



Quarterly Letters

Managed Care By Any Other Name Is Still Managed Care

The articles by Ellrodt et al. and Smith et al. in the recent edition of *Hospital Quarterly* (Vol. 2, No.1) provided an excellent overview of disease management and its potential introduction to Canada. However, both articles minimized the fact that disease-state management is nothing more than a subset of managed care.

Managed care is first and foremost about cost containment. While it is convenient for healthcare administrators to focus discussion on improved patient outcomes and improved quality, the underlying premise is cost containment and the economic dilemma of allocating limited resources in the face of unlimited demand. If managed care was strictly about quality and patient satisfaction it would have been introduced many years ago when money was plentiful.

As a subset of managed care, disease management can be defined as the active case management of targeted patients having specific chronic diseases, and who are at risk for a high utilization of healthcare services. The goal of disease management is to have providers and patients improve outcomes of quality and satisfaction, while reducing costs. The techniques to achieve this include patient education, follow-up treatment adjustments, and compliance monitoring. A disease management or managed care approach to healthcare will require substantial changes to our existing healthcare-delivery system and would involve significant compromises between stakeholders.

Governments, being the largest payers for healthcare services, have a tremendous amount to gain from managed care – especially cost containment. The difficulty in managed care,

for government, is its structured framework when compared to the existing system. Politically, the government is vulnerable when suggesting changes such as those required by managed care. After all, managed care is viewed as all that is wrong with the American healthcare system including cost containment, poor patient care, risk selection and capitation. Governments may also have to trust physicians, hospitals and other payers such as employers to a greater extent and will have to give up the over-riding role they currently have – a very difficult thing for ministries of health to do. For managed care to work, devolution of authority and power must occur.

At present, physicians, chiropractors, psychologists, dentists, rehabilitation agencies, pharmacies, and other healthcare vendors are third-party providers of services and have minimal accountability to the payer for the quality and cost of services provided to patients. Physicians and healthcare providers tend to regard managed care as a method of reducing their incomes, increasing their workloads, decreasing their autonomy and interfering with the patient-physician relationship. In a managed care environment these vendors and providers will be subject to utilization review, quality assurance processes, standardization of care, outcome measurement, performance review, and possibly to alternative systems of payment such as capitation or blended payment systems. They are likely to resist this type of change, for providers – like patients – have enjoyed a relatively autonomous existence within the healthcare system.

Consumers and patients may have the most to lose, for they enjoy the

freedom of choice, reasonable access, unlimited autonomy and little, if any, accountability. For consumers, managed care means limiting their current privileges, for even today, under constrained access, those that are seriously or chronically ill do get the care they need, even though it may not be in the most efficient or coordinated manner. Patients' gains under managed care, may be even fewer if, because of our single-payer integrated-health system, competition does not evolve.

The concept of managed care has, to date, remained an anathema to the Canadian healthcare system. In fact, even the use of the term, managed care, within Canada raises the ire of patients, physicians, governments and health administrators.

Managed care can be abusive, for its principles lie in cost containment. With capitation as the preferred funding model of managed care, the potential for poor patient care, adverse risk selection (“cream skimming”), and mediocre provider competency is probable. However, the positive features of managed care, such as evidence-based activities, consumer cost sharing and accountability, best practices, a focus on prevention, utilization review and provider profiling, are often overlooked.

If, in Canada, we move to a managed care system of health delivery, Canadians must accept both the benefits and the consequences of moving to such a system. The reality is that before managed care or disease management can be implemented and function close to its ideological design, a complete restructuring of the healthcare system is required.

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Process Not Litigation

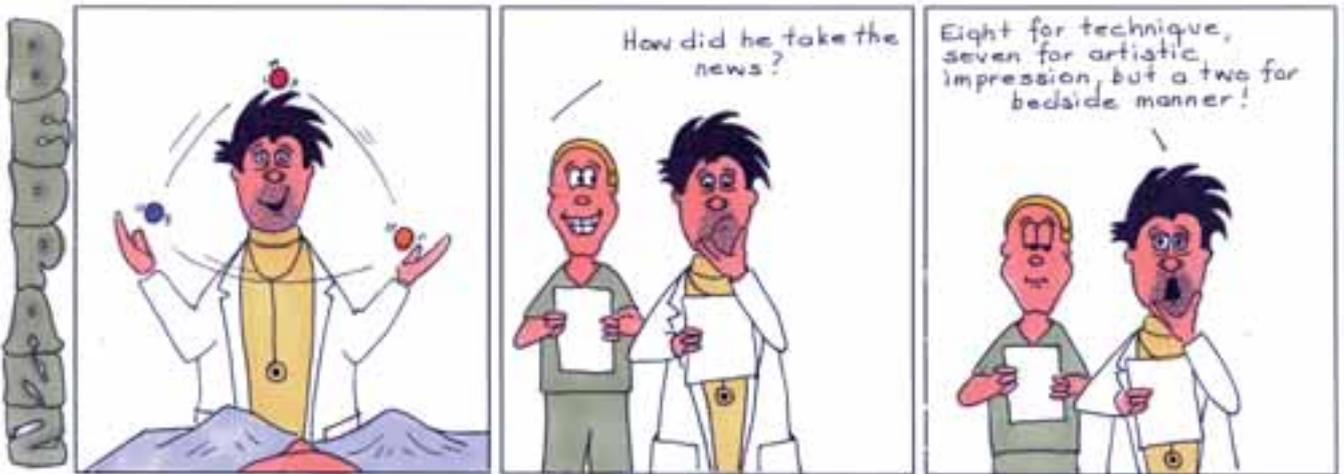
I would like to submit some reaction to the article "Process Not Litigation: Dealing with Physician Impairment in a Hospital" which appeared in the Summer 1998 issue (Vol. 1 No. 4). Let me say that the process described [by the authors] makes inherent sense, and is one consistent with the spirit of medical self-governance and shared accountability between administration and the medical staff.

However, I have some difficulties

with the proposal. First, to define explicit standards of care/utilization that would be acceptable to all members of a department is a very difficult undertaking – although I do agree it is a necessary step to identify outliers. What is more difficult in practical terms is for department chiefs (who in many cases are performing this duty for a short term and perhaps on a rotational basis) to confront their colleagues on issues such as a breach of standards. It is all too easy to ignore the problem of a colleague who

does not use hospital resources responsibly (or how administration would like to see them used) or whose behavior is inappropriate. The challenge in this era of limited financial resources is to create a culture where chiefs are committed to carrying out their mandated roles and afforded the opportunity to do so. 

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Letters to *Hospital Quarterly* can be emailed to notes@longwoods.com or faxed to the editors at 416 368-6292.

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SETTING THE RECORD STRAIGHT

In *Hospital Quarterly*, vol. 2, no. 1:

In the Fall '98 issue of *Hospital Quarterly* the founder of Women's College Hospital in Toronto was incorrectly identified as Dr. Emily Rowe. In fact, the Hospital's founder was the indomitable Emily Stowe, who was the country's first female school principal (1852) and first female physician (1867). Her medical training was completed at a medical school for women in the U.S. because the University of Toronto refused to admit her. Nor were women granted licenses in Canada at that time.

After finishing medical school Dr. Stowe returned to Toronto and opened her illegal medical practice – amid threats of fine or imprisonment, and hostility from the College of Physicians and Surgeons. She and colleague Dr. Jennie Trout were reluctantly later allowed to study at the Toronto School of Medicine in the early 1870s, however, she was not granted a license to practice medicine until 1880. Women's College Hospital had its genesis in the Women's Medical College which Dr. Stowe founded in 1883.

Also in the Fall 1998 issue, the lead author for the article "Disease Management: What Does It Mean for Health System Integration?" was Lutchemie Narine.