which may enable managed care to be successful in enhancing quality of care and preserving value for the service. In the context of these articles it is possible to define managed care in a more precise and specific way.

Managed Care: A way of enhancing the quality of care, developing accountability and bringing value to the consumer by clinician, administrators, purchasers and payors, using basic tools such as practice parameters, education in health quality management, data information management and total quality management, and to develop skills in outcomes management, physician profiling, technology assessment and control, cost containment, vendor and case management and the development of fair reimbursement policies so that resources may be used in an appropriate, efficacious and cost-effective manner. (Figure)

References