injuring the chosen segment.36 Sadly, the procedure is often left to the unsupervised beginner. All biopsy specimens should be serially sectioned because skip lesions as short as 0·35 mm may occur.19

Biopsy of the temporal artery remains a useful confirmatory investigation in patients with giant cell arteritis. Long-term treatment with corticosteroids and follow-up may be started confidently if histological proof of the condition is obtained.

The decision to treat the majority of patients in whom the findings on biopsy are negative must be made on clinical grounds. If the diagnosis is seriously suspected prompt treatment should be started without waiting for confirmation from biopsy.

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Trouble with health maintenance organisations

No panacea for either Britain or the United States

Health maintenance organisations are an American invention for supplying health care in a way that contains costs. Some of the principles of the organisations are now being enthusiastically advocated in Britain, which should increase British interest in some of the recent problems faced by the organisations.

The basic idea of the health maintenance organisations is that consumers enrol in a health plan, normally every year for a yearly premium. This then entitles the consumers to care stipulated under the conditions of the particular organisation. Health maintenance organisations may be divided into three rough categories. Comprehensive organisations employ salaried doctors, own their own hospital facilities, and cover most types of health care, including primary care. Mixed health maintenance organisations have some of the same features as comprehensive organisations and yet contract some care out to independent hospitals that charge fees for their services; they may provide more limited cover than comprehensive organisations. Foundation organisations pay doctors by fees for services but often build in an incentive for them not to provide too much care—they may receive a bonus or “profits” based on either the organisation’s profits or their ability to work within their budget and save resources.

In the 1970s health maintenance organisations were generally promoted by liberals, and federal legislation stipulated that the most sick and those at greatest risk of illness could not be charged more than the average consumer and that there must be periods of time when all comers could register, with nobody being rejected as a bad risk. These stipulations stopped health maintenance organisations being financially viable. Massive federal subsides or public provision of health maintenance organisations would have been necessary to allow them to adopt these progressive policies. As a result the restrictive federal legislation was loosened.

Health maintenance organisations failed to grow in the 1970s to the extent expected, but by 1985 it was estimated that coverage of the population by health maintenance organisations was expanding at 15% a year. But instead of being an embryonic challenge to the existing American health care system, health maintenance organisations are now largely a component of the market system. Health maintenance organisations for profit have grown particularly fast, and the organisations generally have prospered in the more affluent areas, especially on the east coast and in California. By and large health maintenance organisations prosper by skimming the market and not accepting particularly poor risks. They have recently been criticised heavily for being bad at providing high term care and care of priority groups such as the elderly and patients needing emergency care. Thus many organisations do not provide emergency care for non-residents of the states in which they are located.

By the end of 1987 about 28 million Americans were members of health maintenance organisations and growth rates were reaching 18% a year. But now even the fastest growing profit making organisations are often making losses and cutting services. The reaction has been to raise premiums, sell assets, and get rid of staff. Both profit making and non-profit making organisations are in trouble, including many sponsored by Blue Cross or Blue Shield.

Because of the profligacy and waste of the American system of a fee for a service there was great scope for health maintenance organisations—and preferred provider organisations—to tackle inefficiencies with the techniques of corporate management. But health maintenance organisations are clearly not a panacea for the whole healthcare system. There are still at least 36 million Americans who are completely uninsured, and alternative solutions to national problems, such as the old hope of national health insurance, are being revitalised. The yearly growth of health costs has again doubled from a decrease in 1984-5, and the capacity of health maintenance organisations to cut costs—let alone promote equity—is seriously in doubt.

So what does this mean for Britain? The type of American health maintenance organisation that has led to the greatest control of costs is that of the “primary physician gatekeeper”; this relies on primary physicians (general practitioners) to conserve resources by rationing access to specialised services. It has been argued that health maintenance organisations
based on general practitioners could be developed in Britain: general practitioners would be given full budgets according to the number of people they cared for. But quite apart from the administrative and managerial nightmares, there is no reason to suppose that such an organisation would provide a more efficient or effective service than the existing NHS.

The currently fashionable idea of the “internal market” borrows from the concept of the health maintenance organisation; Professor Alain Enthoven, who has recently popularised the idea of the internal market, is a major advocate of health maintenance organisations in the United States. With the internal market the health district would act as the health maintenance organisation, buying and selling care on behalf of its population according to criteria of efficiency as well as equity and geographical location. It could be argued, however, that the district health authority in Britain is already a health maintenance organisation of a sort—receiving its yearly money for its enrolled population from the government. The important question is thus whether anything would be gained by their trading through an internal market.

The Institute of Economic Affairs Health Unit has proposed British style health maintenance organisations, and other proposals for radical reform or replacement of the NHS have also drawn heavily on the concept of the health maintenance organisations. For example, the Adam Smith Institute has proposed that “health management units” should enrol patients and contract with a largely privatised hospital system to provide care for patients, as many health maintenance organisations do in the United States. These schemes are, however, based on ideological acts of faith and offer little to the task of improving equity and allocating resources more effectively in the British NHS. It should not be forgotten that the friendly societies and working men’s guilds that existed before the NHS used capitation fees from working people to contract for health care. Thus to adopt a system of health maintenance organisations could be to return to a voluntary system of care in which coverage was uneven and planning virtually non-existent.

Back in the United States the Rand Corporation has conducted a large 10 year study of health maintenance organisations with a grant of over $100m from the federal government. The study compared health maintenance organisations with other ways of providing and financing health care. The study has concluded that the costs of sharing can cut the usage of healthcare services and that prepaid schemes are cheaper than fee for service schemes but that the availability of care will not match need geographically. This means that the advantages of health maintenance organisations are irrelevant to Britain, where costs are already low, but the disadvantages are very relevant because the provision of care is already unequal. The Rand team’s research has suggested that health maintenance organisations may under-provide just as fee for service schemes overprovide.1 The poor and chronically sick would inevitably be the main losers because of underprovision, and arguments that this would not happen if health maintenance organisations were introduced within the NHS are unconvincing.

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