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Notes on contributors

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Rita Lewis Rita has been active in consumer representation and patient advocacy for over 20 years. She was chaired the Association of Community Health Councils for England and Wales from 1990 to 1992. She served on the Mental Health Act Commission originally as a lay member during the 1980s and subsequently as a consultant. She now serves as a consumer member of the United Kingdom Central Council for Nurses, Midwives and Health Visitors, and the General Osteopathic Council. She is also a member of the Advisory Group on Medical and Dental Education, Training and Staffing and was appointed as a non-executive director of Epsom and St. Helier NHS Trust in April 1999. Rita has published on consumer representation and is a regular contributor to conferences in this field.
# LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AAPCC</td>
<td>Average Adjusted per Capita Cost</td>
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<td>ACT</td>
<td>assertive community treatment</td>
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<td>AHPR</td>
<td>Agency of Healthcare Policy and Research</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>CHC</td>
<td>Community Health Council</td>
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<td>CHI</td>
<td>Commission for Health Improvement</td>
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<td>CMHT</td>
<td>community mental health team</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CPI</td>
<td>Consumer Price Index</td>
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<tr>
<td>DALY</td>
<td>disablement adjusted life year</td>
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<td>DHA</td>
<td>district health authorities</td>
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<td>DME</td>
<td>durable medical equipment</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>DSU</td>
<td>day surgery unit</td>
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<td>ECG</td>
<td>electrocardiogram</td>
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<td>ECT</td>
<td>electroconvulsive therapy</td>
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<td>EE</td>
<td>expressed emotion</td>
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<td>ENT</td>
<td>ear, nose and throat</td>
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<td>FFS</td>
<td>fee-for-service</td>
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<td>FHP</td>
<td>Family Health Plan</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>GHA</td>
<td>Group Health Association</td>
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<td>GNP</td>
<td>gross national product</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
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<td>HEDIS</td>
<td>Health Plan Employers' Information and Data Set</td>
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<td>HIMP</td>
<td>Health Improvement Programme</td>
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<td>HIP</td>
<td>Health Insurance Plan of New York</td>
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xii List of abbreviations

HMO Health Maintenance Organization
HRT hormone replacement therapy
IPA Independent Practice Association
IHD ischaemic heart disease
LOS length of stay
LSE London School of Economics
MCOs Managed Care Organizations
NCQA National Committee for Quality Assurance
NHS National Health Service
NHSE NHS Executive
NICE National Institute for Clinical Excellence
NSF National Service Framework (for Mental Health)
OECD Organization for Economic Cooperation and Development
PCG Primary Care Group
PCP Primary Care Physicians
PCT Primary Care Trust
PMS Personal Medical Services
PPO Preferred Provider Organization
RCN Royal College of Nursing
RCT Randomized Controlled Trial
RVS Relative Value Studies
SHMO Social Health Maintenance Organization
SIGN Scottish Inter-Collegiate Guideline Network
TPP Total Purchasing Pilot
UK United Kingdom
US United States
UM utilization management
URTI upper respiratory tract infection
WHO World Health Organization
INTRODUCTION

In 1997, the Labour government in the United Kingdom (UK) embarked on an ambitious programme of National Health Service (NHS) modernization. There was substantial structural change proposed by the 1997 White Paper, The NHS: Modern, Dependable, the dozen or so major policy documents which have followed and not least the historic NHS National Plan for the service's second millennium. In the past, governments have often been accused of using structural change as a smokescreen to mask inadequate investment in the NHS. Historically the UK has undoubtedly had its healthcare on the cheap relative to OECD comparator nations while the NHS has shouldered more than its fair share of reorganizations. At last, however, we appear to have a government (and now seemingly an all-party consensus) determined to reverse chronic under-investment in the NHS. Whereas the United States (US) has been reining in healthcare expenditure growth from 12 per cent annually a few years ago to only 3 per cent at the end of the Clinton administration, the NHS is to get 30 per cent growth in real terms over only four years.

As we argue in this book, both the Labour modernization agenda and those Tory reforms which it retained owe much to the experience of US managed care organizations (MCOs). Historically this is only fitting since the founders of the Health Maintenance Organizations in California, the home of modern managed care, were inspired, in part at least, by three key elements of the NHS - the pooling of financial risk against a fixed budget, the removal of financial barriers to access and a delivery system based in primary care acting as gatekeeper to secondary care.

In the mid-1990s, however, US managed care systems had developed to a point where they had much to offer back in return. The British authors in this book first became interested in this experience as members of a 1994 study tour with Manchester University to FHP Healthcare in Southern California, then the second largest HMO in the US and subsequently
2 Introduction

incorporated into PacifiCare. The interest thus generated motivated the Department of Health (DOH) to commission a British-led evaluation of managed care and also attracted the attention of other UK-based healthcare analysts. Initial reaction ranged from hostility in some quarters to encouragement, as in the case of Ray Robinson and Andrea Steiner’s 1998 book Managed Healthcare1 which was the product of the DOH commission.

Other leading commentators went further and argued that the NHS already has the major elements of a managed care system in place. We would dispute this view at present. To support the case, we develop an optimal model of managed care in Chapter 1 of this book. This also traces the more recent history of managed care organizations (MCOs) and the pressures and dynamics in the US economy, government and society which have promoted managed care to the predominant model in a pluralistic healthcare market. We also review the findings in the evaluative literature on managed care against the core objectives on the NHS. Managed care owes both its domestic and increasingly international success to the quality of the professional work of people such as Dr Robert Larsen who was Medical Director of FHP during the 1990s. Now a leading US commentator and writer on managed care, he gives an expert practitioner’s perspective in Chapter 2 on the history, current challenges and future direction for MCOs in the US. The agenda he generates has many parallels with the NHS, including the need to standardize quality based on outcome data in order to inform clinical management, and more sophisticated systems for cost control and contracting to incentivize both quality and efficiency.

However, the primary aim of this book is to give practical guidance on applying managed care techniques to further the NHS modernization agenda which we as authors support. Chapter 3 sets out the components of this policy and identifies those areas for service and policy development which managed care can facilitate and which therefore constitute the focal point of this book. It also offers some analysis and comment on the strengths and weaknesses of the NHS Plan. We begin in Chapter 4 at the start of everyone’s healthcare journey, in primary care. A one-time leader of the GP fundholding movement and former Labour Party Parliamentary Candidate, Dr David Colin-Thome writes from his experience as a general practitioner (GP) and Regional Director of Primary Care in London, and from his wider international experience. He sets a challenging agenda for primary care as provider and manager of healthcare processes. Arguing that the new primary care is managed care he sees major opportunities for the new Primary Care Trusts to employ prevention, early intervention, quality assurance through evidence-based medicine, and clinical governance and utilization management to improve the investment decisions in primary care commissioning.

Improving clinical quality begins with the evidence base. Chapter 5 therefore focuses on how to apply evidence-based medicine in chronic disease management programmes, to develop care pathways and guidelines
across a continuum of primary, intermediate and secondary care then how to use these documents to plan and contract for integrated models of service delivery. Evidence-based medicine is a core component of utilization management (UM) – perhaps the single most effective of all managed care techniques. Also known as demand management, some of these techniques are already familiar in the UK. With a focus on primary and ambulatory care in Chapter 6 and on in-patient care in Chapter 7, these and a wide range of other UM techniques are located in a systematic healthcare management approach which spans all service sectors and interventions including prevention and appropriate self-care. Given the supply problems, inequitable access issues and quality deficiencies facing the NHS, there is a huge UM agenda to parallel the managed care experience of the last ten years and radically re-engineer healthcare provision in the UK.

The ageing population poses the NHS one of its biggest challenges. The over-65s make up 70 per cent of emergency admissions to hospital, crowding out elective programmes and generating the annual winter beds crisis in the NHS which has become almost as traditional as Christmas itself. Case management is a relatively new managed care initiative which offers enormous potential benefit to the service. Targeting the high-utilizing, ‘at-risk’ 5-10 per cent of the older population, case management has shown impressive results in improving health status, reducing service usage and improving client satisfaction. Sherry Aliotta, a pioneer of the US programme as an HMO manager and consultant, describes the service and documents its history and the challenges of measuring outcomes in Chapter 8. She then reviews published outcome studies including some early UK experience at Castelfields Health Centre where Dr Colin-Thome is the Senior Partner.

When we first became interested in the experience of managed care organizations to further the NHS reform agenda we faced criticism that we were omitting mental health services. Chapter 9 therefore seeks to redress this. On reflection, and based on both the National Service Framework and the evidence base, we conclude that mental health services are highly appropriate to systems of managed care. Indeed, this chapter serves as a model of how these techniques can be integrated around the needs of one of the most challenging client groups – people with schizophrenia.

There are three further major agendas to consider. First, managed care has led internationally on performance management in healthcare, whether on quality, with the founding of the National Committee on Quality Assurance, or on cost control. This has undoubtedly influenced the major policy drive given in the modernization agenda to the National Performance Assessment Framework. The core management technique here is benchmarking. Hence in Chapter 10 we set out a practical but sophisticated approach to using benchmarks in healthcare management to re-engineer care processes and promote cost-effectiveness.

A core objective of managed care is to deliver services by the most appropriate, competent staff. Supply problems for key professional staff
threaten to undermine the momentum of NHS modernization. However, the current inflexibility and narrowness of professional boundaries and demarcations compound the problem and constitute impediments to re-engineering care processes. Perhaps more than anyone over the last five years, Margaret Conroy has led the national debate on modernizing the workforce through the Future Healthcare Workforce Project. In Chapter 11 she describes how staffing is being redesigned at both national and local service provider levels and integrated into a workforce planning process which is truly needs-led and patient-focused.

Last but not least there is the case for consumer empowerment in British healthcare. This is the one area where the modernization proposals appear a little conservative. In contrast, for American retirees at least, the social insurance mechanism that is the Medicare programme combined with the competition between managed care organizations for their custom, and the right to change plans on a monthly basis, places the consumer firmly in the driving seat. Add to this the member services departments of the better HMOs whose raison d’être is to ensure each enrollee gets the best out of the services on offer and we have a best practice model for consumer empowerment. Hence perhaps the most disappointing section of the NHS Plan is Chapter 3 which reviews alternative funding mechanisms for the NHS and dismisses social insurance – the predominant European model – without regard to consumer empowerment as an assessment criterion for a modern healthcare system.

To be fair to New Labour, Rita Lewis in the final chapter of this book finds much merit in the new proposals on patient advocacy. She is nonetheless impelled to explore the scope for greater consumer participation and empowerment in the NHS. Her conclusions that British healthcare consumers remain limited in choice and influence compared to our American and European counterparts sets a challenging and radical agenda for a future phase of healthcare reform and modernization.

The emphatic re-election of New Labour in June 2001 has given added impetus to our agenda. Provided the economy and tax revenues remain buoyant, UK spending on health care will move to a European Union average. However the alarmingly low turnout at the polls should give ministers pause for thought on how better to engage more people more actively in the political process – particularly over spending decisions in our vital public services.

David Cochrane

NOTES AND REFERENCES

Part one

CONTEXTS
MANAGED CARE AT THE CROSSROADS

David Cochrane

Before embarking on the main course of the book, we need to provide some relevant background on the experience of managed care in the United States. To begin with, the current ‘financial crisis’ facing managed care is reviewed. We then review terminology and set some definitional boundaries on our delineation of managed care organizations. Proceeding to the evolution of managed care in the US, we explore those issues which have fuelled its rapid development over the last three decades of the century to become the predominant American healthcare system. These have mirrored some of the determinants of British health policy such as the requirement of any advanced industrial nation for a healthy workforce, pressure from labour unions, and the need to manage public expenditure. Factors peculiar to the US have included the macro-economic imperatives of containing healthcare expenditure, the power of consumerism in American culture and the battle for public opinion fought on the quality front. We then review the performance of managed care against its major US competitor system, fee-for-service indemnity insurance, before setting out an optimum model for a managed care organization which will facilitate our major goal of assisting the modernization agenda of the NHS.

The turn of the twenty-first century marked something of a watershed year for managed care in the United States. From its promotional position in the early 1990s as an ideal solution to the complex challenges of American health reform, it now finds itself on the defensive on virtually all crucial fronts. Since becoming a major market player, managed care is consistently attacked by critics over the quality of its service provision and limits placed on consumer choice. This was inevitable in a country where the major competitive models are preferred provider delivery systems with highly-paid doctors on a fee-for-service basis funded by the powerful indemnity insurance industry. Healthcare is one of the largest
commercial industries in the US and the aggressive forces of competition are primarily concerned to protect market share. In this context managed care has confronted three powerful vested interests – the enormous earnings potential of specialist doctors, the profit margins of the major insurers and the financial viability of the acute hospital sector where surplus capacity is endemic.

In its defence, managed care had been able to claim with confidence that it could outperform the rest of the American healthcare industry on the major challenge in a country spending 14 per cent of its GDP on healthcare – cost control. Indeed, the model has been credited with dramatically reducing annual growth in national healthcare expenditure in the US from the heady heights of 10 and 12 per cent in the 1980s down to 3.6 per cent in 1998. It is therefore not difficult to understand why the American healthcare industry was jolted in the spring of 1999 when the State of California took over the physician groups of MedPartners Provider Network, covering 1 million members, because of concerns over its lack of solvency. This was a pre-emptive strike to avoid repeating the trauma of the bankruptcy of FPA Medical Management of San Diego, which had occurred a year earlier with the consequent disruption of the healthcare provision for its 400,000 enrollees and their families. The deteriorating cash flow position of many of the largest health maintenance organizations (HMOs) began to send waves of panic through Wall Street, and the stock values of managed care organizations fell. Some healthcare investment analysts then began to draw resonant comparisons to an industry standing on the deck of the Titanic.

Calming the waters, the head of the US federal government’s Health Care Financing Administration (HCFA) employed the more measured language of a ‘market adjustment’. HCFA funds the US government’s Medicare programme which guarantees healthcare provision to senior US citizens with a ten-year cumulative employment record and has been a driving force behind the expansion in the number of elderly Americans enrolled into managed care. According to the Los Angeles Times of 29 March 1999, managed care had been a victim of its own success in acquiring market share while responding to pressure to reduce costs without compromise to quality. As a consequence, some physician groups had simply squeezed themselves out of financial viability. Those Wall Street investors who had grown accustomed to 25 per cent annual growth in earnings were simply pulling the plug, leaving it to others content with more modest returns of 5 per cent and 10 per cent per year to salvage the vessel. Fighting back from a position of market domination, most of the larger managed care organizations announced price increases for 1999 of 5–7 per cent, rises likely to be repeated for each of the following four years.

On balance then, although managed care is currently a little beleaguered in the US, it is far from being in decline. Moreover, it is a model of healthcare funding and delivery that has begun to attract serious attention
from British health policy analysts in the context of the challenges facing the NHS over the first decade of the new millennium. The aim of this work to date has been largely to investigate whether managed care offers the potential to take the NHS strategic agenda forward. The conclusions have been that there are indeed techniques and selected elements of the American experience which offer that potential. More pertinent still, the Labour government is driving the NHS through an ambitious ‘modernization’ agenda which is replete with ideas drawn from managed care (as we will show in Chapter 2).

Managed care borrowed three key elements of the NHS – pooling of risk against a fixed budget, removing financial barriers to access for enrollees and service delivery based in primary care. It is only fair, therefore, that the NHS gets something back in return. The key to deciding which techniques are relevant to the modernization agenda, however, lies in developing a clear understanding of managed care and its achievements in addressing similar issues to those faced in the UK. We can then move to how to apply the more helpful aspects of the managed care experience in specific areas of healthcare delivery and management in the NHS drawing on some worked examples drawn from the National Health Service itself.

WHAT IS MANAGED CARE?

Managed care, a little like the philosopher’s elephant, is easier to describe than to define. In Making Managed Healthcare Work Boland strikes a note of caution at the outset to anyone with expectations that any set of ideas can solve every seemingly intractable health policy problem: ‘Managed care is not a panacea for rising healthcare costs, over-utilisation, cost-shifting, excess capacity and all the other ills which plague the (US) healthcare industry.’

A distinction must be drawn between managed care and a managed care organization (MCO) like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) or the dozen or so other models in Kongstvedt’s typology. These organizations employ some or all of managed care techniques to deliver predetermined and agreed healthcare benefits packages to ‘members’ or ‘enrollees’. These packages are known as ‘plans’. It is really these techniques which define managed care along Wagner’s continuum from indemnity insurance schemes which may require pre-certification for elective surgery or case management of high-cost conditions through to an HMO like Kaiser Permanente which owns and manages its own service delivery networks.

These techniques have been designed to realize objectives that are common to any advanced healthcare delivery system which is ‘to maximise value to healthcare purchasers by channelling volume to high quality providers’. However, two key characteristics of the American context
have provided a framework for the pursuit of these aims. The first is the healthcare cost ‘explosion’ over the last two decades. The forces behind this are neatly summarized by Boland and Abramowitz and will be familiar to a UK audience, although their impact in the US has been rather more extreme.

- healthcare inflation outstripping the general rate;
- an ageing population and associated high use of healthcare resources due to severe chronic disease;
- rising consumer expectations;
- focus in service delivery on acute care or sickness response rather than prevention;
- inefficient management of healthcare resources;
- care that is ineffective or simply unnecessary;
- excess capacity of acute hospitals with average occupancy in the US down to only 64 per cent by 1989 indicating 15 per cent excess capacity;
- unwillingness on the part of politicians and health benefit managers to address excess capacity which has undermined the financial position of hospital companies, with some smaller providers going ‘belly-up’;
- growth of high-priced technology;
- increasing litigation by users, defensive medical practice and malpractice insurance rates.

The second factor is the strength of the American healthcare consumer. There is a powerful ethic of choice in the US which is readily exercised in an insurance-based system where the money simply follows the user. Managed care has therefore evolved within an imperative to maintain customer satisfaction as a central management objective.

There are two major groups of customers in American healthcare – employers and individuals. The market further segments into four main categories:

- Commercial or people of working age funded through the health benefits offered by large employers under mandatory statute.
- Individuals funded by Medicare or the national programme funded by the Federal government for people aged over 65 with ten years’ cumulative employment record.
- Individuals funded by Medicaid (known as Medical in the State of California) or programmes provided by each individual state for people with insufficient means who meet the qualification criteria. These include elderly people with no work record, families with children, and groups with special needs such as those with severe and chronic mental ill-health or a catastrophic physical illness such as AIDS.
- Individuals who self-fund – a small part of the business made up of those who paid their own insurance premiums direct.

Employers review their contracts on an annual basis. Medicare- and Medicaid-funded individuals can change plans on a monthly basis. The
need to monitor and sustain customer satisfaction is thus a commercial necessity for managed care organizations.

In summary, then, the performance objectives of any Chief Executive Officer of an MCO would be:

- cost control and financial viability;
- customer satisfaction;
- quality management.

Profitability would be added in those MCOs which are profit-making although many, including some of the biggest, are not-for-profit organizations.

There are a number of core managed care processes which are discussed in a little more detail later in the chapter and throughout the book. These include pre-paid premiums covering most healthcare services; integrated delivery systems; utilization management; primary care-based purchasing and service delivery; quality management; alignment of incentives; capitation-based payment systems; and member services. Managed care organizations use these techniques to differing degrees along a continuum of increasing management of costs and quality. There are several types of MCOs using these techniques. However, we will focus on the two most common forms – Health Maintenance Organizations and Preferred Provider Organizations or PPOs.

**Health Maintenance Organizations (HMOs)**

HMOs broke ranks with mainstream American healthcare in the 1960s by bringing together the functions of insurer and provider of services into one organization. A little like the NHS itself, they finance and deliver comprehensive health services to an enrolled or funded population.8 Services are largely free at the point of use with some nominal co-pays for doctor visits, pharmacy, etc. – depending on the scope of the plan. HMOs have also led the field in the US in health prevention or maintenance, and devolution of care from specialists to primary care doctors acting in a gatekeeper role. Wagner differentiates five types of HMO: staff, group practice, network, Independent Practice Association (IPA) and direct contact.9

- In the staff model or closed panel, the HMO owns all its facilities and employs all its staff including medical staff. This was one of the earliest of the modern models.
- The group model HMO contracts with group practices of multi-specialty doctors. Group practices share facilities such as an extended primary care centre or hospital. These groups can be ‘captive’ if they contract with a single HMO or ‘independent’ if they have a range of purchasers.
- In the network model the HMO contracts with a range of group practices of doctors usually through capitation or the provision of a fixed
premium to fund physician services to a defined population. These groups may be multi-specialty or ‘primary care groups’ (often including specialists in general medicine, paediatrics and obstetrics). In each case the group is responsible for compensating any subcontracting physicians and in so doing shares the financial risk of contracts to hospitals and other providers who complete the network of service delivery. A number of network HMOs began life as staff models but found it easier to influence cost and quality without the direct management line to service delivery.

• In the IPA model associations of independent practitioners contract to an HMO through the mechanism of a distinct legal entity which acts as their agent. IPA doctors continue to see their own patients and maintain their own offices and medical records. IPAs can be hospital- and community-based. They are often developed and nurtured by HMOs as a means of extending the network of services beyond those doctors prepared to work in tighter organizational and management structures.

• In the direct contract model, the HMO will contract direct with independent physicians without the IPA intermediary.

Preferred Provider Organizations (PPOs)

PPOs are models of MCOs which have developed to address the choice issue while maintaining cost control mechanisms. A PPO provides a channel through which participating providers contract with employer health plans or insurance schemes. As within HMOs, participating providers will be governed by utilization management or other managed care procedures. The major difference lies in terms of choice and access. Enrollees in a PPO can go outside the central plan’s prescribed provider network provided they pay additional insurance and/or co-pay when they use the services. Moreover, some PPOs will go to some lengths to ensure they have contracts with the more publicly reputed providers, such as teaching hospitals.

The choice of provider extends to circumventing the primary care gatekeeper role and going direct to preferred specialist doctors on the traditional American model. However, failure to comply with the utilization parameters which increases the cost of care beyond the contract prices would result in financial penalty to the provider. In this way the PPO can provide a mechanism for sustaining cost control while widening choice for individuals with the means to access it. Many traditional HMOs have also diversified their product range to include PPO schemes in response to market demand, particularly from the commercial sector. PPOs used to be available only to more senior members of a workforce who could afford the additional contributory premiums charged. However, over 90 per cent of employer-paid plans now offer a PPO to all employees.
ORIGINS AND DEVELOPMENT OF MANAGED CARE IN US

Perhaps the major defining characteristic of managed care in the US is the provision of healthcare against a single annual fixed premium paid in advance. Although some form of prepaid healthcare existed in the US before the First World War, modern forms of managed care had their origins in the western United States in the major public works of the 1930s which dragged America out of the Great Depression. The Kaiser Construction Company had the contract for building an aqueduct in the California desert to carry water from the Colorado River to the city of Los Angeles and further north to build the Grand Coulee Dam in Washington State. In 1937, in response to trade union pressure, the company founded Kaiser Foundation Health Plans to finance healthcare for its employees and their families, before extending the scheme to its shipyard workers constructing the American Wartime Navy. Also in 1937, Group Health Association was founded in Washington DC at the behest of the Home Owner’s Loan Corporation in response to the number of mortgage defaults due to the cost of medical treatment. 10 Other employee health plans, including Kaiser Permanente, as well as healthcare cooperatives, were established during the 1940s, and the first individual practitioners’ associations or IPAs appeared in California in the 1950s. Robert Larsen documents this period in more depth in Chapter 3.

Strange bedfellows – federal government cost control and Californian social experimentation

The 1960s was the decade of social radicalism and the first period of rapid growth for managed care. The movement was led by the State of California which had always been at the forefront of social experimentation in the United States, and internationally. By 1970 there were over 30 health maintenance organizations and the model attracted the attention of the Nixon administration as a means of controlling its rising Medicare budget.

In 1973, the HMO Act was passed. This statute overrode legislation in some states which restricted the growth of HMOs. It also provided grants to found or expand these organizations. The Act also addressed early concerns about restriction of consumer choice by obliging employers to offer their employees a choice of managed care or an indemnity plan - a requirement later lifted by subsequent amendment. HMOs could now apply for federal qualification provided they met certain standards in terms of the comprehensiveness of the benefits package offered, range of provider networks, quality assurance systems, financial stability and member grievance systems. Federal qualification was a market advantage giving access to the commercial market and to the grants on offer from the government. 11 A further sophistication was the requirement for ‘community rating’ or the weighting of the premium level within a limited range - usually no more
than 10 per cent – around the average price to reflect the health status of an employer’s workforce proxied by age, sex and industry type.

**Medical politics and cost control - shifting from specialist-led to primary care-led service delivery**

It was about this time that California-based HMOs took another radical step forward. Fee-for-service (FFS) funded by insurance had fostered medicine to be specialist-led. The expectation of Americans was to see a consultant for whatever medical problem they might have. Even a relatively minor skin inflammation would mean a visit to a senior dermatologist. Up until that time, primary care doctors, also called general practitioners in the United States, constituted a somewhat stigmatized minority. However, in the early 1970s a group of medical directors from a number of health plans in California visited the UK. On that study tour they borrowed the idea that a quality healthcare delivery system could indeed be based in primary care. There was enormous potential for cost mitigation in adapting this model to the US.

So began the growth of paneling members to Primary Care Physicians or PCPs at ratios of around 1600 to 1 full-time equivalent. PCPs – the title still preferred over the term GP in the US – would deliver much of the medical care direct and act as a gatekeeper to specialist services. By the mid-1990s, within managed care at least, the balance of PCPs to specialists within the healthcare network had swung to 2 to 1, with two-thirds of all medical consultations taking place between the PCP and the member and only one-third with specialists.

**Spiralling US healthcare expenditure and macro-economic management**

By 1976, 6 million Americans were enrolled in managed care. This figure more than tripled during each of the next two decades until by 1995 there were 56 million enrollees in MCOs. By 1999 this figure had risen to 175 million Americans in some form of managed care. The driving force behind this trend has been the need to control healthcare costs in the US as part of macro-economic management. In the mid-1980s, the US was top of the Organization for Economic Cooperation and Development (OECD) league table on gross domestic product (GDP) committed to healthcare, but towards the bottom on average life expectancy, infant mortality rates and satisfaction ratings among consumers. Ten years later expenditure had swelled to 14 per cent of GDP compared to an OECD average of nearer 8 per cent. Forty per cent of this cost was met directly by the American taxpayer. This growth rate was simply no longer economically or politically sustainable as the Clinton administration and the Republican Congress fought to rein in the US budget deficit and, not least, claim the credit for achieving it. In 1995, Medicare and Medicaid/Medical alone accounted for 16 per cent of the $203 billion deficit. The Balanced
Budget Act of 1997 included one measure to address this. It ended a prior requirement for states to obtain a special waiver from HCFA in order to oblige their Medicare beneficiaries to transfer to managed care.

For the larger employers, healthcare had become the third largest cost item next to salaries and raw materials and was undermining the competitiveness of American products in both domestic and foreign markets. So corporate America took to managed care to contain its costs. In 1993, the managed care market share for the commercial under-65 population had grown to just over 50 per cent. By 1999 between 85 and 92 per cent of people enrolled in health plans paid for by their employers were in some form of MCOs.

In contrast, Medicare proved to be a more volatile market. The advantage for the federal government is clear. The annual premium it pays to an HMO for each Medicare beneficiary is based on 93 per cent (recently reduced from 95 per cent) of the cost in the fee-for-service sector of a minimum package of benefits. (The actual net premium is subject to regional variations reflecting local healthcare cost.) Hence the Health Care Financing Administration saves 7 per cent per head for seniors (over-65's) enrolled in managed care organizations versus fee-for-service indemnity schemes. Despite this significantly lower revenue base, some of the larger HCFA-accredited, for-profit HMOs were making more money from the Medicare programmes than the commercial members. They have also been able to provide benefits beyond the minimum HCFA package and thus include pharmacy. Not only has this proved a market advantage with seniors, it also helps ensure compliance with treatment programmes versus other plans where elderly people have to meet their own drugs costs. The quality and cost advantages to the HMO is that compliance helps keeps seniors healthier and out of hospital.

Even with the additional benefits on offer, market penetration among Medicare-funded Americans has proved more resistant. Even in Southern California only 42 per cent of Medicare beneficiaries are enrolled in MCOs and in some states in the south – Mississippi for example – penetration is zero. Beneficiaries have a wide choice of healthcare plan and are entitled to change plans on a monthly basis and take their funding with them. The impact of negative publicity for managed care has so far kept a cap on the penetration in the Medicare market. For example, Bernard and Shulkin reviewed 277 articles on managed care from the national press. Published in 1998, their study concluded that two-thirds of the articles portrayed so unfavourable a message that the reader was less likely to join or might even decide to leave an MCO.

The 1990s - market growth, regulation on quality and utilization management

The next series of major developments therefore proved something of a double-edged sword for managed care. Employers, federal and state
governments have joined forces to regulate and monitor managed care organizations on quality. The concern with quality in the managed care sector, not reflected in the fee-for-service sector to anything like the same degree, grew out of the following:

- The managed care industry needed to address the criticism from competitors that it compromised quality and choice to save money.
- This pervasive popular view of managed care was shared by the employees of corporate America who found themselves being increasingly enrolled into MCOs and fed back their perceptions to employers that they were opting for second best.
- The federal government was under pressure from lobbying on the part of the indemnity insurance and fee-for-service sector who were losing a lot of business and cited grounds of quality in order to try and reverse this trend.
- The medical lobbies, led by the American Medical Association, exerted both direct pressure on Washington and indirectly on the politicians through their patients. Debate about whether this anxiety arose out of genuine concern for the clinical quality of services or alarm at the impact on the earnings potential of American specialist doctors would be the subject of a book in itself.

In 1991 the National Committee for Quality Assurance (NCQA) was established as an independent body and began accrediting HMOs on a voluntary basis. Twelve years earlier, NCQA had been founded within the managed care sector in response to the war on quality waged by its major critics. Also at that time, the large employers who contracted with MCOs collaborated to develop a performance monitoring framework and required reporting on Version 1 of the Health Plan Employers’ Information and Data Set (HEDIS). HEDIS was adopted and developed by NCQA who in 1993 began to use HEDIS Version 2 as an accreditation tool. Presented as a ‘standardised, objective information about the quality of MCOs’, HEDIS has developed as much as a pragmatic approach to measuring the measurable as it did as an analytical approach to defining objective quality measures and standards.

Although in theory NCQA accreditation is voluntary for HMOs bidding for commercial contracts, it is a distinct market advantage since it is required or requested by corporations such as American Airlines, Boeing, AT & T, Chrysler, Citybank, IBM, Pepsi-Cola and Xerox. It has become a mandatory requirement by HCFA for any MCO wishing to contract for Medicare business and increasingly so, state by state, for Medicaid. Maintaining and reporting the database is a substantial undertaking in itself. During an accreditation survey, health plans are reviewed against more than 60 standards resulting in the assignment of one of four accreditation levels – Excellent, Accredited, Provisional or Denied. Only about 10 per cent of health plans score ‘Excellent’. Accreditation can thus be a stressful experience for any HMO. Once accredited, plans are required to
submit regular reports according to HEDIS audit criteria. In 1999 HEDIS 2000 is a six-volume manual. There are more than 50 measures which must be regularly reported.

As a result of their strenuous efforts to comply with NCQA and HEDIS, managed care organizations can console themselves with independently audited hard data which supports their contention that they provide services which rival the fee-for-service system on quality (see below). In the competitive market of American healthcare, this is powerful information. However, it has not come cheaply. Much of the data has to be captured manually from group practices of physicians. It is a resource-intensive enterprise with the cost to an average health plan of reporting to HEDIS at around $2 million a year.

UTILIZATION MANAGEMENT - THE KEY TO SUCCESS

MCOs have enjoyed success in sustaining efficiency through the employment of utilization management. Utilization management or demand management is the key healthcare management system employed by managed care organizations to control service use and thus cost within parameters of quality. Utilization management has been defined by Kongstvedt as ‘the activities of a healthcare system which control resource use by reducing the need for more intensive services’.21 It is a system of approaches employed to manage demand in any healthcare system which cannot ration – such as the NHS emergency hospital service. The aims are both to prevent healthcare service need and to ensure that when it is delivered it is at the least intense level in resource terms. Specific techniques include admission diversion through hospital at home or home sitting services; simply not admitting patients for diagnostic procedures; switching surgical procedures to a day basis; and early discharge initiatives such as hospital hotels, use of step-down or improved integration of social care.

Admission diversion is only one side of the coin, however. In the US managed care sector, these initiatives were largely in place by the early 1990s when analysts of hospital utilization began to express concerns that admission rates among the elderly were spiralling out of control and length of stay was beginning to flatten out. Sustaining trends of reducing hospital utilization since that time have been widely attributed to admission prevention strategies – notably to case management and chronic disease management.

Case management was originally designed as a total quality management approach to individuals, mostly people aged over 65, with poor health status. The programme developed in the early 1990s following federal government concerns that expenditure on its Medicare programme, which funds healthcare provision for retired people, would be unsustainable as the population age structure changed over the next ten to fifteen years.
Analysis of resource use at that time by HCFA and the American Hospital Administration showed under 10 per cent of 30 million Medicare beneficiaries accounting for nearly 70 per cent of expenditure. Case management targets this small group of high service users and employs secondary prevention to improve health status and prevent acute exacerbations of chronic and/or ‘catastrophic’ conditions and thus some admissions to hospital. It is an ‘assertive outreach’ service based in primary care. Case managers – usually senior nurses – assess and plan packages of care and ensure resources within the healthcare system are deployed to meet the needs of each individual. Specific areas of work include ensuring medical problems are sorted out; educating the client about the disease process including awareness of early warning signs and how and when to access the healthcare system; reviewing current medications; and facilitating compliance with treatment programmes. Sherry Aliotta describes and assesses this service in Chapter 8.

The aim of disease management is to take a more proactive approach to managing a disease in order to improve the likelihood of favourably altering its natural history. It is a comprehensive and integrated approach. The outcome should include improving the quality of care and thus quality of life for the individual and reducing the cost of management of each individual – in particular by reducing their need for hospital-based care. Disease management works across three levels of prevention: primary, secondary and tertiary. It is described more fully in Chapter 5.

EVALUATIONS OF MANAGED CARE

To what extent has managed care met its own objectives? Detailed evaluations of the experience have been carried out recently on both sides of the Atlantic, including Robinson and Steiner’s book commissioned by the Department of Health. These exercises are ‘meta-analyses’ of the American evaluative literature which compares managed care with its primary competitive model in the US, the fee-for-service indemnity system. Although thorough, they are inevitably limited in terms of any assessment of applicability of managed care techniques to the needs of the National Health Service. They also focus largely on the corporate objectives of managed care organizations – cost control, quality and utilization management and consumer satisfaction. The NHS has still more fundamental objectives such as equity and comprehensive cover regardless of means which are still only one side of a philosophical divide in the US. British anxiety about drawing on US experience tends to focus on the absence of these aims in mainstream US health policy. However, in addition to reviewing managed care against the American success parameters, it is possible to answer the following questions which legitimately arise in the UK:
• Does managed care control costs by limiting or denying access to services?
• Do managed care organizations screen out groups in the population who have high healthcare needs and thus demand—such as high-risk groups for healthcare provision, socially deprived groups and elderly people with established chronic conditions?

Cost containment
Robinson and Steiner found some accounting difficulties in making direct comparison between managed care and the fee-for-service sector and their conclusions were largely inconclusive. However, as we have seen, the US federal government is persuaded of the case. Moreover, the increasing penetration of MCOs within the US healthcare market has been associated and credited with dramatic reductions in annual healthcare cost inflation from 12 per cent to 3.6 per cent during the 1990s. The containing impact of managed care growth on national healthcare costs is known as ‘spillover savings’. In 1997 the American Association of Health Plans commissioned its own study from the Lewin Group which estimated that over the five-year period from 1991 to 1996 spillover savings amounted to up to $28 billion. There are also clear price differentials. HCFA saves 7 per cent per head for Medicare beneficiaries who choose to enrol in an HMO. In the commercial sector the savings are proportionately higher. In 1996 the annual premium for an employee and his or her family in managed care was just over $3000. This is 15 per cent lower than fee-for-service, often for a more comprehensive benefits package with fewer co-payments; 94 per cent of HMOs included pharmacy as a commercial benefit, for example. Managed care premiums have also been increasing at significantly slower rates than those in fee-for-service.

The NHS was then spending the equivalent of about $1000 per head and it is tempting to make direct comparisons. Unfortunately, the substantially higher cost base in the US makes such exercises problematic and of little relevance. Not least, staff costs are substantially higher in the US. Nursing salaries which constitute the single largest component of cost in the NHS can be two or three times higher in the US for equivalent jobs.

Service utilization
Robinson and Steiner were more definite in this area. Managed care was associated with fewer hospital admissions and shorter lengths of stay. Also physicians in MCOs were more likely to opt for less costly treatment alternatives given equal efficacy between them. For example, Milliman and Robertson compile the most authoritative databases of healthcare service utilization in the United States. This is subdivided into ‘commercial’, or the under-65 population, and Medicare. The data is case-mix
specific and shows all American delivery systems categorized according
to the extent to which they use techniques of utilization management.
There are three classifications in turn a little pejoratively labelled ‘loosely
managed’ (largely fee-for-service), ‘moderately managed’ and ‘well
managed’ (comprehensive HMO networks) systems. The 1997 data using these
categories shows substantial differences in acute hospital utilization for
all conditions and procedures. Length of stay should not be compared
direct to the UK since the figures are for the acute stage only. Step-down
and rehabilitation utilization is shown separately in the US data.

<table>
<thead>
<tr>
<th></th>
<th>Admission rate (per 1000)</th>
<th>Length of stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loosely</td>
<td>77</td>
<td>4.1</td>
</tr>
<tr>
<td>Moderately</td>
<td>63</td>
<td>3.57</td>
</tr>
<tr>
<td>Well</td>
<td>49</td>
<td>2.72</td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loosely</td>
<td>284</td>
<td>6.99</td>
</tr>
<tr>
<td>Moderately</td>
<td>217</td>
<td>6.79</td>
</tr>
<tr>
<td>Well</td>
<td>149</td>
<td>4.68</td>
</tr>
</tbody>
</table>

Source: Milliman and Robertson (1997)\(^{26}\)

Use of hospital stay is kept within quality parameters, however, as defen-
ders of managed care are at pains to point out. Length of stay by condi-
tion or procedure falls within the range recommended by the American
medical colleges.\(^{27}\)

If there is one area where managed care actually promotes higher service
utilization it is in the field of health promotion. Health maintenance
organizations, as their name suggests, have always prided themselves on
their emphasis on primary and secondary prevention not simply as a
quality issue but also as a sound business investment. Prevention should
reduce utilization at the more costly levels of service delivery – notably
hospital admission. Leaving aside any discussion as to the efficacy of these
programmes for now, MCOs consistently out-perform fee-for-service in
preventive healthcare such as screening, well person check-ups, smoking
cessation, immunization programmes or exercise and dietary advice and
support services. Robinson and Steiner found the evidence ‘most per-
suasive’ in this area.\(^{28}\)

Quality

Quality has been one of two dimensions of performance on which man-
aged care has been consistently attacked by its competitors. This is not
justified. As we have seen, the industry founded what is now the country’s
Managed care at the crossroads

leading independent accreditation agency on quality in healthcare – NCQA. It has also been common for the larger HMOs to commission independent quality reviews for organizations such as the RAND Corporation to address this marketing Achilles Heel. Miller and Luft have undertaken two systematic reviews of 31 research studies on quality in MCOs which span 17 years to early 1997. Some of these have been commissioned by HCFA to focus on the Medicare or over-65 population. The reviews concluded that quality of care in MCOs was either on a par with or better than the fee-for-service sector. Robinson and Steiner divided the 23 studies they reviewed into the typology formulated by Donabedian in the early 1980s – structure, process and outcome. They concluded that fee-for-service and managed care performed largely equally well within each parameter, with some significant evidence of higher process quality for MCOs.

Consumer satisfaction and choice

If expressed dissatisfaction rates are any measure, Americans have always been more critical of their healthcare system than the British. In 1988, a meagre 10 per cent of Americans felt that their healthcare system worked ‘pretty well’ and only 40 to 45 per cent declared themselves very satisfied with the care they received. As we have seen, managed care has a bad image in the US, fuelled by a largely hostile press. Similarly, the research reviewed by Robinson and Steiner revealed customer satisfaction as the one performance measure on which managed care consistently underscored against fee-for-service. In contrast, the data from two major surveys of satisfaction rates in MCOs and fee-for-service reported by the American Association of Health Plans in 1998 shows satisfaction rates of around 90 per cent for both systems.

It seems much depends on the terminology used in the questions. NCQA requires regular monitoring of consumer satisfaction so its data is more complete. It is also more stringent in its reporting since satisfaction rates with accredited MCOs are reported only where consumers are ‘completely’ or ‘very’ satisfied. Even at 56 per cent nationally (across a range of regional variations from 53 per cent to 63 per cent) the figures for NCQA-accredited MCOs are relatively high for the US and provides evidence that these organizations are performing reasonably well in this area.

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Asked whether a choice of doctor or hospital is important to them on a rating of zero to ten, Americans consistently scored nine. Since much of the evaluation of comparative quality shows MCOs performing well, critics of managed care have turned to choice as the major line of attack. It is true that few if any HMOs can compete with an extensive fee-for-service indemnity plan in this area. However, choice is a relative concept and the debate in the US tends to be more about the range and extent of choice of provider. Ninety-two per cent of HMOs now offer workers some form of PPO for FFS – although often a
co-pay is required. However, even within the network, HMOs routinely offer enrollees a choice of primary care physician and hospital which is quite extensive. For example, IEHP, an HMO in Southern California, specializes in health plans for people funded by the State Medical programme (California’s version of Medicaid). Its members are offered a choice of up to 500 primary care physicians working in group practices, and 23 hospitals. PCPs recommend the specialist to the patient but again a choice of several will be offered. Members may change PCP up to twice a year if dissatisfied. The member is also provided with advice on making the selection by the Member Services Department based in the HMO headquarters who are also responsible for monitoring satisfaction and resolving grievances.

Access

Do managed care organizations deny care? First, it has become the norm in the United States, even in indemnity plans, for the referring doctors to require prior authorization of some — usually the very expensive elective — forms of treatment. A medical decision is rarely overturned, however. According to the American Association of Health Plans, denial rates, defined as a health plan refusing to fund a treatment recommended by the doctors, are around 1 per cent in medical and surgical acute care. NCQA report satisfaction rates of 85 per cent with access — defined as MCO members who have not had problems accessing the care they or their doctors believed to be necessary. Moreover, waiting lists are an unknown quantity in the better MCOs. In the State of California, for example, it is a state requirement that patients should wait no more than two weeks for an initial consultation, and surgery — if required — would be routinely scheduled within two to four weeks after that. Even people on Medical would invoke the plan’s grievance procedures if they were made to wait three months for elective hospital treatment.

What then of healthcare-related services such as social care? In the United States social care is funded either through individuals’ own resources or supported by the state Medicaid programmes. Provision can be patchy from state to state depending on the local political tradition. The integration of health and social care networks is the responsibility of case managers who are either nurses or social workers employed by MCOs (see Chapter 8). Medicaid will fund packages of community-based services such as home helps or short- and long-term placements in nursing home care. Social care is means-tested and co-pays of around $10 per week may be charged for community-based services. There are also programmes in some states to pay carers at the national minimum wage level of $5.75 (1999 figures). Sixty-five per cent of nursing home costs in the US are now met by Medicaid.

Recently there have been calls for more consistency in social care provision through the unification of publicly funded health and social
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HCFA’s response to date has been to establish four pilot programmes called Social Health Maintenance Organizations (SHMOs). The SHMOs are funded through Medicare at a higher rate than is payable to conventional HMOs. One of these operates from Long Beach and also draws on the State Medical Programme. Its case managers have the authority to provide packages of social care to maintain a client in the community at a cost of up to 95 per cent of the cost of nursing home care - which is about $36,000 per annum. Over the next few years, it is envisaged that the federal government will increase contracts with managed care organizations to provide health and social care particularly for elderly people and other high-cost client groups on Medicaid, such as those with chronic mental health needs. Whether this will extend the SHMO model or simply build on the existing provider networks remains to be seen, although case management will continue to grow as the planner and coordinator of needs and resources.

Managed care and high-risk populations

Finally, are managed care enrollees representative of the American population at large in terms of health status? First, during the 1990s the number of Medicaid beneficiaries in managed care increased from under 10 per cent to over 50 per cent. This trend seems likely to be sustained into the next century now that states have the authority to require Medicaid beneficiaries to enrol in managed care. Second, when an HMO contracts with an employer to provide health plans to the workforce, it is simply not allowed to screen any individuals, so accepts whatever risks there may be. So with its mix of Medicaid and over 90 per cent of employees from all types of industry, managed care covers a cross-section of American society under 65. These figures support studies quoted by the American Association of Health Plans that have found no difference in the health status of MCO enrollees and the general population, although HMOs cover more low-income families and more minority groups than fee-for-service. As far as the over-65s are concerned, Medicare is a national comprehensive programme covering all cultures and income levels (when the beneficiary was working). HMOs with Medicare contracts are simply not allowed under HCFA regulations to refuse any individual applying to enrol, regardless of pre-existing conditions. They have to take all comers.

That leaves the reducing number of Americans with no health insurance cover at all, which has been estimated to be as low as 5 per cent of the population. There are two major groups: those single persons (often students) from poorer backgrounds who do not meet the Medicaid eligibility criteria because they have no special chronic ill-health needs or are childless, and those younger people who do not regard themselves as in need of health insurance and deprioritize it as an expenditure item. These people can access neither managed care nor the fee-for-service sector and
are reliant on America's hard-pressed public hospitals. Their plight is a structural weakness in the US healthcare system.

AN OPTIMUM MODEL

So managed care performs well compared to fee-for-service on most significant criteria. However, as with any healthcare delivery system, such as the NHS for example, there are variations in quality, range and access to services and resource management between managed care organizations. In any comparative healthcare management analysis, we should not seek to emulate the worst aspects of any system but examine the applicability of the best. To do the argument of this book full justice, therefore, it is necessary to develop a paradigm for managed care which reflects the best practice in the United States. This can be found in some of the managed care organizations which have developed in Southern California, although it is readily acknowledged that high-quality managed care systems can be found in other parts of the country.

Why California? The state has the highest GDP per capita of any in the US. Not only do its healthcare consumers therefore have maximum purchasing power, they also have as wide a choice as any in the US healthcare market. Its white middle-class population, at least, is among the most demanding even of American consumers. Yet market penetration for managed care is highest in this state. Therefore, to the extent that consumer preference is an important measure of quality in American healthcare delivery, the models found in Southern California are unsurpassed elsewhere in the managed care sector.

Not least, the state has a strong claim as the home of the modern fully integrated HMO, and has the widest choice of plans and thus the most intense competition between managed care organizations. Therefore, to explore the application of managed care techniques to the United Kingdom's healthcare development agenda over the next ten years, we need to develop a model based on best practice in Southern California. This would have the following components:

- A single annual payment guarantees a comprehensive healthcare delivery system.
- The central payer organization – the HMO – sub-contracts service purchasing to primary care-based associations of ‘GPs’ and other community-based healthcare professionals.
- Primary care delivers most of the care and hospital costs are under 40 per cent of the total expenditure.
- There is an integrated quality management process based on clinical effectiveness and consumer satisfaction.
- Clinical effectiveness is assumed by employing evidence-based clinical guidelines.
Managed care at the crossroads

• Prevention and health maintenance are integrated service objectives.
• Care delivery systems are integrated with each provider’s role designed on criteria of clinical appropriateness, resource effectiveness and patient focus.
• Utilization management techniques are widely employed.
• To guarantee quality and appropriate levels of service utilization, the HMO has a performance monitoring system for its contracted providers.
• The central payer organization has an autonomous member services department which provides information on choice of providers and use of the healthcare network, monitors satisfaction, seeks to redress grievances and complaints and, critically, feeds back information into the management process.
• Finally, strategic and operational objectives and financial incentives are aligned throughout the system.

These then are the major elements of a high-quality, comprehensive managed care system. Each of these sub-systems of healthcare management will be revisited in detail in the course of this book to show why they are central to the development needs of the British National Health Service which flow from the Labour government’s modernization agenda.

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