



RESEARCH ARTICLE

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Care and Disease Management: Why Managed Care Organizations (MCOs) Need to have an Inclusive Approach to Patient Care

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ABSTRACT

The health sector increasingly uses the terms "managed care" and "disease management," but few people understand them. Managed care refers to any health care system that pays for and provides treatment. Pressure to keep prices low has helped it flourish in the United States, and improved resource management is lowering costs. US managed care plans vary, but they share several traits. These include restricted doctor providers, secondary care access, selective contracting, financial incentives, quality monitoring, and utilization management. The NHS has all of these aspects, making it a united managed care system. Disease management coordinates resources across the health care system to treat patients throughout their illness. Business organizations have noticed that the NHS lacks a well-established system for disease management. Concerns regarding commercial engagement include the separation of basic medical services, the possibility of becoming a for-profit corporation, and the use of patient-based data. New guidelines may allow NHS disease control to increase.

ARTICLE HISTORY

Received May 02, 2022
Accepted May 09, 2022
Published May 24, 2022

KEYWORDS

Disease Management,
Financial Management,
Care Management, Quality
Mentoring, Medical Service

Introduction

Whether run by the government or private companies, keeping the cost of health care down has been a major goal of recent health changes around the world [1]. This is particularly crucial in the US, where per capita health care costs are the highest and a third of the population lacks adequate health insurance [2]. The world is already prepared to receive US managed care, with its primary products, such as disease management, awaiting an import license. Managed care optimizes limited budgets to deliver the best patient care.

Management Care

Managed care is the basis for medication management. The percentage of prescription pharmaceuticals acquired using non-refunded cash is less than 15%, but it is on the decline. Managed care has transformed US healthcare. After the 1973 Health Maintenance Organization (HMO) Act, the healthcare delivery revolution spread swiftly, particularly in densely populated regions. Simple but successful managed care schemes existed in the US approximately 100 years ago. Unmet economic and social objectives led to the creation of managed care. Managed care isn't a single entity or procedure. However, managed care is difficult. Additionally, local demands and regionalization shape it. Managed care balances quality and cost and adapts to suit the demands of patients, commercial and public plan funders, and plan users. This study examines managed care, its impacts and benefits for disease management, as well as its quality and cost in the health care system [3-11].

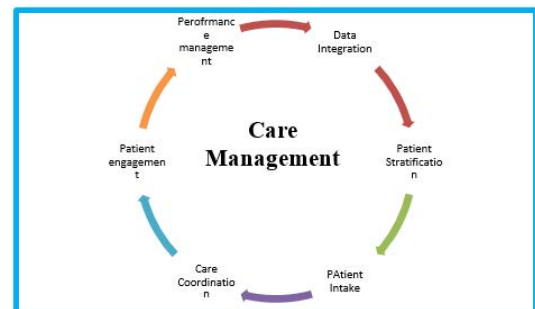


Figure 1: Care Management

Aim and Objective

Aim

The study examines how managed care has developed, its consequences, and its current state in the United States healthcare system. We discuss how to manage the benefits of disease management and maintain both quality and cost effectively.

Objective

- To discuss managed care and disease management.
- To ascertain the influence of managed care and disease management on the National Health Service.
- To investigate the issues in managed care that arises when attempting to balance quality and cost.

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Research Questions

- What is the managed care and disease management?
- What effect managed care and disease management have on the National Health Service (NHS)?
- What are the managed care problems exist in balancing quality and cost?

Problem Statement

This research examines how managed care in the U.S. healthcare system is developing, particularly how it manages disease management benefits and strives to combine quality health care with cost-effectiveness while considering regional disparities in the US.

Literature Review

Research Background

Financial risk-sharing is a fundamental aspect of managed care's cost control strategy to get everyone in the healthcare system to behave profitably [12]. Doctors, hospitals, pharmacies, and others must agree to decrease payment rates and typically have financial incentives to make patient-friendly choices. Physicians are compensated on performance [13]. Members pay lesser copayments for inexpensive or chronic illness-helping medications.

Management Care

Managed care is "any health care system that integrates medical care financing and delivery." A planned and coordinated approach to affordable, high-quality health care [14,15]. Both supporters and opponents of this idea stress the importance of the words "quality" and "cost." Because it has all of these traits, the NHS is the best model of a socialized managed care system [16,17].



Figure 2: Health Care Management

Disease Management

In the US, disease management grew out of managed care because the drug business didn't want to lower prices when they were told they couldn't write as many prescriptions [18-20]. Disease management coordinates resources throughout the health care system and disease life cycle. In contrast, managed care focuses on care components and lowers unit costs through aggressive contracting and provider management [21]. Throughout the illness's "life," we must monitor all care components. It's also critical to determine the disease's cost and organize caregivers.

Care Managed and Disease Care Practices

In the United Kingdom, general practice relies on professional generalists. Primary care includes first-contact, longitudinal, coordinated, and comprehensive treatment. General practice has incorporated them since the inception of the NHS [22,23]. Scholars have extensively documented how managed care has expanded primary care in the United States. In the United States, family medicine is a minority discipline, and the uneven distribution of family physicians makes comparisons with US doctors challenging. Managed care motivates specialists to train as primary care physicians, increasing their number [24,25]. However, the health plan, not the doctor's, is comprehensive.

Disease Management



Figure 3: Disease Management

Disease management is less likely to inspire clinical generalists [26]. Many US family physicians no longer handle mental disease, asthma, or diabetes. This is because disease managers differentiate care by condition [10]. The entire corporation, not just the doctor, is responsible for coordination. These modifications affect the "gatekeeper [12]." A similar split of patient care may influence US GPs, as disease management determines care delivery. The emergence of for-profit direct patient care companies threatens government-funded health care ideals [27]. Some of the largest US managed care opponents argue that within corporate organizations, delivering cost-effective treatment for patients and generating as much money as possible may not always align [28]. Without increased revenue, businesses won't invest in disease prevention.

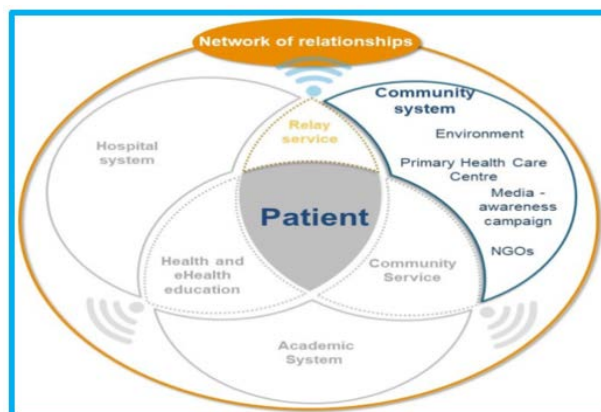


Figure 4: Patient Care

Literature Gap

The US literature gap in disease management and care coordination includes a lack of research on how disease management models

Citation: Gokul Ramadoss (2022) Care and Disease Management: Why Managed Care Organizations (MCOs) Need to have an Inclusive Approach to Patient Care. Progress in Medical Sciences. PMS-E112.

influence clinical generalists and primary care professionals [29]. Further research is required to understand the impact of these models on basic care, especially for patients with multiple diseases [26]. Profit businesses affect illness management and how their potential conflicts of interest affect it [20]. Long-term effects and patient attitudes toward illness management require more study [13].

Research Methodology

This research examines how disease management influences U.S. healthcare organization using secondary data. Secondary data from literature, and research articles utilized to identify disease control trends, gaps, and outcomes. This strategy enables to analyze all data to determine how care is handled and its impacts.



Figure 7: Research Approach

Research Design

This study uses planned secondary data analysis to investigate how illness management influences care coordination in the United States healthcare system. The present study examines current literature and articles for patterns and trends. This helps us understand how illness management influences care coordination.

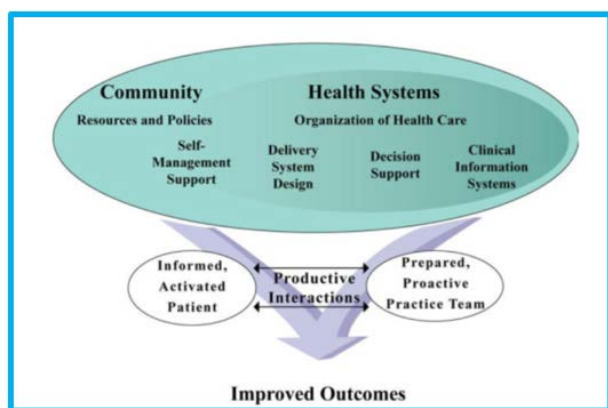


Figure 5: Network of Relationship

Research Philosophy

This research philosophy is interpretivism. By examining current data in context, this perspective helps us comprehend how complex disease management is and how it influences care organizations. Interpretivism examines the experiences and meanings of human disease management. This is similar to using secondary data to understand how these approaches affect care coordination.

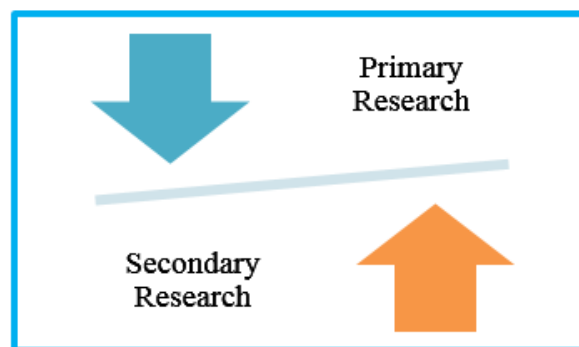


Figure 8: Research Design

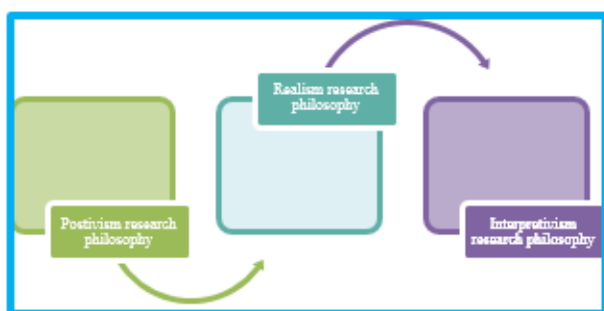


Figure 6: Research Philosophy

Research Approach

This study's research was "deductive." A deductive strategy employs secondary data to verify and support well-known disease prevention and care coordination assumptions. We use current data to challenge disease management ideas based on primary care practices and patient outcomes. This reveals how the US healthcare system manages care.

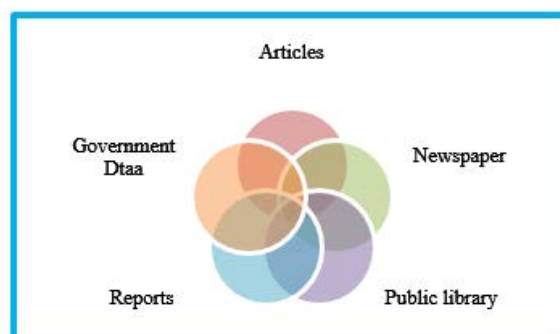


Figure 9: Data Collection

Ethical Consideration

Ethical challenges include protecting data privacy by employing anonymous and private sources, validating data sources' veracity, and crediting original authors. The research objective is to avoid bias in secondary data analysis and interpretation. This ensures honest and accurate results reporting.



Figure 10: Ethical Consideration

Results

The US uninsured rate has been steady for a decade. Others criticize the US government's inability to provide universal health care, while others blame the insurance market. For unknown reasons, 1990s managed care improved health plan quality management [7-17]. When the managed care sector faced accountability for misbehavior, physician credentialing significantly improved. Managed care corporations created provider profiles to hold physicians and institutions accountable for both quality and cost. As managed care businesses compete on quality metrics, certification has become a commercial activity. The US GAO examined how health plans use federal and other clinical practice guidelines. We devised standards to govern the costly, medically complex, or widespread duties of physicians [8].

Findings and Discussion

Theme 1: Managed Care and its Impact on Health Insurance

The concept of managed care is not new. The fee-for-service insurance system employed by independent specialists dominated US health care until the second half of the 1980s [2]. Previously, no health insurance company existed. Users (employers and workers, with the employer bearing the majority of the costs), as well as providers (hospitals and physicians), coped without taking any action. After rates rose without restrictions, faster than general and medical inflation, the largest corporations demanded reform [19]. When the insurance sector learned this, they offered to cover the employer's health care expenditures and provide all workers with agreed-upon health benefits for a price. They became active care providers, turning the HMO concept into managed care [3].

Theme 2: Quality Assurance

In managed care, US healthcare delivery systems compete like never before. Health insurers monitor costs, clinical outcomes, and economic consequences [14]. They found the most affordable physicians, hospitals, and pharmaceuticals. Monitoring these outcomes can optimize resource utilization and reduce variance [13]. Many individuals have costly and common health issues, including obesity, hypertension, dyslipidemia, coronary heart disease, asthma, heart failure with complications, and more [23]. The Disease Administration Association of America educates and coordinates management activities.

Theme 3: Maintaining Coverage within Rising Costs

Even though treatment has improved, the U.S. population and plan sponsors can't maintain medical and medication coverage without raising user costs. Many new medications are expensive

bioengineered injections [22]. In managed care, specialty pharmacists effectively manage expenses and utilize expensive medications. Benefit designs incorporate higher prescription limits and drug usage controls [3]. It's usually essential or recommended to use generic medications first. Lower levels typically restrict benefits, thereby limiting coverage. Members usually pay more upfront. They must pay \$2,500 before their health insurance pays [16].

Theme 4: Financial Performance

Health plans evaluate each plan's profitability. Medical loss ratio (MLR) by dividing healthcare costs by plan owner premiums [17]. Consider a \$100 payment and \$90 in medical expenses. The MLR is 90%, while the health plan preserves 10% for non-profit profit or retained earnings [18]. An MLR of 90 or above is usually good. If premiums were \$90 but medical expenditures were \$100, the health plan would lose money [24]. This indicates 111% MLR. Next year, the health plan will either raise the plan sponsor's premium or impose tougher benefit restrictions (such as a higher copayment) to reduce inappropriate usage or increase member cost-sharing. If the plan sponsor declines, the health plan can't provide a bargain for next year [2,9]. This strategy encourages plan owners to establish strong benefits and copayment arrangements so that members are accountable to the doctor.

Conclusion

Disease control is rising in this country, and the pharmaceutical industry may lead. The distinction between primary and secondary care blurs. This could lead to additional NHS non-profit management strategies as trusts and general practice collaborate. Whatever the outcome, the NHS can learn from the US. This includes resolving the three issues above, considering new ideas, and avoiding "drive-by" mastectomies and other oddities caused by managed care administrators' enthusiasm. Rejecting managed care and its impacts demonstrates a failure to understand reality and ensure "we do the right thing." There is a nationwide discussion concerning the expansion of managed care in the US.

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