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HEALTH MAINTENANCE ORGANIZATIONS IN THE UNITED STATES: POTENTIAL FOR INTRODUCTION INTO CANADA

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HEALTH MAINTENANCE ORGANIZATIONS IN THE UNITED STATES: POTENTIAL FOR INTRODUCTION INTO CANADA

If you have seen one managed care plan,
you have seen one managed care plan.[1]

INTRODUCTION

Unlike Canada and many other OECD countries, where one single insurer (the government) funds health care, the United States has a health care system that is characterized by a large number of funders and purchasers. Public health care insurance under the Medicare and Medicaid plans covers approximately 25% of the population.[2] This figure jumps to 61% for private health care insurance, which clearly dominates the sector (see Table 1).[3] Most Americans have health care insurance through their employers' benefit plans; alternatively, they can purchase health care insurance privately.

Moreover, in the U.S. health care system there is not necessarily, as in Canada, a clear separation between health care insurance and health care delivery. This coexistence of the two aspects in a single organization is what the Americans call "managed care," and it accounts for a large part of the market for health care insurance and delivery in the United States. Health Maintenance Organizations (HMOs) are one example of this.

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(1) Neelam K. Sekhri, "Managed care: the US experience," *Bulletin of the World Health Organization*, Vol. 78, No. 6, 2000, p. 832 (http://www.who.int/bulletin/tableofcontents/2000/vol.78no.6.html).

(2) *Medicare* is a federal health care insurance program for those who are 65 years of age or older as well as some younger disabled persons and people experiencing terminal kidney failure. *Medicaid* is a joint health care insurance program of the federal government and the states, provided to people on low incomes.

(3) Despite the availability of public and private health care insurance plans, it is estimated that some 39 million Americans, or 14% of the population, are not insured. Furthermore, a large number are under-insured.

As shown in Table 1, 177.9 million Americans, or 62% of the population, are enrolled in a managed care organization, either through their employer, individually, or through the Medicare and Medicaid public health care insurance programs. Close to 88% of Americans covered by a private health care insurance plan are enrolled in a managed care organization. Similarly, some 15% of Americans covered by Medicare and close to 57% of Americans covered by Medicaid are members of managed care organizations.

TABLE 1

U.S. HEALTH CARE INSURANCE AND COVERAGE, 2001

	Population (millions)	Population distribution (percentage share)	Managed care (millions)	Managed care (percentage of population)
Medicare	38.0	13.3	5.5	14.5
Medicaid	34.5	12.1	19.6	56.8
Private health care insurance	174.4	61.0	152.8	87.6
Uninsured population	38.7	13.6	0.0	0.0
TOTAL	**285.6**	**100.0**	**177.9**	**62.3**

Source: Managed Care On-Line (http://www.mcareol.com).

More than 90% of primary health care doctors work under contract with managed care organizations. Finally, managed care organizations that are listed on the stock exchange account for approximately 60% of the managed care market.(4)

HMOs and Preferred Provider Organizations (PPOs, or organizations that provide services at low rates, a form of managed care organization that is growing in popularity at the expense of HMOs) are the two main components of managed care in the United States (see Table 2). HMOs are undoubtedly one of the most original experiments in the field of health care management attempted in recent decades in OECD countries. Despite criticisms, they remain an essential component of the U.S. health care system and a source of inspiration for countries wishing to reform their own health care systems.

(4) The last two statistics are taken from Sandrine Chambaretaud and Diane Lequet-Slama, "Couverture maladie et organisation des soins aux États-Unis," in *Études et Résultats*, Direction de la recherche, des études, de l'évaluation et des statistiques, Ministère de l'emploi et de la solidarité, France, No. 119, June 2001, p. 10 (www.sante.gouv.fr/htm/publication).

TABLE 2

AMERICANS ENROLLED IN MANAGED CARE ORGANIZATIONS, 2001 (in millions)

Health Maintenance Organizations (HMOs) Preferred Provider Organizations (PPOs)	79.5 98.4
TOTAL	**177.9**

Source: Managed Care On-Line (http://www.mcareol.com).

This document analyzes the HMO experiment in the United States and draws some conclusions with respect to the Canadian health care system, especially concerning reform of the primary health care sector. The first part explains what an HMO is, describes the various models, and lists the characteristics and principles that they have in common. The second part deals with criticisms directed at HMOs. The last part examines the potential for introducing HMOs into Canada.

HEALTH MAINTENANCE ORGANIZATIONS: DESCRIPTION, MODELS, PRINCIPLES AND SHARED FEATURES(5)

A. What is an HMO?

HMOs are networks or organizations that integrate and co-ordinate the following three functions on behalf of their members: health care insurance (private or public), delivery, and purchasing.

Some HMOs are for profit, while others are not. They include insurance companies, doctors, health care providers, hospitals, and other health care institutions that operate as businesses, with specific arrangements that vary from one organization to another. Some HMOs employ health care providers (doctors, hospitals, laboratories, medication, home care) directly, while others contract out for these services.

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(5) The information in this section was taken from the following documents:

- Patricia LePore, *Managed Care and its Variations*, obtained from the Web site of the American College of Physicians and the American Society of Internal Medicine (http://www.acponline.org/counseling/managed_care.htm).
- Chambaretaud and Lequet-Slama (2001).

In short, HMOs play the role of intermediaries, to various degrees and at different levels, between: insurers and health care providers; general practitioners and patients; and general practitioners and other health care providers (hospitals, laboratories, specialists, etc.). The wide variation in arrangements among the parties that constitute HMOs means that there are as many models as there are HMOs.

The HMO concept was developed in the United States in the 1970s[(6)] in order to resolve three related problems: the passive approach of traditional health care insurance; fragmentation in the provision of health care; and the rapid increase in health care costs.

HMOs were seen, first, as a more economical alternative to traditional health care insurance, which is based essentially on paying doctors for services provided without any cap on total costs, and on after-the-fact reimbursement for the cost of services provided. HMOs have introduced new methods of paying doctors, and incentives designed to promote the rational use of resources and to contain costs.

Second, the provision of health care was previously very fragmented. Each field of care (primary, secondary, and tertiary) had its own work methods and its own data on patients, without any real integration among them. Often, data on patients' health care were not shared. HMOs integrate different health care sectors to offer a wide range of care based on a patient-centred approach. Closer integration of health care insurance and health care delivery also helps to control costs. HMO premiums are often lower than those of traditional health care insurance companies.

Finally, the creation of HMOs was an innovative attempt to contain rising health care costs, at the request of insurers and also employers, who pay the lion's share of their employees' health care insurance premiums. HMOs, as managed care organizations, are based on the principle that more careful resource management and a medical approach based on preventative health care allow for better cost control. This control can be achieved by:

- setting standards for health care delivery;
- monitoring patients more closely and encouraging them to adopt a healthy lifestyle;
- restricting access to health care solely to those services provided within the HMO;

(6) In 1973, the U.S. Congress passed the *Health Maintenance Organization Act*, which created the legislative framework for HMOs. Since that time, several amendments have been made to the Act to adjust the HMO formula to changing conditions in the health care system and to changes in the needs of the American public.

- rationalizing access to specialized resources; and
- encouraging greater competition among different health care providers and institutions.

The purchase of health services is the key element that distinguishes HMOs from traditional health care insurance companies, and that differentiates the U.S. and Canadian health care systems. This function is similar to that of "sickness funds" in other countries, such as Germany and the Netherlands. Purchasing is an important function that introduces a new dynamic into the health care system. In effect, it involves negotiating individual contracts with health care providers, defining responsibilities, and paying for services. This approach is very different from traditional health care insurance, which is responsible only for paying for services.

B. What Are the Various HMO Models?

Originally, HMOs functioned as both insurers and *direct* health care providers. Over the years, some HMOs have distanced themselves from the direct provision of services by limiting their role to that of intermediary between patients and health care providers. Despite their great diversity, HMOs can be divided into four major categories, depending on the status of the doctors and hospitals with which they are affiliated and the administrative structure through which health care is delivered. These are:

- the Staff Model;
- the Group Model;
- the Network Model; and
- the Independent Practice Association Model.

1. The Staff Model

This type of HMO directly employs doctors and other health care providers. In addition to their salary, doctors may receive bonuses based on performance and productivity. The HMO owns primary health care centres and even hospitals. It may also own diagnostic, laboratory, and home care services. Patients can access integrated health care services only through a family physician (or general practitioner), who is the "gatekeeper" and point of access to the HMO's services.

In this model, doctors maintain their practice exclusively within the HMO. Generally speaking, all ambulatory care is provided under the same roof. This type of HMO has the most control over the delivery of services by doctors and other health care providers. It is also the most expensive type of HMO to establish, because it requires major investments in equipment and capital for a relatively limited group of clients.

From the doctor's viewpoint, this model has several advantages. First, the salary and regular work hours help to guarantee financial stability. Moreover, the administrative aspects of medical practice (invoicing, receiving, etc.) are taken care of by the HMO, leaving the doctor more time to concentrate on patients. Finally, doctors have access to equipment and services that they might not have in a private practice (laboratories, X-ray equipment, etc.).

However, this model also has some disadvantages for the doctor. Chief among these is a certain loss of control over his or her practice and professional independence, because the HMO maintains a high degree of control over health care delivery through the application of guidelines and clinical protocols. Although this is a major irritant for many doctors and patients, HMOs' control over health care delivery, and thereby over health care costs, is the aspect that interests analysts from other countries.

2. The Group Model

Unlike the Staff Model, the Group Model does not directly employ doctors. Instead, groups of doctors under contract to the HMO, often in multidisciplinary teams, are paid on a capitation basis (a fixed sum per patient).[7] The group is responsible for deciding how to allocate payments among members. Doctors must be members of a group in order to provide services and they may provide services only to members of the HMO. Generally speaking, all health care services, except for hospital care, are provided under the same roof.

Similarly, the HMO does not necessarily own any hospitals; usually, it contracts with them to obtain services.

Like the Staff Model, the Group Model makes it easier to monitor the use of health care services, apply clinical practice guidelines and standardize health care delivery. The

(7) For further information on capitation and other methods of paying doctors, see Michael Holden and Odette Madore, *Remuneration of Primary Care Physicians*, PRB 01-35E, Parliamentary Research Branch, Library of Parliament, Ottawa, 2002.

advantages for doctors are similar to those of the Staff Model: notably, regular hours and salary. However, the group of doctors does have a certain degree of control over medical practice.

3. The Network Model

The Network Model concludes contracts with various groups of primary health care doctors, specialists in various disciplines, and hospitals. The doctors work in their own offices rather than in a primary health care centre provided by the HMO. They are paid on a capitation basis for services provided to HMO members but also maintain their own practices outside the HMO. However, they remain subject to the HMO's clinical practice guidelines, its monitoring of the use made of their services and its quality assurance programs, which are measures through which the HMO can control costs.

The groups with which the HMO concludes contracts work co-operatively to provide all necessary health care to the members of the organization. Doctors accept the financial risk of covering the full cost of the care they provide to HMO patients, which may be higher or lower than the agreed amount.

4. The Independent Practice Association Model

This model is the least restrictive in terms of medical practice. Independent Practice Associations are syndicates or associations of doctors that conclude service agreements with HMOs, based on negotiable terms and fees. Belonging to a syndicate gives doctors more clout in negotiating working conditions with the HMO, while allowing them to remain largely independent in their private practice. The doctors are paid in various ways (capitation, payment per service, or a fixed amount), since they maintain private practices and also provide services to HMO members.

This type of HMO is more difficult to manage because doctors are dispersed. However, it offers its members a wider network of health care providers. It also allows its members to use their own family doctor, if they so wish. One disadvantage is that patients must usually go to different locations for different kinds of treatment (primary health care, cardiology, pediatrics, gynecology, etc). Moreover, each location maintains its own medical files, which makes it more difficult to share patient information.

5. Other Types of Managed Care Organizations

Preferred Provider Organizations (PPO) were developed in the United States in response to certain criticisms levelled at HMOs. Unlike HMOs, PPOs allow more freedom to members and health care providers. Members are not limited to consulting only those doctors approved by the organization, or to consulting their family doctor first. However, they are motivated to do so by the fact that, if they do, they pay a much smaller portion of the cost of the care provided. Doctors are paid a fee per service, not on a capitation basis; they must agree, however, to charge the amounts negotiated for PPO clients. General practitioners do not act as gatekeepers, as they do in HMOs.

The Point of Service (POS) model is halfway between an HMO and a PPO. Essentially, it is an "open HMO," meaning that its members can decide to be treated within the network managed by their HMO or they can opt for treatment outside the network and be reimbursed for their expenses. In the latter case, however, they must pay a significant fee as a disincentive.

Table 3 summarizes the main features of the various kinds of managed care organizations in the United States.

C. Characteristics and Basic Principles of HMOs

HMOs and other forms of managed care organizations use incentive mechanisms. Patients are motivated to use approved health care providers and institutions; and these, in turn, are motivated, through selective contractual and payment arrangements, to provide health care. According to some analysts:

> A fundamental concept of HMO is the integration of financing and service delivery to enrolled individuals (i.e., the roster). This integration is the foundation of tools and techniques used in varying degrees by all forms of managed care plans to improve service quality and accountability while controlling costs. Integration affects the design of benefits, the selection and payment of providers, and the management of utilization. Incentives and disincentives are used to influence the behaviour of providers, to motivate enrolled individuals to use participating providers, and to encourage compliance with plan procedure.(8)

(8) John Marriott and Ann L. Mable, "Integrated Models: International Trends and Implications for Canada," in *Striking a Balance: Health Care Systems in Canada and Elsewhere*, paper commissioned by the National Forum on Health, Éditions MultiMondes, 1998, p. 604.

TABLE 3

MODELS OF MANAGED CARE ORGANIZATIONS IN THE UNITED STATES

MODEL	FREEDOM OF CHOICE FOR PATIENTS	FINANCIAL INCENTIVES FOR DOCTORS	IMPACT ON MEDICAL PRACTICE
HMO – Staff Model/ Group Model	Members are insured solely for services provided within the HMO.	Doctors receive salaries and may also receive performance bonuses.	Direct control through clinical practice guidelines, monitoring of the use made of services and quality assurance programs.
HMO – Network Model	Members are insured solely for services provided by the HMO.	Doctors are paid on a capitation basis. They must therefore accept the financial risk of covering the cost of care they provide to the members of the HMO.	Indirect but very strict control including guidelines, monitoring of the use made of services and quality assurance.
HMO – Independent Practice Association Model	Members may consult their family doctors.	Doctors receive a mix of capitation fees, salary and fees per service.	Controls on the practice of medicine are much less strict. In return, doctors accept a greater financial risk.
Point of service (POS)	Members may receive care within their HMO or outside it, but in the latter case they agree to pay high disincentive fees.	Doctors are paid for each service provided, but the rates are negotiated in advance and are usually lower that those charged in their independent practice.	Indirect outside control.
Preferred Provider Organization (PPO)	Members can obtain care outside the HMO. However, it is much less expensive to consult a doctor affiliated with the HMO.	Doctors are paid for each service provided, but the rates are negotiated in advance and are usually lower than those charged in their independent practice.	Indirect outside control.

Source: Economics Division, Parliamentary Research Branch, Library of Parliament.

Despite their diversity, managed care systems that combine the funding (or insurance) function with the provision and purchase of health care have certain features in common. These relate to the enrolment (or rostering) of members, the scope of care provided, the gatekeeper role of the family doctor, the prevention of illness, and strict control over service delivery and expenses. In other respects, however, HMOs vary widely with regard to how doctors are paid (salary, capitation or fee per service), the rostering of patients with a specific doctor or offering freedom of choice, disincentive fees, etc.

1. Enrolment of Members

- Enrolment in an HMO is voluntary. HMOs face competition.
- Enrolment is usually arranged through the member's employer. The employer negotiates the type of health care insurance coverage.
- Those who enrol in an HMO have access to the full range of care that it provides, in return for a pre-established annual premium. This premium is fixed, regardless of use. HMOs are thus motivated to control expenditures.
- Regardless of any changes in the member's health, he or she is protected by the HMO's obligation to renew contracts with all its clients, unless the member decides otherwise.
- HMOs serve the people who have enrolled in them. Members are, therefore, usually bound to a specific HMO for one year. HMOs are sometimes the only health care insurance plan offered by employers. Under the Medicare program, members are not restricted to one particular HMO and can change HMOs when they wish.
- Enrolment in or access to an HMO depends, above all, on an individual's employment or his or her ability to pay. The principles of universality and equal access to health care, which characterize the Canadian public health care system, thus do not apply to U.S. HMOs.
- The patient's freedom of choice is limited by the fact that he or she may use only the services provided through his or her HMO. If a patient receives services outside the HMO, he or she must pay those costs (except in emergencies).

2. Range of Services Provided

- In return for the premiums received, the HMO must uphold its contractual responsibility to provide members with, or give them access to, the full range of health care for which they are insured. Such care is not necessarily limited to doctors and hospitals; it may extend to all health care providers, to other health care institutions (such as nursing care centres), home care, dental care and medication.

- HMO members generally receive very wide coverage. This coverage ensures that health care is effectively co-ordinated, although it varies from one HMO to another and even within an HMO. In fact, an HMO may offer different health care insurance plans to different members. The plan used depends on the employer's, employee's or individual member's needs and ability to pay.
- Members have the right to demand the services that they need, but they must obtain them through the HMO. Care received by a member from a source outside the HMO is only partially insured, if at all.
- The direct delivery of a wide range of services requires a certain minimum number of members. Because the number of members differs from one HMO to another, the range of health care services insured also varies from one HMO to another. The government has not intervened to define basic health care services for the population as a whole, although it has done so for people who have access to Medicare and Medicaid.

3. The Gatekeeper Role of the Family Doctor

- Members must choose a family doctor, who will act as a gatekeeper and be their point of access to all the HMO's services. Moreover, the patient must consult his or her doctor in order to gain access to more specialized services or care offered outside the HMO.
- As a gatekeeper, the doctor ensures that only necessary services are provided and that this is done in the most appropriate manner. The doctor manages and guides the member's use of health care services, liaises with him or her, and co-ordinates the medical records.
- The gatekeeper role is thus central to the HMO's operations, and to the entire issue of the trade-off between access to services and cost control. In fact, an HMO's financial viability is directly linked to the services that its doctors offer to members.
- Through capitation, financial risk can be transferred from the insurer to the provider. The doctor who acts as gatekeeper, and is paid on a capitation basis, assumes a significant financial risk, since the doctor must cover any health care costs that exceed the capitation payment he or she receives from the HMO. On the other hand, if the care provided costs less than the captitation payment, the doctor may keep the surplus. The doctor must therefore closely monitor the diagnostic tests, treatments and medication that he or she recommends or prescribes, in order to keep track of the payments authorized by the insurers and to ensure that medical expenses do not systematically exceed revenues.

4. Prevention of Illness

- Since HMOs have to assume the financial risk associated with providing health care, it is in their interests to maintain their clients' health by emphasizing a preventive care approach. Prevention, education and proactive health care are important to an HMO's effective functioning, and are regarded as a long-term investment.

5. Strict Control

- HMOs maintain careful control over the quality and use of the health care services they provide. Health care providers accept these controls. HMOs subject doctors to more administrative controls than do other forms of health care insurance.
- HMOs also exercise strict control over premiums by carefully managing expenditures on and by doctors and hospitals. An HMO's financial stability depends essentially on its capacity to attract clients through offering high-quality services at a competitive cost.
- HMOs tend to rely heavily on operational agreements and computerized systems to organize, manage and rationalize the provision of care and the movement of patients within their organization. Some HMOs have automated their medical records(9) in order to improve communication among health care providers concerning members, optimize the use of resources required for various health problems and levels of care, identify trends in the use of health care services, and provide feedback to health care providers about the effectiveness of prescribed treatments.

6. Information Systems

- Intensive use of state-of-the-art information systems and the gradual conversion of medical records to electronic format are elements in the HMOs' strategy to control costs, integrate care, reduce the time spent on administrative duties and improve their members' health. It is estimated that of the $1.2 trillion that Americans spend each year on health care, between $250 and $450 billion is devoted to administrative costs.(10)

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(9) Jeff Goldsmith, "Integrating care: A talk with Kaiser Permanente's David Lawrence," *Health Affairs*, Vol. 21, No. 1, January/February 2002, pp. 39-49 (http://www.healthaffairs.org/).

(10) W. Eric Pfeiffer, "Shock Therapy at Kaiser Permanente," *CIO Insight*, 15 April 2002.

- Automation of medical records, though complex and subject to many legal and ethical issues, is viewed by HMOs as one way to reduce errors and substantially improve the quality of health care. Similarly, the increased use of both on-line and off-line information systems helps to give health care providers easy access to the latest knowledge available in their fields.
- Some HMOs are also developing Web platforms that will enable them to offer their members more comprehensive and less expensive services more rapidly.

CRITICISMS AND LESSONS LEARNED[11]

A. Criticisms

When they were first created, HMOs represented an innovative attempt, in the field of managed health care, to integrate different health care sectors and contain the increase in health care spending. However, as indicated in Table 4, membership in HMOs is now dropping, following a constant growth over some 20 years. Table 4 also shows that the total number of HMOs in the United States is declining, as the result of many mergers and acquisitions aimed at consolidating an industry that is looking for financial viability.

TABLE 4

HMO ENROLMENT AND TOTAL NUMBER OF HMOs

	Number of Members (millions)	Annual Growth (%)	Total Number of HMOs	Annual Growth (%)
1992	38.8	6.3	560	–
1993	42.1	8.5	555	-0.9
1994	47.1	11.9	543	-2.2
1995	53.4	13.4	562	3.5
1996	63.3	18.5	630	12.1
1997	72.1	13.9	651	3.3
1998	78.6	8.9	643	-1.2
1999	80.5	2.6	613	-4.7
2000	78.9	-2.0	563	-8.2
2001	78.0	-1.1	531	-5.7

Source: These data were obtained from the *InterStudy Publications* Web site (http://www.interstudypublications.com/pdf/121DIRPressR.pdf).

(11) Sekhri (2000), pp. 830-844.

In short, HMOs are losing ground, because their clients are increasingly opting for other forms of health care insurance such as PPOs. In other words, HMOs are at a crossroads.

How do observers rate the HMO experience? Criticisms of HMOs can be generally divided into five categories:

- risk selection;
- control of the practice of medicine;
- quality of care;
- freedom of choice for patients; and
- cost containment.

***Risk selection*:** The most important reservation expressed about HMOs, and one that also applies more generally to all forms of private health care insurance, concerns risk selection. It is in the HMOs' interests to avoid insuring clients who are at risk. Thus, high-risk individuals may be kept out of the market because of the prohibitive cost of the premiums they are required to pay.

***Control of the practice of medicine*:** Another strong criticism relates to the strict control imposed on doctors in the performance of their duties. In order to provide a patient with specialized care (hospitalization or other specialized care within or outside an HMO), a family doctor must often obtain authorization from an administrator responsible for reviewing the appropriateness of care. Without such authorization, the HMO might decide not to pay for that care.(12)

This policy is irritating both to doctors, who must constantly justify their actions, and to members, who may see it as infringing on their right to obtain health care. It may also be viewed as a breach of the Hippocratic oath, especially when a doctor has to choose between the provision of health care to a patient and respecting the cost controls dictated by HMO guidelines. A doctor may also be placed in an awkward position with respect to a patient whose condition requires treatment that is not covered.

(12) David S. Hilzenrath, "HMO to Leave Care Decisions up to Doctors," *Washington Post*, 9 November 1999, p. A1.

Furthermore, HMOs' right to monitor the health care prescribed by doctors to their patients has led to the creation of a bureaucracy that costs more than it helps to save. In 2000, one half of HMOs spent more than 13.7% of their revenues on administration.(13)

***Quality of care*:** The quality of health care provided by HMOs has also been criticized. For example, the results of surveys conducted by the Kaiser Foundation between 1997 and 2001 show that Americans have become increasingly concerned about the quality of the care provided by HMOs and other managed care organizations (see Table 5).(14)

A private not-for-profit organization is currently tasked with evaluating the performance of managed care organizations, including HMOs, in terms of health care quality in the United States. This organization is the National Committee for Quality Assurance (NCQA), to which HMOs may apply for certification on a voluntary basis. The NCQA consists of representatives of health care consumers, providers, and the industry. Its mandate is to provide consumers with information needed to choose a private health care insurance plan.

TABLE 5

PUBLIC OPINION ON MANAGED CARE
(AS A PERCENTAGE OF THE NUMBER OF RESPONDENTS)

In recent years, HMOs and other managed care organizations have:				
	September 1997	**August 1998**	**April 1999**	**August 2001**
Reduced the time that doctors spend on their patients	61	64	61	67
Made it more difficult to gain access to specialists	59	62	63	59
Had little impact on the cost of health care	55	59	55	59
Reduced the quality of care given to patients	51	50	50	54
Made it easier to gain access to preventive services such as immunization	46	40	38	39

Source: Kaiser Foundation, "The Public, Managed Care and Consumer Protections," *Kaiser Public Opinion Update*, August 2001 (http://www.kff.org/sections.cgi?section=market).

(13) The InterStudy National HMO Financial Database 2001.

(14) The Kaiser Foundation is an independent foundation that evaluates and publishes reports on health and health insurance policy in the United States (http://www.kff.org/).

The NCQA maintains that its certification and statistical system encourages health care providers to compete in terms of the quality of care, rather than the price and range of care. The certification program measures the performance of each HMO against some 16 criteria grouped into five major categories: accessibility of care, competence of the staff, adequacy of the care provided, the state of health of those enrolled, and follow-up for the chronically sick.(15)

In its 2001 report,(16) the NCQA noted that members of HMOs generally reported that they were very satisfied with the quality of care received during the previous year. This assessment applied to accessibility of care and the quality of the members' relations with health care providers. The survey also indicated a high level of satisfaction with HMOs' client services and claims processing. Although this was an improvement over previous years, the NCQA noted (with surprise, but without comment) that fewer HMO members indicated that they were very satisfied with their health care insurance plan when they assessed its overall performance, despite positive comments on specific points and particular experiences.

***Freedom of choice for patients*:** Restrictions on their freedom to choose a doctor and access to care have provoked a strong negative reaction to HMOs on the part of consumers. Americans want more choice,(17) more flexibility and better access (wider and more stable) to the care they require. The stability of the health care system is a key issue for consumers in the United States; several HMOs have declared bankruptcy and hospitals have closed.

***Cost containment*:** Finally, HMOs' cost containment measures during the last decade have caused a great deal of discontent among members and health care providers. Critics maintain that HMOs are limiting the consumption of medical services, including essential care. After years of losses for several HMOs, these organizations are facing unprecedented demands for financial viability from their sources of funding: insurers and employers.

(15) National Committee on Quality Assurance (http://www.ncqa.org/).

(16) National Committee on Quality Assurance, "The State of Managed Care Quality, 2001" (NCQA'S Web site, 13 May 2002).

(17) Dedra A. Draper *et al.*, "The Changing Face of Managed Care," *Health Affairs*, Vol. 21, No. 1, January/February 2002, pp. 11-23.

B. Measures Taken by HMOs

Given loss of market share and the need to restore financial viability, several HMOs have decided to make radical changes in the way they operate. Thus, many of them recently eliminated the requirement for pre-approval of treatment suggested by doctors for their patients. HMOs have also introduced new packages that abandon the principle of the gatekeeper and offer access to health care providers that are not affiliated with the organization (provided that members pay additional fees).(18) Some analysts maintain that these measures change the nature of HMOs, bringing them closer to other models of managed care such as PPOs, which are in fact their main competitors.

POTENTIAL FOR INTRODUCING HMOs INTO CANADA(19)

Despite the criticisms of HMOs, some analysts maintain that these managed care organizations should be carefully considered by countries wishing to reform their own health care systems. According to one analyst:

> Although the backlash by consumers and providers makes the future of managed care in the USA uncertain, the evidence shows that it has had a positive effect on stemming the rate of growth of health care spending, without a negative effect on quality. More importantly, it has spawned innovative technologies that are not dependent on the US market environment, but can be applied in public and private systems globally. Active purchasing tools that incorporate disease management programmes, performance measurement report cards, and alignment of incentives between purchasers and providers respond to key issues facing health care reform in many countries. Selective adoption of these tools may be even more relevant in single payer systems than in the fragmented, voluntary US insurance market where they can be applied more systematically with lower transaction costs and where their effects can be measured more precisely.(20)

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(18) Laura B. Benko, "Loosening their grip: As HMOs' popularity continues to erode, more plans turn to less-restrictive rules. But with costs rising, what's next?", *Modern Healthcare*, 15 April 2002 (http://www.modernhealthcare.com/archive/article.php3?article=8585).

(19) This section summarizes the main findings contained in the following documents:
- Marriott and Mable (1998), pp. 557-696.
- Yvon Brunelle, "Système de santé – Une réponse américaine," *Santé Société*, Vol. 9, No. 2, Spring 1987, pp. 34-37.

(20) Sekhri (2000), p. 830.

Would it be possible and appropriate to introduce managed care into Canada's health care system, with a single funder? Is it realistic to assume that typically Canadian HMOs can be established? To adapt the HMO to the Canadian context, it would be necessary to:

- change the way in which doctors are paid;
- redefine the concept of freedom of choice for patients and insurers, notably in order to avoid the problem of risk selection;
- remove obstacles to the integration of different levels of care;
- develop an improved health information system; and
- open the door to multidisciplinary practice.

According to researchers Yvon Brunelle, Denis Ouellet and Sylvie Montreuil, HMOs could be introduced into Canada without contravening the principles of the *Canada Health Act*, as long as certain adjustments were made. In particular:

- Universal access to health care could be retained within an HMO structure if the insurance premium were paid by the government, out of the taxes used to fund the existing health care system. The government would fund HMOs on a capitation basis, using criteria such as age, sex and previous use of services.
- Universality would not be jeopardized because each person could choose between the existing system and HMOs. Furthermore, HMOs could offer coverage at least as extensive as that provided by the existing system.
- The patient's freedom of choice would be limited to some extent, but the patient could change his or her options at regular intervals. The trade-off for restrictions on mobility could be more extensive coverage.
- HMOs could operate without contravening the public, not-for-profit nature of health care insurance. An HMO could be a group of institutions managed by public administrators on a not-for-profit basis.(21)

Moreover, the problem of risk selection could be avoided if the government set standards for the delivery of health care services and adopted capitation as the method of payment. In that case, organizations would not have to compete in negotiating health care plans or in selecting who would be allowed to enrol, and they would receive sufficient funding to cover the cost of serious health problems.

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(21) Yvon Brunelle, Denis Ouellet and Sylvie Montreuil, "Le Québec peut-il créer ses HMO?", *Santé Société*, Vol. 10, No. 3, Summer 1988, pp. 53-59.

Two researchers, John Marriott and Ann Mable, have set out principles and characteristics that should guide the development of models of integrated care such as HMOs in the Canadian health care system:

- Basic services should be defined by the central authority (i.e., the government) in order to ensure the system's consistency and uniformity across the country. Health care providers would have the option, however, of adding complementary services. Basic services should cover a full range of care. Health care providers should not have the authority to refuse service or to transfer responsibility for providing it to other providers.
- Each organization's clientele should be defined and registered. All members of the public would enrol with the organization of their choice, which would be required to accept everyone who enrolled, regardless of health status. Everyone would have the right to leave his or her organization and to enrol with another organization; the applicable capitation payments would be transferred to the new organization.
- The capitation formula should take demographic factors into account, including age and sex, in order to reflect regional variations and the differing needs of various population groups. In this way, funding would match the actual cost of providing services to the persons enrolled.
- HMOs should be free to make their own organizational and financial arrangements, including contracts, with service providers.
- HMOs should be private not-for-profit organizations. This formula seems best suited to Canadian principles and objectives with regard to health care. Any surpluses resulting from efficient service delivery could be used to improve services. In a for-profit system, on the other hand, resources might be reallocated with a view to making a profit, because the owners or investors would expect their investments to provide some return.
- HMOs should emphasize overall well-being and primary health care in a multidisciplinary context, in which the family doctor would have a key role. This type of organization would meet the objectives and principles currently guiding the reform of health care in Canada.
- HMOS should make a formal commitment to quality and evaluation.(22)

These researchers suggest that current reform of the primary health care sector is opening the door to further integration of different levels of care, which could promote the emergence of HMOs. Several provinces have decided to create primary health care teams responsible for a certain number of patients and paid on a capitation basis. HMOs could be

(22) Marriott and Mable (1998).

created out of these teams if they were given responsibility for providing specialized care, hospital care, and other services. If this were the case, the primary health care team could establish a board of directors with the authority to purchase or provide the whole range of services required. In other provinces where regional boards are already well established, those boards could take on the role of HMOs.

CONCLUSION

HMOs are an original, even unique, model of managed care organization in the United States. They flourished between 1970 and the late 1990s, attracting large numbers of members and adjusting their development to the needs of the U.S. population. Today, they are at a crossroads; nonetheless, their characteristics and basic common principles have merit, and are attracting the attention of countries interested in reforming their own health care systems.

Observers generally agree that the development and future prospects of HMOs should be considered within the context of the U.S. health care system, which is very complex as a result of its multiple funders and purchasers and its unique mix of public and private health care insurance. Any analysis of the potential for introducing HMOs into other countries must, therefore, assume certain adjustments; it must also take into account the specific context of each country's health care system.

In the Canadian context, experts maintain that introducing HMOs would entail a number of changes, including:

- changes in the way in which doctors are paid;
- a redefinition of the concept of freedom of choice for patients and insurers, notably to avoid the problem of risk selection;
- better co-ordination, and integration of different levels of health care; and
- an improved health information system (a health "information highway") and promotion of multidisciplinary practice.

The role of HMOs could be transferred to primary health care teams or to regional health boards. In short, it is one option that deserves to be carefully considered.