HMOs: America Today, Britain Tomorrow?

Medicine American style and the growth of HMOs

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The USA is spending nearly \$2000 a year on health care for every man, woman, and child (about four times the British figure),¹ and amidst a barrage of measures and suggested measures to contain the costs there is considerable support for the growth of competitive medical plans. Some health maintenance organisations (HMOs) have formed "for profit" corporations which have attracted investors not only in Wall Street but also on this side of the Atlantic. The financial success of some of these corporations has been impressive.

One of the key figures behind the growth of HMOs is Dr Paul Ellwood, founder of Interstudy, an organisation in Minneapolis that is often referred to as the HMO think tank, and head of a private consultancy firm that advises doctors, hospitals, large employers, insurance companies, and other investors, who seem increasingly anxious to jump on the HMO bandwagon, on how to start health plans of their own. *Fortune* magazine once described him as the man who "more than anyone else, has ceaselessly nudged the bloated leviathan of American medical care . . . towards the white waters of competition." HMOs need to be looked at in the context of this leviathan to appreciate why these organisations, which had been around for some time, suddenly found favour.

The traditional fee for service system

From before the first world war and through both the Roosevelt and Truman administrations proposals to start a national health insurance scheme were often raised but repeatedly defeated. This was partly because of a national bias towards free market enterprise rather than state intervention and control but, more relevantly, because of sustained opposition from the medical profession, which spared no effort in its campaigns to persuade the public that "socialised medicine" was wrong. This attitude still runs deep, and medicine has remained a predominantly private service, with doctors charging their patients on a fee for service basis.

In the 1930s and '40s most patients paid their bills directly to the doctor, but as the cost of care rose it became apparent that the only way to survive financially if illness struck you or your family was to take out health insurance. Realising the state of play, the medical profession decided to support the growth of health insurance companies as lesser evils than the newly emerging HMO cooperatives, which the American Medical Association once described as "medical soviets."² Local medical societies sponsored Blue Shield plans while local hospital associations sponsored Blue Cross plans—local non-profit insurance companies devoted to maintaining fee for service cost reimbursement and "free choice of provider." These are

now linked into a vast nationwide network. Other commercial insurance companies followed, and by 1962 about 70% of people had some form of health insurance cover. For the working population and their families this was usually provided by their employer. Two large segments of society were excluded, however: the poor and the elderly.

In 1965 this imbalance was in part redressed when two federal social security programmes were implemented: Medicare and Medicaid. Medicare undertook to pay the costs of medical care for those 65 and over, and Medicaid, which is implemented at state level, was introduced to cover the indigent (very poor), the disabled, some old people, and single parent families. Eligibility for Medicaid varies from state to state to the extent that it may make financial sense to move to another state if you have just been diagnosed as having a potentially expensive illness. Medicare was extended to cover the disabled, including patients with chronic renal failure, in 1972, and by the early 1970s, about 90% of Americans were said to have some form of health insurance cover, although this still left over 20 million uninsured and a similar number underinsured.

Doctors ruled, OK

Over the same period most doctors in America have pursued a well trodden path: training as specialists and then "hanging their shingle" in solo practices or joining others in multispecialty group practices. Here they have charged patients self determined fees set at near the going rate in the area. The more they did the more they earned so there was a tendency to recommend—and when possible carry out personally—as many investigations and procedures as were deemed "necessary." Action has been worth more (chargeable at a higher rate) than simple consultation so the emphasis has been on investigation and treatment rather than counselling and prevention. With little accountability and handsome rewards for doing things "their way" it was an era of unparalleled clinical freedom. It was also an era in which some doctors abused the system and provided unnecessary, and even undesirable, care, thus contributing to rising health costs.

Inpatient care tended to bring in about twice as much per hour as outpatient care,³ so there was a low threshold for admitting patients to hospital. Once in there was no pressure to discharge patients; with 4.5 acute beds per 1000 of the population, America has arguably well over twice the number it needs. High rates of hospitalisation, an increasing proportion of elderly people, and high technology medicine all played their part in increasing the costs of hospital care, but until recently hospitals were not concerned to reduce their charges for they got reimbursed, usually in full, either directly by the patient or by the third party insurer, according to prices they set themselves or at a flat amount based on the going rate in the area. They could thus survive with bed occupancy rates at 60-70% or less and at the same time provide free inpatient care for a small percentage of medical "indigents" by simply upping the rates for those who could afford to pay.

Patients' expectations

With an excess of doctors and hospitals patients have had enviable access to medical care—always provided, of course, that they could afford to pay for it. And unlike Britain, where access to specialist care is usually channelled through the GP, patients in America have been free to go straight to a specialist of their own choice (free choice of doctor being a “right for patients” that the medical profession long guarded jealously). There are few family practitioners outside the rural areas so patients have not expected to go to one doctor for

medicine have raised expectations that may be hard to fulfil; patients are reluctant to accept that some medical problems are insurmountable, others unpredictable, and that fate may result in a bad outcome. This is especially relevant in obstetric care, where everyone expects a perfect baby and will assume there has been medical negligence if they do not get one and then almost automatically proceed to sue the doctor.

The litigation problem

The fact that a law suit has no basis in fact is no barrier to filing one. There is no penalty for making a false accusation of malpractice, and lawyers, who get 5-50% of the settlement fees, have encouraged litigation. Doubtless this explains why there are car stickers that read, “Become a doctor, support a lawyer.” In the cases that go to court juries may let sympathy for the plaintive override objective analysis of the facts. Pursuing the illustration of a less than perfect child, their thoughts might run as follows: the parents will have to contend with the problem for the rest of their lives; money isn't everything but it helps; if the doctor loses he won't suffer because he is insured. One surgeon I met spelt the situation out succinctly: “I'm insured for \$5m,” he said, “so there is no point in a patient suing me for more than this and little point in suing for less.”

Fondness for litigation is not only a problem for the medical profession, apparently even the weather men get sued for promising sunshine and failing to provide it, but it does explain why doctors are anxious to be seen to be doing everything they can. Two examples of this are a tendency to keep patients on ventilators long after there is any reasonable hope of meaningful recovery and the practice of sending home terminally ill patients trussed up with tubes so that “hyperlimentation” may be continued to the bitter end. Fairly or unfairly, it must also be pointed out that these measures may result in high medical bills and hence larger financial rewards for the doctors.

In search of a change of direction

To revert to the mid-1960s and the introduction of the Medicare and Medicaid programme it soon became clear that giving this large percentage of the population open access to health care would cost the federal government a good deal of money. By 1970 Medicare was swallowing about 0.6% of the gross national product (by 1980 it was 1.2%, and the current figure is of the order of 1.8%). There was also concern in the then Nixon administration about the managerial competence and cost effectiveness of the National Institutes of Health, the large number of overbedded unoccupied hospitals, the maldistribution of doctors, and the autonomy of the medical profession—which allowed doctors to fix prices, control insurance plans, and generally keep themselves outside any meaningful form of government control.⁴ Looking for a change of direction of federal health policy, the government was receptive to the suggestions of Dr Paul Ellwood and others, who were convinced that the solution lay in promoting alternative health care systems (HMOs) to compete with the fee for service system, rather than by increasing government regulation.

Ellwood's force as a campaigner may be gauged by another anecdotal description: “The most dangerous man in American medicine. His crime: promoting a preposterous thing called competition. His weapon: a crazy idea called the HMO.” But it was not surprising that HMOs were not widely regarded as a panacea for America's health care problems: there were few of them and most were concentrated on the west coast.

The early HMOs

One of the first HMOs, and the oldest HMO that is still running, was the Ross-Loos Clinic. This was started in 1929 by Drs Ross and Loos, who were looking after the employees of the Los Angeles Department of Water and Power, and this organisation persuaded

The Park Nicollet Medical Center. The main site of a successful HMO in Minneapolis, which has recently formed a for profit management company and is expanding to Seattle, Wisconsin, and Atlanta.

holistic care. Not surprisingly, therefore, most specialists have been used to seeing a hotch potch of patients, including those with non-organic illness and others who simply pick them by mistake.

Irrespective of the appropriateness of the patient's choice of doctor, or the doctor's choice of treatment and investigations, the insurance companies, which are billed after the event, have had scant opportunity to do anything other than pay up, unless they could prove that the bill was extortionate or frankly fraudulent. This has been a particular problem with hospital bills, and some employers, who have ultimately ended up paying most of the cost of hospital care for the working population, urge their employees to go through their hospital bills with a fine toothcomb and if they find they have been billed incorrectly the employer will give them half of the overcharges they find. Some insurance companies adopt a similar approach.

The fact that patients, especially articulate middle class patients, have come to expect prompt specialist attention is not surprising. Who would settle for a brief glance from a junior mechanic when you could get a Rolls Royce service at no extra cost? They have also got used to getting care when, where, and from whom they want it; and with age no barrier to coronary artery bypass grafts or dialysis they have even been free to pursue immortality.

These factors combined with ready access to high technology

them to start a prepaid programme to provide medical care for the department's employees. The clinic was such a success that other groups of municipal employees were then enrolled. But despite, or more likely because of, this success Ross and Loos were expelled from the Los Angeles County Medical Society. They did get reinstated but it was evident that most physicians in fee for service practice were highly adverse to the idea of medical care being controlled by large employers and physicians being hired by them on set salaries.⁵

Another example of establishment opposition to the newly emerging health cooperatives was in response to Group Health Association of Washington DC. The development of this non-profit making HMO in 1937 was fuelled by members of the Home Owners Loan Corporation, who were dismayed by the fact that large medical bills were a major cause of customers defaulting on their mortgage payments and they saw it as a way of stabilising medical costs. As Group Health began to flourish the local medical society impeded recruitment of physicians on to its staff, made it difficult for Group Health doctors to get their patients admitted to the local hospitals, and in general created so much opposition that Group Health finally took the society to court. Group Health won and the US Supreme Court ruled that the District of Columbia Medical Society was guilty of restraint of trade and hence violation of the antitrust laws.

At about the same time the Kaiser Permanente Medical Care Programme was getting established in California. Henry J Kaiser, among the most famous of American industrialists, was impressed by the medical system that Dr Sidney Garfield had established to provide care for the 5000 men who were constructing an aqueduct to carry fresh water from the Colorado River to Los Angeles. These men had faced a 200 mile trip across the desert to Los Angeles in an oven on wheels (ambulance) if they got injured or fell sick,⁶ and Dr Garfield had persuaded the insurance company which was underwriting the medical costs of the construction workers to pay him \$1.50 per month per man, in advance, in exchange for his providing on site medical care. Initially this was provided from a 12 bed hospital on skids but as the scheme caught on the facilities expanded and Dr Garfield was able to treat illness and injuries sustained off the building sites in both the workers and their families in exchange for a voluntary payment of a nickel a day (about 20p in today's currency).

Kaiser asked Garfield to set up a similar programme for workers and their families at the construction site of the Grand Coulee Dam and later, in 1942, at his shipbuilding plants in the San Francisco bay area. Both schemes were successful, and with the security of having a predictable basic income it was possible to expand and build a series of new medical facilities. The Kaiser Permanente Health Plan subsequently went public and continued to expand; today it owns hospitals and health centres in 10 areas across the US, and with about 4.9 million members it is the largest HMO in the US.

The most striking aspect of Kaiser and the other early HMOs was that they were able to provide good care to large populations at reasonable costs. It was this that led their protagonists to conclude that the American health care system would greatly benefit from developing prepaid group practices, which had incentives to maintain health, to compete with the fee for service system with its built in incentives to treat illness and lack of motivation to prevent it.

HMOs get government backing

The pro-HMO campaigners eventually won the day, and in 1971 the federal government announced that its goal was to develop 450 HMOs by 1973 and 1700 by 1976 and to have enough HMOs to enroll 90% of the population by 1980.⁷ The day was short lived,

however, and pressure from the medical profession and the large insurance companies saw to it that not even the first of these goals was realised. By 1973 there were still only 100 HMOs enrolling 4.5 million people, about 2% of the population, and over half belonged to Kaiser. The movement regained some impetus, however, when the Health Maintenance Organisation Act of 1973 was passed, which, among other things, promised financial aid (about \$232m in grants and \$185m in loans) for the development of HMOs and stated that all employers with more than 25 workers on one site who already offered health cover had to offer their employees the choice of an HMO as well as conventional medical insurance.

These measures, and a succession of amendments to the unwieldy legislation of 1973, encouraged the development of new HMOs and by 1980 there were 236. Most were on the west coast, however, and many were small, half with fewer than 10 000 members.⁸ Not all survived; some closed because they were not financially viable, others were simply swallowed by large ones, and public awareness of these organisations remained low.

In the early 1980s there was a rapid acceleration in the growth of HMOs and other competitive health plans; Interstudy, which keeps a national HMO census, reported that by June 1985 there were 393 HMOs enrolling 18.9 million people. The average plan size was 48 000, but large HMOs continued to dominate. Between June 1984 and 1985, 92 new HMOs began operating, and of those, two thirds were independent practice associations.⁹ Various factors have contributed to this recent growth of HMOs. Among these the most important are, firstly, that HMOs have been shown to provide good care at 28% less than the fee for service sector,¹⁰ and employers, who have become increasingly concerned about the cost of providing health cover for their employees (a survey of 850 employers in 1983 showed that on average over \$2000 was spent per employee per year¹¹), have found them an attractive option. Secondly, the large numbers of doctors and the breakdown in their political and economic power have enabled HMOs to recruit good doctors more readily than before. Thirdly, the competence and skill of the management systems coupled with the amount of capital that they have behind them have enabled the larger HMOs to develop and diversify to provide increasingly attractive packages embracing more and more aspects of health care.

How wide is HMO appeal?

The above discussion makes it clear that HMOs make sense to health economists and large purchasers of health services but what about the man in the street? How aware is he of the corporatisation of American health and what factors influence him to join an HMO? The next article in this series will focus on this point and explain the day to day running of an HMO and some of the pros and cons of joining one from a patient's point of view.

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