HMOs: America Today, Britain Tomorrow?

Exit the white coat, enter the pinstriped suit

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American medicine is being transformed from a profession into a business, and concern has been expressed about the "conflict between medical ethics and money making goals."¹ Those with a commercial bent have also been concerned, but not in the same way. They have seen the restructuring of nearly 11% of America's gross national product as a marvellous opportunity for making money.

The restructuring process has seen a steady erosion of fee for service practice and the rapid development of alternative health delivery systems that have been, and continue to be, created and expanded by large insurance companies, hospital management companies, multispecialty group practices, entrepreneurial physicians, private businessmen, and health maintenance organisations (HMOs)—the major alternative to the fee for service sector.²

Advertisement in the BART, San Francisco's underground. How convincing would "Ahh the NHS" sound?

Most HMOs were started on a not for profit basis, but the trend has been to shift to a for profit status, and several HMOs publicly trade stocks. Two years ago these were an investor's dream, and, although the bloom has apparently gone off the peach now, investors both in America and overseas are still attracted to HMOs, encouraged by broadsheets from their stockbrokers that suggest: "We find the real growth potential available to HMOs and HMO hybrids to be immense . . . we anticipate the years of sustained growth and the success of a variety of different approaches that was characteristic of the fast food industry during its rapid growth period."³ Now this attitude, to pursue the fast food analogy, may stick in the gullet, but few doubt that "the era of financing health care to support the development and application of scientific principles and knowledge . . ." is over. Decisions are no longer being made by physicians, and "... businessmen are becoming the most important influence in the redesign of the health care system."⁴ But some sections in society are losing out as pressure to contain the cost of medical care increases.

Doctors in Britain who would sanguinely dismiss all this as America's problem might like to pause briefly and look into the future: a California based health care company is spending £250 000 on an HMO feasibility study of England and plans to invest £5m in four to six private family health centres in London next year.⁵ Furthermore, half our private acute hospital beds are owned by American or Arab for profit corporations, which may "expect to repatriate sufficient funds to satisfy their home based share holders some time in the future."⁶ Whether escalating costs in

the private sector will persuade the 8% or so in Britain who currently seek care outside the NHS to return to the fold seems doubtful, but either way it is of interest to look at some of the commercial aspects of HMOs and consider how the "industrialisation" of health is affecting the poorer section of the population.

Starting an HMO

Starting an HMO is expensive. It is necessary to "buy in" top flight management teams and computers (several million dollars worth) and possibly, depending on the type of HMO, to construct new health facilities. There is no need to build hospitals in the USA now for there is a glut of them and they can always be acquired. Few plans expect to break even until they have enrolled about 30 000 people, which in practice seems to take three years or so.

Clearly it's one thing attracting custom and another keeping it (patients enrol for only one year and will move on if dissatisfied). So what are the criteria for running a successful HMO? Needless to say this question has been endlessly researched if incompletely answered, but certain factors seem crucial: effective management teams, good doctors, low administrative costs as a percentage of total revenue, built in incentives to control the use of medical resources, and control over the hospitals that the plan sends its patients to. Another crucial factor is picking the right area, and HMOs have more chance of thriving in cities where the cost of indemnity insurance is high and there is a surfeit of doctors.

Interestingly, there is no apparent cut off point for the size of an HMO (although some say that Kaiser, with nearly five million enrollees, has got too cumbersome and that the administrative wheels don't run as smoothly as they did); or for the number of HMOs in an area; or for the percentage of the population in that area that opts for this form of care. Indeed, if 15% of the population of the city are enrolled with HMOs their membership then seems to climb more steeply. In Minneapolis St Paul, for example, 40% of the population now belong to an HMO.

Rules and regulations

An HMO cannot start operating until either the state HMO office or the Federal Office of HMOs has granted its approval. There is little uniformity among the state requirements, and some states have not yet even passed HMO Acts, for the development of HMOs has been a patchy affair. Most HMOs, especially those that have operations in several states, opt to get federally qualified. Approval from the federal office may take up to two years to obtain and entails lengthy negotiation and mountains of paperwork. The office must be convinced that, apart from fulfilling certain statutory requirements, the plan is financially viable and has adequate management systems, and that there is a guarantee that in the event of the plan going bankrupt the enrollees are not at risk for the costs. The plan must also show that it has the systems necessary to monitor use of resources and quality of care and that there are built in incentives to persuade doctors to practise cost effectively.

Once a plan has become federally qualified the main check on its operation is internal for all plans need to check their activities continuously to operate efficiently. The federal office sends out inspectors from time to time to assess the health services, finance, marketing, management, and legal aspects of a plan, but their brief is much less rigorous than on the initial assessment for the office simply does not have the resources to monitor the 320 federally qualified HMOs. It does, however, on occasion, threaten HMOs with removal of federal recognition if a plan is in financial difficulty or the quality of the care it provides is unsatisfactory.

Focusing on the market

Finding and defining your market is obviously the crucial first step; reaching it is the next, and in the current competitive environment HMOs need to employ skilled marketing experts. I spoke to one at the Harvard Community Health Plan, who said that the budget for his department was 3.8 million dollars, representing 1.5% of the plan's total revenue. (Other plans spend up to 4% or even more on their marketing.) His force of 25 people was responsible for targeting new employers, persuading existing ones to enrol more of their employees, and encouraging the Medicare population (over 65 year olds) to enrol. The latter were canvassed directly by letter, provided they lived within five miles of a health centre, and open days were held so that they could judge the facilities for themselves.

A quarter of the marketing budget went on advertising, including advertisements on television, radio, billboards, and so on. Since there is no "body" that regulates the amount of advertising by a health plan it is imagination and of course money that are the limits. A glance at the local newspaper, and even the telephone directory, may give an indication of just how competitive the medical scene is and how this varies from one area to another. Publicity is obviously extremely important, especially in areas where there are several different HMOs; as the marketing director at the Harvard plan said, "It's not by accident that our name appears in the newspaper every week. We cultivate the media assiduously and press relation officers ensure that anti-HMO stories get as bland a coverage as possible." Subtle sniping between different HMOs and between HMOs and the fee for service sector on television, for example, seems par for the course.

Where the money goes

If from 1.5 to 4.0% of total revenue goes on marketing where does the rest go? Clearly it varies from one plan to another, but in most HMOs hospital care accounts for 30-35% of the plans' total medical costs. The national figure is 40-45%, and the disparity indicates how successful HMOs have been at keeping patients out of hospital. Total outpatient costs, including salaries, may make up about 50% of the budget and administrative costs a further 10% or so. Variable amounts are allotted to research (usually clinical research), community services, teaching activities, and so on.

Any medical visitor to America inevitably hears a lot about malpractice insurance, so I was interested to hear how much this might cost a health plan. To take the Park Nicollett Medical Center, Minneapolis, a not for profit HMO with 280 doctors, as an example, malpractice insurance costs the plan \$2m a year. This represents about 2-3% of its revenue, and the amount has been creeping up steadily.

Staying the pace

HMOs have worked on the principle that they can provide as good or better care than the fee for service sector, at as little as two thirds of the cost, simply by "trimming fat"—that is, working more efficiently and cost effectively. Undoubtedly this was so, but, as the fee for service sector has been forced to become more cost conscious and appreciably more cost effective, HMOs face an increasingly

difficult task maintaining profitability amidst burgeoning competition. They do this mainly by expanding to reach new markets and by mounting stricter and stricter internal controls.

Nowhere are these controls more evident than in hospital care, and the medical director of Maxicare, a successful for profit HMO with over 670 000 members and groups of physicians in 13 different states, explained how he keeps an eye on the inpatient care. (This would, of course, be impossible without computers, and Maxicare has as many computer terminals as it has employees—which puts the number at over 1200.) "Ideal" bed occupancy rates were set and monitored on a monthly basis. For a working population the ideal figure was 315 days per 1000 people enrolled per month, for Medicare patients (65 years and over) it was 2000 days. If the bed occupancy rates for individual groups came back at more than the ideal figures investigations were made to find out why there was excessive use. If they came back at less, underuse was suspected. This was equally worrying, for cutting corners just to make a profit would damage its reputation, and maintaining high quality care was an essential part of Maxicare's strategy.

Another part of all HMOs' strategy is to keep a close eye on what services their competitors are offering and for how much. Pleasing the customer is all important, and as much probably hinges on access to care as on the quality of that care. Americans find it hard to conceive how we in Britain put up with our long waiting lists and interminable waits in casualty, GPs' surgeries, outpatient departments, and so on, and the lack of freedom to see the doctor of our choice. They are used to ready access to medical care, provided they can afford it, and HMOs are well aware of this. It explains why, among other things, HMOs are tending to build increasing numbers of small satellite clinics so that going to the health plan will entail no more effort than going to the supermarket. Convenience medicine, like convenience shopping, does seem to pay, which doubtless explains why there are 24 hour walk in "urgi clinics," where the patient decides what constitutes urgent and simply calls in and gets instant attention, from an encouraging pat on the shoulder to a full executive screen, whatever the need demands.

Finding the money

HMOs have to expand to get the financial strength to compete. Bigger and bigger organisations, all of which are competing to undercut each other without compromising quality of care, have set a punishing pace. Expansion entails not only acquiring new customers, new hospitals, new groups of physicians, and so on but also finding managerial staff of a high enough calibre to reproduce the health plans' success in a new area. Good managers are extremely hard to find and hence very expensive to hire—indefinitely more so than good physicians—but they are absolutely essential.

Raising sufficient capital for new ventures, including expanding into different states and diversifying to provide a variety of different services, often entails more than enrolling new customers and investing the income. Capital is also raised by selling equity (shares) in the business to venture capital organisations or directly to the public. HMOs also raise money from the public by selling fixed interest bonds. Raising "new" money is becoming much more difficult than it was; hence some organisations approach overseas investors. Maxicare, for example, mounts an annual European "roadshow" to sell stock.

The need to raise capital has been the most compelling force in driving non-profit making HMOs to become for profit (or to develop for profit subsidiaries), and about half of America's HMOs are now run on this basis. Some argue, Dr Paul Ellwood among them, that there is no meaningful distinction between the two sorts of organisation any more. "Some not for profit organisations make up to 17% profit a year anyway," he said, "And all have to make some profit to meet and maintain their current commitments let alone expand." Others don't agree with this view, and believe that the need to make a profit, not only to maintain existing services but also to reward investors, may sharpen the HMOs' incentive to underuse medical services.

Of course, there is nothing new about making money out of

medical care; doctors have been doing it for centuries, but until now "it has rarely been the provider's unabashed *raison d'être*."⁸

All's not fair

Most agree that HMOs, especially the for profit corporations, are very efficient at pricing competitively, emphasising profitable services, and providing good quality care. The problem is that they are serving primarily the middle classes and hence operating in the

An emergency unit in Los Angeles. A sight we may become familiar with if American Medical International's proposal to build Britain's first private casualty unit in Windsor is approved.

richer areas of America. They don't pretend to be philanthropic and seem to have little enthusiasm for enrolling Medicaid (indigent) patients, although the state does partially reimburse them for the cost of caring for such patients. They certainly have no incentive to provide cut price premiums for the working poor who are not offered insurance cover by their employers and cannot afford conventional insurance rates, either with an insurance company or with an HMO.

I spoke to one man, a taxi driver, who fell into this category, and he put the position pragmatically: "I gave up my medical insurance two years ago because it was costing me and my wife \$200 a month and paying out that amount we could not afford to buy the basic necessities." In answer to the question What will happen if you get ill? he replied "I just hope I don't."

This driver was one among an estimated 35 million people (15% of the population) who are thought to be without health insurance and, it is claimed, whose health may be being adversely affected as a consequence.⁹ There are county hospitals that provide good care for the poor, but these have a limited capacity and cannot provide the outpatient care that is needed or undertake routine surveillance, antenatal care, and so on.

In the past private hospitals and physicians in fee for service practice provided an appreciable amount of free care for the poor,

but in today's competitive, cost saving environment they cannot afford it. Hospitals in particular cannot admit such patients even though as many as half of their beds may lie empty. This situation may be aggravated if the Reagan administration's plans to repeal the Hill Burton Law of 1946 are enforced.¹⁰ This required public hospitals built with federal funds to provide a minimum amount of specified free care (equivalent to about 3% of their annual operation costs). Those in favour of abandoning this law point out that it is unwieldy, and that many hospitals ignore it anyway.

To return to the taxi driver, who gave me his views on the medical system gratis: "It's not very fair, I'd rather have less of this high powered technology around and cheaper premiums"—he thought he would be in a better position once he got to 65. At this age he would be eligible for Medicare and hence the federal programme would pay all his health bills . . . but will it?

A less than rosy old age

The federal government has in recent years made a series of far reaching moves to reduce its huge outlay on health for the growing number of elderly people, all of whom are eligible for cover under Medicare. The first of these was the introduction of the Prospective Payment System, widely referred to as DRGs (diagnostic related groups), in October 1983. This restricted the amount of money it was prepared to reimburse providers for acute hospital care of the elderly. Inpatients became "diagnosis capped" with one of 467 different diagnostic categories, and that set the ceiling on what the hospitals received. (Some expect this approach will be taken up more widely, so that eventually providers will be paid a fixed fee to take care of a group of potential patients regardless of their individual diagnoses.¹¹) Long term custodial care is hardly covered at all, and it appears that Medicare pays only 2% of the nation's nursing home bill,¹² leaving the rest to the patients (and their families), very few of whom can afford to take out insurance cover for this form of care. The cost of long term care is such that of those who need it, two thirds face a rapid decline into poverty. At this point they become eligible for Medicaid, and this programme pays for about 54% of the total nursing home bill. But patients need to be really poor to be eligible for this programme, and it too has been subject to cutbacks.

Conclusion

Growth in membership of HMOs reached a record 25% in 1985, and most people expect that membership will continue to grow—at what rate and how far is not known. Some believe that as much as half of the population will be enrolled in an HMO by 1995 and that 10-20 large "super meds" such as Kaiser will dominate, although smaller efficient regional organisations will continue to flourish. The more reactionary maintain that HMOs will peak before too long, but even they admit that the fee for service sector will never be quite the same again. Pressure from the competing alternative delivery systems and the financial constraints imposed by government, insurance companies, and large employers will ensure greater regulation and more cost effective practice.

In a health care environment that has changed considerably in the past few years, and is still actively fermenting, HMOs have acted as catalysts for change by exposing the uneconomical and inefficient practice of the fee for service sector and showing that there is a viable, cost effective alternative. Observers in Europe, the Middle East, and some Third World countries have followed their development with interest, and some proponents of HMOs believe that these organisations have the potential for selected international application.

Far from being the socialist, even communist inspired organisations that the medical profession in America once regarded with such distrust, HMOs, especially for the profit corporations, have emerged as blatant examples of pure capitalism. This worries even the enthusiasts, who admit that their continued growth is having some adverse effects: contributing to the widening gap between

those that can afford health insurance and the poor who can't; squeezing the academic, teaching, and research institutes; and damaging the medical infrastructure in the rural areas. These factors together with the challenges and dilemmas posed by advances in technology and an increasingly large population of elderly people are weighty problems facing America's health care planners.

But these problems are not unique to America. We face them in Britain too, and arguably from a much weaker position in that our resources for health care are less, and in the current climate, failing to keep pace with demand. No one I spoke to in America, however, thought that HMOs were the answer to Britain's problems. Indeed, most thought that Britain was the last place for an HMO revolution, which is most likely to succeed in a wealthy country where a fee for service system dominates.

For all its warts, the NHS has much to commend it, not least because it ensures some equity of care. Unfortunately, at present neither the money nor the morale seems to be there to improve the service and prevent dissatisfied better off consumers from turning to the growing and increasingly American owned private sector. To suggest that chronic underfunding is not the major problem for the NHS would be untrue, but it is not the only problem, and we might benefit from doing more than merely observing the changes in America. Adopting both at primary care level and in hospital practice, some of the management systems, tight internal controls,

incentives to doctors to practise cost effective medicine, and respect for the comfort and convenience of patients—key factors behind the success of America's HMOs—might well benefit the NHS.

Meanwhile, it is salutary to remember that the discontent among a sizable proportion of America's doctors, who have seen their power and autonomy decline with such rapidity, is largely due to their reluctance to read the writing on the wall.

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A middle aged man developed a painful skin reaction—presumably allergic—to the use of a first aid spray for minor burns containing benzocaine. Is he likely to be allergic to other local anaesthetics?

Although the incidence of allergic reactions to topical anaesthetic agents is low, such reactions are well documented, and usually the reaction is to the active drug rather than to a preservative.¹ Benzocaine is an ester, and several patients have been shown to cross react with other local anaesthetic agents, especially those with an ester grouping.^{2,3} Nevertheless, there appears to be little cross reactivity with amides. Thus a patient allergic to benzocaine should avoid drugs that contain benzocaine such as benzocaine (AAA throat spray, Intralgain, Nestosyl, Medilave gel), novobiocin sodium (Audicort), phenazone (Auralgin, Auraltone), chlorhexidine gluconate solution (Hibitane), adrenaline acid tartrate (Rybarvin), methyl nicotinate (Transvasin), and tyrothricin (Tyrozets). Similar esters are to be found in Locan, which contains amethocaine and amylocaine, and procaine, but that is only used parentally. Amides such as lignocaine are probably safe. This anaesthetic is present in preparations such as Xyloton, which is used in dental anaesthetics and sprays, Locaine ointment 5%, used in surface anaesthesia, and Xyloproct, used for haemorrhoids.—W J CUNLIFFE, consultant dermatologist, Leeds.

- 1 Cronin E. *Contact dermatitis*. Edinburgh: Churchill Livingstone, 1980:196.
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Is it safe to start pertussis immunisation in a 3 year old girl with congenital optic nerve hypoplasia who is otherwise developing normally and in whom there is no family history of epilepsy? Pertussis immunisation was omitted from the primary course of immunisations due to the uncertainty of her development at that time.

Congenital optic nerve hypoplasia is often associated with neuroendocrine dysfunction and anterior midline cerebral defects, especially absent septum pellucidum. Even if clinically inapparent neurological defects are present this girl's condition is stable and pertussis immunisation is not contra-indicated.^{1,2} As this condition is not common a specific benefit risk ratio is not available, but I think that it would differ little from that of a normal child. Further consideration should be given to her age, the current incidence of pertussis, and the presence of younger family members. Most mortality and severe morbidity results from pertussis infection in the first year of life, particularly the first six months. The severity of the disease tends to lessen with increasing age, but the younger child can still expect to suffer a prolonged illness with troublesome cough and vomiting. Pertussis vaccine, however, would not normally be offered over 6 years of age. At present notifications of pertussis are rising in Britain, and this probably represents

the start of the next of the three to four yearly epidemics, the last ones having been in 1977-9 and 1981-3. Pertussis vaccine acceptance rates are slowly rising from a low of 30% in 1978 but were still only 65% in England and Wales for 1984. The outbreak is therefore likely to be sizeable though slightly smaller than the last two. An older child often brings pertussis into the house and may then infect younger siblings, these being more at risk and who also may not yet be old enough to have received a full primary course of immunisation, if any. I would recommend pertussis immunisation for this girl as infection is likely during the coming epidemic. This would also help protect any younger siblings. As her other routine immunisations have been given, monovalent pertussis vaccine should be used with two boosters at monthly intervals thereafter.—GLYN R WILLIAMS, lecturer in infectious diseases, Glasgow.

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Is there any justification for using a combination of steroids and antibiotics in a short course in the hope of reducing some of the discomfort and complications of herpes zoster, in particular when it affects the first division of the fifth cranial nerve? Can carbamazepine be used prophylactically in the same way to prevent the full horrors of postherpetic neuralgia? If so what would be an appropriate dose?

Steroids reduce the incidence of postherpetic neuralgia¹; in one study of patients over the age of 50,² 65% of the control group developed postherpetic neuralgia lasting up to two years, whereas only 15% of the group treated with steroids suffered this complication, and in no case did it persist longer than six months.² The steroid regimen used was 40 mg prednisolone daily for 10 days, with gradual reduction over the next three weeks. Patients with contraindications to steroids were excluded from the trial, and complications of treatment were not observed. Skin healing was appreciably quicker in the group treated with steroids. There is no justification for using prophylactic antibiotics in zoster; they should be reserved for secondary bacterial infection. Acyclovir eye ointment is effective, however, and should be given to all patients with affected eyes; they should also see an ophthalmologist. Systemic acyclovir (10 mg/kg thrice daily, reduced in renal failure) should be reserved for patients who have impaired cell mediated immunity or who have particularly severe zoster that is still spreading. Carbamazepine is ineffective in preventing postherpetic neuralgia and was used in the control group of the above study as a placebo, with the results described.—J E BANATVALA, professor of clinical virology, London.

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