ALTERNATIVE Rx REMEDIES

Last December 29, President Nixon signed the Health Maintenance Organization Act of 1973—"another milestone in this Administration's national health strategy," he remarked at the time—authorizing the spending of $375 million over five years to create new HMOs in cities across the land. The Act is far from adequate and in fact signals a considerable cooling down of the White House's formerly warm commitment to the proliferation of HMOs. Nevertheless, the new legislation may add some 300 new organizations to the 115 already operating, and hence constitutes the strongest challenge yet made to our fee-for-service health care system.

HMOs are health care associations that provide full medical services for a prepaid fixed annual fee. At no further charge, enrolled families are entitled to all the health care they need, ranging from regular checkups to major surgery. Physicians who agree to deliver this service usually forswear traditional pay-as-you-go arrangements in favor of either a straight salary or a "capitation" fee, an amount based on the total number of subscribers. If, for example, an association has 10,000 members, each participating doctor's annual income might equal $5 per member, or $50,000.

Although the term "health maintenance organization" is relatively new in medical nomenclature (it seems to have been coined in 1970 by Dr. Paul Ellwood Jr., of the American Rehabilitation Foundation in Minneapolis, in a paper called "The Health Maintenance Strategy"), the organizational technique has been around for more than 40 years, and nearly 9 million Americans already receive prepaid health care from the prototype plans. Some of the older programs took shape soon after World War II, around the time that Truman's fight for national health insurance was failing in Congress. The whole concept can therefore be viewed as another invention born of necessity, but unlike Blue Cross and commercial health insurance, its reliance on group practice—and, in many instances, on salaried doctors—violates at least two AMA commandments: *Thou shalt not combine* and *Honor thy fees and emoluments.*

The AMA has strenuously opposed prepaid group medicine ever since 1929, when it tried to expel Dr. Michael Shadid for the sin of organizing a prepayment health cooperative in Elk City, Oklahoma. In their beginning years, all subsequent plans endured boycotts and lockouts by local medical societies and hospitals, winning a toehold in the health care establishment only after long and costly court battles. Indeed, in more than half the states the AMA succeeded in pushing through legislation that expressly prohibited prepayment health plans and certain other forms of group practice.

But by 1971 the AMA was in trouble, its historic opposition having been seriously challenged by an old friend, Richard Nixon. In his health message to Congress that year the President said: "Studies show that [subscribers to HMO-like plans] are receiving high quality care at significantly lower cost. Patients and practitioners alike are enthusiastic about this organization concept. So is the Administration." The President went on to describe the HMO idea as "a central feature of my national health strategy."

The passage of an Administration-supported bill to channel massive Federal subsidies into new HMOs in communities from coast to coast seemed in the offing. HEW Secretary Elliot L. Richardson spoke of "1,210 operative HMOs" by 1980, giving 90 per cent of the population the opportunity to participate. It was generally assumed at the time that the model had proven its validity and merited—in the jargon of the day—"full implementation."

Nonetheless, the AMA argued that HMOs were still in an experimental stage, full of dimly understood imperfections, and what was needed was a small Federal subsidy for "demonstration" projects to gradually smooth out the wrinkles. This was the position eventually taken by Congressman Paul G.

Rogers (D.-Fla.), who as chairman of the House subcommittee handling health matters was sponsoring an HMO bill of his own. "The philosophy of the House bill," he said, "is demonstration of the HMO concept. We want to see if it works before making a wholesale Federal commitment to the idea."

Rogers' bill, which authorized only $335 million for HMOs, was competing with two others: an Administration measure calling for expenditures of more than $2 billion, and one sponsored by Senator Edward M. Kennedy (D.-Mass.) carrying a price tag of $5.1 billion. Both of these proposals, moreover, included provisions to override the 22 still-extant state laws prohibiting prepayment or other group medical practice, a matter Rogers was silent on. At this juncture, most observers were predicting passage of strong HMO legislation along the lines recommended by the White House. But they had not reckoned with the AMA, or with the fact that an election year was approaching.

The AMA quickly mounted a campaign aimed specifically at the White House. It was guided by Dr. Malcolm C. Todd, a surgeon in Long Beach, California, who was then a member of the society's house of delegates and is now its president. Todd had been dispensing political aid and comfort to Nixon since his 1950 Senate race against Helen Gahagan Douglas, and he served as chairman of a group known as Physicians for the Reelection of the President, a position that under the circumstances looked a lot like the catbird seat.

Todd has told John Iglehart, a reporter for the authoritative *National Journal*, that he wrote the President "several times" about HMOs and received replies. He would not reveal the content of his letters, but it seems likely that he emphasized the difficulties of raising campaign funds from doctors worried about HMOs. "As chairman of the Physicians' Committee," he said at the time, "I have a problem in raising money for Nixon because of this HMO thing. . . . They say, 'I don't know about this HMO thing' when they are approached for contributions." Todd also argued that people who wanted to change the health care system through such a program were not likely to vote for Nixon anyway.

It wasn't long before HMOs ceased to be "a central feature" of the President's "national health strategy." HEW officials stopped speaking of massive subsidies and began talking instead about "demonstrations" and "experiments," adopting the language of Congressman Rogers and the AMA. In the spring of 1972 the Administration withdrew its support from any measure that would preempt state laws barring group practice—thereby ruling out the creation of HMOs in at least 22 states. At a House hearing in August an uncomfortable Secretary Richardson was asked how the committee should deal with such prohibitions on the state level. "We think that you should go as far as, in effect, you think the traffic will bear," he responded.

As it turned out, the traffic bore considerably more than the Administration was prepared to admit, and the legislation that was ultimately enacted—a compromise between the Senate Kennedy bill and the House Rogers bill—contains a strong preemption clause overriding state law. It also contains a "dual choice" provision requiring any employer of more than 25 persons to include HMO coverage, if it is available, among the health insurance options submitted to his workers. That will make HMOs competitive with traditional fee-for-service packagers like Blue Shield and the commercial insurance companies. On the other hand, the law defines HMOs so rigorously—it insists upon a full offering of dental services, for example—that some of the older plans, like Kaiser, fail to quality as HMOs under its standards.

Although not everything health reformers had hoped for, the HMO Act goes far beyond what either candidate Nixon or the AMA intended. And the original prepayment plans the AMA tried so hard to destroy, even if technically denied official HMO designation for the moment, have come to be recognized as the developers of the concept endorsed by Congress and grudgingly blessed by the President. Perhaps the best way to assess and savor this victory—a rare event in health reform—is to examine those few gnarled heroes that have for so long fought the basic battles.

The Prototypes

The largest of the HMO prototypes is Kaiser-Permanente, launched in 1945 by the late shipbuilder and industrialist Henry J. Kaiser. Its 23 hospitals and 58 clinics serve 2.5 million families, most of them on the West Coast. In the San Francisco Bay area, one out of every five persons gets his medical care from a Kaiser plan.

Two other well-established and highly regarded HMO-type programs are Seattle's patient-owned Group Health Cooperative (GHC) of Puget Sound, with 68,000 family memberships, 7 clinics and a 302-bed hospital, and the Health Insurance Plan of Greater New York (HIP), with 275,000 subscribing families and 28 medical centers. Like Kaiser, both GHC and HIP started in the late 1940s, the former an offspring of the strong cooperative tide that had been running in the Northwest for three generations; the latter, a creation of various labor unions, foundations and Mayor Fiorello LaGuardia, who was a friend and patient of one of HIP's founders, Dr. George Baehr.

These three pioneers in the HMO approach together represent more than 80 years of experience, and they have compiled a remarkable record. Though they differ from one another in their forms of ownership and management, all of them depend upon prepayment schemes that entitle participants to comprehensive medical care, and all have found ways either to abolish or dilute traditional fee-for-service practice.

The evidence suggests that President Nixon was right the first time: The quality of medicine being practiced by these plans is generally superior to that being offered by private physicians and by conven-

tionally organized hospitals. They have taken a giant step toward eliminating some of the weaknesses that have long plagued our health care system—the patchwork insurance coverage, the exaggerated dependence on hospital care, and the uneven availability of medical services (seldom on Wednesday, never on Sunday).

By fixing patients' premiums and doctors' incomes in advance, the plans give both parties an added incentive to engage in preventive medicine. Patients with early symptoms need not delay in seeing a physician—the bill has already been paid; physicians with healthy patients need not worry about where their next fee is coming from. In effect, this approach to medicine is similar to that of the ancient Chinese, who paid their village doctor an annual sum only if the village had enjoyed good health that year.

The emphasis on prevention has lowered the cost of medical practice. In 1972, for example, when the national per capita cost of health care was $274, the figure for Seattle's Group Health Cooperative was $100 less. The biggest savings were in hospital expenses, which averaged $137 nationally but only $47 per GHC member. Proportionately, GHC subscribers spend 60 per cent less time in the hospital than do other Americans, in part because the cooperative has a policy of providing out-patient treatment whenever possible. At the GHC hospital the incidence of tonsillectomies and hysterectomies—operations Denenberg puts at the top of his "needless surgery" list—is about half the national rate.

The other plans can cite equally impressive figures. Since 1960, Federal employes have had their choice of several types of health benefit programs, including prepayment, wherever they have been available. (About 5 per cent have elected the latter.) An HEW study of these government workers indicates that in 1968 Blue Cross-Blue Shield subscribers spent twice as many days in hospitals as plan subscribers, endured twice as many appendectomies, mastectomies, hysterectomies, dilatations and curettages, and had almost three times as many tonsillectomies.

Another study, published in the *American Journal of Public Health*, compares such crucial indicators among Federal employes as premature births and mortality rates. Here is a portion of its findings (expressed in percentages):

Indicator	Prepayment	Fee-for-Service
Premature births		
White	5.5	6.0
Nonwhite	8.8	10.8
Infant mortality		
White	2.27	2.73
Nonwhite	3.37	4.38
Annual mortality of the elderly (18 months or more after joining a plan)	7.8	8.8

In general, then, it seems fair to say that prepayment subscribers receive more health care for their money than they could get in the open medical market. The premiums are not cheap, however, and except for a few instances where the Federal government contributes subsidies, they are beyond the reach of poor people. Annual rates for a family of four run from $500-750. HIP charges less, but its members must obtain their hospital coverage through Blue Cross, placing it in the same range. In most cases, the payments cover all surgery, hospitalization, clinic visits, drugs, X-rays and house calls by doctors or nurses. Maternity and postnatal care (except at HIP) cost extra, as do eyeglasses and psychiatric therapy. At the GHC, for example, the first 10 psychiatric sessions are free; further sessions are $5 each.

In other words, subscribers do not invariably pay less than fee-for-service patients; it depends on a family's medical luck. As a rule, though, they are less hesitant about summoning help. "If one of my children has a bellyache," says a HIP member in New York, "I just trot her down to the medical center. But I'd think twice if I knew each visit would cost us $20." More important, perhaps, HMO families need not fear bankruptcy from a major illness—the coverage is complete, and there is seldom a ceiling.

Still, a certain number of subscribers regularly stray outside their plans for additional medical assistance—some because they wish to verify their group physician's findings, others because they want an appointment sooner than some specialist at their plan can provide. About 10 per cent of Kaiser subscribers see outside doctors. At HIP, where most specialists work only part-time for the plan, the figure is somewhat higher.

In emergency situations, the plans seem superior to conventional health care arrangements. Had he belonged to one, Governor Harold Hughes probably would have found a physician ready to come to the aid of his ailing son-in-law. The plans are organized to provide around-the-clock service, and if house calls are not their favorite activity, physicians will make them when necessary.

"We never turn down a patient," says a Kaiser administrator in Los Angeles. "When a subscriber calls at 3 A.M., he won't get an answering service telling him to call back at 9. He'll get help." Mrs. Henry Low, a GHC member, recalls that late one night her baby woke up with a temperature of 104 degrees. A nurse at the Seattle clinic told her over the phone to soak the baby in a tub of warm water. Then the nurse called a GHC pediatrician. "He telephoned us three times that night," says Mrs. Low. "I was very impressed."

Changing Doctors

One reason the AMA says it is skeptical about prepayment plans is that they prevent subscribing families from freely choosing their physicians. It is true, of course, that members are limited to those doctors who work for the association; yet the selection remains reasonably broad—about the same, say, as that available to the average resident of a medium-size city. Families with children are usually assigned their own general practitioners and pediatricians as regular family doc-

tors, but a family can always change physicians, and many do. A mother in Los Angeles recently asked Kaiser to assign her another pediatrician because the first one could never remember her name. It may actually be easier to switch doctors within this framework, where there are no difficulties of transferring records, than within a fee-for-service framework.

Prepayment plans do have their problems and ambiguities, mainly deriving from the fact that they must operate within the larger medical body politic. They sometimes find it hard to attract and keep doctors, particularly high-priced specialists like orthopedic surgeons who may be reluctant to abandon fee-for-service practice. As a result, a few specialists are paid more than $100,000 a year and these salaries tend to drive up the price of premiums. At Kaiser, through a complicated system of separate regional legal entities, physicians become partners in profit-seeking enterprises and divide net income among themselves.

The standard doctor-patient ratio in the existing plans is 1:1,000, relatively low for health care organizations. This improves the quality of care, but it also shuts the door on hundreds of thousands of applicants. In southern California Kaiser has barred new groups of subscribers since 1965. A few months ago GHC, too, announced it would accept no more members, thus violating the nearly sacred open-door principle of cooperativism (introduced by the Rochdale weavers of England in 1844).

The HIP Approach

HIP, like Kaiser-Permanente, is divided into quasi-independent doctors' groups—28 in all—that operate their own medical centers, to which subscribers are assigned according to geographic convenience. But only 300 of HIP's 1,100 participating physicians currently work for the plan full-time, a situation that perpetuates their free-lance, entrepreneurial status. This has frequently prevented HIP from imposing its own policies and standards upon the doctors' groups, and it is now offering the groups a bonus of $12,500 per year for every additional full-time physician they bring in.

HIP's inability to reign with authority over its disparate physicians' groups, plus a certain amount of customer erosion at the hands of competing organizations, brought it to the verge of bankruptcy in 1972. Its statutory reserves dwindled from 5-2.5 per cent of its premium income, and once it missed a monthly payment of $4 million to its doctors' groups. Today, asserts Allan Kornfeld, HIP's new executive director, the organization is solvent, thanks to improved efficiency and to a 15 per cent rate hike among city employes, who form a large bloc of its membership.

For most HIP subscribers the plan probably remains the best, and least expensive, way of obtaining health care. Yet because it does not offer hospitalization coverage, participants are at the mercy of Blue Cross' escalating prices. HIP officials are asking Blue Cross to reduce rates for their members, on the grounds that their utilization of hospitals is lower than the community average. They are making no effort, however, to persuade the association to reform hospital practices—that is, to do for hospitals in New York City what Denenberg made Blue Cross do for them in Philadelphia. "That's not our bag," explains Kornfeld, although that way lies at least a corner of salvation.

From the experiences of HIP and the other plans, it is evident that health care programs function best when their control is centralized, so long as there is room for a strong consumer voice. Seattle's GHC most closely resembles this model, since it is owned by the patients (who elect the board of trustees), it manages its own clinic and hospital facilities, and all its physicians work full-time for the organization. Both Kaiser and HIP have elaborate consumer complaint machinery, as well as various consumer advisory panels, but their patients do not assist in making policy decisions. The critical difference between the two lies in Kaiser's superior administrative control of its constituent parts.

The GHI Story

Indeed, it may be argued that *any* tightly managed organization can provide HMO-type benefits. An example is Group Health Incorporated (GHI), an imaginative insurer that has been accomplishing wonders in New York City and environs since 1938. Its director, Dr. George W. Melcher Jr., sees the plan as "a champion of fee-for-service medicine." GHI's 3 million group subscribers—most of them labor union members in the metropolitan area—can receive services from any of 4,000 participating general practitioners or 6,000 participating specialists, all at previously agreed-upon rates. (A subscriber may also go to a nonparticipating physician, but that doctor is free to charge him more than what GHI has agreed to pay, and the patient must make up at least part of the difference.)

Although GHI does not pay hospital bills, it was the first insurer in the nation to cover in-hospital doctor services, and it also pioneered payments for X-rays, laboratory tests, dental work, and psychiatric care. Its group insurance contracts sometimes carry more extra charges than do HIP contracts—for example, GHI may impose a surcharge on the subscriber for house visits made at night—yet its overall premiums are comparable to those levied by HIP and the other plans, and in some instances they are slightly lower.

By and large, then, GHI has competed successfully with both HIP and conventional medical insurers like Blue Shield. Moreover, its participating doctors are committed by contract to providing subscribers with the same comprehensive, 24-hour medical service offered by HIP, Kaiser and GHC. And all this is being accomplished under the tattered banner of "free choice." As one of its brochures explains, "Early experience convinced GHI that medical care of high quality re-

quires close rapport between physician and patient, such as is available only when the patient may choose his physician. GHI subscribers may select any physician, anywhere in the world" (but they shouldn't expect full compensation).

There is, of course, a certain spuriousness in the assumption that good doctors and bad doctors, like fresh fruits and vegetables, can be readily sorted by the customer, or that "freely chosen" is the same as "wisely chosen." In this matter every patient can testify to his own inadequacies. It is true, however, that some families who already *have* a doctor and wish to continue with him prefer a GHI-type arrangement to membership in a group-practice plan. In fact, it appears to be no accident that two of the oldest and most highly regarded HMO prototypes, Kaiser and GHC, are on the West Coast, where transiency is more a way of life and the doctor-patient relationship may be less a factor.

Withal, what GHI's success seems to prove is not the expendability of prepaid group practice but the indispensability of tight controls. Since until recently GHI owned nothing—no hospitals, no clinics, not even a thermometer—its controls derived for the most part from its accounting methods. "Basically," says Dr. Melcher, "we're record-keepers. We know what the patterns of practice are."

Knowing the patterns of practice, and possession of a highly sophisticated data processing system, has enabled GHI to closely scrutinize the thousands of bills it handles each day. GHI not only takes precautions against overcharges, it also questions bills that reflect excessive services: charges for several different blood tests, for instance, in connection with an examination that normally requires only one; apparent overuse of X-rays or drugs; too many vitamin injections; or even, in certain cases, too many office visits. In addition, GHI encourages subscribers who are slated for surgery to get a second, independent diagnosis to reduce the incidence of needless operations. Dr. Melcher's axiom, if intentionally overstated, nevertheless has a point: "The less time a doctor spends with a patient, the more he does for that patient."

When GHI watchdogs spot a billing discrepancy—a straying from "patterns of practice"—they point it out to the physician. There is seldom an argument, and hardly ever a repetition of error. The upshot of these indefatigable procedures is that the plan saves millions of health care dollars. Blue Cross and Medicare could do as well if they but had the incentive (they already have the computers). In fact, under a separate contract with Medicare, in which GHI serves as an "independent carrier"—processing all the Federal program's bills in Queens County—the company claims to have cut costs 50 per cent!

Curiously, GHI is beginning to look more and more like a health maintenance organization. It now owns a 250-bed hospital in Queens (where it has reduced costs by 30 per cent), it operates a network of dental clinics, and it has purchased an optical service. "We're no longer just an insurance company," says Dr. Melcher, "we're a health service corporation." The new ventures have been launched in response to expressed consumer needs. GHI's board of trustees consists of 15 doctors and 15 laymen; the laymen are vocal and, having learned a lot about health care management, they are practically professionals.

"At heart we're do-gooders," says Dr. Melcher, and probably his counterparts at Kaiser, HIP and GHC would, when their desks were clear, confess to something similar. Yet in this best of all possible markets each administrator must be careful to temper benevolence with bookkeeping.

Dr. Sam's Dream

A few years ago in Denver, Dr. Samuel Shukert forsook a lucrative private practice ($130,000 a year) and began offering ghetto residents a "total health care package" for premiums ranging from $20-40 a month. The package provided for unrestricted visits to or from the doctor, and for free hospital and dental care. It was an instant success among the patients, but Dr. Shukert's income quickly approached zero, and soon thereafter the state's Insurance Commission hauled him into court for selling insurance without a license and for offering a health plan that was, in the commission's judgment, fiscally unsound. "Dr. Sam" is no longer operating his "one-man HMO," which suggests that doing good is not exactly the same as doing well.

To be sure, there is little in the prepayment concept that guarantees good management, or even good intentions. Better by far a "Dr. Sam"—whatever his actuarial imperfections—than those lean, hungry, get-rich-quick prepayment operations masquerading as HMOs that have lately arisen in California and elsewhere. "They send loudspeaker trucks around the streets," reports Dr. Max Fine, director of the Committee for National Health Insurance. "They offer fried chicken to anyone who joins the group. And they send solicitors door to door, and pay them $3 a head for every patient they sign up."

In many cases persons who do sign up are persuaded to cancel what little health care coverage they already have, only to find later that their "HMO" won't deliver what it has promised: "24-hour" clinics open at 10 A.M. and shut down a few hours later; drugs and injections cost extra; and hospital bills are charged directly to the patient. The many scandals in California have been so embarrassing to Kaiser that officials there are now saying their enterprise, when you stop to think about it, is not really a health maintenance organization; it's something else, as yet unnamed.

There may be a kind of Gresham's Law at work in health care politics, by which bad programs drive out good ones and techniques designed to serve families of modest means end up enriching the already affluent. Private greed invariably thrives in a market defined by public desperation, and California's fly-by-night operations have reached about the same stage of moral develop-

ment as the sham medical schools that Flexner exposed in 1910. They will not, one hopes, be allowed to drink from the Federal trough, but they serve as a warning of how a promising tool can become a dangerous weapon in grasping hands.

The new HMOs that will be created by the Health Maintenance Act of 1973 could turn out to be precisely what we need: sensible and humane institutions that offer us a genuine alternative, at last, to fee-for-service foolishness. But since in many instances they will be owned by the same organizations that preside over the larger health care system—the big hospitals and the big insurers, or their nonprofit "spin-offs"—they could also end up making the customary accommodations, protecting the system rather than challenging it.

That is the lesson of Medicare and Medicaid: The system takes care of its own. Just as Dr. Harvey Cushing warned President Roosevelt in 1935 that nothing could be accomplished "without the good will of the American Medical Association which has the organization," so the health insurance industry now reminds us that nothing can be accomplished without its support. "People aren't standing in line to enroll in HMOs," a Blue Cross official told me. "Somebody has to sell the concept." And what better salesman than Blue Cross?

In any event, no one now believes that the health care riddle has been solved. The ink on the HMO Act was barely dry before President Nixon announced yet another scheme, this one a baroque blend of public and private insurance subsidies. The Administration's latest bill goes to the top of an astonishingly high stack of Congressional proposals for health reform, at least two of which are likely to be debated this year. In aggregate they represent not necessarily the best thinking of our health care experts —though there is some of that in them, too—but rather the best survival strategies of our present health care institutions. Everyone, it seems, is convinced that American medicine is slated for reform; and everyone wants a piece of the action.