Not-So-Strange Bedfellows: Public Health and Managed Care

Picture a group of public health professionals 10 or 15 years ago, relaxing after a long day of American Public Health Association sessions. They have been discussing the failings of the US health care system and imagining an improved version, consistent with public health values. It would be a population-based system that viewed prevention as integral to its mission. It would seek to decrease the frequency of unnecessary medical tests and interventions, and it would place health care tasks in the hands of those most suited to perform them, increasing reliance on primary care practitioners and giving more responsibility to nurses and physician's assistants. It would try to markedly improve equity and access to care while controlling costs and maintaining or improving quality. It would add accountability to the provision of health care.

In tribute to this vision, glasses are raised, toasts made. And most of the group will leave the table with a resigned sigh, convinced that they will never actually see such a system, no matter how much sense it would make.

Today, the public health idealists who sat around that table would probably be reluctant to admit that many of the elements they envisioned are actually part of the current health care landscape, in the form of managed care. Somewhere along the line, managed care's negative aspects—of which there are plenty—have overshadowed its positive features. Shameless profiteering, restricted choices for patients, restricted decision-making latitude for physicians, and poor customer service are but a few of the complaints that have put health maintenance organizations at the bottom of public opinion polls.[1] In addition, in the broader health care delivery system, not limited to managed care, the issues of equity and access have not been resolved. Nevertheless, as we criticize managed care for its flaws and inadequacies, we should not ignore the considerable common ground and common purpose that exist between public health and managed care, and we should not discard the improved elements of the health care system that have been features of many managed care plans.

A Need for Collaboration

Having worked in both areas, we have observed that the suspicion between public health and managed care is mutual. The managed care world, like the rest of the private sector, is woefully ill-informed about public health's role and contributions, and managed care has few incentives and even less inclination to bring public health to the table. Public health often displays an equally shocking ignorance about the mechanics of health care delivery and a knee-jerk antagonism toward the structure and administration of the health care delivery system. Ignorance and apathy on one side and ignorance and hostility on the other are not the best recipe for collaboration. Yet collaboration between public health and managed care is precisely what is required to improve the health of individuals and communities.

The fact is that managed care and public health are codependent in the most straightforward sense of the term: we need each other to get the job done. Modern public health—including immunization, cancer screening, heart disease risk management, injury prevention, and protection from environmental hazards—simply cannot be practiced without collaboration from the health care delivery system, which is often a managed care system. Our current challenges in public health—such as eliminating health disparities, improving the quality of life in an aging population, and combating an epidemic of obesity by integrating physical activity and healthy eating into our daily lives—require participation by health care providers in their offices and in their role as community leaders.

Health plans can structure programs, outreach efforts, and incentives to help meet these challenges. In the process, the health plan members benefit and the institutional (or corporate) goals of the plans are furthered. Also important in this scenario are the purchasers of health care, the employers of workers whose benefits include health care. The content and processes that a plan offers are heavily influenced by what the purchaser requires and is willing to support. The more purchasers value prevention, the more they see community health as being in their long-term interest, the more likely they are to support substantive collaborations between public health and health plans.

Guidelines for Quality of Care

Five years ago, after a consultative process that included state and local health departments, employers, and the managed care industry, the Centers for Disease Control and Prevention (CDC) laid out recommendations for itself to follow.[2] Most of these recommendations have been acted upon and, along with independent actions at state and local levels, they provide examples of successful collaboration. These examples of collaboration can be grouped into 3 areas similar to those laid out by the Institute of Medicine in *The Future of Public Health*[3]: assessment of needs and progress, choice of interventions, and implementation.

Assessment

At the national level, the Health Plan Employer Data and Information Set (HEDIS)[4] has been a remarkable tool for assessing needs and progress. Developed by the National Committee for Quality Assurance (NCQA), HEDIS serves as a "report card" on the quality of care provided by 441 managed care plans caring for more than 51 million Americans. HEDIS measures not only the quality of care provided to employees insured by their employers but also the quality of care provided to our most vulnerable insured populations, those who are covered by Medicaid and Medicare.

Relying heavily on the US Preventive Services Task Force's *Guide to Clinical Preventive Services,*[5] the CDC worked closely with NCQA on the development of HEDIS. The results include a strong emphasis on prevention. Of the 17 HEDIS measures of effectiveness of care, 5 measure primary prevention (immunizations, prenatal care, and advice to quit smoking) and 3 measure secondary prevention (screening for breast and cervical cancer and chlamydia).

Because managed care organizations depend on their HEDIS scores for accreditation, they pay special attention to the areas measured. This attention is paying off. For example, NCQA reports that from 1998 to 1999 cholesterol screening among persons with coronary heart disease increased from 59% to 69%.[6] HEDIS also shows areas where improvement is still needed. In 1999, the first year of measurement, only 16% of sexually active women aged 21 to 25 years had received a chlamydia screening test in the previous year.

At the state level, the Missouri Department of Health is assessing the quality of care provided by managed care plans to guide Missouri consumers in choosing among these plans. To create its *1999 Show Me Buyer's Guide,*[7] the department used consumer satisfaction data collected directly from consumer surveys, as well as clinical data provided by the managed care plans via HEDIS. The guide identified plans with higher-than-average or lower-than-average performance in overall member satisfaction. Areas in which satisfaction was measured included number of doctors in the plan, care received, referral to specialists, approval processes, and clinical areas (e.g., prenatal care, breast cancer screening, diabetes care, and advice to quit smoking). Missouri is one of many states that are collaborating with managed care organizations to provide this sort of guidance to consumers.

Interventions

The choice of interventions is another area for collaboration between public health agencies and managed care organizations, and "The Guide to Community Preventive Services"[8] is a good example of successful collaboration at the national level. In this guide, the Task Force on Community Preventive Services offers evidence-based recommendations for effective preventive interventions. Many of the recommendations relate to the delivery of effective clinical preventive services and are immediately usable by managed care organizations seeking to improve the health and health care of their enrolled populations. For example, the task force strongly recommends the use of reminder-recall systems to increase the number of persons receiving immunizations.[9]

The task force consists of 15 members, including 2 from managed care organizations and 1 from a national organization of employers interested in health. With the input of these representatives from the private health care system, the task force has chosen 7 areas for review in its first volume to be published in 2001: diabetes, immunizations, motor vehicle occupant injury, oral health, physical activity, sociocultural environment, and tobacco use.

A good local example of collaboration in choosing interventions is a diabetes program in San Diego, Calif. Diabetes is a disease with a major burden of illness, and it is among the costliest items in a health plan. Public health interventions are directed toward early recognition of the disease and prevention of its serious sequelae, such as renal disease, retinopathy, heart disease, and the need for amputation. The San Diego Health and Human Services Agency has joined with more than 20 health plans, physician groups, insurers, hospitals, voluntary organizations, and educational institutions to form Community Health Improvement Partners, a group that targets public health priorities including access to care, school health, needs assessment, immunizations, mental health, and diabetes.[10] The diabetes program, Project Dulce, focuses on the needs of underserved Latino populations. The intervention uses group education, skill building, social support, and exercise groups implemented by community health educators and is linked to clinical and case-management programs.

Similarly, the Jacksonville Plan of Prudential Health Care in Florida improved the glycemic control of its members with diabetes through a program using a nurse educator and emphasizing prevention.[11]

Implementation

The third area for collaboration is implementation of preventive activities. In one example of this type of collaboration, the CDC has recently undertaken a national partnership with managed care organizations and employers to increase the use of influenza and pneumococcal immunizations by adults. The managed care organizations include the American Association of Health Plans, the Alliance of Community Health Plans, the BlueCross

BlueShield Association of America, and the National Institute for Health Care Management. The employer groups include the Managed Health Care Association, the National Business Coalition on Health, and the Washington Business Group on Health.

As a first step, these partners chose adult immunizations as one of the most cost-effective missed opportunities for prevention in the United States. Then, using the recommendations of the Task Force on Community Preventive Services,[9] the national partners began developing state and local collaborations in Connecticut; Denver, Colo; and Detroit, Mich, to increase the delivery of influenza and pneumococcal immunizations. The local collaborations, which involve state and local governments, employer coalitions, the majority of local managed care organizations, and the peer review organizations supported by the Health Care Financing Administration, will measure immunization coverage at baseline and over the next 3 years to document the program's effectiveness.

More Must Be Done

These are but a few examples of the types of meaningful partnerships with managed care that can help further public health's prevention and population health objectives. Countless other opportunities await. If public health waits to be invited, however, the wait may be long. Whether we are satisfied with the current health care system (a rather small cohort) or would like to see a national health service in the near future, public health professionals have a responsibility to improve the public's health. We can do this more efficiently, effectively, and thoroughly, through a closer collaboration than we currently demonstrate between public health partners—government, voluntary, professional, and academic—and all parts of our health care delivery system, including managed care.

Jeffrey P. Koplan, MD, MPH
Jeffrey R. Harris, MD, MPH

The authors are with the Centers for Disease Control and Prevention, Atlanta, Ga.

Requests for reprints should be sent to Jeffrey P. Koplan, MD, MPH, Centers for Disease Control and Prevention, 1600 Clifton Rd, Atlanta, GA 30333.

This editorial was accepted September 19, 2000.

References

1. Military tops confidence poll. *USA Today.* September 13,2000:1.
2. Centers for Disease Control and Prevention. Prevention and managed care: opportunities for managed care organizations, purchasers of health care, and public health agencies. *MMWR Morb Mortal Wkly Rep.* 1995;44(RR-14):6–12.
3. Institute of Medicine. *The Future of Public Health.* Washington, DC: National Academy Press; 1988.
4. *HEDIS 2000. Narrative—What's in It and Why It Matters.* Vol 1. Washington, DC: National Committee for Quality Assurance; 1999.
5. US Preventive Services Task Force. *Guide to Clinical Preventive Services.* 2nd ed. Alexandria, Va: International Medical Publishing; 1996.
6. *State of Managed Care Quality 2000.* Washington, DC: National Committee for Quality Assurance; 2000.
7. Center for Health Information and Evaluation. *1999 Show Me Buyer's Guide: Commercial Managed Care Plans.* Jefferson City: Missouri Department of Health; 2000.
8. Truman BI, Smith-Akin CK, Hinman AR, et al. Developing the Guide to Community Preventive Services—overview and rationale. *Am J Prev Med.* 2000;18(suppl 1):18–26.
9. Task Force on Community Preventive Services. Recommendations regarding interventions to improve vaccination coverage in children, adolescents, and adults. *Am J Prev Med.* 2000;18(suppl 1): 92–96.
10. From the board room to the community room: a health improvement collaboration that's working. Community Health Improvement Partners. *J Quality Improvement.* 1998;24(no. 10).
11. Aubert RE, Herman WH, Waters J, et al. Nurse case management to improve glycemic control in diabetic patients in a health maintenance organization: a randomized, controlled trial. *Ann Intern Med.* 1998;129:605–612.