Editorial

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# On the Role of Managed Care and Management of Chronic Diseases

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## Editorial

Chronic conditions are generally difficult and complex to manage, with late diagnosis as a main contributing factor. Other reason may be linked genetic and other comorbidities. One of the most prevalent chronic conditions is diabetes and a significant number of patients diagnosed with diabetes are those with Type 2 diabetes. Beneficiaries with chronic conditions still remain undiagnosed as a result the true prevalence of those affected remains underestimated. Chronic diseases estimates in South Africa are better recorded in the private health sector than in public sector, the private sector has better data collection tools and systems than the public health sector. Medical schemes, which are private health insurance carriers, keep an up to date chronic diseases data, mainly to manage and fund such conditions. There is a select list of chronic conditions which form part of the minimum benefit; these are called Prescribed Minimum Benefits (PMBs). Medical Schemes Act prescribes that all medical scheme schemes must offer these benefits and ensure that members have access to these minimum health services. A total of 25 chronic conditions which are known as Chronic Disease List (CDL) include most prevalent conditions such as Diabetes (type 1 and type 2), Asthma, Hyperlipidaemia, Hypertension etc. are also included in the PMB list of benefits. Medical schemes are required by the Act to cover CDL conditions on all their plans. This cover includes funding for diagnosis, routine visits to the medical provider and the ongoing care. It is evident from recent survey studies that member still does not understand their benefit entitlement inclusive of PMBs. A greater part of the problem is the lack of education programs to members on benefit design and structure, additionally; it may be that medical scheme communication on benefit entitlement is neither not adequate nor effective. Equally so, health care providers also have a role to play as they are at the cold-face of beneficiaries or members, they need to be playing a pivotal role in informing members of their benefit entitlement if they form part of managed care agreement. Managed care agreement forms an engagement between a medical scheme and a managed care entity managing in the overall treatment and funding cycle of beneficiaries. The foremost benefit of such arrangement is to make certain that medical schemes members benefit from the following:

- The impact on treatment options and cost thereof
- Limitations that may be on their healthcare provider
- Alternative treatments available
- Treatment value chain of the treatment process and all the key role players

Chronic conditions including those that form part of the PMBs are managed through managed care programs which are largely designed to control cost in the private health care sector. Managed care programs are also viewed as techniques targeted at influencing clinical behavioral patterns, both by healthcare providers and beneficiaries of medical schemes. There is also a strong emphasis that managed care programs over and above clinical, financial, and risk management, appropriateness and cost-effectiveness of health services should also consider educating members. Affordability of care is also of critical importance. One of the key aspects of managed care that have not been explored extensively in South-Africa is the impact thereof on clinical outcomes. Good management of diseases is one that yields favorable clinical outcomes and also improves the quality of life of beneficiaries. Other benefits, of course, are the reduction in healthcare costs. In the management of chronic diseases process, managed care entities develop managed care rules, clinical guidelines, and protocols. Managed care rules-based clinical and disease management programs include:

- Active disease risk management services
- Disease risk management support services;
- Hospital benefits management services;
- Managed care network management services and risk management services; and
- Pharmacies benefit management services.

Clinical guidelines which are the core aspect of managed care programs ordinary require that beneficiaries comply with certain minimum requirements, these include the following:

- Minimum number of tests to be conducted per year,
- Investigations,
- Number of routine visits or consultations

Some beneficiaries mainly to societal reasons do not company or default on some of these requirements and thus contribute to the overall treatment program of the condition.

Noncompliance potentially has inadvertent consequences to beneficiaries, such as renunciation of benefits. At most, medical scheme rules also depict that beneficiaries need to register to disease management programs prior to entitlement to such benefits. Most beneficiaries are not previewed to such requirements as a result remains unregistered to such programs. Consequences thereof are that such members are at a risk or being poorly managed and may only report to the programs when the condition has deteriorated significantly, which may end up being costly and difficult to manage. The ultimate loss of members is that they may be losing out on benefits they are in any case are entitled to and are funded by the scheme as per the Act. PMBs full entitlement is also subject to treatment received from a designated service provider (DSP) otherwise a beneficiary may be subject to a co-payment unless DSP or the service required is not available where the beneficiary resides. Managed care programs employed by medical schemes still have a significant role in managing chronic diseases if employed correctly, could also still be used a cost containment strategy. A pre-emptive approach such as promoting primary and preventative care within a managed care program is imperative reducing hospital costs through lower hospital admissions.