Labor's Point of View on HMOs

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AT THE FOUNDING convention of the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) in 1955, a resolution was passed which called upon Congress to enact a health program to include ". . . a program of federal aid, such as grants and low interest loans, to further the development of nonprofit, direct service, prepayment medical care plans, based on group practice."

In December 1973 we gained most of this objective. The Health Maintenance Organization Act of 1973 allows grants for the planning and development of new nonprofit HMOs and Government-guaranteed loans for their initial operating expenses. We did miss out on the "low interest loans" however, because the act provides for loans at the going interest rate—today it is 12 percent or more.

Our 1955 resolution had nine goals, and eight were achieved with the passage of the HMO Act. The ninth goal—organized labor's most important one—is to establish, in the words of the 1955 resolution, "a national health insurance system which would make complete prepaid health protection available to all Americans." Today we call that goal the National Health Security Program. In our view, only this kind of program will provide the sound financial base to pay for the comprehensive range of services that HMOs can provide.

HMOs can and do provide preventive care, physical examinations, early diagnosis and prompt treatment—in fact, virtually every kind of care needed to maintain the health of their members or to cure them as quickly as possible when they are ill. This is why HMO members require hospitalization only about half as often as the remainder of the population and, of course, this reduces costs because hospital care is the most expensive kind of medical care. More important, however, is the alleviation of unnecessary suffering of patients whose illness is untreated until it reaches an acute stage and they require hospitalization. Thus, it is essential for the growth of HMOs that a national health insurance program will include preventive care and encourage early diagnosis and treatment.

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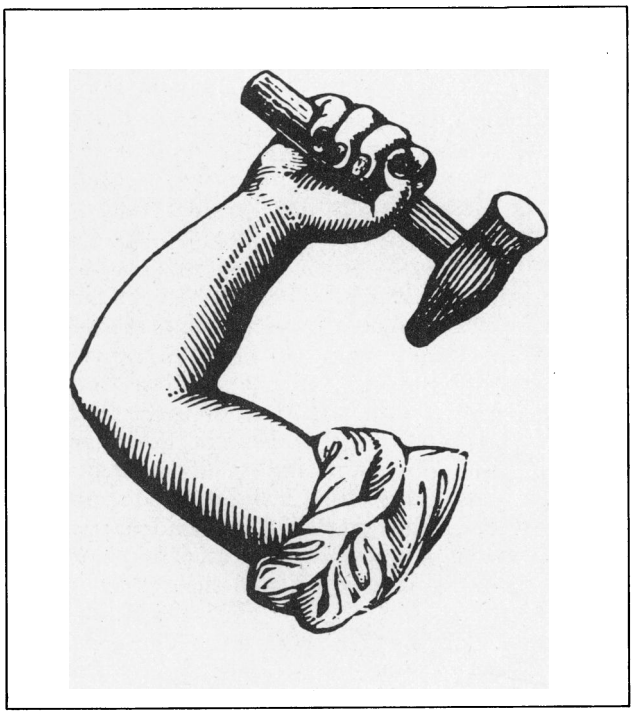

Fee-for-Service Versus HMOs

Not only does the future growth of HMOs depend upon across-the-board financing of health care, but the ability to control costs under national health insurance will depend also on the development of more HMOs that reimburse their medical staffs by capitation payment rather than by fee for service. Such HMOs are generally called group practice prepayment plans. Capitation payment reimburses physicians a flat amount for each patient they care for, regardless of how few or how many health services a patient needs. This system strongly motivates physicians toward keeping HMO members well.

Under the traditional fee-for-service method, on the other hand, the sicker the patient the more the physician earns. So it is understandable that fee-for-service physicians are not overly enthusiastic about preventive care. Fee-for-service is a piecework system of paying physicians and as any labor group knows, piecework was invented as an incentive to encourage the production of more pieces. In fact, piecework payment seems to have as powerful an incentive in medical care as it does in manufacturing—it is fine for the physician, but it is bad for both the health and the purse of the patient. This is particularly true for surgical procedures. How else can you explain that where physicians are paid by capitation or salary, as in U.S. prepaid group practice

plans and in the British health system, the number of surgical procedures in relation to population is about one-half as many as are performed by U.S. fee-for-service surgeons? However, it is not my intent to criticize fee-for-service practitioners; like their patients, they are victims of the system.

In an HMO, patients are not just less likely to get unneeded medical care—the care they receive is likely to be better, because physicians work in a cooperative rather than a competitive setting. The physicians in group practice can pool their skills for the patients' benefit. In group practice, physicians in the various specialties are organized so as to be mutually responsible to their patients and to each other. Another reason for the better medical care is that before a physician joins a medical group he is screened regarding his qualifications. And after he does join, his work is observed by the other physicians, including the medical director. Moreover, he can readily consult with other specialists to determine the course of treatment for patients with difficult or serious illnesses or conditions.

Of course, if we have to rely solely on quality of care as a selling point for HMOs, it may be difficult to convince some people that this type of medical care would be best for them. Most people who have faith in their physicians would not opt for a group practice physician for what may seem to them to be an abstract advantage which they have no way of judging. We in the trade union movement well understand that most people make judgments on the basis of dollars and cents. And they should know what they are buying and how much it costs—whether it is groceries, an automobile, or medical service. The premium that prepaid group practice plans charge is high. But, while some non-HMO plans have more comprehensive coverage than others, none cover preventive care; furthermore, there are always non-covered medical expenses that workers must pay out of pocket. This is why workers generally have a smaller total expenditure, including both premiums and out-of-pocket expenses, if they belong to prepaid group practice plans rather than if they have traditional insurance arrangements.

Role of Consumers in HMOs

Most important to workers is their role as consumers of medical care which, if obtained in HMOs, will be enhanced under the HMO Act. The law requires that no less than one-third of the governing board of the HMO must be subscribers (consumers) to the plan. To be eligible for Federal grants, the HMO Act also requires the plan to have a grievance procedure for resolving patients' complaints.

While as consumers we know little about clinical medicine, we do have a legitimate interest in having a voice as to how, when, and where medical services are provided. We want to know whether there are long waits to see a physician, whether the patient is treated with appropriate respect, whether alternative methods of treatment and associated risks are explained to the patient, and whether adequate followup treatment will be provided. Consumers also have a legitimate interest in knowing whether their physicians prescribe brand-name drugs when lower-cost equivalents are available. Consumers have no voice in any of these matters when their care is provided by a solo practitioner. In fact, such concern would be deemed "interference with the practice of medicine" and would not be tolerated by some members of the medical profession.

A common thread runs through almost all the group practice plans. Their policymaking boards are not controlled by physicians. As new HMOs are developed, a major concern of the labor movement certainly will be the extent of effective labor and consumer involvement in the HMO policymaking boards.

Medical Foundations

Thus far, I have used the terms HMOs and prepaid group practice plans interchangeably. But, under the new law the term HMO also includes the so-called medical foundation. Medical foundations were started in California as organizations that were sponsored and controlled by the local county or city medical societies. These foundations have contracts with the State of California to deliver health services for a fixed sum to persons under the State's Medicaid program. They also have contracts with some labor-management trust funds, as well as with some individual employers. These contracts give assurance to the State or to the contracting group that the cost of medical services will not exceed the contract price over the term of the agreement. However, participating physicians in medical foundations are paid on a fee-for-service basis rather than by capitation. Therefore, the total fees charged by the participating physicians could exceed the contract price.

To prevent excessive costs, the medical foundation establishes a peer review committee of physicians to review medical claims. When this committee determines that unnecessary medical services have been provided or that excessive fees have been charged, the offending practitioner is contacted and urged to conform to the standards of practice as established by the foundation.

Some medical foundations have successfully regulated costs. They have also bettered the quality of care by seeing to it that the performance of participating physicians meets an acceptable standard. But, to my knowledge, no medical foundation has yet been effective in the absence of the threat of competition from a prepaid group practice plan.

Conclusion

It is clear that the way to better care, even under the fee-for-service system, is to organize more prepaid group practice plans. Thus, we have a challenge to use the new Federal program to develop HMOs that can meet the needs of our members and of consumers in general for better health care at the lowest possible cost. In most communities, this will mean that the trade union movement, working with other community groups, should take the lead in developing group practice HMOs.