HMOs: America Today, Britain Tomorrow?

Nuts, bolts, and the customers

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One doctor I met described health maintenance organisations (HMOs) as more of a basket of fruit than a bunch of grapes but it is possible to get a taste of the whole by looking at one in detail. In this article the Harvard Community Health Plan in Boston acts as the model for the day to day running of an HMO and the advantages and disadvantages of these organisations from a patient's point of view.

Focusing down

The Harvard Community Health Plan has just over 207 000 members and among its 3000 or so staff it employs 360 doctors. It is a non-profit organisation started by the medical school of Harvard University and its brochure says that it is "New England's most experienced HMO," which since 1969 has been "serving the residents of Eastern Massachusetts with high quality health care that's convenient and affordable." Until 1980 the Harvard plan was Boston's only HMO but now it is in fierce competition with 10 others.

The plan owns nine health centres, and patients join the one that is nearest to home or nearest to work. Unlike the Kaiser Permanente Medical Care Program, the Harvard plan does not own its own hospitals but is affiliated with, and hence admits patients to, "some of the most respected hospitals in the Boston area." These include the Beth Israel and Massachusetts General hospitals. The first of the plan's health centres was built in the heart of the city, but as other HMOs sprang up suburban centres were established to reach a new range of customers.

Most people (88%) join the plan through their employer and—in common with all HMOs—the Harvard plan is openly unenthusiastic about underwriting individuals who are not part of a group—that is, the unemployed, the self employed, and those working for very small companies who do not offer health insurance as a fringe benefit. The going rate for a family is $230 a month, irrespective of the number of children, and $86 for a single person. The employer pays all or a proportion of this premium, leaving the patient to pay the rest. All the employees must be accepted (this is a mandatory requirement for HMOs) irrespective of whether the workforce is fit young men, or women, or a pot pourri of young and old. Furthermore, despite the very different rates of use of medical services by different groups, the plan can offer only one rate. The one discount on offer is the suburban premium: $206 for a family, $81.50 for an individual. This is lower because if the patients need hospital care they go—indeed, must go for 90% of their care—into district hospitals, which have cheaper rates than the large teaching centres. New laws are being introduced, however, to allow HMOs to make themselves more attractive to employers by negotiating special rates which take into account the age and sex structure of the workforce. This flexibility is important—for insurance companies have not been slow to categorise people into low and high risk groups and offer competitive premiums.

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The customers

Again in common with other HMOs, the Harvard plan initially attracted young patients and their children from the working population, especially those who were new to an area and did not know the local doctors.[1] These patients are attractive as enrollees, for their medical costs are lower than those of a cross section of the population, with its 14% load of over 65 year olds. But times are changing, and many HMOs are now keen to sign up Medicare patients.[2] This volte face stems from the effects of legislation that was introduced in October 1982, when the federal government announced that if Medicare patients got enrolled in HMOs, who would as usual undertake to provide comprehensive care, it would pay the HMO 95% of the average area cost of looking after such patients.

Medicare patients were attracted to HMOs because these offered total medical care, including dental and ophthalmological services, under one roof. There was also the advantage that if they joined an HMO they would not have to fill in the various forms that must be completed after each visit to a doctor if the patient seeks reimbursement of the cost of that visit through an insurance company. The attraction was thus mutual, and such is the enthusiasm of HMOs to sign up America's senior citizens that apparently 38 different health plans have applied to go to Florida, where the sun shines all year round and 35% of the population are over 65.

All mod cons

Established classic HMOs (as opposed to independent practice associations) tend to have impressive custom built health "facilities." These vary in size, but the larger ones can enrol 30 000 patients or more. On site radiology, laboratory services, and electrocardiography are usually standard, and many have dental facilities, opticians, audiometrists, chiropodists, physiotherapists, and even ultrasound departments, in addition to a well stocked pharmacy. These centres compare with the average British GP surgery in the way that five star hotels compare with seaside B and Bs, the most striking difference being that the HMO health centres seem geared to pleasing the customer. Frontline reception staff undergo training to learn how to communicate and provide a good service (rather than act as a Dobermann pinscher preventing access to the doctors). And beyond the smile at reception comfortable, tastefully decorated waiting rooms seem to be the norm.

At all the centres I visited patients who were new to the HMO were invited to attend for an initiation visit, during which they not only learnt what the centre had to offer and how it ran but were invited to choose their own doctor. The skills and personalities of the doctors who worked at the clinic were discussed with them and

the patients were then invited to pick the doctor who most appealed to them. If the match proved unsatisfactory they were free to switch to another of the plan's doctors.

In house organisation

Surgery hours tend to be longer than in Britain, and at the Harvard plan, the health centres operated from 8 30 am to 10 pm seven days a week. Appointments were booked from 9 am to 9 pm Monday to Friday. Each centre also had an urgent care unit that was open until 10 pm. After hours, patients phoned in for advice and spoke to either a nurse practitioner or a doctor, who advised whether they needed to be seen. If they did they had to make their own way to the designated hospital casualty department for it seems that doctors seldom do domiciliary visits and some never do. When they arrived the on duty doctor for the HMO would assess them and arrange admission if necessary.

Appointments were scheduled as follows: 30 minutes for a first visit, 15 minutes for a follow up, and 45 minutes for patients over 65 years old, on the basis that they often have multiple problems and usually take longer to undress. Waiting times were adhered to, and if patients were kept waiting more than 10-15 minutes I was told that someone came up, explained why, and gave them the choice of hanging on, seeing one of the doctors who was free, or booking an appointment for another day. With recent memories of what most of us in Britain accept—a wait of an hour or so in a small, shabby NHS general practice—and of endless occasions when I as a GP kept people waiting for similarly long periods, the contrast was striking. Furthermore, I could not help reflecting that one scruffy copy of last year's *Daily Telegraph* colour supplement did not compare favourably with the glossy publications available in most HMO health centres that include "take away" leaflets on topics such as asthma, losing weight, and giving up smoking.

The ratio of patients to full time doctors in the Harvard plan health centres was about 1600 to one. Each centre of each HMO obviously has a variable complement of staff, but in one of the Harvard plan's health centres that I visited, which looked after about 35 000 patients, there were 10 internists (general physicians) and seven paediatricians together with an allergist, a nutritional expert, a cardiologist, a dermatologist, a neurologist, an obstetrician and gynaecologist, and a rheumatologist. These specialists worked full time for the plan but rotated from one centre to another during the course of the week.

Since family doctors are still rare most "holistic" care is provided by internists and paediatricians who are expected to act as gatekeepers, keeping referrals to specialists to a minimum, to keep costs down. Primary care is getting more emphasis, however, and the Harvard students now spend several weeks attached to one of the Harvard Community Health Plan's health centres. But they are not there just to learn about primary care; Dr Gordon Moore, who has been responsible for reshaping the undergraduate curriculum at Harvard, made it clear: "Students must learn about prepaid health systems," he said, "and, although there is no undergraduate managerial teaching as yet, young doctors need to acquire a business culture."

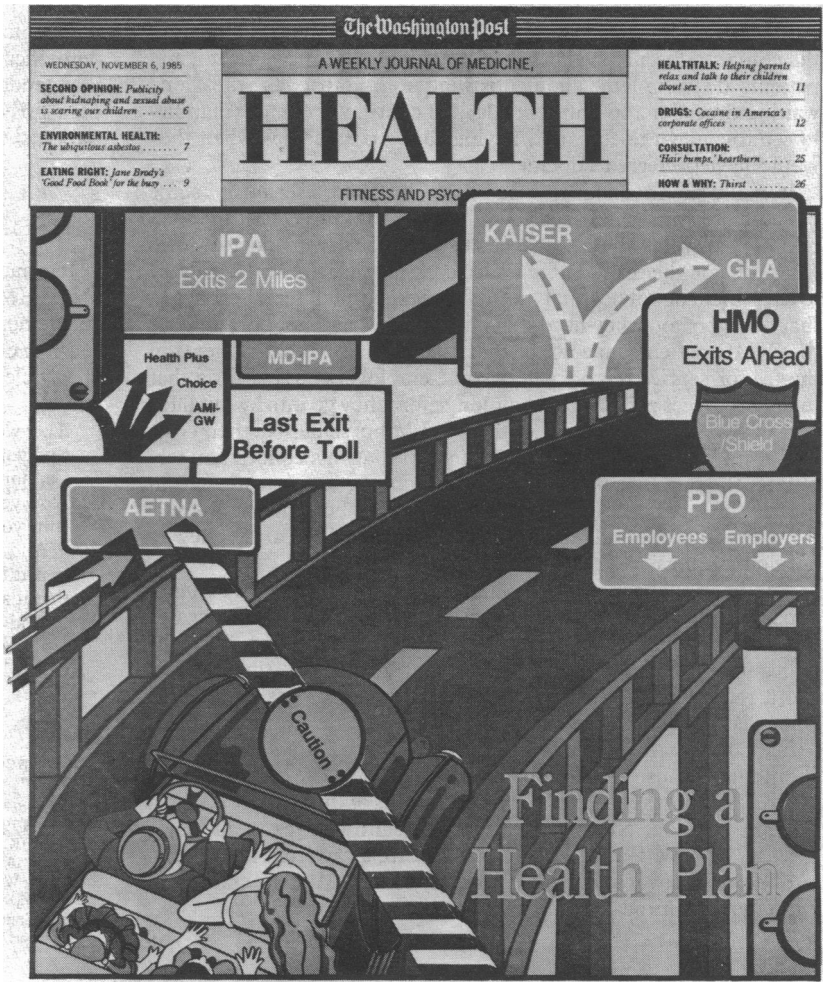
HMOs use nurse practitioners—fully trained nurses who have undergone one or two years' extra training—and assistant physicians to undertake simple clinical procedures and assume full responsibility for non-serious medical conditions such as sore throats, sprained knees, and so on. Trivial problems are thus fielded off, leaving the doctors with more time for the potentially more serious medical problems.

Reasons to join an HMO

Among the most widely quoted advantage for patients who join HMOs is "one stop shopping." That is, the patient goes in with a cough, sees his familiar internist, gets a quick second opinion from the visiting chest physician, has a chest *x* ray examination and blood test, and comes out with a bottle of ampicillin, all in one go under one roof. Furthermore, the process is completed with minimal paperwork, at least from the patient's point of view, which as I have said is particularly welcome for the elderly, for in the fee for service sector insurance companies will not pay up if their claim forms are not filled in accurately.

Another great advantage is that that there are no hidden costs; most patients pay only a dollar or two for the visit and perhaps a similar amount for the prescription. This is in sharp contrast to the fee for service sector with its "deductibles" (the amount of each bill a patient has to pay before the insurance company chips in) and "coinsurance" (the percentage of any hospital bill the patient must pay). These extra payments have been rising steadily and are now being pushed on to the patient by employers who are anxious to make them "hurt" for the cost of care. Making patients feel the costs in this way seems to work: in one experiment where people were randomly assigned for three to five years to a plan giving free care or to one that required enrollees to pay a share of the bills those who paid made fewer visits to the doctor and were admitted to hospital a third less often.[3]

HMOs make much of the fact that they are "concerned" with



This cartoon from *The Washington Post* gives a good idea of the bewildering number of options for those seeking health insurance. (Reproduced by kind permission of Tyrone Huntley, Washington DC.)

maintaining health, and, whether or not this is true, it is attractive for patients to know that they do not have to pay extra for seeking "well" care. It is also nice to have the opportunity to feed back thoughts about the service provided, and in HMOs opinions are canvassed regularly. Furthermore, these opinions and any complaints—for example, about rude doctors, offhand staff, uncomfortable chairs, and even too many aspidistras in the waiting room—are all taken seriously. Finally, HMOs offer the advantage of knowing what your expenditure on health for the year is going to be, and hence allowing both the patient and his employer to avoid the financial upheaval of any sudden large, unexpected medical bills.

Not all that glisters is golden

But behind the Monet prints, the carpets, and the friendly air of the clinic staff is all a bed of roses? Inevitably the answer is no, and patients do complain: about obstructive discourteous staff, long waiting times for appointments, lack of continuity of care, inability to see their own doctor, and having to see paramedics when they would have preferred a doctor.

It would be nirvana if it were not so, but, more seriously, some patients are concerned that HMO doctors are, or at least may be, reluctant to refer them for specialist opinions from doctors who work outside the plan. There is also concern that the HMO will try to keep them out of hospital (even if in their opinion, and perhaps in that of others too, they need to go in). Here it is worth pointing out that HMO patients may not be that much worse off than patients in the fee for service sector, where some employers are insisting that their employees get a second opinion before they go into hospital for non-urgent surgery, and if they do not, reimbursement of their costs may drop by 50%.[4] It may also be argued that this concern merely reflects the fact that patients are used to being overinvestigated in the fee for service sector. Nevertheless, at the bottom line there is the uncomfortable and inescapable truth that HMOs earn money by not doing things.

Another drawback is that if patients seek urgent care in a casualty department without getting authorisation from one of the health plan's doctors the HMO won't pay unless their definition of urgent tallies with the patient's. The HMO may also be less than helpful about refunding the cost of medical care received outside the area when visiting relatives in another town or state, for example, unless patients follow the plan's protocol to the letter. Patients who move about a lot because of their job or because they choose to escape from the freezing north to Miami for three months of the year are also in a difficult position. Not even Kaiser has health centres in all major cities and if a patient seeks non-urgent care away from home he is unlikely to be covered. To overcome this some HMOs are starting to implement reciprocal arrangements.

Limitations of choice

A limited choice of both doctors and hospitals is an inevitable sequel of belonging to an HMO. This worries some patients, especially those who are used to going to the "top man" and getting treatment in the "top unit" (HMOs have had the reputation of employing less than top class physicians). In respect of choice of provider the Independent Practice Association has definite advantages for it can recruit from established doctors who continue to work in their own premises and use existing hospital networks.

Limitation of choice is, however, not only a problem for patients who enrol in HMOs: many employers and insurance companies are persuading people to get their medical care from a restricted group of "preferred providers." This introduces another acronym—the PPO or preferred provider organisation, which is a loose amalgam of doctors or hospitals, or both, who offer employers or insurance companies discount rates in exchange for access to a large group of patients. The carrot to persuade patients to go to these preferred providers is, needless to say, financial. Patients get reimbursed in full if they go to the PPO and not at all or only part if they don't.

Another point that worries some patients is that HMOs dictate not only where you get hospital care but when you go in and how long you stay. Then there is the geographical problem: some patients do not join HMOs for the simple reason that their town does not have one or, if it does, that they live too far away from its nearest clinic. Others don't join because a plan may offer a very unattractive deal to sick or potentially sick patients who want to join as individuals. For them it may be Catch 22: the patient with one kidney might be told that he can join but the plan won't cover him for renal problems, and the lady with rheumatic heart disease will be offered cover for everything except cardiological problems. Pregnant women are normally turned down flat.

The reasons for this stance are obvious. Plans are reluctant to sign up people who are certain to cost them a lot of money. (So are the conventional insurance companies, of course, but they can pass the cost on to the patient by raising the deductible and coinsurance payments.) This no doubt explains why few HMOs provide detoxification centres for alcoholics and drug abusers and why there is a tendency, so I was told, to send patients to see the health plan's psychologist, rather than a psychiatrist. In both cases these patients' medical needs are unpredictable and likely to be long term.

Grass roots opinion

It is hard to get a feel for what the average man in the street thinks about HMOs. Opinions I heard ranged from enthusiastic to highly suspicious with some claiming that HMOs offer a second class service. Of course many people just do not know what to think, and an article in *The Washington Post* (6 November 1985) suggested why:

> The world of medical insurance is changing almost every day. Suddenly there are HMOs, IPAs, PPOs, Choice, IPAs, MD-IPA, CapitalCare, and a mind-numbing array of other health care options. Now you can shop among these and other plans for the coverage that suits you best.
>
> And that's good.
>
> But there are so many different plans of so many different kinds that it's bewildering.
>
> And that's bad... unless you sit back and say: "What's really available? What is best for my family and me? What will be the best deal if I suddenly get expensively sick?"

References

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3 Manning WG, Leibowitz A, *et al.* A controlled trial of the effect of a prepaid group practice on use of services. *N Engl J Med* 1984;310:505-11.
4 Stein J. Industry's new bottom line on health care costs: is less better? *Hastings Center Report* 1985 October:14-8.

Is any calcium supplement required for an otherwise fit young adult whose intake of dairy produce is very low? Should this replacement, if any, be given with vitamin D and if so in what dosage?

Although dairy products provide over half the average daily intake of calcium in the United Kingdom,[1] poor calcium status is not necessarily a corollary of a low intake of these foods. Many populations maintain well calcified tissues on intakes that would be regarded as inadequate by current United Kingdom standards. The soundest approach, however, would be to make a complete dietary assessment to determine the calcium intake and to make decisions based on this information. Provided that the patient is eating a good mixed diet and is not housebound, the combination of diet and sunlight should be adequate in meeting vitamin D needs, especially if, as the question implies, the patient is fit.—D SOUTHGATE, head, nutrition and food quality division, Food Research Institute, Norwich.

1 Ministry of Agriculture, Fisheries and Food. *Household food, consumption and expenditure, 1983.* London: HMSO, 1985.