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# SOCIAL WORK IN A MANAGED CARE ENVIRONMENT

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Managed care has created a new service environment that, to a large extent, eliminates distinctions that have sustained social work ideology and the profession throughout its history. A managed care approach shifts the emphasis of need assessment from that of the individual to that of the group. It eliminates the distinctions between agency-based and nonagency-based practice, between private and public practice, and many of the distinctions between not-for-profit and for-profit practice. This chapter considers why such distinctions that have served as the core of the social work profession are disappearing and discusses the new set of opportunities, challenges, and problems that have emerged with this approach.

Prior to 1990, managed care strategies were largely confined to health maintenance organizations (HMOs) serving a middle-class population through employee coverage plans. Competition for new health and mental health patients in the early 1990s, however, led managed care organizations (MCOs), seeking new markets, to become rapidly involved with the provision of services to the poor covered by Medicaid. From less than 10%, or 2.7 million of 28.3 million Medicaid beneficiaries in 1991, MCOs have captured 48%, or 15.4 million, of the 32.1 million beneficiaries in 1997 (Washington Post, 1998; Kilborn, 1998). Managed care strategies have become a major factor in the organizational plans of health and mental health agencies serving social work's traditional target population. Such strategies are spreading throughout the human services. In addition to the health and mental health areas, managed care strategies have already been implemented in corrections, child welfare, homeless services, and other sectors of social work activity (Barry, 1998; Shichor, 1995; Bickman, Summerfelt, & Noser, 1997).

*Managed care* refers to a variety of techniques packaged as unique strategies aimed at marshaling appropriate clinical and financial resources to ensure needed care (Winegar, 1996).

A given managed care strategy is uniquely constructed to fit an individual organizational recipe for reducing operating costs, expanding service options, increasing flexibility of asset utilization (i.e., of how employees, funding, and resources are used), and sharing risks associated with the helping endeavor (i.e., financial risks). The problem is always how to achieve these objectives.

A managed care strategy can also be conceived of as a combination of change- and control-oriented techniques that will lead to the aforementioned objectives. Though no unitary model of managed care exists, the managed care revolution is likely to effect changes in service ideology, organization, financing, government, and the relationship of providers to consumers and their families. Managed care strategies involve alterations of all these factors in different program packages. In fact, current wisdom indicates that when you have seen one managed care organization, you have seen one managed care organization.

## MANAGED CARE STRATEGY: A COMBINATION OF CHANGE- AND CONTROL-ORIENTED TECHNIQUES

A managed care strategy employs a defined set of financial, access and utilization, and service control techniques to implement organizational change. In order to discuss the possible implications of changes brought on by the advent of a trend for organizations to adopt managed care strategies, it is first necessary to understand what the change-oriented techniques are and how they are used in managed care organizations (MCOs).

### *Financial Control Techniques*

Financial control techniques include prepayment for a complete service package to a provider, and financial risk transfer to a client via deductibles or copayments. Prepayment for a service package as opposed to fee for service or item/intervention by intervention billing usually involves a capitation or case rate methodology. Though computed on a per capita basis, both of these methodologies involve paying for serving a population group rather than an individual. A capitation strategy asks the organization to provide a specified service package to a target population and pays a prearranged fee for each member of the population, regardless of whether or not they use the service. Since it is hard to estimate what the cost of care will be for an entire population, prepayment methods often employ a case rate methodology, whereby the organization receives a fixed fee for each patient based on the average cost of utilization for people in their severity or disorder category experienced by the organization in previous years.

Since, in the past, care was usually paid for on a fee-for-service basis and often covered all costs for the patient, the insurer assumed all the financial risks of underestimating the cost of care. Providers had the incentive to provide all the care they believed necessary, without regard to cost. If providers erred, it was usually on the side of overprovision of services. By paying the provider in advance for taking on the responsibility, the insurer transfers this financial risk. Providers' incentive is now to prescribe care conservatively. Clients, who in the past paid nothing for their care, shared no financial risk. The combination of lack of financial risk by both client and provider led to a situation thought by some to involve "moral hazard," i.e., the acquiescence in service utilization that often had little direction and might be considered by some as overprovision. Copayments and deductibles, which have now become commonplace, transfer some of the financial risk and responsibility for seeking care and following the treatment regimen to clients. Such sharing of responsibility for seeking care is meant to encourage a preventive health orientation among clients and discourage them from seeking unneeded care.

Unfortunately, need is a relative term. Working-class people, with marginal incomes, often find copayments to be too onerous and are discouraged to pay even modest amounts for preventive care. Such individuals are often weighing current tangible needs (e.g., a teddy

bear for a child or, perhaps, a better meal) against some future risk that might be discovered in a prenatal care visit.

Another financial control technique involves the use of provider networks, in contrast to in-house staff. The role of the MCO shifts in this strategy from service provider to contractor for services, insurer, and quality overseer. Instead of employing a staff to offer services, the MCO employs a group of providers, at prenegotiated fees or at a case rate. Such providers may be private practitioners in their own offices or may be part of an organization that joins provider networks. Providers in such networks are invariably credentialed and have a documented claim to expertise in the treatment of the target condition. They are, however, responsible for their own overhead.

### *Access and Utilization Control Techniques*

Access and utilization control techniques include: establishing a single point of entry for the service system, delineating specified levels of care, and implementing utilization management and review. Establishing a single point of entry for the system allows for the control of duplication of service provision by patient/clients shopping around. It also seeks to facilitate continuity of care.

This technique does not require a fixed geographic point of intake; it could include several physical offices with networked computer connections. Most important is the centralization of intake, so that all cases in the system are known and no duplicate services are offered. Continuity is achieved by having an information system that is case based (as opposed to intervention based) and can be accessed by all service providers.

Delineating specified levels of care enables an organization to target groups with different service needs. It helps delineate that portion of the service population that are chronic and in need of long-term care, and better determine the costs of interventions with this population. Particularly important are high service users, who may account for as much as 50% of the budget expenditures and whose care might be organized more efficiently and effectively.

Utilization review involves the review of practitioner treatment decisions by a person who usually has the power to authorize or deny expenditures. Such reviews can be prospective, concurrent, or retrospective (Tischler, 1990). Reviewers can be skilled supervisors or less skilled individuals operating from management service protocols. From a professional practice perspective, these reviews are most controversial. They threaten the tradition of independent practice and raise questions about confidentiality of the practitioner-client relationship. Denials of authorization for additional treatment sessions in outpatient mental health often are based on average numbers of sessions recommended by other members of a provider network and, in the worst case, are outright attempts to reduce the number of service contacts simply based on administrative mandates to cut costs.

### *Service Provision Control Techniques*

Service provision is often controlled by a case manager who has overall responsibility for the treatment plan and for insuring continuity of care.

Service provision control techniques require the use of the least intrusive service interventions while also doing what is necessary to enable the client to meet his or her goals for seeking help. In behavioral health this involves the issue of the least restrictive alternative — usually a noninstitutional solution. This strategy has often been interpreted as the least expensive care alternative, though better managed care companies have come to realize that the least expensive approach might be penny-wise and pound foolish over the

long term. For example, shortened duration of psychiatric hospital stays, denying clinicians enough time to resolve patient situations, may lead to increased probability of return (Segal, Akutsu, & Watson, 1998).

Service provision control strategies often limit service to the provision of "medically necessary care." Medically necessary may be defined by usual practice, though there is an emphasis on finding and utilizing outcome-driven interventions. Medically necessary may be further delimited in definition to that care that involves a cost-efficient trajectory of recovery. A cost-efficient trajectory of recovery refers to approval of service up to a point where continued treatment begins to yield diminishing or little if any improvement. Such strategies are particularly controversial in behavioral health care given the absence of good outcome data on the effectiveness, and the course of behavioral disorders and the long-term care needs of chronic patients. The latter group often requires large resource investment to achieve small changes over long periods.

## ANTICIPATED CHANGES IN SOCIAL WORK PRACTICE

Social work has developed in response to public social service needs, but more importantly to market demands for skills that could be quickly obtained at a reasonable cost. In the 1960s, for example, the advent of the community mental health center in the United States created a demand for relatively inexpensive practitioners with counseling skills. The social work practitioner's two-year graduate education was a cost-effective and expedient solution to market demand.

Clinical social workers, with at least master's degree training, are now the most prevalent group of mental health practitioners in the United States. In 1995 their numbers reached 36 per 100,000 — compared to 12.5 per 100,000 for psychiatrists and 26.7 for clinical psychologists. Furthermore, they have the broadest geographic distribution of any provider group — matching or exceeding the numbers of any other mental health professional group in most states of the union (Ivey, Scheffler, & Zazzali, 1998).

### *Service Ideology and Allocation Principles*

Social work has traditionally emphasized the uniqueness and value of each individual. Managed care principles emphasize the good of the community. Under managed care, service allocation principles shift from a clinical/medical treatment approach based on meeting individual need to a public health preventive approach based on maximizing group benefits. This shift is precisely the type of change experienced during the advent of the community mental health center movement during the 1960s and early 1970s (Feldman, 1992, 1994). The current implementation of managed care should produce results quite similar to those experienced during the 1960s and 1970s period.

The community mental health center (CMHC) movement from its initiation broadened service offerings to a healthier population. Though conceived of in a public health preventive framework, actual primary prevention efforts were a small part of the services that were actually offered. In fact, a broader population with nonchronic and less serious conditions were served. This led to significant criticism of the CMHCs' effort (Chu & Trotter, 1974) and attempts to ensure that those with more serious conditions and those who were members of high-risk groups, minorities, and the poor had access to services (The President's Commission on Mental Health, 1978). Reductions in federal support and increased mandates to serve the most seriously ill led to a reduction of popular support for the program. Today's government actions regarding managed care are directed at ensuring access to care

by all qualified recipients and, therefore, are still in the stage of encouraging the expansion of the service target population. While new major efforts are directed at serving the poor covered by Medicaid, these efforts eliminate only one of the criticisms of the community mental health movement. Services, under MCOs, are being directed to a broader and healthier population of poor recipients — thus raising access questions related to long-term care of the seriously mentally ill. As the focus of care shifts to a healthier population, the processes of care will further exacerbate the exclusion of the more chronic patients.

Therapeutic processes are being adjusted to conform to a group-focused ideology, including explicit utilization review and rationing procedures. The effect is to shorten the duration of care, or the number of approved sessions covered by the MCO (Alperin & Phillips, 1997). Practitioners are encouraged to use short-term treatment techniques with very delimited goals. It must be emphasized that in a limited resource environment, extended service to one individual, whose path to recovery shows minimal change after initial efforts, is a form of rationing, i.e., since others are not being served while those under care receive extensive resource effort, often with minimal gain, to the exclusion of other needy individuals. Yet, the shift in the process of care in itself leads to a selection of patients whose needs fit the new treatments. Conversely, other individuals in need of long-term supportive care may be excluded if special provisions are not made for them.

Service outcomes are more explicitly cost driven in the MCO than in fee-for-service plans. In the past, little consideration was given to the cost of a specific intervention and its relation to a projected outcome. Effort was made to meet needs. The group-focused model is a model based on efficient use of resources and the specification of the relation of these resources to specified outcomes. Given that most of the savings that can be had in the treatment of the seriously mentally ill come from the avoidance of hospitalization, MCOs concentrate much of their effort in serving the seriously mentally ill toward this end. The difficulty in obtaining measurable changes in this population in brief treatment periods is leading to the denial of service to this population on the basis of poor recovery trajectories. Further, the difficulty of demonstrating actual relationships with changes in the client condition (a matter discussed elsewhere; cf. Segal, 1997) has led to greater reliance on measures of client satisfaction in MCOs. Since such satisfaction is often more in evidence with less disturbed individuals, we may expect further pressures to cater to this less disturbed group.

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How the principle of medical necessity is employed in practice will be a major factor in how the system will deliver service. A mental health plan, for example, may allow 30 visits, but in practice see a medical necessity for only 4. In a worst case scenario, the plan has taken the credit for its liberal benefits and has carefully chosen its provider network so that it has excluded those likely to actually advocate for the covered number of visits. This type of choice is made easier with the presence of information systems that allow for complete documentation of a provider's treatment strategy. Further, given a behavioral perspective, providers' performance and practice strategies are to some extent shaped by the feedback they receive as to colleagues' practices. In a tight market, where provider membership in a network is contingent on performance, that is, consistent with organizational goals, the new type of treatments and objectives are internalized as part of practice ideology and the need for utilization review eliminated.

In a best case scenario, practice is more outcome driven, clients receive the help they need and nothing more, service provision is extended to a larger client group, and clients are subset according to chronicity and the need for long-term supportive and preventive care as part of the MCO's protocols. The MCO is able to use its resources more flexibly and,

in so doing, finds that its supportive care programs are preventive of expensive hospitalizations. Utilization review in turn becomes an initial procedure that is curtailed as the protocols produce desired outcomes. Medical necessity is interpreted in a manner that brings needed care to all members of the covered group.

## ROLE OF GOVERNMENT

The role of government has shifted during the past 23 years from regulation and control strategies initiated by political action to deregulation and promotion of a market-based system of care. The combination of the Employment Retirement Income Security Act of 1975 (ERISA) and the 1985 U.S. Supreme Court decision in *Metropolitan Insurance v. Massachusetts* limited the power of the states to regulate health plans and effectively shifted the regulation of health care from the public to the private sector, i.e., to the competitive marketplace. Most importantly, these federal actions made health and mental health coverage a matter of negotiation between employers and their employees. Since 85% of the American public have insurance coverage through employment or some government program, the government was effectively taken out of the regulation picture by these actions (Stone, 1998).

In considering mental health care for the poor, the trend has been one of decreasing state allocations. Unable to fund increases in services without politically unpopular tax increases, states have tried to gain control of budget increases by shifting responsibility for all but the oversight of services to the local or county level of government and by capping expenditures. In efforts to provide mental health and health services to more of the poor, especially those working poor who remain uninsured, local jurisdictions have attempted to shift costs to Medicaid, a federal entitlement program. Funding a service under Medicaid, however, obligates the state to pay 50% of the costs of care. Unfortunately, until very recently, state Medicaid costs have been rapidly increasing, well outpacing revenue growth, and approaching 20% of state expenditures. To curb what to some is an uncontrolled bleeding of state general funds, states have adopted a managed care strategy. Obtaining waivers from the Health Care Financing Administration (HCFA), states have suspended some of the major provisions of the Medicaid law, particularly freedom of provider choice and "statewideness." The former allows the locality to force Medicaid recipients to accept services from a health maintenance organization's designated network of providers; the latter allows the nature of services to differ from area to area — thus allowing for significant experimentation (Frank & Gaynor, 1993, 1994). Given these changes in the Medicaid requirements, departments of mental health at both the state and county levels are divesting responsibility for service delivery in favor of an oversight role. They are becoming contractors rather than providers by seeking cost-effective arrangements in the form of *public-private partnerships* and subcontracts to *for-profit organizations*.

### *Organization of Services*

Services will more frequently involve the use of restricted panels or networks of providers. This can happen either in a carve-out (i.e., a specialty mental health organization or, more likely, a specialty behavioral health care organization that provides both mental health and substance abuse service) or in a carve-in format. The carve-in covers all health care services as part of a general health care plan.

Provider networks are likely to be recruited as independent contractors who will have to conform to plan requirements to continue their membership. Who the client belongs to is a point of contention, though plans demand access to records.

In short, an HMO, often a former public mental health authority, will offer a *single point of entry* for access monitoring, control, and referral within a closed *provider network*. Priority will be given to outpatient versus inpatient care. *Flexible service* provision with blurred professional roles and reliance on self-help will be emphasized. *Professional providers* for networks will be sought on the basis of accepted credentials and skills, with the preference going to the least expensive yet competent personnel. *Integrated services* based on the provider's acceptance of responsibility for total care provision will be negotiated.

### *Financing*

In the past, under fee for service, the client chose the provider he or she wanted and the insurance company paid. There were millions of clients (buyers) and a few hundred thousand providers (sellers). HMOs or prepaid health plans, by virtue of signing up most potential clients and limiting their choice to a closed network of providers, have themselves become the buyers — thus drastically reducing the effective number of buyers to a few hundred or less. Prepayment helps create a market for mental health services whereby those few buyers, who control the demand of many, have a strong position in negotiating prices for care from a large number of sellers (i.e., providers). With the advent of HMO or prepaid plan networks that restrict freedom of provider choice to their own network, the demand of the millions of buyers is expressed in the market as the demand of a few buyers negotiating prices with a large number of providers. This phenomenon has lowered the price of care to the cost of the least expensive credentialed practitioner. It has further led to payment for services based on the minimum cost for the service. This market discipline has for the moment given social work an edge.

Social work has always emphasized in its philosophy the need to help people to help themselves and to not do for people what they can do for themselves. These basic principles of social work, more stated perhaps than practiced, recognize one of the key components addressed in managed care financing schemes — the risk of moral hazard and the need to avoid it by the sharing of financial risk by the client. Services offered at no cost to the client are often overused and undervalued. Payment arrangements under managed care usually involve *shared financial risk* with the client and the provider. Copayments are typical and place a value on service. From a social work perspective in dealing with the very poor, such payments might be minimal or in kind, but still add value to the service offered. Risk is distributed to providers via contracts involving *capitation* or *case rate* methodologies.

### *Provider-Client Relationship*

*Combining of the fiscal and treatment functions* changes the nature of the service. The social work practitioner has always had a dual role of social control and social service. He or she has always served two masters. Now the social worker internalizes a rationing ideology to benefit the social group as well as serve the individual. To the extent that it is the benefit of the social group rather than exploitation of the individual in service of profit, this role seems consistent with past social work performance.

In a fee-for-service plan the incentive is for the provider to offer as much service as possible to each individual. In effect, given the limitation of agency budgets, this is a form of rationing based on offering all you can to the individual being helped and ignoring the

needs of those not in attendance. A capitation or case rate methodology has been criticized for offering the perverse incentive to provide as little service as possible. This strategy does, however, make the organization responsible for the entire population. In offering too little service the organization remains the responsible party (though most such organizations have been made immune to malpractice suits). Further, since the reimbursement is paid up front and not tied to a specific service, the provider has a greater flexibility in the type of service provision than in a fee-for-service system. The fee-for-service system reimburses for limited and specified services, often not needed or inappropriate to the patient. It also often fails to provide for other services that the patient requires.

Clients and their families get *flexibility and diversity* of service in return for *shared risks and burdens*. Client satisfaction is taken as a major outcome for evaluating program results. Access becomes contingent on *medical necessity* and the *cost of treatment*.

## DISAPPEARING DISTINCTIONS IN CORE SOCIAL WELFARE PRACTICE AREAS

### *Agency-Based and Independent Practice*

Social work has been an agency-based profession largely confined to public social and health service organizations and private nonprofit organizations. The role of social workers as independent private practice providers has largely been confined to the United States. Even there, this role has been a source of some conflict and concern deriving from the belief that those who have entered the private practice market had in some way been unfaithful to the profession's commitment to serve the most needy in public service organizations (Specht & Courtney, 1994). The lure of a better income and working conditions have in fact attracted some of the most talented members of the profession to private independent practice. By changing the role of public health and mental health organizations from that of service provider to that of a contractor and insurer that relies on networks of independent providers to offer services, the managed care approach has eliminated the distinction between agency-based practice and independent practice. Independent practitioners, by virtue of their enrollment in provider networks, are drawn back into the service of public health and mental health service clientele.

### *Public and Private Practice*

The distinction between public and private practice has been evaporating with the increasing reliance of the public social services on contracting to private nonprofits and the increasing dependence of the latter on such contracts to stay in business. Managed care strategies, in their reliance on contracting and provider networks, take this process a step further by eliminating this distinction at the practitioner level.

"Any willing provider" laws mandate the inclusion of licensed and qualified providers from a variety of fields in the provider networks of MCOs. Such providers, many of whom are private practice social workers, are increasingly finding employment in these provider networks (Anderson & Berlant, 1995) serving public clients. Today's managed care environment has created a demand for credentialed practitioners in behavioral health care who are willing to contract with MCOs at a discounted fee. Mental health practice patterns typically evidence overlapping roles and functions among the major provider groups within mental health organizations (Madenlian, Patison, & Saxon, 1980). These practitioners must be skilled and available at a reasonable cost, i.e., competitive in the provider market. They

must have flexible skills in community work and be able to work with bureaucratic mandates. While the three major mental health professions (psychiatrists, psychologists, and social workers) are likely to see their skills as fairly distinct, this perception is not shared by purchasers and clients (Murstein & Fontaine, 1993). Further, a recent study of outcomes of psychotherapeutic interventions failed to distinguish between the efforts of the three major professions, while showing that all three outperformed other professional groups, e.g., marriage and family counselors, and other lesser trained practitioners (Consumer Reports, 1995; Kotkin, Daviet, & Gurin, 1996).

Social workers, costing less than psychologists and doing similar work, with the exception of extensive testing, are better trained in community-based practice than psychologists and are more used to dealing with large bureaucracies than the latter group. They are trained with greater speed, and evaluative studies of therapeutic outcomes, as noted, show no significant distinctions between the professions. Social workers do, however, show better client outcomes than marriage and family counselors and other lesser trained practitioner groups (Consumer Reports, 1995; Kotkin et al., 1996). The result has been a shift of managed care organizations toward the employ of larger groups of social work practitioners (Ivey, 1997). This shift is creating a new demand environment for social workers. Social work practice and social work practice settings are changing to adapt to this new demand environment featuring managed care strategies. On the downside, social workers must maintain their flexibility and adaptability lest they be challenged by less expensive professionals or consumer providers. Social work credentialing must be guarded to defend the field against deprofessionalization. Yet no amount of guarding will achieve such a defense if the profession does not adapt proactively to the needs of the market.

### *For Profit and Not for Profit*

The distinction between for-profit and not-for-profit practice is eliminated at the practice level, since the risk — i.e., the responsibility for the cost of the intervention — is shared by the provider and the client. This creates a burden for the provider because the provision of service in both the nonprofit and the for-profit setting is carried out with consideration of costs as a factor in the clinical decision making. In the nonprofit MCO, the clinician is working with the awareness that he or she is must provide services under the constraints of a fixed fee. Services costing more than the fixed fee will have to be absorbed by the organization budget. This could mean a loss of bonuses at the end of the year, a need to take a reduction in salary, or a direct charge against profit, in the case of the independent practitioner. The MCO gets paid whether or not the client shows up, and each service offered is a direct charge against the balance that the provider goes home with at the end of the day.

What remains of the distinction between not for profit and for profit is who takes the profit. In the not-for-profit, the savings go back into the organization to expand the service potential; in the for-profit, the profits go to the owners/shareholders. This is perhaps the greatest problem for public health and mental health organizations adopting a managed care strategy. While for some adopting such a strategy has been associated with becoming a for-profit enterprise, in fact adopting a for-profit status is in no way necessary for the switching to a managed care approach (Alameda Alliance for Health, 1995). What is necessary is the broadening of the agency role from provider to that of contractor/insurer/provider. In completing the latter transition, the public agency is in the position to capture the flexibility of the managed care organization without the shift to the demand for profit generation — a demand that often comes at the expense of service provision.

## OPPORTUNITIES AND DANGERS

### *Flexibility of Service Delivery*

In the past, a major problem in the delivery of services to the seriously mentally ill has been the inability to pay for social and material services that were not considered medical. Thus, while people could be housed in a hospital, they could not be put up in a hotel to prevent deterioration that might follow from being released to a homeless status. Often the time involved in transporting a patient to work could not be covered on a fee-for-service payment schedule. Homemaker support, necessary to keep the patient in his or her apartment, could not be paid. A capitated fee allows the service to spend the money as seen necessary and allows for the maintenance of the patient in the community.

### *Avoidance of High Cost of Treatment*

The only way that the flexibility and expansion of services to a broader but still needy population can be achieved is the avoidance of inpatient care or other high-cost treatments. Since that is where the money is currently invested and no managed care advocates are talking about increases in budgets — they are promising expanded service within current budget constraints — the consequence is the avoidance and shortening of hospital stays, perhaps inappropriately (Segal et al., 1998).

### *Taxing the Practitioner*

The burden of care and the provision of service are transferred to the practitioner. This in some areas is reaching a point where practitioners are leaving the field. They not only have the risk of care, but are now also being asked to shoulder the responsibility of "economic advocacy," i.e., the responsibility to appeal adverse decisions on reimbursement made by an MCO that may harm the patient — and maintain a standard of care acceptable within the profession — regardless of the payment decisions of the employing MCO (Phillips, 1997).

### *Insuring Quality of Care and an Outcome Orientation*

The mental health organization is supposed to provide the oversight to ensure quality of care and to produce the data systems to yield a service based on an outcome orientation. This is truly a difficult task in behavioral health care when the interventions are not closely tied to the outcomes. Further, the current reliance on the clinical trial for the evaluation of service programs has produced little by way of results other than "no difference." In fact, planning in the mental health field is often based on a lack of findings of differences between the more and less expensive conditions. The latter findings are, however, often obtained as a result of naive research approaches with poor measurement applied to chronic problems that have little probability of change in the course of the time allotted for the clinical trial.

### *Buying the Positive Outcomes*

Getting lost in the search for profits is a big problem for well-meaning MCOs. No matter how idealistic and effective the managed care arrangement, if it can be bought to satisfy profit-seeking objectives, the flexibility and the benefits gained in a managed care approach can easily be subverted. Thus, a poor MCO buys a good one for the sake of buying the product name and not for the sake of maintaining good practice.

### *Abandoning of Chronic Care*

The shift to a public health model has the potential to sacrifice the needs of the chronic client for the needs of the general community. This is a value commitment that needs to be carefully monitored along with the strategies that bring flexibility and responsibility to the practitioner.

### *Avoidance of Nonprofitable Markets*

Having rushed into the service of the poor, many MCOs are now abandoning rural and other nonprofitable markets — usually markets where their negotiating positions are less powerful. Some HMOs are retreating to the selling of administrative support services to public systems, e.g., management information systems, rather than taking on the responsibility of developing service networks or becoming the insurer of these poor populations.

## CONCLUSION

A managed care strategy offers social work the opportunity to return to its basic principles — i.e., helping people to help themselves and not doing for people what they can do for themselves. It has the potential to offer tremendous opportunities with respect to employment. Demand for social workers is likely to increase under managed care because they are relatively inexpensive professionals, quickly trained, and trained in the use of community resources and the implementation of a flexible and pragmatic approach to service. While social workers should not embrace the strategy of managed care, they should not run from it or blindly oppose it. They need to aggressively pursue it, fighting its major drawbacks (the for-profit management, the possible abandonment of the chronic patient) while adapting to a competitive marketplace. Social work is a profession that is now in the right place, at the right time, and available at the right price (an improved income if current practice in HMOs continues). Managed care has given the field the opportunity to bridge the gap between private and public practice, allowing social workers who have pursued private practice careers to now offer their services to social work's traditional clientele. It can be a launching platform for flexible and innovative service. Yet, the market can be cruel, and a totally defensive stance to managed care approaches, given the momentum they have already obtained, could be very costly to social work in terms of its long-term position as a provider of health and mental health services.

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