Letter from . . . Chicago

Prepaid health

GEORGE DUNEA

The unattractive term "health care delivery," now firmly established in the American language, implies that health care, like salami, can be delivered in a grocery van—and conjures up the figure of a man in a white coat bringing cartons of soft drinks and potato chips, a cabbage, a new invigorating facial tonic, and a giant-size package of disposable health care. A bill, scribbled on yellow paper and left pinned to the merchandise, symbolises the rapaciousness of capitalist degeneracy. More equitable then would be to pay a monthly predetermined premium and receive in return all the groceries you need, or at least all the groceries your grocer thinks you need. In medicine, such prepayment plans date back to the ancient Chinese, who paid their doctor when they were well but not when they were sick. They are now being tried in America to solve the problem of rising costs; and, being based on the principle that health can be maintained as well as delivered, are appropriately termed health maintenance organisations (HMOs).

Growth of the HMOs

Prepaid medical plans, though sometimes advertised as the greatest medical advance of the century, date back at least to George Washington, who contracted with doctors to oversee the health of his plantation workers. During the nineteenth century, the army, the railroads, and some industries in isolated areas frequently made similar arrangements. In 1927 a study group of medical, public health, and education leaders recommended that organised consumer groups should contribute to a common fund in return for complete medical services for their members and their families. Two years later the Ross-Loos Clinic in Los Angeles offered the first prepaid health plan, to be followed in 1933 by Kaiser-Permanente, the largest and best-known organisation of its kind, currently providing medical care to some 2·5 million people in California, Hawaii, Oregon, Colorado, and Ohio.[1]

Other large plans are the Health Insurance Plan of Greater New York, the Group Health Co-operative Plan of Seattle, the Group Health Association of Washington DC, and the Union Health Services in Chicago (1952). Differing in organisation and in benefits offered, such plans may operate their own hospitals, refer patients to one given hospital (thus enabling them to negotiate favourable rates), or provide no inpatient treatment but expect the referring groups to guarantee a variable amount of free hospital care. Some groups are controlled by hospital or professional corporations; others, such as the Seattle plan, are dominated by consumers; and yet others rely on subscribers enrolled through labour unions, the benefits being part of a collective bargaining contract. Paramedical staff frequently play an important part, being used to conduct multiphasic screening, to detect early disease, to triage those who are worried but well, and to relieve the doctor from routine tasks that can be delegated.[2] The physicians are often employed full time, but in the smaller plans they may also practise privately. Some groups offer incentive bonuses, others straight salaries. In some plans patients have their own personal physician, who may also have a subspecialty interest and who may refer freely to the other doctors in the group—or, with the medical director's permission, to outside physicians. Large plans frequently offer a wide array of services, having to refer out only in unusual circumstances. In general, it would appear that most plans give adequate medical care at a reasonable price.

For many years, however, the growth of prepaid medical practices was severely restricted, at least in part because of opposition from organised medicine, so that by 1970 only 30 such plans had come into existence.[1] In the early 'seventies, in the face of rising medical costs, the Nixon administration became convinced that prepaid medical plans were the answer to the "massive health-care crisis" and, in 1973, sponsored the first HMO legislation. The law provided grants for feasibility studies, planning and development, and direct federal loans for initial operating costs. It also established a mandatory employer dual-choice option, requiring employers with 25 or more employees to offer the choice of an HMO as an alternative to other health insurance systems available in the area. The administration predicted that by 1976 some 1700 HMOs would be serving 40 million Americans and allocated $375m over a period of five years to HMOs qualifying for federal certification.

To qualify for such certification, however, HMOs were required by law to provide an extensive package of services. This included dental and eye care for children, health education programmes, short-term mental health services, treatment for alcoholism and drug abuse, radiotherapy, home health care, and family planning services. There was a potentially disastrous requirement of an open enrolment period for one month a year, and of uniform premiums for all members, whether well or ill. Furthermore, doctors were discouraged from participating in these programmes by being required to spend over half their time in prepaid subscriber care. The high initial costs and the prospect of financial losses during the first few years caused further difficulties, and it became apparent that the law would have to be changed if the HMO movement was to flourish.[3]

Lengthy manoeuvring followed, culminating in legislative changes by President Ford in 1976, and by the Carter administration in 1978. Many of the earlier restrictions were lifted or relaxed, and heavy funding was continued despite objections that such favoured treatment was not providing a fair market test, but was setting up HMOs as the established form of medical care.[4] Yet the government remains convinced that HMOs constitute a less expensive alternative to the present system, and, by currently concentrating on metropolitan areas with populations of over 250 000, hopes that within a decade some 400 HMOs will serve a population of at least 20 million people.

At present some 210 HMOs, about half of which are federally certified, are providing care for a population of some 8 million people. The HMOs are of different kinds and are all constituted

Cook County Hospital, Chicago, Illinois 60612
GEORGE DUNEA, FRCP, FRCPED, attending physician

differently, but they generally have boards of directors, managers, administrators, and medical and paramedical staff. The doctors, full time or part time, may be directly employed or form a medical group contracting with the parent organisation to provide medical care; in another kind—the fee for service HMO, usually sponsored by a local medical society—the doctors participating in the programme maintain their private offices, where, in addition to seeing their usual patients, they also treat the members of the prepaid plan on an agreed capitation schedule. In many types of HMO the doctors agree to assume a certain degree of risk and may receive an end of year bonus if they have kept down overall expenses.[5 6]

So far HMOs have met with varying degrees of success. Several dozen have become bankrupt or, unable to attract patients, have survived only because of continuing government subsidies and grants.[7] In some of the wealthier areas, however, HMOs are apparently prospering, being favoured by the dual option requirements, by government grants, and by the recently acquired freedom to pick and choose whom they enrol.[4] At least one old established prepaid plan has been torn by conflict between the lay board and its physician employees, culminating in a prolonged strike by doctors.[8] Some of the larger inner city plans, developed to serve the poor by contract with Medicaid, have been plagued by fraud, administrative ineptitude, and slow reimbursement from the State, and several have gone out of existence.

Uncertain prognosis

What, then, is the future of HMOs? Are they a transient phenomenon, an idea whose time has passed,[9] or a temporary way out for a government committed to provide universal care at a time of rising costs?[10] Some observers believe that the HMOs will continue to grow and will always play a part, albeit small, within a pluralistic system. But pessimists predict a nightmare in decades to come, with HMOs being the only health care system, with long queues of sick people lining up to be processed by impersonal computers and indifferent clerks, with long delays and unsympathetic care, with patients never seeing the same doctor twice, and with the eventual prospect (by 1994) of patients having to resort to the blackmarket fee-for-service system or even flying to the United Kingdom, which by then would have abandoned its experiment with socialist medicine.[11]

Meanwhile, only the most naive seriously believe that HMOs can maintain health. In fact, observers have found that many HMOs practise less preventive medicine than private doctors. Even so, overall premiums are lower, suggesting that HMOs have the potential to save money. Such savings may be effected by using paramedical personnel to triage the patients with minor complaints who might otherwise swamp the system.[2] Most of the savings, however, appear to be achieved by some 30% fewer admissions to hospital.[12] It is also believed that there may be less surgery because the surgeons are being referred more cases and tend to become more selective rather than operate on marginal indications. There may also be some savings from more cautious prescribing and ordering of investigations, but, as the overall costs of salaries and equipment are fixed, ordering fewer investigations might merely increase the cost of each individual test. Yet for many doctors HMOs offer a pleasant way of practising medicine, one in which financial barriers to care have been removed.

Doctors also enjoy the companionship and congenial atmosphere of working in a group, the ease of securing consultations, the absence of administrative overheads and worries, and the lack of pressures to overtreat and overprescribe.[3] Some doctors feel more secure, especially as they do not have to worry about being sued for malpractice. They may also enjoy the shorter hours and the feeling that when they're off they're off and don't have to carry a beeper. Hence HMOs are especially attractive to women doctors with small children and to those wanting a 9 to 5 job. They may be less enticing to the hard driving practitioner who works seven days a week and gets up at 5 in the morning, who may not appreciate earning less money than his colleagues, who may feel smothered by restrictions and administrative interference, and who wants to be his own boss. So, as long as a viable fee-for-service alternative exists, HMOs may have difficulty in recruiting or retaining quality doctors. For administrators, on the other hand, HMOs offer unlimited opportunities in the form of power, importance, and pay (some HMOs have administrative costs that are half of their turnover), nor has it escaped notice that even the most ardent protagonists of prepaid plans will usually resort to the traditional private practitioner when they or their families become ill. Perhaps in caring for indigent patients HMOs might offer certain advantages, because registration with one plan would limit the welfare patient from wandering from doctor to doctor, from hospital to hospital, shopping around and, in the process, having all his investigations unnecessarily repeated. So far experiments with prepaid plans in indigent areas have not been successful.

In general, however, patient satisfaction with HMOs has been variable.[1] Some studies report no lower rates of dissatisfaction than with private doctors. Yet some patients have complained about long waiting lines, inadequate emergency services, lack of continuity, or absence of a personal doctor/patient relationship. Some patients are surprised to discover that they have signed up for a system that limits their choice,[6] that they must stick with one doctor, that they can go to only one emergency room, that they cannot fly to the Mayo Clinic to have their coronary bypass or their valve repair. Patients do not have an automatic right to see a consultant, and if they become ill while travelling out of town the plan will often arrange for an early transfer to the base hospital, to avoid losing money by having to pay a large hospital bill. In many plans the policy is to discourage referrals and consultations, an approach that might be unacceptable to a well-educated and demanding public. And, although the protagonists of HMOs reasurringly talk about monitoring under use, those who have served on hospital utilisation review committees may not necessarily share their optimism. So that we are still left with the issue of conflict of interest[13] inherent in any system where doctors stand to gain financially from undertreatment. It may not be easy to reassure the patient who suspects that his doctor has failed to prescribe or order tests merely because he wanted to increase his share of the bonus from unspent money. For it is almost as if our white-coated grocer were trying to give away as little cheese and turnips and tomatoes as possible, while his partners at the grocery shop try to keep the record straight by conducting peer review to prevent underutilisation.

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