Emphasize prevention, bundle health services, and designate a physician-gatekeeper to decide whether a patient should be referred to medical or allied health specialists. This is managed care. Managed care is increasingly being identified by employers and the government as the most economical solution to soaring health care costs. Dietitians working in health maintenance organizations (HMOs) and other managed care systems say that they enjoy the freedom and independence to develop innovative and effective programs, but they are concerned that the drive to compete in a volatile market may result in reduced services and increased copayments and fees for nutrition programs such as weight control.

ENROLLMENT IN MANAGED CARE
Managed health care is the system used by approximately 15% of Americans, according to a 1990 US Bureau of Census report (1). In 1989, 59% of individuals with employer-sponsored programs were enrolled (2). In 1980, the 235 HMOs in the United States had an enrollment of 9 million (3). By 1989, there were 604 HMOs in the United States and enrollment had reached 32 million (3). However, use of HMOs is not evenly spread throughout the country. For example, as a result of formidable negotiations with employers in Minneapolis, Minn, 50% of the state's population belong to HMOs (4). The Health Care Financing Administration, along with several state government agencies, have suggested improving Medicare and Medicaid coverage through managed care options (2,5).

HMO expansion slowed in 1990 and 1991; enrollment grew only 6% compared with growth rates of 25.2% in 1985 and 36% in 1986 (6). Analysts predict that enrollment in managed care programs could explode in the next few years as states initiate health care reform. As of January 1, 1992, five states have more than 20% of the population enrolled in HMOs; Massachusetts has the highest HMO enrollment with 30.4% of the population enrolled. Twelve states with health reform projects funded by the Robert Wood Johnson Foundation include managed care components (7).

HOW DID MANAGED CARE BEGIN?
The concept of prepayment is not new. One theory is that prepaid medical care was practiced in ancient China (8). In the United States, prepaid medical care was first documented in reports of the Committee on the Cost of Medical Care (1927-1932). At that time, increasing specialization made family practitioners harder to find and costs of medical care were rising (8).

The formation of HMOs as we know them today was spearheaded by charismatic and inventive individuals who were trying to fill a gap in medical care. HMOs were formed as cooperatives or not-for-profit service organizations. Early HMOs included the Group Health Cooperative of Puget Sound in Seattle, Wash; the Health Insurance Plan of Greater New York; the Group Health Cooperative of Puget Sound in Seattle, Wash; the Kaiser-Permanente program, which began in the Northwest (8).

By 1973, new managed care systems differed from their more benevolent pioneers. They resembled industrial organizations, used modern management and fiscal techniques, and were more bureaucratic. In the 1980s, large for-profit organizations entered the managed care scene. Most recently, the principles and practices of managed care are being partially or completely adopted by existing insurers, health care institutions, and physician practice groups. As we approach the 21st century it is becoming more difficult to identify HMOs as separate entities.

WHAT IS MANAGED CARE?
The accepted, basic concept of managed care is that all medical care will be provided in exchange for a set monthly fee. Members see a primary-care physician, called a "gatekeeper," who provides routine care and approves referrals to medical and allied health specialists. The primary-care physician is employed by, or contracts with, the health plan (9). It makes sense to emphasize prevention with the intention of controlling health care costs before conditions require expensive treatment. Preventive strategies such as routine medical examinations are included as part of the package. However, classes in weight control, cholesterol education, and diabetes education usually require the enrollee to pay additional fees (10).

WHAT IS THE STRUCTURE OF MANAGED CARE?
Several models of managed care systems have been clearly identified (see the Figure). However, many traditional fee-for-service hospitals now offer their own managed care packages, and traditional insurers are contracting with exclusive providers with set fees. Combinations of various managed care and fee-for-service programs may exist in one facility or practice. Thus, individual health care professionals may find themselves charging a fee for one consumer, employed by an HMO for another, and serving as a contracted exclusive provider for another.

Dietitians are either employed as in-house staff at HMO-owned or provider facilities or they contract individually with a group practice (11). A survey conducted in 1989 documented that larger HMOs used in-house dietitians more than smaller HMOs and that contracted nutrition services were used infrequently. This study also found that the use of in-house nutrition services increased from a low of 39% for HMOs less than 4 years old to a maximum of 80% for HMOs more than 10 years old (12).

NUTRITION SERVICE IN MANAGED CARE
The preventive philosophy and cost-containment goals of managed care should lend themselves to better use of dietitians to enhance prevention and provide a lower-cost alternative to nutrition care by a physician. Marcella Katz, nutrition consultant, documented nutrition services in prepaid health plans as early as 1963 in the Health Insurance Plan of Greater New York (13). Dietitians served ambulatory patients in 51 medical groups that had patient enrollments ranging from 5,000 to 50,000. Doctors referred patients to the dietitians for special problems.

When the HMO Act was passed in 1972, dietitian Ruth Kocher expressed her views on the value of the dietitian in the HMO setting (14). She foresaw that primary-care services such as health testing, health care, and health maintenance would expand, but that costs would be controlled by having nonphysicians perform these services. She proposed that all health professionals should assume new responsibilities for planning and supervising
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References

The future for nutrition in managed care

Both satisfaction and concern have been expressed for the future of dietetics practice in managed care. There is little doubt that managed care will be a primary focus in health care reform. The American Dietetic Association has taken the position that nutrition services are an essential component of preventive and therapeutic health care and that they should be provided by qualified nutrition professionals (16). For this to occur, at least three concerns must be addressed.

First, as managed care programs maneuver for position in the highly competitive health care market, nutrition programs cannot be compromised to cut costs. Commitment of adequate resources to both preventive and medical nutrition therapies allows dietitians to develop economical and effective programs.

Second, nutrition professionals should be designated to deliver nutrition care. Use of other professionals may compromise quality and may actually increase health care costs.

Third, as copayments for managed care services are increasingly implemented, additional fees for nutrition programs should be kept consistent with other charges. Excessive fees may lead to reduced participation and may make the gatekeeper-physician reluctant to refer clients.

Splett (17) observed that as health care financing systems undergoes transformation from unmanaged fee for service to managed care, all care is bundled so that the payer has a hands-off view with regard to definition of what is to be included. If, in fact, nutrition needs of patients are not included in the bundle, licensure or accreditation issues could be raised for the institution. We hope that administrators will recognize the value of nutrition services without having to address accreditation issues.

Health care reform and growth in managed care have positive implications for preventive and medical nutrition therapies. However, the potential for cutting nutrition programs or initiating disproportionate fee payments will continue to be a threat in this competitive system until the decision makers are convinced that nutrition services result in reduced long-range health care costs. HMO dietitians report that although some companies provide nutrition services with the resources to develop creative and successful programs, many others shortchange or overlook nutrition services. Dietitians need to be persistent in advocating and documenting the value of nutrition services. The era of health care reform offers the ideal opportunity for nutrition to be recognized as an economic essential in health care delivery.