Exa:mining the Managed Health Care Continuum

There is much talk about the continuum of health care. But does this continuum apply to managed health care? If so, what does this continuum look like? And if not, what alternative philosophical approach applies? The answer may lie in theories of cultural anthropology and how our society views health and health care.

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Campbell and Newsome did not address this diagramming of managed health care as a continuum. However, managed health care as a whole is characterized by a sequence or progression of minute degrees of caring and managing, similar to degrees of "good" and "bad." Rather than classifying managed care as a balance between the concerns of caring and managing, it probably is more appropriate to define it in terms of a combination of varying degrees of caring and managing.

According to Campbell and Newsome, value should be a cornerstone of the managed care philosophy and is defined as quality coupled with reasonable costs. Therefore, it makes sense that any discussion of managed care should include quality as part of its continuum. As diagrammed in Figure 2, quality is dynamic and dependent on its application either to caring or management aspects of managed care.

Despite the addition of quality to the continuum, the use of a continuum as the best way to diagram managed care remains in question. This article investigates the pros and cons of this approach and looks to anthropology and culture study tools to help provide an answer.

**SUPPORT FOR THE CONTINUUM**

Edward Sapir was an American anthropologist and linguist who, in 1917, presented a counter argument to the then popular Kroeberian Culture Autonomy Theory discussions. The Kroeberian theory was that culture was autonomous or "superorganic" and unrelated to organic sciences, including the social sciences. The theory stated culture exists despite human interactions or understandings (see Figure 3). In brief, Sapir felt that the effect people had on others was infinitesimal, but present every day and must be included in any study of culture. He observed a variety of differences on a continuum as soft, or contrastive, and representative of people's personal outlooks and experiences. No two individuals would see an event or pose a question in the same way. Because human experiences were factored into accounts of the nature of reality, Sapir felt that culture was a combination of reconstructionistic and reductionistic traits. He defined reconstructionism as the left anchor that preserves "experience" and is supported by the humanistic sciences of anthropology, history, sociology, and others. He defined reductionism as the right anchor of the continuum; the conceptual, nomothetic end, heavily supported by the basic sciences of physics, biology, chemistry, and mathematics. Disciplines such as psychology and economics could yield information toward either anchor of the continuum.

There is a strong correlation between Sapir's continuum and the continuum of managed health care. Caring links directly to reconstructionism as both experiential and humanistic in nature. Managing, as defined on the continuum, links directly to reductionism as the conceptual, nomothetic components of managed care. Just as Sapir saw culture as a combination of reconstructionism and reductionism, managed health care is viewed as a combination of caring and managing.

However, even with this support for a managed care continuum, the question remains: Is this a strong enough argument to continue modeling managed health care on a straight line? Does this model truly offer a realistic picture of health care in our society?
THE HEALTH CARE CULTURE

Health care—how it is defined and what it is—is influenced by society and its dominant culture. As anthropologist Clifford Geertz stated, “A society's culture consists of whatever it is one has to know or believe in order to operate in a manner acceptable to its members.”

As modeled in Figure 4, the broad nature of health care consists of health care practitioners in managed health care providing professional knowledge to address health-related needs. This broad model of health care is not meant to be directional nor to proclaim equality among the components listed in the figure. Health care is a fluid system that works as a whole unit in which one component may be dominant over the others. However, the dominant component may change at different times, as influenced by society and what is happening at a particular point in our cultural history. A health care practice is the interaction of the person (i.e., patient) with the health care practitioner under the expectations placed on that interaction by society. This interaction produces the guidance which establishes philosophy, practice management, and person-specific care. Health-related needs are those that the person presents or the health care practitioner discovers on initiation of medical therapy. These needs are managed by the person and the practitioner working together, a relationship that is the foundation for health care utilization in a society.

The philosophy of a health care practice is the set of values that guides the health care practitioner with respect to caring for the person's health-related needs. Practice management is the infrastructure that supports the health care practitioner in caring for the person's health-related needs. And person-specific care is that which is provided to the person by the practitioner in response to health-related needs.

The knowledge of health care use in society, grounded in the sociology of knowledge, questions the relationship between the context of illness beliefs and the ideas and social positions of both people and practitioners.

Without health care practice and health-related needs, there would be no need for philosophy, practice management, and person-specific care. Managed health care would cease to exist under such circumstances.

Because managed care is influenced by society as part of the whole health care concept, a continuum is not robust enough. The richness found in the interaction between caring and managing, as health care practitioners, persons, and society working together, is lost in the continuum presentation. Two alternatives to the continuum follow.

ALTERNATIVE ONE

The first alternative comes from the field of sociology, specifically, in the area of social policy research in relation to the delivery of health care. Eliot Friedson, a sociologist in the Department of Sociology at New York University, addressed social policy with a focus on medical organizations (specifically physicians). His efforts stemmed from the expansion of human services in the 1960s which led to a period in the '70s during which economic and government controls took an upward turn. These controls, Friedson saw, had permanent effects on public funding, taxes, access to services, and technical and human quality of services. Social control, central to effective social policy, decides what to accomplish and how
much to invest in these efforts. Social control happens concurrently with the establishment of a system by which sufficient oversight is exercised over those carrying out policy to ensure what was intended is accomplished.

Friedson discussed the models of social control that were exhibited in the 1970s: professional and bureaucratic models. In the bureaucratic model (an administrative or managerial hierarchy) work was controlled and directed by supervisors who were not trained to perform the basic, productive work. As bureaucracy increased, colleagues had less autonomy in how much service was individualized. The professional model was one in which work was directed and controlled by the workers themselves. This model also allowed more client control in making decisions.

Friedson worked out balance between the two models of social control, stating, “Bureaucratic authority is used to establish a constraining framework of administrative controls around work settings within which professional authority is then nominally free to control the actual performance of work.” Friedson’s application of this theory to group medical practice appears in Figure 5. Today, a predominantly bureaucratic model characterizes health care, as seen in the rapid expansion of managed health care organizations.

It can be inferred that the professional model aligns with caring, while the bureaucratic model aligns with managing, as shown in Figure 6. Caring is where the health care practitioner, interacting with the person, enables that person to “do better,” looks to “care and cure,” acts as a “patient advocate,” and “does no harm,” as Campbell and Newsome discussed. Similarly, managing is where the “bottom line is protected,” the “market share is increased,” “cost and waste are reduced,” and a “profit is generated.”

Figure 6 breaks the continuum into two halves to eliminate the sense of progression. Rather than Friedson’s phases of medical care practices, this figure also incorporates Campbell and Newsome’s stages of managed care evolution. This picture emphasizes how a combination of both caring and managing qualities define managed health care.

**ALTERNATIVE TWO**

The second alternative comes after search of leadership and management studies in organizational research.

Robert Blake and Jane Mouton conducted management research in the early 1960s that resulted in the management grid model (see Figure 7), which was designed to help managers become aware of their individual management styles. Blake and Mouton’s research included the development of a questionnaire that assessed a manager’s leadership characteristics. The resultant scores ranging from 1 to 9, were plotted in the managerial grid. The horizontal scale indicated a manager’s concern for productivity; the vertical scale dealt with the manager’s concern for people. The two scales of concern were linked in the manager’s definition of his or her use of power to connect people to production. Blake and Mouton used the grid to define several management styles: 7

- **(1,9) Country Club Management.** The concern for productivity is at the very lowest range possible and the concern

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for people is at the highest possible.
\( \Delta (9,1) \) Task Management. Productivity is the chief concern, and there is very little concern for people.
\( \Delta (5,5) \) Dampered Pendulum Management. The manager tries to keep peace, both with subordinates and with superiors. The manager pushes for production just enough to keep the boss satisfied and the subordinates happy.
\( \Delta (1,1) \) Impoverished Management. The manager cannot keep anybody happy. He or she considers the demands superiors are making to be excessive and subordinates to be incompetent and unproductive.
\( \Delta (9,9) \) Team Leader Management. Productivity and the needs of the employees are both very high concerns, and an environment of openness and trust pervades the work area.

The grid axes relate caring via concern-for-people aspects and managing via concern-for-production aspects. Concern for people includes having an accountability of results based on trust and obedience to sympathy, understanding, and support of another person. Concern for productivity refers to results, the bottom line, profits, and the growth and development of the organization through services provided by a staff organization.

Figure 8 provides the richest pictorial for managed health care. This grid can show the degree to which managed health care is caring and/or managing by referring back to Campbell and Newsome's original suggestion that "each topic encountered in the text be placed in a unique position to acquire a feel for interpreting the various interests at play." For example, a topic with a high degree of caring and a low degree of managing would fall somewhere in quadrant I. In using the grid, the truer emphasis is on how caring and managing work together in managed care rather than appearing to oppose one another as the continuum. The grid further illustrates the harmony of caring and managing, and not the balance between the two. When discussions arise concerning managed health care, it is more encouraging to think of caring and managing as being in harmony.

**CONCLUSION**

The definition of managed health care and the model(s) used to diagram its characteristics and values will continue to evolve in the coming years. The experiences of health care providers, society, and consumers will shape the caring and managing demands that complete the managed care picture.

The limitations of the alternatives described in this article are rooted in the human experiences that shape reality. This means that no two people will see an aspect of managed health care in exactly the same way. Thus, the picture can never satisfactorily describe managed health care; at best, it is only a tool toward understanding.

Managed care will continue to provide health care while managing scarce resources. However, managed care is not about various trade-offs on a continuum of caring and managing. It is about creating and maintaining a balance of caring and managing that is harmonious with our culture and contributes to the well-being of our society.

**References**