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HEALTH REVIEW NO 1

Managed Health Care: a new system for a better health service

Michael Goldsmith & David Willetts

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MANAGED HEALTH CARE

A new system for a better health service

Michael Goldsmith and David Willetts

CENTRE FOR POLICY STUDIES

8 Wilfred Street, London SW1E 6PL

1988

Preface

The future of British health care is now open for discussion. The outlines of an agenda for change are already becoming clear -- separating the functions of financing and providing health care, an 'internal market' for publicly financed health care, and new encouragement for 'topping up' with private money. What is now needed is a proper assessment of how best to make such ideas work in practice. That is what the Centre for Policy Studies hopes to provide in a new series of Health Policy Reviews to be published over the coming months, each of which will investigate more fully one particular aspect of health policy.

The authors

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Why Health Maintenance Organisations are relevant to the NHS

The NHS has been rationing access to health care in Britain since 1948. Poor management and lack of incentive have contributed to lengthening waiting-lists and low morale amongst the providers. Now there appears to be a crisis of confidence in the ability of the present system to change from a successful rationing system into a successful providing system.

Health services in the USA reached a crisis earlier than Britain. In the USA the crisis arose from the increasing difficulty of financing health care. By the early 1970s the increasing costs of providing health care overtook the capacity of health financing systems, until the ludicrous point came when citizens had to sell their houses in order to be able to afford essential operations. In particular, poor and elderly people were finding it more and more difficult to afford good health care.

Financing in America is now moving away from health insurance and towards managed health care in the form of Health Maintenance Organisations (HMOs), and Preferred Provider Organisations (PPOs). HMOs are organisations which manage care which is obtained either from outside providers or from their own resources for a fixed annual subscription. They usually receive subscriptions from employers on behalf of their employees. PPOs are similar but deliver care to people who have indemnity insurance plans, under a policy which restricts their choice of provider, but saves on the cost of provision. Doctors and hospitals contracted with the PPO provide care to a prearranged standard.

This fundamental move towards managed health care has occurred in the teeth of a powerful medical profession which, from its early days, organised itself through the American Medical Association in order to eliminate competition and fight the efforts of insurers to contain costs. The AMA had vigorously opposed any alternative to medical insurance and, particularly, Health Maintenance Organisations and other pre-payment plans.

HMOs were first set up in the early 1950s when socially-minded doctors in the field of primary care determined to deal with the problems caused by fee-for-service medicine. Under that system, every item of service, both from the doctor and the hospital, had to be paid for out of disposable income, or else from an insurance policy the cost of which was continually rising. But in the HMO model, care was paid for either by fixed annual capitation fees or subscriptions. Unlike group practices in Britain which provide primary (GP) care, HMOs also provided secondary (hospital) care for their members.

They developed in two forms. In one (the staff model)

HMOs directly employed all the doctors as permanent staff; and provided beds either in their own hospitals, or through outside providers working under clearly defined contracts. In the other form, the Independent Practice Association (IPA) contracted with independent practitioners who provided the services within strictly defined rules -- medical audit and quality assurance being provided by the IPA itself.

Hospital beds are mainly provided by sub-contractors on a capitated or fixed daily bed rate basis. In the former system hospitals are paid a set amount for each subscriber to the HMO, and the hospital has to guarantee that it will provide all the admissions required for the total capitation payments which it receives from the HMO. In the latter system, a fixed daily bed rate contract means that the HMO calculates how many beds it is likely to require for its subscriber base which it negotiates for at a fixed rate from the providing hospital. Under both arrangements, the hospital has to agree to provide all necessary services for patients, including operating theatres, x-rays, drugs, etc., for the one fixed fee.

HMOs have always been financed either by employer contributions, or employee subscriptions. They deal with groups not individuals because of the difficulties of 'adverse selection' (ie. an individual wanting to subscribe to an HMO would be aware of his pre-existing health problems and would therefore constitute a greater risk than the random member of a large group). It is necessary to have approximately 100,000 patients within an HMO to even out the risks.

One of the most important factors in their success is the employee's choice between different neighbouring HMOs and between different doctors within any particular HMO. But HMOs still offer less choice of provider for the consumer than fee-for-service medicine and the insurance plans (e.g. Blue Cross and Blue Shield).

HMOs have grown rapidly and now account for over 30% of American health care. Increasing amounts of such care for the poor and elderly, funded under the Government's Medicaid and Medicare programmes are now contracted out to HMOs (instead of being provided under the fee-for-service system). This is because HMOs offer the elderly and the poor better value health care with more extras such as 'free' false teeth and spectacles. HMOs also save the Federal Government money because their cover costs the Government only 95% of the the fee-for-service system.

(This saving derives from the negotiating strength of the Federal Government when it was setting up the experiments with HMO care for the Medicare programme. In order to persuade the Government to give HMOs a chance to demonstrate their efficiency, the HMO negotiators agreed to do the job for whatever the Government was spending in the fee-for-service sector less 5% which would be direct government savings. This bold claim has now become enshrined in the system and it is rumoured that the

Government will soon start negotiating this 95-percentage down because of the profits which many HMOs are now making on some schemes.)

The lessons from forty years of HMOs in the USA are extremely important for Britain. The HMO model has succeeded though its ability to control costs and to balance them against quality of care. The most successful Medicare and Medicaid contracts have used IPAs rather than staff model HMOs. IPAs are more flexible and generate stronger incentives to provide better care than the staff model which brings together finance and provision in the same organisation. Moreover, IPAs are closer to the British tradition of self-employed GPs. Therefore the scheme outlined in Chapter 3 is closer to the IPA than to the staff model.

The medical profession both in the USA and Britain has always argued that if costs are pared quality will suffer. But the Rand Corporation studies which have been published in the New England Journal of Medicine have shown that HMOs not only reduce the cost of health care by 25% against fee-for-service medicine, but also maintain the quality and even enhance it for certain groups. The reasons for this become clear when analyses of the workings of an HMO are made. The HMO selects only those doctors who have a proven record of competence and efficiency. Within both the staff and IPA models, the doctors are paid their fees either on the basis either of a salary or of capitation rather than by item of service. Financial incentives both to over-prescribe and to over-hospitalise disappear; the savings a doctor makes increases his remuneration. Doctors' tendency to over-use is also checked by utilisation review procedures. And, in addition, in the IPA model doctors have other financial incentives; their profits are linked to their performance.

Utilisation review, which is critical to all types of HMO and Preferred Provider Organisation (PPO), is a system whereby the work of individual doctors is scrutinised by their peers. Each team of doctors is usually led by a managing doctor who is still practising in the same branch of the profession. There is a matrix system of management under which this managing doctor (or Area Chief) shares responsibility for care with a local Chief of Service, who is in charge of all the doctors at any one site. This means that there are two different doctors observing the work of their peers, who are available at any time for consultation over problems. Furthermore, doctors must conform to protocols which specify the clinical route which is preferred for any given condition. These protocols are designed by the doctors themselves so as to avoid accusations of clinical interference by management. The guidelines within which the doctors must work are rather narrower than those which they must follow in the NHS; and very much narrower than in insured fee-for-service medicine in America and in private medicine in Britain.

Doctors who wish to admit patients to hospital must follow a specific procedure and may, indeed, in some cases have to fill in questionnaires which reveal whether the patient has met the criteria laid down (by the doctor's peers) for the admission of patients suffering from the relevant disease. A Medical Director looks at each case and decides whether patients need to be admitted. It would naturally be expected that this would lead to delay in admission. In fact, this is not so because a good network of communication makes it possible for the relevant Utilisation Review Director and his staff to find beds for patients in urgent need within minutes, if necessary.

On top of the 'utilisation review procedures', there is considerable medical audit and quality control. Committees of doctors spend time examining cases and medical histories to check that the types of treatment which their peers have given conform to the standards laid down for that particular HMO. Such reviews "with teeth" are a condition for an HMO to be "federally qualified". This means that doctors who over a long period perform inadequately or, indeed, HMOs whose standards fail to come up to scratch are either sanctioned, or removed from their positions on Medicare or Medicaid.

Objections by the British medical profession to such a system would be two-fold. The first would be that clinical freedom was being undermined. This is the charge always thrown at managers who try to examine what a doctor is doing. But clinical freedom is not sacrosanct. Thoughtful doctors know that it is clinically reactionary. It is an extravagance which Britain can no longer afford. The second objection to peer review would be that too much time on audit committees would detract from patient care. However a lot of time is already spent by senior NHS clinical staff on various medical and administrative committees. If those committees were, as in the HMOs, dedicated to peer audit and medical review, the standard of medicine might be improved.

In HMOs, doctors only manage themselves and their patients - they don't have to manage the system. Efficient and qualified business managers (all of whom have an MBA or equivalent qualification) are employed to run an efficient service because they are competing with other health providers. This competition makes HMO managers doubly accountable. Not only do they have to sell themselves to individual employers, who decide whether the an HMO is good enough to supply services for their employees, but, once contracted by the employer, the HMO then has to sell itself to the individual employee and his family, who may be given by his employer as many as five to ten choices of HMO or indemnity plan. An HMO is therefore in competition not only with other HMOs, but also with fee-for-service medicine and with various types of indemnity plans (Blue Cross, Blue Shield, etc.).

HMOs save most on hospitalisation which is at least 25%

lower than in other medical systems in the USA. When FHP (an American HMO) investigated the British system in 1986 it calculated that a 15% reduction could be made in NHS hospitalisation by using HMO methods. This would mean that the 890 patient bed days per thousand people, about the British average, could be reduced to below 750. This is a useful saving as, on average, every day in hospital costs the NHS about £100.

This lower hospitalisation is only partly due to utilisation review before admission. Great care is also taken, once the patient is admitted, to make sure that he spends no needless days in hospital -- as happens in Britain, due to inefficient management of in-patient cases. Patients stay in bed waiting for tests to be done and may have to wait over a week for complicated x-ray examinations because they are in competition with out-patients for space in the x- ray department. Blood tests, which should have been available before a consultant's ward round, may not be ready, so that the patient waits half a week until the next ward round.

In the American system, HMOs provide utilisation review nurses, commonly known as discharge nurses, to monitor the progress of their patients in hospitals. The discharge nurse, who is employed directly by the HMO, works on the ward of a hospital, whether or not the hospital is owned by the HMO. She is responsible for monitoring the progress of that HMO's patients and making sure that investigation and treatment is only performed where necessary; and is then done as speedily as possible, without waste.

In Britain, the consultant may have decided to discharge the patient, who nevertheless stays in because the Sister or social worker reports that he does not have a suitable home to go to or that he has not enough domestic support. This does not happen in HMOs because the discharge nurse is responsible for ensuring that patients are discharged swiftly and makes the necessary arrangements for support in advance. If patients cannot be discharged directly to their homes, they are sent elsewhere for less expensive and intensive treatment, often called a sub-acute nursing facility (SNiF for short). At the SNiF, there are fewer nurses to patient; and their qualifications do not have to be so high. The facility is not unlike the old style of convalescent nursing home which the NHS has been eliminating over the last 15 years.

Furthermore, if the patient is well enough to be at home but still needs nursing, it is, of course cheaper to provide care at home rather than in an expensive hospital bed. HMO patients, therefore, are often discharged early and are visited maybe hourly or two-hourly by a home-care nurse. In theory this is also available in Britain through the District Nursing services. In practice DHAs do not give these services enough priority to make early discharge practicable.

To sum up, British hospitalisation rates could probably be cut by 15% by reviewing utilisation before admission, and by using discharge nurses to shorten hospital stays along the lines of HMOs in America.

One of the other principles behind HMOs is the emphasis on preventative medicine. If patients stay healthy they do not require so much direct health care. Some health economists doubt that prevention will save on health care in the short or medium term. It has, however, been found that HMOs' intensive preventative medicine campaigns do save on utilisation. In many HMOs, patients are given preventative medicine advice by the attending physician and are referred for health education at the end of the consultation. Such education takes the form of a short talk from a heath educator, followed by a video film, together with some literature for the patient to read at home. Before they are able to collect their prescription ,the pharmacist will check that the patient has indeed taken part in the health education which the doctor has recommended. For example, a patient with high blood pressure and obesity might be prescribed some anti-hypertensive medicine which he could obtain only after the relevant section on the prescription had been initialled by the health educator.

HMOs invest a considerable amount of money in this health education. They also involve themselves in keep-fit programmes and other intensive campaigns aimed at combating adverse effects of obesity, stress, smoking and alcohol and drug abuse. This is not coercion as subscribers have specifically opted for this type of health care system.

When a managed health care system develops, a direct financial incentive will exist to put more emphasis on prevention.

Early experiments with managed care in Britain

No one would suggest that transferring HMOs lock, stock and barrel from the USA to Britain would solve all the problems of the NHS. Its present difficulties stem from many factors - poor management, lack of advance planning, and lack of choice. Despite all the protestations, it is not so much a lack of finance, as the vastness of the organisation and the lack of any competition between its constituent parts, which is making the NHS squeak and groan.

The NHS is in effect one very large, very inefficient HMO without any competing HMO. A break-up of the NHS into small constituent parts might allow some of the methods have been successful in American HMOs to be translated across the Atlantic. Experimentation with the group pre-paid type of health care model has been very limited here.

In 1982 the co-author of this paper developed the Harrow Health Care Centre. This was Britain's first pre-paid, private, primary care group practice. A large health centre was purpose-built, and six general practitioners were employed as a team to provide total primary health care and some out-patient secondary health care. The service was paid for by annual subscriptions of about £90, almost like a club. Thus the patients themselves still received health care "free at the point of service", just as in the NHS.

Patients received all their services, including drugs, x-rays, minor operations and physiotherapy on site, without having to be referred to any other institution. A range of other services was provided, far more than is normally found in NHS primary care. These ranged from marriage guidance and child behaviour counselling to cardiac testing and screening, and to alternative medical services like hypnotherapy and acupuncture. The experiment, still running five years later, has successfully delivered high quality medical care -- a shining forerunner of what could be.

Financially, however, the Harrow Health Care Centre was not a success because, unlike the American HMO model, it was not confined to groups. Individuals were allowed to subscribe as well. This meant that only those in Harrow who felt that they required more primary health care than was delivered by their NHS GP subscribed to the service. The term "health awareness" was used to measure the attitude of these patients. There was a high consultation rate for most of the services. But healthy patients felt that they did not need to pay £90 a year for this form of primary care. In America this would have been avoided by having large groups joining the system so as to spread the risk. In any large-scale trial of this type of system here, the number of individuals seeking NHS treatment would act as a large group in terms of risk-spreading.

The Harrow experiment received much critical acclaim and helped to change many current work practices in NHS primary care. One of the major innovations pioneered at the Harrow Health Care Centre was limited-list prescribing. It influenced the then Minister for Health, Kenneth Clarke, and his officials who introduced a similar type of control of pharmaceutical costs and expenditure into primary care in the NHS.

The only other experiment in HMO-style care was a feasibility study undertaken by FHP, a large Californian HMO, between 1985 and 1987. The co-author was asked to act as a consultant to FHP in order to ascertain whether there was a market for HMOs in Britain. These could have either taken private subscribers or contracted with the NHS to deliver primary and secondary care for NHS patients -- for whom FHP had offered to operate an HMO in order to demonstrate that the quality of care they gave would be at least as good as the NHS for less expenditure or, alternatively, better than the NHS for the same expenditure. Such an experiment was familiar to FHP because it had been one of the original presenters of the HMO case to the US government in its Medicare programme. This feasibility study showed that there was not (in September 1986) a ready market for HMOs to operate privately in Britain. In its discussion with FHP, the Government was lukewarm about a demonstration project within the NHS. That the Government is now, only 18 months later, considering radical reforms to the NHS illustrates how much attitudes are changing.

3.
Choice in the provision of Health Care

Since 1948 health care has not only been funded by taxation but also been provided directly by the State. Delivering health care, not just financing it, has been a function of government. Competition has been discouraged and the service has shown the familiar problems of all large public sector monopolies.

The main proposal of this paper is, therefore, to split up responsibility for funding health care from responsibility for providing it. A new tax-funded health financing organisation would be the main purchaser and distributor of public health care. This facility could be called a 'Managed Health Care Organisation' (MHCO).

MHCOs would be set up by the Government, combining in one unit the financing function of the existing District Health Authorities and the Family Practitioner Committees. Regional Health Authorities (RHAs) might not be necessary. The new organisation would see its main role as the expert purchaser of health care for the community. It would be a sensible compromise between the current extremes of FPCs and DHAs. FPCs finance primary health care by contracting with independent self-employed general practitioners but take little part in either cost control or management. DHAs are supposed not only to buy and manage health care, but also directly to provide it. This overloads them with potentially conflicting roles.

The MHCO would contract out the provision of services like an FPC but manage the utilisation and delivery of health care like an HMO. MHCOs would be created by taking existing DHAs and combining them with those parts of FPCs which fall within their borders.

A Health Care Financing Administration (HCFA) might finance the MHCOs on a variable capitation basis. This means that every MHCO would receive funds based on the community mix which it had attracted. Payments would relate to age, sex, geographical conditions and morbidity patterns, and be based on quarterly assessment by the HCFA of the MHCO's registered clientele. Funding would be based on the same type of criteria as the Resource Allocation Working Party (RAWP) has been using in present NHS funding arrangements.

The network of District Health Authority hospitals would be broken up. There is a large body of opinion which wants NHS hospitals brought back into the community, with community representation and community responsibility for running the local hospital. This would be not unlike the Landeskrankenhause in West Germany, where the local community hospitals are run by management committees, just as NHS hospitals were before the 1974 reorganisation. In the German system, capital funding for local hospitals is provided by the government, but all revenue comes from the patients' social or private insurance.

The MHCO would buy in services from providers and offer managed health care in exactly the same way as HMOs do in the USA. The same management systems, as have already been described, would be used by the MHCO managers to provide high-quality, cost-efficient care to NHS patients. The MHCO would contract with both the newly-formed, community-run NHS hospitals and also with private hospitals for the provision of specified services. Private hospitals would be competing with the newly-formed NHS community hospitals to provide services to the MHCOs.

In this paper, management is regarded as an essential function of MHCO -- the purchaser of health care. This ensures enlightened purchasing decisions and is necessary for the proper enforcement of the contract. But, of course, the MHCO is most likely to buy health care from those providers which are managing themselves well. Our linking of management and finance is not meant to imply that providers will not also have management systems of their own.

Both the Government and NHS managers have been attracted to an 'internal market', as suggested by Professor Alain Enthoven in his pamphlet Reflections on the Management of the National Health Service. The competition described above would be one way of introducing this internal market to the NHS. Competition between different hospitals makes sense because they would become keener to provide a high standard of service at lower cost. The MHCO managers would become adept at buying services from hospitals on a fixed cost basis. Very often these contracts would allow a community hospital to provide beds either at a fixed daily rate (to include all services given to the patient), or on a capitation basis (based on the profile of that MHCO's customer base). Other experiments in contracting out could also be used - for instance, payment using Diagnostic Related Groups (DRGs).

The MHCO would contract with doctors and other providers in the same way as HMOs, primary care services being supplied to the MHCO by GPs on an IPA basis, almost exactly as at present through the FPC. However, tighter performance-linked contracts would be used to enhance the standards of primary care. This was envisaged by the government in its 1986 Green Paper but was not properly delivered by the 1987 White Paper. Consultants and other hospital doctors (training grades) would either be employed on contracts by the local MHCOs or directly by the community hospitals, subject to peer review and utilisation control as already outlined in this paper. The advantage to the NHS of this type of contractual managed system is that the contract for consultants would be held by the local MHCO which would manage the provision of hospital care (as opposed to the present unsatisfactory system whereby consultants' contracts are held by the region, thus making it impossible for District General Managers to enforce them).

Community nursing services, and other aspects of community care, would also be provided by the MHCO for its consumers.

This could be either by direct employment, or through contracting out services in an arrangement like that of the IPA.

The 'health care shop' fits neatly into an IPA scheme. In this type of care, doctors, dentists, pharmacists, nurses, physiotherapists and others work together under one roof as a partnership. Such a partnership could contract with the MHCO as an IPA to offer comprehensive primary care and community services. This is similar to the experiment which took place at the Harrow Health Care Centre. Consideration was given to this in the 1986 Green Paper but again no action was recommended in the White Paper. Vested interests saw it as a threat to existing General Practice.

For the great majority of consumers, pharmaceutical services would still be offered in the High Street by the local chemist. The costs of prescriptions and dispensing fees would be paid by the MHCO at a local level, rather than through the national Prescription Pricing Authority as in the present system. Local MHCOs could then impose disciplines in low-cost generic and limited-list prescribing.

This new system has certain similarities with the ingenious Health Management Unit (HMU) recently proposed by Dr Butler and Dr Pirie in <u>The Health of Nations</u> which resembles the model of GP as budget-holder, proposed by Professor Alan Maynard. The HMU depends on GPs bringing their registered patients into the system at the time when the GP joins the Unit. Such an arrangement has serious practical problems. It is not truly consumer-oriented, because patients would have no freedom to choose either which HMU or which provider they wanted unless they changed their GP. Patients, however, do not find it easy to do so; and it is unlikely that even inadequate HMU management would influence them to leave the care of someone whom they saw as a good GP if he was unwilling to leave the HMU. GPs are unlikely to have much interest in changing HMUs because they are by nature conservative. In any event, on present showing, they would have little management information on which to base any choice. And it is unlikely that, unskilled as they are in management, they could assess the HMUs' methods.

In contrast the MHCO does not put ultimate financial, and therefore management, power into the hands of GP. On the contrary, it makes the GP, the hospital and community services contend for the favour of patients. Budgetary and management power rests with the MHCO, which in turn depends for funding on its success in marketing -- and in giving eventual satisfaction to the consumer.

The appeal of the HMU is that it is relatively easy to set up; but its fatal flaw is that it may become as powerless to manage the contractors as FPCs are today. Although the changes required in setting up the MHCOs appear slightly greater, so are the potential gains.

4. Making health care more flexible -- opting out and topping up

One of the great advantages of this paper's scheme is its flexibility. Choice in health care and topping-up to buy extras becomes easier.

Patients would be free to change their MHCO if they wished. MHCOs could be smaller than existing DHAs to increase the chance that people in most parts of the country would have a real choice of MHCO. Government funding would go with the individual to the MHCO of his choice. To ensure that MHCOs were properly financed for the mix of their patients, public funding would be based on a formula resembling RAWP in England, or AACP (Age Adjusted Capitation Payments) in the USA. Private managers would also be free to set up their own MHCOs to compete for publicly funded patients.

The ability of the population to top up on their tax-funded health care is also important to a successful health care system. Patients would also want to use their own funds to buy extra services, notably hotel facilities like single rooms, bathrooms, personal phones, and a wide choice of meals (which are not a priority use of public money). It might also be possible to pay for medical extras such as cosmetic surgery. But medical extras beyond this, such as choice of consultant or hospital provider, would probably not be available from an MHCO. (This would not be managed health care and is not available in American HMOs either.) Consumers who still want a consultant of their choice would be free to contract directly with him, paying with their own money or through private medical insurance.

Finally, competition alone is not enough to raise quality. There is a strong case for a consumer-oriented inspectorate of health care. This would work in much the same way as the government inspectorates of education and the constabulary. It should be staffed by professional and lay members; and be required to carry out assessment of any establishment which offered NHS care. If recommended improvements were not carried out in a reasonable length of time, the franchise from the HCFA to provide NHS services could be withdrawn. Similar sanctions take place in the USA, where licences to provide health care are subject to review of HMOs' quality assurance programmes.

Conclusion

The traffic across the Atlantic in ideas about health policy is two-way. Americans come here to see how we ration health care more effectively than any other Western country. We go to America to observe the principles of consumer choice and business efficiency as applied to health care. Health maintenance organisations have particularly interested British experts since they combine the qualities of cost-control, patient choice and efficient delivery.

It is not possible simply to adopt an American model and apply it unchanged to Britain. But there are lessons which America can teach us about managed health care systems.

In this paper we have developed a new system which clearly distinguishes the managing of public funds and the delivery of health care. The Managed Health Care Organisation (MHCO) manages public money to ensure that patients receive care of high quality from the providers. Under our scheme NHS hospitals would compete in a free market to provide services, under contract to the MHCOs. Doctors would be freed from direct involvement in management in order to concentrate on practising good medicine. And the consumer would be able to choose between MHCOs and also be able either to top up with extras or to opt out altogether.

Thus, cost-effective high quality health care would be brought about by dividing the roles of financing and delivering health care, by sound management, and by freedom of choice.