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Editorials

Managed Care and Public Health

Integrating the principles of public health into the health care delivery system has always been a challenge. In the disaggregated health care delivery system that existed before the advent of managed care, physicians were trained poorly (if at all) in public health matters, and the mainstream health care delivery system left issues of public health to the health departments. State and local health departments, later with support from the federal government, created an entire infrastructure to address a broad range of public health needs.

Certain activities, such as surveillance and community assessment, were population-based and transcended personal health care. Others, such as provision of immunizations, management of patients with infectious diseases, and diagnostic laboratory testing, entailed both public health activities and personal health care. Although they were dependent primarily on government grants, these programs could seek reimbursement from third-party payers where appropriate, and they could do so without prior authorization, since clients were free to choose their providers for covered services and insurers exercised minimal control over utilization of covered benefits.

This disaggregated approach had the disadvantage of not integrating public health principles into traditional health care delivery; consequently, many opportunities for public health interventions were lost. However, it had the advantage of permitting the development of a parallel delivery infrastructure that was committed to public health principles.

Public Health and Managed Care

Today the system is quite different. Managed care is now the health care norm, with models that range from a closed-panel health maintenance organization to more loosely structured networks of providers who offer discounts to the plan with limited controls on uti-

lization. Managed care systems for low-income families and individuals (those most likely to depend on public health clinics) use tight design and controls to compensate for the absence of cost sharing. Managed care organizations thus have the capacity to dramatically influence who provides care, how the care is furnished, and who receives compensation.

The integration of financing and service delivery into unified arrangements creates the potential for greater integration of public health principles into managed care. However, commitment on the part of managed care organizations to address public health issues is still absent, for the most part. Indeed, as Miller et al. have observed, the very philosophies of public health and managed care are quite different: the former thinks of populations and identification and treatment of risk while the latter thinks of individuals or covered lives and risk avoidance.¹

The goal of managed care is to prevent and cure disease among members of the managed care plan. However, although the primary duty of managed care organizations is to their members, the organizations function within a larger community, and their operations must be consistent with public health goals. On the other hand, the goal of public health is to ensure the health of the community at large, and public health officials see their duty as promulgating this approach among all health care providers in the community.^{1(p678)}

The transformation to managed care has coincided with harder times for public health. The decline in grants investing in the public health infrastructure is only one aspect of the problem. The switch to managed care means that many public health clinics can no longer seek third-party reimbursement (even from Medicaid) if they are not part of the network of a client's managed care organization, a status that only a small proportion of public health agencies have achieved. At the same time, health agencies have a legal and moral obliga-

tion to furnish care to the public at large, a fact that causes health departments to use increasingly scarce discretionary dollars for services that were once covered by third-party payers.

Far too often, the response of public health has been to decry the very existence of managed care and to blame the managed care system for public health's problems, or to predict the imminent demise of managed care and express the hope that a return to the "good old days" of fee-for-service will come sooner rather than later. Neither approach is likely to succeed.

The Challenge for the Future

Managed care, properly managed, offers tremendous potential for the public's health, especially for populations who have traditionally had poor access to health care. For example, before managed care, Medicaid beneficiaries were entitled to coverage but often had difficulty finding providers willing to serve them. Managed care organizations that are responsible for the coverage of Medicaid beneficiaries must ensure access to real services, not just coverage. While there may be some debate about the scope and quality of those services, managed care, implemented correctly, can indeed increase access to care for certain populations. Furthermore, the responsibility of managed care

organizations for the quality of care and for their clients gives public health a means to influence the standard of care through development of population-wide measures of performance.

It is naïve to think that managed care is going to disappear. Some form of management of care will always be with us, both as a cost containment measure and as a quality control or accountability measure. The question is not *whether* care will be managed, but *how*.

If this is indeed the reality—that managed care is here to stay and that the infrastructure of the US health care delivery system is changing dramatically—then the challenge for public health is 2-fold: (1) How can public health influence managed care by integrating public health principles into the workings of managed care? and (2) How must public health adapt to compete in a managed care environment, collaborate with a changed health care delivery system, or both?

These questions, easy to pose, encompass a broad array of critical subsidiary issues. They are also difficult to answer. It is our hope that the pages of this Journal, in the months and years ahead, can be used to describe what has been happening to public health in an evolving health care delivery system; to assess what strategies public health must adopt to ensure

the continued strength of a population-based perspective in health care delivery; to consider what can be done to create a better understanding and accommodation of the tension between population-based and individual-based approaches to health; and, just as important, to discuss how public health must change its structure and approaches to achieve traditional public health goals in a changing system.

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