Regulation of Health Maintenance Organizations
(Submission to LEGCO Panel on Health Services)

Personal Declaration

My full time work is with the Hong Kong Professional Teachers' Union as a medical director and primary care doctor. I am also a Founding Director of a medical care management company in operation since 1996. However, the present submission is solely my personal view and does not represent nor express the interest of these two affiliations.

Context and Focus

The present discussion with the Panel on Health Services is scheduled at a crucial period: Radical reform of traditional dependence of Hong Kong residents on publicly funded healthcare is being considered by the Government. It is important for any debates about the regulation of health maintenance organizations (HMO) to be placed within the context of desirable and undesirable reforms sought for healthcare structure and financing.

It is common knowledge that HMOs in their American forms are not in existence in Hong Kong. Only medical insurance companies with affiliated with managed care organizations (MCO), managed care techniques and even capitated schemes are in operation but constituting a minor sector within our health care market.

This submission will focus on answering the following three questions:

(1) Will the introduction of American HMOs into Hong Kong's market serve a need in Hong Kong's healthcare reform?

(2) Should managed care and health insurance be regulated in Hong Kong?

(3) What innovative legislations and regulatory framework are needed to enable HMOs to function for peoples' health in Hong Kong?

The Often Forgotten Essence of Healthcare

I shall start by discussing what is the essence of healthcare. Healthcare is an organized way of letting everyone have access to healers and modern-day medical technology. We have to examine the process of the transactions. Economists often characterized the relationship between patient-doctor that of *a principal* and *an agent.* Thus the emphasis is often on monetary and marketable labour terms. Without denying the financial or business aspects of the transaction are important issues to deal with, we should not forget the fundamental essence of the relationship, as characterized by two perspectives:

One was provided by a sociologist James Coleman, in describing the trust of seriously ill patients in their doctors as "in which the risk one takes depends on the performance of another actor" (1). David Mechanic and Mark Schlesinger (2) described this relationship more comprehensively, "the success of medical care depends most importantly on patients' trust that their physicians are competent, take appropriate responsibility and control, and give their patients' welfare the highest priority". It is precisely this trust relationship that requires doctors to be selfless and dedicated as is dictated by their professional ethics.

I THE REDEEMABLE FEATURES OF HMOS

Will the introduction of American HMOs into Hong Kong's market serve a need in Hong Kong's healthcare reform?

The pioneer form of HMO started in 1930 in south California, when an ingenous doctor devised the first capitation plan for healthcare payment. Since most of the construction workers he served could not pay for the medical service they badly needed, he initiated a scheme whereby each worker would pay a small amount every week to the scheme and enjoyed all subsequent medical care as frequently as needed. In 1937, a benevolent industrialist, Edgar Kaiser was thinking of ways to maintain the health of workers he employed to build the Grand Coulee Dam in Washington. He persuaded Dr. Sydney Garfield, the capitation scheme creator, to implement a pre-paid health plan with joint contributions from employees and employer. Hence Kaiser and Garfield actually started the first HMO, which went on to become the present-day Kaiser-Permanente HMOs ((3), pg.19). The Kaiser group remain one of the most economical, efficient MCO with commendable. outcomes. The main reason for this amazing track record, that I like to infer, is because Kaiser never lost sight of the vision that healthcare plans are meant to procure trustworthy medical care for everyone irrespective of their earning power, rather than to seek profit.

American HMOs are health plans put out by highly capitalized bodies known as 'managed care organizations' (MCO), experienced in the twin business of insurance as well as delivering health care. These plans are offered to a specific population, who pay pre-determined yearly rates – known as capitation. Enrolees are able to enjoy a comprehensive range of care - from preventative, curative to rehabilitative. Preventive service such as annual monitoring of chronically ill, health screening for the healthy, PAP smears and mammograms for women at risk and batteries of vaccinations for children are all provided for in the package. These are generally not available to purchasers of indemnity insurance. The high coverage of preventive service is similar, as in other aspects as well, to the National Health Service of UK. The latter pay general practitioners a annual bonus if they can reached the 80% coverage goal for carrying out 'PAP smears' on women in GPs' lists. Carrying out PAP smears is an effective way of preventing cervical cancers of the womb.

While President Clinton failed to legislate for universal coverage for healthcare financing in 1993, the market forces as well as past favourable legislations enabled HMOs to

dominate the healthcare insurance/plan market between 1993 to 1996. Most health insurance companies that were unwilling to increase capitalization and grapple with the business of managed care dropped out of market. Prudential, Aetna, Cigna, Blue Cross, Metropolitan Life and Travellers were some of the notable exceptions.

At that juncture, I received some applications in Hong Kong from US-returnee-doctors to join the Panel of doctors I convened for my Union. These are Hong Kong-trained specialists and primary care physicians who could not survive the upheavals. With the HMO sweep, solo doctors and those with relatively less US credentials faced service barriers. At this point, having experienced the difficulty of imposing credentialing in my Panel in the Hong Kong environment, I became a convert to the virtues of managed care. In the recruitment function of a new healthcare company, which I organized in 1996, the main speaker and a honoured guest were both health managers experienced in ways of managed care in the US.

I discuss below two positive and one negative reasons as to why Hong Kong should introduce HMOs into future healthcare scene

Favourable Cost Control of HMOs

The current climate in the US[(a)] is rife with legislators and medical associations trying to swing legislation to favour professional autonomy and outlaw managed care. Health economists called this as 'trying to put the clock back' to pre-managed care era.

Health economists warned of the possible dire consequence of this backlash. In recent history of US healthcare, only managed care had slowed down the alarming rise in healthcare cost. David Dranove ((3), pg.162) recounted that ,

> "at the start of the 1990s, before MCOs took over, private sector health care spending was rising by more than 10% annually, and many experts predicted health care would account for 20% of the GDP by the year 2000. As recently as 2003, a Congressional Budget Office report pegged that figure at 18.9 %. Thanks to MCOs, private sector health care spending rose at 5% annually during the 1990s, and total spending on health care remains below 14% of GDP. Because of managed care, the 1993 Congressional Budget Office report overstated year 2000 spending by $300 billion. It is safe to conclude that were it not for the growth of managed care, projections that health care would represent 20% of GDP would not be too far off the mark."

[(a)] . The initial non-profit-benevolent HMOs experienced great deal of competition from late comers to the band-wagon - profit-orientated HMOs. The profit motive runs counter to the 'selfless dedication' motive of doctors. Under the 'corporate' culture of big companies, ability to cut down on referrals and technological care to patients became a norm for HMOs, doctors were encouraged to do so by being rewarded with a percentage of the profit from 'money saved'. This confusion of the purpose of healthcare had been copied by Hong Kong's first CEO of the HA when he insisted it was right to collect a handsome bonus from 'money he saved' on the top of his handsome salary.

With the above account, I hope to establish the first positive point for HMOs: that HMOs were started by selfless people (doctors and industrialists) to solve stringency of finances with impressive accomplishment in comprehensive healthcare delivery to enrolees. The HMO takeover of the US healthcare market demonstrated an increase in efficiency (or reduction in redundant spending) resulting in significant impact on total cost of US healthcare in the 1990s..

Impacts of the 'Managed Competition' and 'Internal Market'

Health economists alluded to one factor behind the run-away cost inflation of healthcare - 'supplier-induced demand'. By this they mean that the consumption of new drugs and technology are often decided by doctors alone because the consumer (the patient) lacks the technical knowledge to make a judgement. This unchecked freedom to intensify medical procedures will result in inflationary rise in expenses. In Hong Kong, the charges of specialist doctors and private hospitals are often not very accessible information for patients. Because of these basic imperfect conditions for a market, no government will consciously plan to use the unregulated 'free' market to deliver and finance healthcare.

One-payer schemes are healthcare financing supported entirely by central government's tax dollars or a compulsory central insurance scheme. One example is UK's NHS. Around 95% of hospitalization cost in Hong Kong is dominated by the Hospital Authority which being government-run and government financed, making our system almost like a one-payer financing system. In one-payer system, because the money is distributed from top to the bottom, consumers and local agents (doctors) have very little say on how money should be spent. Hence inefficiency, lack of public and consumer participation, out-dated and non-user-orientated practises cannot be easily corrected. Consumer dissatisfaction has been rising because of increase public awareness of healthcare rights and advances in biomedicine. Inefficiency and under-funding result in long queues for medical procedures, which is really subjecting patients to the unfair way of implicit rationing.

Alain Enthoven (4) is credited as being the originator of the 'managed competition model' in the late 1970s. The central idea is to formulate conditions for ensuring that competition occuring between insurers is on the basis of cost and quality rather than risk avoidance[(b)]. President Clinton's aborted plan for eliminating the 46 million uninsured for health care was aiming to carry out 'managed competition' among insurers, HMOs and 'integrated delivery systems'. It was never carried out since it was rejected by both the Houses. The Netherlands adopted the concept by accepting the Dekker Report that branded the model as their aim in 1987. The Dutch reform has since then worked towards this goal in an incremental way.

[(b)] When the Harvard Report (on Hong Kong's healthcare delivery) invoked the idea of "money follows the patient", what they really mean was 'managed competition'. It was widely misunderstood by the public and elites alike because of a misleading cartoon used in the Report.

Enthoven's ideas also influenced Margaret Thatcher in the 1989 reform of the monolithic NHS, resulting in a diluted form of competition. The split between purchasers (GP Fund holders & Health Authorities) and providers (hospital Trusts) created an 'internal market'. This is a tame form of competition since the providers remain in public control. The New Zealand reform also adopted the 'internal market' model where purchasers 'contract' or 'commission' services from hospitals, introducing a degree of competition between hospitals.

Almost every developed country that embarked on healthcare reform in the last decade has adopted either the 'managed competition' or 'internal market' ideas as ways to improve efficiency and quality. Quality improvement measures invariably involve opinions of end-users – patients and the public. Hong Kong's relatively small population enjoy both low taxation and a highly equitable, universal, low-cost healthcare. America is a much bigger country with *laisser faire* approach towards healthcare that has become the most expensive in the world. We should be able to weed out unreasonable aspects of managed care and adapt it to work for peoples' health. Bonus payment based on stringent control of care as well as utilization management that are unpalatable to doctors also run counter towards building up the trust relationship between doctors and patient. These are not the essence of managed care and can be excluded in Hong Kong's version.

American Consumer-Driven Health Care

There are sufficient hints dropped that the Administration seems to favour importing the present American 'solutions' to healthcare financing – in the form of Health Saving Accounts and 'high-deductible health plans (HDHPs). This is most unfortunate. US healthcare is the most expensive in the world, yet it achieves relatively poor health outcomes by OECD standard and fails to insure 16% of its population. The backlash against managed care has resulted in yet further cycles of inflationary pressure. The resort to consumer-driven health care (HSA combined with HDHP) is a desperate measure which is highly faddish and unproven (to control cost). Health economists have predicted its failure to control costs. Early reports from the Commonwealth Fund's survey (8) has already shown that consumer-driven health plans achieved higher out-of-pocket costs, lower satisfaction, more missed health care among patients who bought such plans. The only laudable feature was greater cost-consciousness among consumers.

If HSA s and HDHPs are carried out in Hong Kong as a solution to our healthcare financing problem, it would destroy two long-held lauded qualities of our healthcare: Universal coverage and high equity. That amounts to accepting the fact that 'a caring society' is no longer a desirable and commonly shared core value for Hong Kong people. Hong Kong will do better to bring in HMOs with high degree of regulation and compulsory health insurance for financing.

II REGULATION OF HONG KONG'S MANAGED CARE

Should managed care and health insurance be regulated in Hong Kong?

Reasoning on First Principles

Currently, not only managed care is unregulated, health insurance companies and health management companies and large doctors' groups are all not regulated. The argument that favours maintaining status quo say that these entities are governed by the Business Licensing act, Medical Council's Code of Conduct for Doctors and Insurance Companies Act. If we single out the doctors and companies featuring doctors as as a group provider, it is rather illogical to say the Code that regulate individual doctors can also regulate the company/group practice. When a doctor operates a solo practice, she/he is responsible for every aspect of her/his practice, such as drug purchasing, dispensing and administration. It is not reasonably to require a doctor to be answerable to every aspect of the practice when she/he works in a large group practice/company. The company concerned should delegate the group responsibility of drug and vaccine purchase to other professionals in an ethical way. Large groups undertake division of labour, hence individuals cannot be responsible for areas delegated to other workers. The need for regulating companies and large groups that deliver healthcare is obvious because medical care have special ethical requirements.

Hong Kong's Managed Care

The most cogent reason on the need for regulation is evidence of the detrimental effect of health insurance companies/groups' functioning on traditional culture of trust between patients and doctors.

1) Medical discount cards are being pushed as sweeteners for the sale of credit cards, life insurance and other non-health-related products. With 6,000 doctors, including hundreds of under-utilized specialists competing for the limited primary care market, many doctors succumb to the "cheap payment is better than no patients" pressure. This damages the professional reputation of doctors, and is not helpful in building rapport between doctors and patients.

2) A doctors' panel run by an well known insurance company (with affiliation to its The US) are being sold as 'managed care' type of arrangement. Two years' ago, during its attempt to recruit me as a provider, refused to name the doctor who was acting as convenor. The primary care panel also contained names of specialists, causing possible confusion to patients. How could patients and provider-doctors ensure an ethical service when they did not even know who set the rules for the panel?

3) A local doctors' group with sufficient capital purchased the majority ownership of a chain of practicing doctors' clinics. The Group's common practice is to move

the original owner-doctor to another clinic. The end-effect of the 'musical chair' realignment of doctors seems to establishment patients' loyalty to Group rather than to individual doctors. While all these are perfectly legal, one would wonder at the ethics of destruction of patient-doctor long-term relationships.

My contention is that, in the absence of regulatory rules, medical providers/insurers manage healthcare services, with or without undeclared managed care techniques, will have no need to be transparent and ethical professionally. Being motivated mainly by profit seeking, what makes money goes. While profit-seeking HMOs in the US, operating under the tough US regulatory system, still commit acts that run counter to a caring service, it is indefensible to let Hong Kong's healthcare companies go unregulated.

III NEW LEGISLATION NEEDED TO CONTROL HMO

What innovative legislations and regulatory framework are needed to enable HMOs to function for peoples' health in Hong Kong?

Two papers (5,6) that examined regulation of health insurance in the US allow us to gauge the problems society face when large sections of the population depend on provider-insurance organizations for continuous healthcare. Much of the principles and reasoning will apply to any jurisdiction, but considerable modification will be needed if Hong Kong were to legislate laws to control HMOs. The following discussion will only focus on legislation that can control entities working with managed care.

HMOs in the US are run by giant corporations. To give some examples by 1990s, out of 6,000 acute hospitals in the US, VHA, an alliance of non-profit hospitals, owned 1,800. Premier, another non-profit alliance owned 1,700 while Columbia/HCA, the largest investor-owned hospital system, owned 320 hospitals (7). Any single one of these can easily have capitals many fold of Hong Kong's HA. If free rein is given to them, one or two American HMO can easily dominate the private healthcare scene. Such a scenario would not be conducive towards competition, not to say the unacceptable situation that board rooms in New York should determine how local doctors should act. To ensure that Hong Kong's providers and doctors retain some degree of autonomy from foreign corporate control, it is necessary to limit the size of corporate ownership.

Overbay and Hall (5) described Risk-Bearing Provider Groups (RBPG). The projected example of RBPG is the 'physician-hospital organization' (PHO), described as "consisting of at least one hospital and one physician practice group that accepts partial or full capitation for at least some of its patients." PHO acts as subcontractors for HMOs ('downstream capitation') but also offer capitated health plans to smaller sized populations. The case were made for them to be exempted from the vigorous capital reserve requirement because the 'service contract' nature of agreements will allow a PHO to fulfil its contract even if it underestimated the cost of premium at the time of signing.

The Hong Kong law that regulates managed care should exclude any organizations other than the defined MCOs from operating capitated health plans. RBPG can be any of the the two types of organizations: PHO ('provider-hospital organization' which is modified from its original words because the word 'physician' carries a 'specialist in internal medicine' connotation) and 'primary care network organization' (PCNO). These two types of provider-organizations are already in operation in health provision, except that the payment is usually by fee-for-service and not capitation.

SUGGESTED CAPITAL AND OWNERSHIP REQUIREMENTS FOR HONG KONG MANAGED CARE ORGANISATIONS

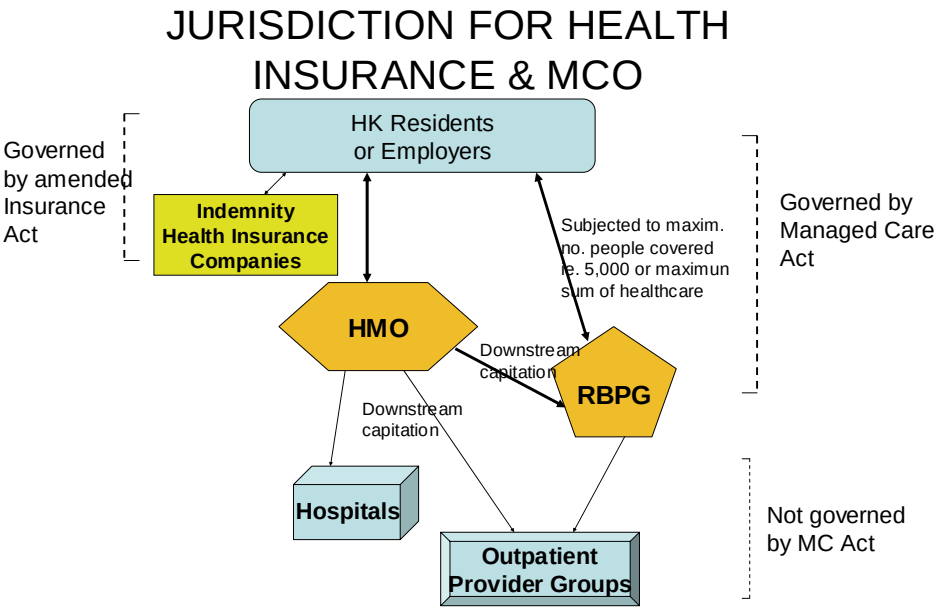
	Mandatory Working Capital	**Insurance Co. &/or HMO Ownership**	**Local Hospital &/or Medical Group Ownership**	**Provider-Doctors Owner-ship (a)**
HMO (new HK)	**HK 5 million**	**Not more than 40%**	**Not more than 50%**	At least 10%
RBPG (new HK)(b)	HK $500,000	Not more than 30%	Not more than 30%	At least 40%

(a) Provider-doctors ownership: in US State laws (5), if a high component of the contracted service is delivered by the owners themselves, the managed care entity carries relatively little capital loss risk, therefore can be exempt from insurance laws and required much lower working capital.
(b) RBPG (Risk-bearing Provider Group): in Hong Kong, this new managed care entity can either be a Provider-Hospital Organization (PHO) or Primary Care Network Organization (PCNO).

A straight-forward definition of ***MCOs in Hong Kong*** will be ***any healthcare company that enters into contractual agreement(s) with residents, companies or other healthcare entities to deliver healthcare service by capitation (pre-paid, fixed premium per head).***

Needless to say indemnity insurance companies and other non-managed care entities will not be allowed to contract health service by capitation, with the exception of GP Groups or specialist doctors of less than 5 partners.

The diagram below summarizes the difference in regulatory jurisdiction that are needed to govern the various stake-holders in healthcare



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