

# HMOs: America Today, Britain Tomorrow?

## Even the rich can't afford it

TESSA RICHARDS

Medical care in America is in the middle of a revolution. The cost of care has rocketed. Doctors are complaining of loss of power, autonomy, patients, and pay. Hospitals are fighting for survival. Academic institutions are under threat.<sup>1</sup> And in the midst of this unrest a controversial form of delivery of health care—the HMO—is gaining momentum. HMOs are unlikely to be the answer to all America's complex health care problems but they have attracted tremendous interest not to mention near vitriolic polemic. So what exactly is an HMO and why have they caught the eye of our orchestrators of health care in Britain? In an attempt to answer these questions I spent a couple of weeks in America last November looking at HMOs and in a series of articles hope to shed some light on the subject.

### Pressure for change

After years of open ended commitment by health insurers, Medicare, etc, to pay for all the care that the providers and consumers of health have come to regard as the patient's right, the climate has changed. The federal government, concerned that expenditure on health has risen from 7.5% of gross national product in 1970 to nearly 11% in 1983,<sup>2</sup> (the British figure for 1983 was 5.6%) has introduced tough new measures to reduce its outlay on health and these are biting deep. Indeed, "cost containment" has become the central objective for all those who are currently paying America's expensive health bills, and this has resulted in repeated calls not only for a change towards alternative, less costly, forms of delivery of health care but also for a change in society's attitude to what constitutes good medical care.<sup>3</sup> Continued pruning and mention of rationing of care have provoked considerable misgiving.<sup>4,5</sup> Most of the alternative forms of delivery of health care that are being advocated entail restricting the patient's choice of "provider" (his doctor or hospital, or both), and among the most successful—at least in containing costs—have been the prepaid health plans. These plans are usually described under the blanket term of health maintenance organisations, or more conveniently HMOs.

No two HMOs are alike but there are two main models. The first, and classical, model is the prepaid group practice. Here patients enrol with an HMO on a yearly basis and pay a set fee per month—in advance—in exchange for a guarantee that the health plan will provide all their medical care over the ensuing year. Some of the larger HMOs own all their own hospitals and health centres. Others just own health centres and contract with local hospitals to provide inpatient care. Doctors are employed on a full time basis and paid a fixed salary to provide a wide and contractually specified range of medical services.

The second major type of HMO is the independent practice



HMO logos: competition is the name of the game.

association or IPA (no "health delivery system" in America is without its acronym). Here, established doctors working in individual or small group practices form an association and agree to manage patients who enrol with the IPA on set terms. Again patients join on a yearly basis and pay a set monthly premium. The association pays its member doctors a certain amount to manage each patient. If the doctor overspends on that patient he has to reimburse the IPA. If he spends less then he and the association make a profit. The essential element is that he takes a financial risk in providing care for that patient. Unlike the doctors who enrol with a classical HMO, those who join an IPA are free to see private patients, who are not enrolled with the IPA. Indeed non-IPA patients often make up the bulk of their work and income.

### HMOs in competition

The IPA form of HMO is growing faster than the prepaid group practice model because it uses existing networks of physicians who continue to work in their own premises and admit patients to

hospitals that they are affiliated with, obviating the need to shell out large sums on building new clinics and hospitals. Between the independent practice association and the classical prepaid group practice lie a number of HMO hybrids; the distinctions are now becoming blurred. What they share is the principle that care is paid for in advance at a predetermined rate. If all the patient can muster is the occasional sore throat the health plan makes a profit; if he needs coronary artery bypass surgery it doesn't. Thus the health of the HMO depends on spending less on health care for its members than it gets in from them in premiums. HMOs of either type are essentially urban phenomena and are concerned primarily with acute care. They do not, for example, provide long term custodial care for the elderly or chronically sick, and until recently avoided enrolling patients over 65 years because their health care costs are relatively high.

The competition between different health plans and other providers of health care has escalated to the extent that from the morning newspapers, past the billboard hoardings, through to the evening television, patients are bombarded by advertisements from different health plans urging them to "choose me." Once they have made a choice and enrolled for one year they must comply with the rules, and a basic tenet of belonging to any HMO is that patients must receive all their care that year from that one HMO. If they seek non-urgent medical care outside the plan the plan will not pay the bill. If at the end of the year they are dissatisfied they can switch to another HMO or take out another form of health insurance.

Combining the financing and delivery of medical services in one organisation is in sharp contrast with the traditional system in America, where the patient goes to any doctor he likes and gets charged on a fee for service basis. The bill is then submitted, by either the patient or the doctor, to a third party—one of the large private insurance schemes or a federal insurance programme—which reimburses the patient or the doctor for the cost of all or part of the care that has been provided.

### HMOs as catalysts

There is nothing new about HMOs. They have been around for over 70 years, and despite the fact that they have occupied innumerable column inches in American medical and economic journals only about 9% of the population belong to one of America's 337 (approximate figure) HMOs. Nevertheless, in the early 1980s membership started to grow at about 15% per annum, and by the end of 1984 figures showed a rise of 22% from the previous year.<sup>6</sup> This factor, coupled with the proliferation and diversification of HMOs into a wide range of competing health plans, has taken everyone by surprise. More importantly, by showing that patients can be provided with comprehensive care at anything from 10% to 40% less than the cost of comparable care in the fee for service sector,<sup>7</sup> apparently with no decrease in the quality of care, HMOs have triggered off some fundamental changes in the approach to providing health care in America.

The key to their success in reducing costs has been "a relentless pursuit of strategies to keep people out of hospital,"<sup>8</sup> for rising costs of hospital care have been the major determinant of the total rise in health care costs. (In 1983 they accounted for about 40% of the total health bill.) HMOs have also adopted a firm line with their clinicians and subjected their every move to strict audit.

The reins of most HMOs are held firmly by non-medical management teams, who have shown that by adopting standard commercial methods health care can be transformed into a viable, and in some cases highly profitable, business. Their attitude is straightforward: health care is America's largest industry (far too important to be left in the hands of doctors) and must be run efficiently just like any other business. The idea that it could be run on any other lines, for example, on a charitable basis, is sheer romantic nostalgia.

The response of doctors to what has been a full frontal attack on their role as controllers of the organisation, delivery, and financing of health care has varied. A few have grasped the nettle and are up

and leading at the sharp end of successful HMOs. Most have not, and there is still a wealth of philosophical and practical opposition to the idea of turning health care into an industry and promoting medical services as a commodity that can be bought and sold in the market place. This attitude, coupled with a lack of interest or flair for management, which is perhaps characteristic of doctors anywhere, probably explains why many HMOs exclude them from their higher echelons. They prefer to employ their doctors as hired hands, necessary cogs in a health care business.

Although more and more doctors are opting to join HMOs (one I met had signed up with 25 different plans in the past year) it has less to do with embracing their competitive cost containing ethic than the pragmatic need to get patients. This is now a serious problem for America has 2.5 doctors per 1000 of the population (compared with 1.65 per 1000 in Britain) with expectations of 30 000-40 000 surplus physicians by the year 2000.

### The British angle

Britain has had no experience of HMOs, but the fate of the Harrow Health Care Centre, Britain's first prepaid group practice, which has now been taken over by an American health consortium has been followed with interest. It has not been without its problems, but despite these it seems likely that other centres will follow. American health corporations are looking abroad for new investment pastures, and as they observe mounting dissatisfaction with the NHS and an enlarging private sector, Britain is seen as potentially fertile ground. The Office of Health Economics has predicted that the private sector will "continue its transformation into a sector of commercial corporate activity utilising the technology and delivery systems developed outside Britain,"<sup>9</sup> and by this implying a move towards the new systems that have been developed in America.

The NHS may not be about to follow British Telecom and British Gas down the road to privatisation, but the suggestions of Professor Alain Enthoven,<sup>10</sup> a leading American expert on the economics of health care, who was invited to give his views on ways to increase the efficiency of health service management in the UK, attracted much interest,<sup>11-15</sup> especially his suggestion to introduce market competition between district health authorities to give them an incentive to manage their budgets more efficiently. In an article in the *Economist* he concluded that "if British policy makers were to seriously examine a radically different scheme for health care I would recommend the competing HMO model as the most promising candidate."<sup>16</sup>

Since the government appears to be contemplating just that and has cast a favourable eye on HMOs,<sup>17</sup> it seems a good idea to take a look at HMOs from the perspective of a British doctor. In outlining the development of HMOs and some of the pros and cons of this form of delivery of care I make no apology for presenting a subjective account, or for not unravelling the complexities of American health care. Not only does the latter vary considerably from state to state and from urban to rural areas, but the pace of change is such that even the experts are having trouble keeping abreast of it all. "Chaos reigns," said John Iglehart, a leading commentator on American health care. "Everyone is trying to get into everyone else's business and everything's happening at a phenomenally rapid rate."

### End of a golden era?

A changing health care climate and uncertainty about the future inevitably prompts comparison with older, better days, and several doctors I met spoke of the golden era, which, they said, had come to an abrupt close. But what has been so special about medicine in America over the past couple of decades to warrant this description? Golden for whom? The health statistics do not suggest that patient care has improved dramatically, and those who have been footing the increasingly massive health bills have been frankly unhappy.

Even after allowing for inflation, the figures show that there has been a threefold rise in spending per head over the past 20 years.

In truth it seems that the main beneficiaries of the gold in this era have been the providers of care. Estimates in the late 1970s suggested that 18% of health care spending was taken up by doctors' salaries, which in 1981 averaged \$93 000,<sup>18</sup> with top salaries in the \$300 000 range, and that doctors controlled or influenced most of the rest of the spending. Life may not have been a bed of roses, and many doctors are quick to point to the problems of practising under the constant and expensive threat of malpractice suits, but there is no denying that the profession as a whole has done very nicely.

Before moving on to look at how HMOs have contributed to the change in the status quo it is important to appreciate how the traditional fee for service system evolved and flourished until the early 1980s, and this will be discussed in the second article in this series. This is not to imply that it is not still the major way in which health care in America is delivered, for it is, but doctors working in this sector are beginning to practise in less expansive styles for they are aware that "the fee for service system will not survive unless it can match the cost effectiveness of HMOs and well organised private clinics (such as Mayo, Ochsner, Lahey, and Cleveland)."<sup>19</sup>

## References

- 1 Schwartz WB, Newhouse JP, Williams SP. Is the teaching hospital an endangered species? *N Engl J Med* 1985;313:157-62.
- 2 Wesley N Jr, Hester RD. Costs, choice, and competition: some considerations of alternative delivery systems. *J Natl Med Assoc* 1984;76:1079-84.
- 3 Thurow LC. Medicine versus economics. *N Engl J Med* 1985;313:610-4.
- 4 Angell M. Cost containment and the physician. *JAMA* 1985;254:1203-7.
- 5 Dunea G. Letter from Chicago. Cutting to the bone. *Br Med J* 1985;290:1576-7.
- 6 Enthoven AC. *Reflections on the management of the National Health Service*. London: Nuffield Provincial Hospitals Trust, 1985 (Appendix: Model HMOs and the evolving consumer choice in the USA, p 43).
- 7 Enthoven AC. The Rand experiment and economical health care. *N Engl J Med* 1984;310:1528-30.
- 8 Iglehart JK. Health policy report. HMOs (for profit and not for profit) on the move. *N Engl J Med* 1984;310:1203-8.
- 9 Laing W. *Private health care*. London: Office of Health Economics, 1985:52-3.
- 10 Enthoven AC. *Reflections on the management of the National Health Service*. London: Nuffield Provincial Hospitals Trust, 1985.
- 11 Macrae M. Health Care International. *Economist* 1984;April 28:23-37.
- 12 Anonymous. Who's afraid of a medical experiment? *Economist* 1985;March 13:65-6.
- 13 Brown C. Treasury presses Fowler for NHS changes. *Guardian* 1985;July 13.
- 14 Anonymous. Gridlock and incentives in NHS. *Br Med J* 1985;291:992-3.
- 15 Rayner G. HMOs: set for a British invasion? *Health and Social Services Journal* 1985;May 16:610-1.
- 16 Enthoven AC. Some reforms that might be politically feasible. *Economist* 1984;June 22:19-22.
- 17 Sunderland JM. Health maintenance organisation—a prescription for primary care services? *Hospital and Health Services Review* 1985;November:272-4.
- 18 Morone JA. The unruly rise of medical capitalism. *Hastings Center Report* 1985;August:28-31.
- 19 Roe BB. Rational remuneration. *N Engl J Med* 1985;313:1286-9.

# Philosophical Medical Ethics

## Ordinary and extraordinary means

RAANAN GILLON

In the last two articles I pursued the theme of killing versus letting die, and particularly the "Clough doctrine": thou shalt not kill; but needs't not strive Officially to keep alive. I argued that no consistent moral difference could be found between acts and omissions to support the Clough doctrine but that something similar could be supported as a rule of thumb by accepting that intentionally bringing about the death of one's patients (whether by action or omission) is, at least generally speaking, wrong (I argued against the absolutist claim that it is without exception wrong). On the other hand, knowingly risking death or other harm in the pursuit of the patient's good may often be justified, provided the importance of the good and its probability of being attained are sufficiently great to outweigh that risk of death or other harm. This position corresponds, at least roughly, with the fourth clause of the Roman Catholic doctrine of double effect.

In this article I wish to pursue the same theme, and especially the question of striving to keep alive, via another Roman Catholic doctrine, that of ordinary and extraordinary means. Unravelling and stripped of its misleading name, this doctrine offers patients and doctors, regardless of their religious orientation, a reasonable and straightforward basis for assessing how much to strive to keep alive. To this critical non-Catholic the doctrine seems remarkably similar to the fourth clause of the doctrine of double effect, which again seemed uncontroversial in requiring sufficient or proportionately grave reason when the pursuit of good means risking or inflicting harm. Thus the doctrine of ordinary and extraordinary means

states, in essence, that the good of saving life is morally obligatory only if its pursuit is not excessively burdensome or disproportionate in relation to the expected benefits.

The distinction between ordinary and extraordinary means seems to have been introduced in Roman Catholic theology in the sixteenth century by the Spanish theologian Dominic Banez, who said that while it was reasonable to require people to conserve their lives by ordinary means such as ordinary nourishment, clothing, and medicine, even at the cost of ordinary pain or suffering, people were not morally required to inflict on themselves extraordinary pain or anguish or undertakings that were disproportionate to their state in life.<sup>1</sup> The doctrine was applied by Pope Pius XII in 1957 to an anaesthetist's questions about when to use and stop using mechanical respirators in the case of deeply unconscious patients, who, if not already dead, would be likely to die soon after disconnection from mechanical ventilation.<sup>2,3</sup> According to the Pope, people had "the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health." "Normally," however, "one is held to use only ordinary means—according to circumstances of persons, places, times, and cultures—that is to say means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends."

### Doctors can act only with patient's permission

In relation to the doctor's obligations the Pope reminded his audience of anaesthetists that "the rights and duties of the doctor are correlative to those of the patient. The doctor in fact has no separate or independent right where the patient is concerned. In general he

Imperial College of Science and Technology, London SW7 1NA  
RAANAN GILLON, MB, MRCP, director, Imperial College health service,  
editor, *Journal of Medical Ethics*, associate director, Institute of Medical Ethics