# Prepaid Group Practice Medical Care Plans

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THERE is an inexorable trend toward more health services for the American public. In fact, the trend toward "more" is evident throughout the health field. It is apparent whether we look at needs or demands, services or capabilities, not to mention dollars. This trend offers both an opportunity and a challenge for prepaid group practice medical care plans to improve and extend comprehensive health services. This discussion describes some of the administrative problems that arise in starting and carrying on direct service prepaid group practice.

Group medical services are increasing in response to a growing demand. A compelling force toward more health services is the steadily growing conviction that medical care is a social right. Our high standard of living and our increasing awareness of the capabilities of modern medicine foster the growth of this conviction. The day is approaching when society and its institutions will be held morally responsible for the availability of life-saving and health-restoring care.

Means (*1*) argues that the "pursuit of health is the right of every citizen." August (*2*) points out that this right has the same kind of justification as do the other so-called rights of man. They are rooted in our almost religious feelings about individualism and individual worth. It is only a short step from the "right to health" to the "right to medical care." Placing health in the category of the rights of man involves the transformation of a social desire into a moral imperative.

The educated desire for more health services coupled with the economic capability of paying more is accompanied by a demand for efficiency and quality control of the expanded, more costly product. Not only the consumers as individuals and as organized in cooperatives, labor unions, and the like, increasingly demand comprehensive care with quality controls. Management, which as a result of collective bargaining is assuming financial responsibility for increasing proportions of the personal health care bill, is also insisting more and more on efficiency, quality, and cost controls.

Prepaid group practice is becoming ever more widely recognized as an effective method for achieving these ends. The economies, for example, in hospital use among populations served by prepaid group practice, are documented.

## The Essential Triad

All those working to improve and expand prepaid group practice must recognize that the triad of professional group, consumer group, and suitable facilities is the essential basis for comprehensive health services. Plans fall short of their objective or even fail because of deficiency in one or more of these three basic elements.

One small plan is burdened today with a hospital and its overhead because of initial overemphasis on a facility without adequate atten-

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tion to consumer organization and enrollment. On the other hand, the Health Insurance Plan of Greater New York in its early days compromised on facilities for physician groups, and this compromise has delayed its full realization of the professional quality potential of group practice. Inadequacy of facilities accessible to their expanding enrollment is a current problem for the Northern California Kaiser Health Plan. Group Health Cooperative of Puget Sound recognizes the urgent need to expand its central facilities and build a southwest clinic.

Groups of physicians, even medical school faculties, can successfully organize a professional group, but they may be quite unaware of the problems of organizing consumers to pay premiums and use services. Conversely, a consumer cooperative eager to establish its own health plan is having difficulty finding physicians who can discontinue their practices, organize a group, and wait for adequate support from prepayment.

Timing development of the elements of the triad so that the professional group is prepared to give service in a facility to the consumers when they begin paying premiums is not simple. Metropolitan Hospital and Clinics of Detroit found itself temporarily overstaffed professionally until the Community Health Association's successful enrollment campaign in December 1961. The resulting fourfold increase in enrollment now finds them temporarily understaffed.

Many problems exist within the basic triad. A primary consideration is resources. Most subscribers of the large plans with reasonably comprehensive benefits pay only a portion of the premiums; part or all of the premiums are usually paid by employers under negotiated labor-management contracts. Families with modest incomes frequently cannot afford to pay individually the full premium, for example, of combined enrollment with the Health Insurance Plan of Greater New York and Blue Cross. A consumer cooperative whose members have various employers may find it difficult or impossible to get employer contributions, and some members may be self-employed.

The temptation to settle for second-rate care, fee-for-service payments, deductibles, elimination of hospital benefit, or other compromises is very real. Such compromises with comprehensive care may be increasingly disappointing to the subscribers and may tend to reflect on prepayment group practice as such.

Long-standing precedents such as small fraternal organizations operating on a personal basis seem attractive. Great wisdom and understanding are required to develop a sound program with restricted resources.

### Organization and Administration

Some advance financing must be available for the development of a plan. This is necessary for staff and consultant expenses, purchase, modification, and equipment of facilities, and enrollment expenses for such items as information literature, forms, and identification cards. The dedicated work of volunteers will be helpful, but this cannot substitute for the months of staff work supported by expert knowledge and experience required to bring a plan to full-fledged operation.

The medical group must be organized, and its relation to the enrollment and premium-collecting organization which represents and speaks for the consumers must be defined. Some successful programs, such as the Kaiser enterprises, have separate organizations for the two functions. The Kaiser Foundation Health Plan contracts for service with the Permanente groups, which are physician partnerships, while it also negotiates contracts and collects premiums from consumer groups. Group Health Cooperative of Puget Sound, on the other hand, employs its physician group through contracts and owns its facilities.

In any plan, the professional responsibility for medical practice must be fixed in the physician group and undiluted. Nonmedical matters such as business operations, location and furnishing of facilities, allocation of income among professional and other services, and communications with members, including response to their wishes and complaints, involve considerations and skills other than medical. Organization and administration of the plan must integrate professional and other elements in a balanced operation. Such integration is not unique to prepaid group practice; every successful hospital depends on mutually satisfactory relation-

ships between professional medical staff, other necessary services, and the population served.

### Enrolled Population

On the consumer side, the size and composition of membership materially affect the stability and the service potential of the plan. A population of at least 15,000 is desirable to support a medical group of adequate size to provide family physicians, pediatricians, and the other basic specialists on the full-time basis which is desirable for comprehensive care.

In rural communities where distances limit the population accessible to the medical facility, a few thousand subscribers can constitute a happy consumer organization for a group of family physicians backed up by part-time specialists from the nearest medical center. Such professional organizations can economically provide care of high quality, with the convenience to the consumer of visiting one facility instead of traveling from family physician to an array of specialists and back again. Group practice, moreover, provides a stimulating professional environment and has demonstrated in various small communities over the country that it offers an effective solution to the continuing problem of attracting physicians to rural areas.

It is a mistake, on the other hand, for every small urban group to insist on its own little plan. It is shortsighted indeed for such groups not to join forces and pool their resources to support an adequate service.

A plan is on a sounder basis, moreover, if it is composed of multiple and preferably diverse enrollee groups rather than single-industry populations, even of substantial size. Plans open to membership from the community are more firmly based than those with membership restricted to a specific organization such as a labor union.

Methods of protecting the plan against adverse selection of potentially high users must be adopted. The composition of membership as to age and other factors which affect potential need for health care should be balanced. Waiting periods, waivers for preexisting conditions, and extra charges may be considered after the basic benefits, premiums, and financial agreements with the medical group have been set. Many of these restrictions can be avoided if sound group enrollment procedures are established.

### Utilization Control

Optimum use of the services available from a plan requires an informed membership, convenient facilities, and an understanding, cooperative staff. Utilization should be controlled by teaching subscribers how to use the services and by professional decisions regarding the need for service.

Extra charges may be necessary as revenue measures for increasing a plan's income, but they are neither logical nor effective as "hesitation fees" for controlling utilization. Overuse or abuse of services should be corrected by education and by consumer relations machinery.

Actually, either underuse or overuse of services dictated by other than medical considerations is inimical to the interests of both medical group and subscribers in a prepaid direct service plan. If preventive or early diagnostic or therapeutic care is postponed or neglected for financial reasons, the subscriber suffers through impairment of health and efficiency, and the medical group suffers through the increased effort and expense of providing care for an illness that could have been prevented. If because of prepayment, hospitalization is extended beyond that medically indicated, the plan suffers financially and rates go up.

### Relation to Other Health Programs

Multiplication and expansion of health service programs such as home care, or specific disease control programs such as cancer and heart disease, and of programs for special population groups such as crippled children and the aged constitute another opportunity and challenge to prepaid group practice plans. This is the establishment and maintenance of effective working relations with all such programs.

The peculiar genius of prepaid group practice in fostering comprehensive care should be recognized and used by the many specialized health services. The American Public Health Association's 1961 resolution on reimbursement of direct-service health care plans supports this

principle (*3*). The resolution proposes that existing and future health programs that procure health services allow for use of direct-service plans with payment on a per capita or other prepaid basis. The plans need to be systematically alert to community health services for which their enrollees are eligible, and should work out effective methods of using such services as elements of comprehensive care. For example, various community agencies finance needed physical rehabilitation services, and these can appropriately be provided by prepaid group practice plans to their enrollees. Prepaid group practice plans should work actively for implementation of this principle.

### Evaluation and Experimentation

This discussion has by no means covered all the elements of successful prepaid group practice. It does indicate the diversity and flexibility that experience under various circumstances has dictated, and points up the challenge to continue experimentation and evaluation of these and other elements of prepaid direct service group practice.

Well-established, successful plans need to continue to study and evaluate their own operations in order to maintain and improve their services. The discussions in the annual report for 1960 of the Group Health Cooperative of Puget Sound exemplify the forward planning that must be done. In this report the medical director analyzes the trends of age and other characteristics of the membership and projects their effect on the plan's facilities and services. Such an analysis admirably discharges the obligations of a plan's administrator to its membership.

Successful plans also have a responsibility to the community and to society to use their knowledge and experience for the greatest good. Their members know the satisfaction, the economy, and the security of comprehensive care through prepaid group practice. They have an obligation to assist other consumer, professional, and community groups to obtain this boon.

### Summary

The trend toward more health services for the American public constitutes an opportunity and a challenge for prepaid direct-service group practice plans to improve and extend comprehensive health services. Measures which will help are: (*a*) better self-appraisal and analysis of their operations and results; (*b*) better understanding by both the health professions and consumers of the challenge and techniques of comprehensive care; (*c*) acceptance by all members of the health community—both those serving special populations, such as children, the aged, and the medically indigent, and those dealing with specific health problems or diseases, such as physical rehabilitation or cancer—of the need to foster and use prepaid group practice as a means of accomplishing their individual missions; (*d*) recognition by those who undertake to establish new plans that the triad of organized consumers, professional group, and suitable facilities is the essential basis for comprehensive health service through prepaid group practice.

#### REFERENCES

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