

Export of managed care: Europe, Latin America and implications for India

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Health care inflation two to three times higher than the general inflation rate is not a phenomenon confined to the United States: all western countries face the same. In western European countries with growth of the welfare state in the inter-war years, universal health coverage was enacted into law. General taxes paid for health care. In the 50 years since these laws were written, populations of most European countries have increased dramatically. People are living longer with a much higher burden of chronic disease. Scientific advances have led to newer and more expensive technologies and therapies. Progress in the pharmaceutical industry has led to drugs accounting for 10-15 per cent of the national annual health care expenditure, compared to 3-5 per cent just two decades ago. It is therefore not surprising that governments in all European countries have been struggling with the problem of paying for health care without explicitly increasing taxes.

Unlike western Europe, the United States (US) opted for a system of tax incentives for corporations to provide private health insurance coverage to most of its citizens. Business cost containment efforts in the US have evolved into the system of managed care which limits access and consumption while transferring some of the costs to the consumer. (1) The perceived success of these market reforms in the US in the early 1990s in limiting the rate of growth in health care expenditure (2) have encouraged European governments to experiment with similar measures.

Managed care in Europe

The difference between the American and European versions of managed competition is that Europeans tend to entrust the responsibility to the government, whereas the Americans leave this task to private agencies. (3) To the extent that in countries with tax-supported universal coverage, there is no role for market competition in the financing of health care, European governments have attempted to contain costs through policies that affect the supply side of the equation such as capitation, diagnosis-related groups, utilisation review, practice guidelines, technology and manpower controls, and global budgets. A few countries have abandoned the concept of comprehensive coverage and have introduced user fees for some health care services. In paying attention to the supply side of the market, what has been ignored to date is the demand side: modification of consumer demand by education.

Britain: Free universal health care, supported by general taxes, is provided through the National Health Service

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(NHS). Primary care is provided by general practitioners (GPs) who act as gatekeepers. Most GPs are self-employed and are paid by the government through a combination of capitation and fee for service. Secondary and tertiary care is provided through publicly-owned, semi-autonomous, self-governing hospitals. Specialist physicians are salaried but may supplement their earnings by treating private patients. In an effort to contain costs and improve services, micro incentives were introduced in 1991 by organising GPs into primary care groups, with some control over health care budgets. Competition developed between health authorities and GP groups. Small improvements in the growth of hospital productivity and reduction in the pharmaceutical expenditures of GP fund holders did occur. However there was no sustained improvement in the waiting times for elective surgery, for specialist and GP appointments, a major cause of public dissatisfaction. Market reforms failed because the incentives in the system were too weak and the constraints too strong; hospitals/health authorities were not allowed to keep any surpluses achieved; the government did not close down failing hospitals. And perhaps the ethics of market competition were contrary to British values. (4)

Ireland: The Irish health service is a tax-funded system administered through regional health boards. Low income families (30 per cent of the population) are entitled to all health services without charge. The rest must pay for GP and pharmaceutical services and hospital use. Currently, close to 40 per cent of the population have private health insurance. In 1994, a new law opened the market for health insurance competition while introducing a risk equalisation scheme. (5)

Switzerland: Switzerland, with no publicly funded universal health coverage, has one of the highest costs of health care. With retrospective cost subsidisation by cantons, there is no incentive for hospital cost containment. This keeps hospital density at 113 patients per 10,000 inhabitants, compared to 41 per 10,000 inhabitants in the US. In 1996, rising costs led to introduction of managed competition. Cantons fixed a health insurance premium based on household income. Existing sick-funds were allowed to compete for clients leading to the creation of health maintenance and preferred provider organisations. The new policy has increased the financial burden to households in the guise of premiums. Risk skimming by insurers is prohibited. Although a risk-adjustment formula has been implemented, the risk determinants (age, gender) are very weak predictors and urgently need revision. (6) In a country which is a centre of world insurance, it is surprising that better predictors of risk were not incorporated.

Sweden: The Swedish health care system, financed by general taxation, covers all citizens irrespective of ability to pay. But the urban middle class was dissatisfied with increasing waiting lists and poor access to primary care. The financial crisis in the mid-1980s forced many counties to put hospitals on fixed (and reduced) budgets. Supply of

care was cut back and several smaller hospitals were closed, reducing the total employment in health care by 25 per cent. Managed care reforms have turned out to be what was desired: hospital productivity has increased and waiting lists trimmed. But efficiency has been expanded at the expense of equity as the elderly and disabled are sent home early from hospital. The proportion of private care (inpatient and outpatient) has increased sharply in recent years. A number of reforms have increased patients' co-payments, thereby increasing private spending on health care. In Sweden, thus, public spending has been kept down, co-payments have increased significantly and private providers are playing an increasing role. (7)

Germany: In Germany, medical care is provided according to an individual's needs, whereas the payment for care is based on the individual's ability to pay. Both the supply and finance side of the health care market is provided by largely self-administered system of organisations. The federal and state governments are restricted largely to setting the legal framework. With increasing health expenditures, the Structural Health Reform Act was passed in 1993 to stabilise the financial position of health insurance funds without a major increase in premiums; and to introduce more effective reforms to increase competition. By extending the right of choice among different insurance funds, competition among funds has increased significantly. To prevent adverse selection processes ('cream-skimming'), a mechanism of risk-related transfers between funds has been initiated. (8)

Denmark: The decentralised and largely publicly funded Danish system is characterised by publicly owned hospitals while general practitioners are private entrepreneurs who work under contract for the counties. Hospitals are financed by global budgets, while general practitioners are paid by a mixed remuneration system of capitation fees and fee-for-service. Health insurance is voluntary. There is a choice between two health plans with Group 1 members (98 per cent of the population) having free access to their GP and referral to a specialist while Group 2 members are allowed free choice of any provider, but a co-payment is required for all medical services. Hospital treatment is free. About 81% of the total cost of health care is financed through general taxation, and the rest is paid for through user co-payment proportional to income. Unlike other countries, entry to general and specialty practice is rigidly regulated. A limit is set on specialists' incomes; when their activity reaches a certain level, the fees are reduced for additional activity. (9)

Belgium and the Netherlands: In Belgium and the Netherlands, health care is mostly financed by payroll taxes. Health care is provided by private nonprofit institutions, and compulsory health insurance coverage is provided by private nonprofit 'sickness funds'.

In the Netherlands, the high income population is not eligible for publicly funded health care and has to purchase private health insurance. As part of cost-containment, the regional sickness fund monopolies have been abolished and sickness funds have been permitted to competitively enroll eligible applicants, to selectively contract with

providers and negotiate lower fees. Sickness funds receive a prospective, risk-adjusted per capita payment. Sickness funds are permitted to charge their subscribers a community-rated out-of-pocket premium.

Since World War II, Belgium has had a compulsory national health insurance system for a basic package that covers hospitalisations for all and outpatient care for about 88 per cent of the population. Supplementary insurance is voluntary. The management of insurance is left to 'sickness funds' reimbursed on a risk-adjusted capitation formula. (10)

France: The French population is almost universally covered by National Health Insurance (NHI). Because of gaps in coverage, most seek complementary insurance from private sources. An unusual mix of freedom and regulatory constraints characterises the system. Private practice is dominant in the area of ambulatory care, while more than two-thirds of hospital care is provided by public hospitals and one-third by private facilities. Patients have access to all medical services. At the time of delivery they pay the full charges to the providers and later obtain a partial reimbursement, calculated on the basis of negotiated fees adjusted by applicable co-payment, from the NHI. Private practitioners are paid on a fee-for-service basis but are not able to set the prices for their services. The NHI negotiates with private practitioners to set the price of their services. Two major problems challenge policy makers: social and regional inequities, and the imbalance between resources and expenses of the NHI. (11)

Managed care in Latin America

In most Latin American countries public pension plans, funded by the government, employers, or both, provide basic health care coverage for a majority of the population. For workers who are not covered by social security, and for unemployed people, most countries have also established public-sector hospitals and clinics. Private practitioners and hospitals provide care to the well-to-do. The quality of care varies greatly in this system of implicit rationing of expensive tests and procedures for the poor while the fee-for-service private sector caters to all the needs of the well to do.

Throughout Latin America, public pension plans have acquired large funds managed by governmental or publicly regulated agencies. In explaining their financial motivations for entering the Latin American marketplace, corporate managed-care executives have consistently referred to the importance of access to these funds. (12)

In the widely debated 1993 World Development Report, promulgating the ideology that "health is a private matter and health care a private good," the World Bank argued that inefficiencies of public-sector programs hindered the delivery of services. The report advocated incentives for purchase of private insurance, privatisation of public services, promotion of market competition, and emphasis on primary care and prevention. Most Latin American countries have been compelled by the International Monetary Fund to implement these 'structural adjustments'. Although privatisation of health care does not necessarily

lead to the introduction of managed care, the two often occur together and involve the participation of US and other multinational corporations. (13)

The growing upper middle class of Latin America constitutes a potential new market for managed care. Executives have anticipated that managed care will attract wealthier consumers because of the advantages of offering a regular primary care provider, continuity of care, and the management of costly subspecialty services and high-technology procedures and devices. Payment for these consumers' managed-care premiums will come from a combination of employer contributions, co-payments by patients, and significantly, public pension plans. Most joint ventures in managed care involve investor ownership, for-profit status, a designated enrolled population, prepayment for services, and a contracted physician panel that assumes financial risk in providing primary care and specialty care. However, the required co-payments have introduced barriers to care. In Chile and Argentina public hospitals (that have escaped privatisation) are facing an influx of patients covered by private managed care plans who cannot afford these co-payments. Moreover, as for-profit managed-care organisations have taken over the administration of public institutions, increased administrative costs have diverted funds from clinical services. (12)

Implications for India

India shares many attributes with Latin America: weak central authority, almost nonexistent access to legal redress and widespread corruption. In this climate, managed-care organisations can make their businesses grow with the support of 'friendly' ministries of health. An affluent middle class, probably numerically larger than in most European countries, would be attractive to for-profit managed care organisations from abroad. A comprehensive health care system with continuity of care, easy access, specialty services when appropriate, quality control, well defined rates and co-payments, would be welcomed by the middle class. Such a development would not be a disaster if it led to the establishment of a universal health system, with fees adjusted to income, that emphasises coordination of care with a commitment to prevention, education and research. Unfortunately, that is not likely. Managed care organisations have already started their initial approach and this new form of corporate imperialism in health care may only siphon off capital.

Conclusion

Principles of managed care are not necessarily bad for the patient. That not-for-profit managed care can provide quality care at an affordable price with equity, ease and timeliness was shown in a study comparing the British NHS and a non-profit managed care organisation in US, the Kaiser Permanente. Kaiser achieved better performance, shorter waiting times for elective surgery and specialist appointments, at roughly the same cost as the NHS while paying higher salaries to its GPs and specialists, and more for pharmaceuticals. The major differences were a much

higher length-of-stay per admission driving up costs, fewer physician extenders and less extensive computerisation in the NHS. (14)

The key issue in health care reform is the appropriate mix between markets and government in health care delivery. Governments need markets to help ensure that the services provided are appropriate and resources are not squandered. Markets need government to ensure that pricing is fair and all segments of the population are served equitably. (15) Neither managed care nor markets are the devils: unbridled, exploitative profit at the expense of quality and equity is.

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