Surfing the internet.

Internet

The internet has recently received a lot of publicity because the number of people connected to the system is growing rapidly. In addition to offering instantaneous email facilities, it is possible to link up with thousands of other computers on the system to get access to news, information, photographs, sound, or video on virtually any subject that you can imagine. Like it or not, computers are becoming increasingly integrated into our professional lives. Computers give us the ability to do tasks that were only dreamt of just a few decades ago and mastering them can help us to do our work faster and more efficiently.

The ABC of Medical Computing is edited by Nicholas Lee, consultant ophthalmologist, Western Eye and Hillingdon Hospitals, and Andrew Millman, occupational physician, Gloucestershire Royal Hospital.

Interview with Alain Enthoven: is there convergence between Britain and the United States in the organisation of health services?

Penny Newman

Is the organisation of health care in Britain becoming similar to that in the United States? Since the introduction of the internal market radical change has gripped the NHS. In the United States, despite the failure to implement coherent health care reform, a health care revolution is under way, driven by cost containment. At the centre of these changes is managed competition. Alain Enthoven, Marriner S Eccles professor of public and private management at Stanford University, has been the principal proponent of managed competition in both countries. His writings inspired the NHS reforms in 1989 and President Clinton's advisers to adopt managed competition in 1994, though ultimately he became opposed to the Clinton plan. In this interview with Penny Newman he redefines managed competition, explores the similarities and differences that have arisen between Britain and the United States, and describes recent trends in the United States, many of which are being mirrored in Britain. He illustrates a degree of convergence between the two countries. This was unthinkable 10 years ago when comparing the fee for service system in the United States with the NHS.

"Managed care-managed competition"

PN: Managed competition has become a familiar term in Britain and the United States. Please could you describe the essential elements?

AE: Lately, I've often been calling it "managed care-managed competition" to emphasise that what are meant to compete are comprehensive care organisations. Here in the United States we mean organisations that provide a comprehensive list of medical care services. They do it for a per capita amount set in advance so they don't get more money for doing more things. But they do prosper by keeping their patients healthy and satisfied. Patients have a choice so that if they aren't satisfied they can choose a different managed care organisation for the next

enrolment. These organisations are chiefly called "health maintenance organisations" or HMOs.

I start by emphasising managed care because I think there is a great deal of potential for improving the economy and quality of medical care through organising systems. We have gone way beyond the world of the individual doctor just doing his or her own thing. When people have complex medical problems they need to be cared for by an integrated, comprehensive care system that starts with a focus on the patient, figures out what resources will best maximise that patient's health status, and then organises the resources efficiently.

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Secondly, there is the framework in which the organisations compete in order to provide patients with value for money. Much of managed competition is a set of economic principles which aim to focus the incentives for these organisations to do the right thing. The rules ensure that people have an annual choice, that they can stay in the health maintenance organisation of their choice for the year, that the price is set in advance and can't be raised if they are sick, and that the same price is charged to anybody in the same rating category—for example, individual adults or families. Consumers have to be premium price conscious—it is very important that they are responsible for premium differences. If you have a choice between plan A and plan B, and plan B costs \$20 a month more the consumer should be expected to pay the \$20 if he wants

**North Thames Regional
Health Authority, London
W2 3QR**
Penny Newman, senior
registrar in public health

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plan B. He won't do that unless he sees value for money there.

Consumer choice

PN: So in the United States the purchasers are the consumers and their employers and the health maintenance organisations are the providers or contractors of primary, secondary, and tertiary care. How does that compare, do you think, with the United Kingdom?

AE: Let me say I'm not in very close touch with what's been happening in the United Kingdom since I wrote my report—I'd like to come back sometime and study how it's going. But, conceptually and as I understand it has evolved, the important difference with the United Kingdom is that in the United States the market is driven by consumer choices.

As a subscriber in the world of managed competition I have a choice of health maintenance organisation and I get information on the price and indicators of quality, and I take my pick—so I am the ultimate purchaser. Secondly, my employer or sponsor contracts with the participating health maintenance organisations and specifies the rules which I described earlier, so they are a kind of purchaser but they are more of a market maker. Thirdly, the health maintenance organisation puts together, by contract or hiring people, an integrated, efficient provision of all those services for its voluntarily enrolled members.

Now I think the most important way in which that differs from Britain is that you have district health authorities or commissioning agencies which act on behalf of most consumers living in a specified area. Here in the United States, if the health maintenance organisation I choose doesn't provide efficient and effective care and the costs rise too much, I can switch to a different one at the next annual enrolment.

I could imagine this could come about one day in Britain if general practitioner fundholders pooled into large partnerships. Let's say you had a hundred general practitioner fundholders getting together in one large partnership and accepting the whole capita-

tion payment on behalf of all those people. Then they might compete with another partnership of fundholders and they might become like a health maintenance organisation. But I think the big thing, as I understand it, is in the United Kingdom patients don't switch very much from one general practitioner to another. People expect to go to their local general practitioner. We think more in terms of competing alternatives—it's part of our culture.

PN: Would I have the same choice of health maintenance organisation if I had a complex chronic condition?

The important difference with the United Kingdom is that in the United States the market is driven by consumer choices.

AE: Yes. Four health maintenance organisations compete to serve Stanford employees. All of them cover the same comprehensive list of services. All of them would treat my complex chronic condition. The rules are that at the annual open enrolment the health maintenance organisations accept all comers. The situation would, however, be different for a non-employed individual, and that needs to be corrected.

PN: Do you think people are capable of making choices—for example, about the quality of care provided by these competing organisations?

AE: I appreciate that evaluating medical care and quality is very difficult. But in my view the individual consumer, if armed with as good information as we can make available, may not be a very good purchaser of care but is nevertheless the best purchaser. That is, most free autonomous human beings are the best people to decide what they like and what's in their own best interest. If there are real quality problems that needed to be addressed by experts the sponsor or employer would be the appropriate locus. The ordinary consumer is not likely to understand medical journals or how to interpret data without so much time and help that it would make it prohibitively costly. So at the employment group level, just like your commissioning agency, you can bring expertise to bear.

My sponsor [Stanford University] presents me with a menu of prescreened alternatives. My choice of health maintenance organisation would be strongly influenced by factors such as convenience, quality of service, whether staff answer the telephone promptly, whether they keep me waiting, whether they appear competent, whether the doctors appear interested in my problem—things which I can judge. The consumer chooses an organisation based on the information available and the attributes he or she can judge for themselves. What's important is to put market pressure on providers to give patients good customer service.

General practice fundholding

PN: I would like to explore your comparison between fundholding general practices and health maintenance organisations. Do health maintenance organisations act in a similar way to fundholding general practices?

AE: We have many different systems and styles of health maintenance organisation, and some of them resemble large fundholding general practices. Among the differences, health maintenance organisations are responsible for the full range of services from treating

Professor Alain Enthoven

ingrowing toenails to bone marrow transplantation. Fundholding general practices have a much narrower range of responsibility. Health maintenance organisations need to be larger to spread the risks and support the expertise needed to undertake or buy secondary and tertiary care—I am thinking of several hundred thousand patients. Also in health maintenance organisations primary care physicians usually work more closely with specialists than is the case in Britain.

As competition has intensified in the United States, and when one organisation has responsibility for the total process of care, people start working together . . . to improve patient satisfaction.

On the other hand, there are similarities. In both countries physicians take responsibility for managing a defined set of resources to get the best value for patients. Health maintenance organisations emphasise primary care, as compared with the rest of our system, in which people self refer to specialists. Each patient is expected to select a primary care physician and work with him or her to determine specialty referrals. I can readily imagine fundholding general practices expanding in numbers of doctors and patients and in scope of services and coming more and more to resemble health maintenance organisations.

PN: What things do “good” health maintenance organisations do that make them successful in the marketplace?

AE: Well, the phrase I often use [attributed to S Garfield, founder of Kaiser Permanente] is that you need “to attract the loyalty, commitment, and responsible participation of physicians so the physicians feel empowered, in charge, responsible, and interested in figuring how to make the whole organisation work better.” Among the things physicians can do include ensuring continuous quality improvement. I think quality improvement is very important. In many cases improving quality costs less, as mistakes cost money. Physicians are sitting down together to study a particular condition, review the literature, and discuss the best way to provide care before writing guidelines. Some of this is becoming computer assisted. Health maintenance organisations are encouraging hospitals to introduce critical paths which reduce the need for detailed progress notes—if everything goes according to plan the nurse just checks it off. Another innovation is the increased and appropriate use of paramedical staff—for example, to undertake sigmoidoscopy and cardiac catheterisation. In a capitated organised system you can do that, but in the fee for service system which health maintenance organisations are replacing in the United States doctors get paid only for specific medical services to patients.

One of the things I find most exciting is that as competition has intensified in the United States, and when one organisation has responsibility for the total process of care, people start working together and become interested in innovating to improve patient satisfaction. For example, in Southern California new technologies and the introduction of increased patient education and rehabilitation have reduced the length of stay for hip replacement from about 18 days to four in 10 years. With more aggressive outpatient care the need for hospitalisation for paediatric asthma is reduced. A health maintenance organisation providing

the total range of care can reallocate resources within its organisation from the inpatient sector to the outpatient system.

Purchaser-provider relationships

PN: Can we explore the relationship between health maintenance organisations and hospitals? What do you think is the optimum in order to achieve improved patient care?

AE: Some health maintenance organisations own their own hospitals, some have preferred providers or close relationships with particular hospitals, and others have numerous contracts. I think if you are purchasing specialist care, in the better arrangements the health maintenance organisation will create a “marriage” or long term partnerships—buyer-seller relationships, but ones which exist in an atmosphere of trust and cooperation where both parties understand that they have an interest in improving the product and cutting the cost. The contract is structured to rewarding the doctors for using resources efficiently and the hospital for providing good services. I think if you are a customer you can demand performance, which is difficult to do if it's an in house monopoly. The long term best interest of the hospital lies in the success of that health maintenance organisation—like their marketing arm, which is how they get patients—so they have to listen sympathetically.

Sophisticated purchasing is still early in its development in the United States. But some people are learning to do a very good job, including building into the contract a quality improvement programme—they will set certain goals and confer regularly to evaluate progress on these goals in an atmosphere of mutual trust.

PN: Does having a preferred provider relationship mean reduced access?

PN: It does mean that the patient is referred to particular hospitals and not others. If I belonged to a health maintenance organisation and got sick I would know which hospitals I would go to when I enrolled.

What's important is to put market pressure on providers to give patients good customer service.

Patients know in advance and select their health maintenance organisation and its associated hospitals in advance. I feel the patient is more likely to make an intelligent informed choice during the annual enrolment period when he or she can sit down and talk it over with his or her family and make a choice. I don't think the right to go to any hospital in the world is a highly valued right. I think people are more interested in being sure there is some organisation that can take care of them. If they have an emergency they can be treated anywhere and will be stabilised and transferred later to the hospital with which the health maintenance organisation has a contract.

PN: What impact are the employers and health maintenance organisations having on the shape of hospital care in the United States?

PN: One of the things that is happening is that there is more of a trend in favour of less hospital use. I already mentioned that health maintenance organisations are encouraging more care to be provided on an outpatient basis. This means that we have way too many hospitals. Many of them are not for profit organisations. If they are for profit they shut down and deploy their capital

into something else. If they are not for profit they'll hang in there, for ever stretching out their reserves and taking losses until they are driven into bankruptcy. We have had some hospital mergers—a very good thing, I think—closing a hospital by redirecting its activities to less costly uses such as stroke rehabilitation, doctors' rooms, and low tech care while transferring all acute care.

A health maintenance organisation providing the total range of care can reallocate resources within its organisation from the inpatient sector to the outpatient system

We have way too many specialists. Health maintenance organisations contract with a limited number of specialists to ensure that they have enough patients to be fully proficient in the specialty they trained in. One of the keys to a successful health maintenance organisation is to be able to adjust the specialty mix to the needs of the population served. In the United States we are going to see more highly trained specialists unable to get a job.

I think medical academia is very slow to get the word and slow to adapt and to adjust. Two to three years ago few graduates went into primary care. Now we are not short of primary care physicians. We have the same ratio of primary care physicians to the population as in the United Kingdom—roughly 1800 people per doctor. We would not have been able to maintain that if the previous trend had continued, but now medical students are coming to realise that what's needed is primary care physicians. If they go into radiology or cardiology they might not be able to get a job.

PN: A lot of what you have discussed sounds very familiar and is also happening in Britain. For example,

general practitioner fundholders are forming consortiums or "multifunds" and purchasing the full range of care in the total purchasing projects. There is an emphasis on a shift of activity and resources from secondary care into primary care. Some hospitals have adopted critical paths and use clinical guidelines. Some purchasers are moving to preferred provider relationships, and in some major cities—notably London—there are proposed hospital mergers. Are we heading in the same direction as the United States?

AE: I'd like to think that there is some convergence. I think there is a long way to go, as you are coming from a very socialised and monolithic kind of system in which the element of consumer choice has not been very strong. My impression is that it is not a part of British culture to want to change doctor or the services very much. You take the general practitioner who was assigned to you. I don't know how much a cultural change could occur in Britain. It would be a big change for people to move from one general practice to another because they felt the service wasn't good.

In both cases market forces can be used to provide incentives for doctors and other medical personnel to improve the quality of care and reduce the cost and therefore give better care. I had a call from a journalist the other day from Britain who said: "This is terrible. We have cut throat competition going on." But from the patients' point of view that's wonderful. She said: "the prices are coming down"—that's marvellous because you have limited resources and more people can receive better care. Our experience is showing there is lots of room for innovation in medical care processes.

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Dilemmas in rationing health care services: the case for implicit rationing

David Mechanic

With tension between the demand for health services and the cost of providing them, rationing is increasingly evident in all medical systems. Until recently, rationing was primarily through the ability to pay or achieved implicitly by doctors working within fixed budgets. Such forms of rationing are commonly alleged to be inequitable and inefficient and explicit rationing is advocated as more appropriate. Utilisation management in the United States and quasi-markets separating purchasing from provision in the United Kingdom are seen as ways of using resources more efficiently and are increasingly explicit. There is also advocacy to ration explicitly at the point of service. Mechanic reviews the implications of these developments and explains why explicit approaches are likely to focus conflict and dissatisfaction and be politically unstable. Explicit rationing is unlikely to be as equitable as its proponents argue and is likely to make dissatisfaction and perceived deprivation more salient. Despite its limitations, implicit rationing at the point of service is more sensitive to the complexity of medical decisions and the needs and

personal and cultural preferences of patients. All systems use a mix of rationing devices, but the clinical allocation of services should substantially depend on the discretion of professionals informed by practice guidelines, outcomes research, and other informational aids.

Medical care has always been rationed by the supply available, by its distribution, and by the public's ability to pay. As medical care has become more important in people's lives, and as its capacity to impact on health has grown, government has taken increasing responsibility either for providing medical services directly or for mandating them through an insurance system. Governments in all nations seek means to limit public expenditure and mandates for health services. Explicit approaches include fixed global budgets and limits on the benefit package and eligible providers. Rationing also occurs implicitly through cost sharing, waiting lists, and requiring professionals to work within a constrained budget.

Rationing is a "complex interaction of multiple

King's Fund Institute,
London W2 4HT
David Mechanic, visiting
fellow

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