A Surprisingly Popular U.S. Export: Managed Care

Just Call It Something Else, Suggest Its Proponents From Australia to Trinidad

By Carol Gentry
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Managed care may be taking a beating in the U.S., but other nations are hankering for it—hankering, at least, for its promise of quality care at a reasonable price.

With major U.S. insurers investing in health companies around the world and U.S. consultants pitching the concept to government systems, it seems managed care may follow the example of fast food, rock music and blue jeans. "The world is all going in this direction," says Peruvian physician Eduard Salas.

Latin America has become a managed-care laboratory, with more health-maintenance organizations than the U.S. and an estimated 60 million enrollees. Membership is growing 20% a year in the Philippines. Even some countries in Asia and Africa are experimenting with home-grown versions.

Hossam Badrawi, who says he founded Egypt's first health-maintenance organization nine years ago, notes he did so after years of studying alternatives. "We looked everywhere—Asia, Europe, the U.S.—and we thought the HMO system is best," Dr. Badrawi says.

But many international champions of the movement can't call it managed care in their own countries. They say they must find euphemisms because the news media have beamed stories about America's growing hostility toward the system around the world, tainting the two-word moniker beyond redemption.

"If we called it managed care, we would get into trouble," says Tennison Sieunarine of Trinidad, medical adviser to the first prepaid plan in the Caribbean. "My people would think we are only interested in cutting costs, instead of wanting to improve patient care."

That lament was echoed by others at the summit on International Managed Care Trends, which attracted more than 500 delegates from 56 countries to Miami Beach, Fla., two weeks ago. "We have a lot of managed care in New Zealand, but we don't call it that," says David Rankin, chief executive of a plan in Wellington. Australians have dubbed it "evidence-based medicine." In fact, the summit's sponsor for next year, the Academy for International Health Studies, Davis, Calif., will change the meeting's name to remove the offending words, says Jonathan C. Lewis, president of the academy.

Whatever they call it, managed care's fans praise its stated goals of keeping people well, cutting waste and measuring which treatments work best. The irony isn't lost on W. Allen Schaffer, chief medical officer at Cigna Corp., Philadelphia. "The American system gains much more respect and appreciation outside the United States," he says.

Managed-care giants Cigna and Aetna Inc., of Hartford, Conn., have invested hundreds of millions of dollars in health companies outside the U.S. in the past few years. An Aetna joint venture with Sul America created Brazil's largest health insurer, says Howard Kahn, who heads Aetna's global health business. The company also has a large stake in health insurers in Chile, Argentina, Colombia and the Philippines.

United Healthcare of Minnetonka, Minn., has entered several joint ventures around the globe with American International Group Inc., a global general and life insurer based in New York. But United has concentrated mostly on consulting in Europe and elsewhere, because it carries lower risks while the company gets to know each culture, says Mark Moody, United's vice president for international operations. "You can't just say, 'Take this and plug it in,'" Mr. Moody says. "We're not exporting widgets."

Cigna's experience proves caution is warranted. The company took a $400 million write-off last quarter after one of its Brazilian investments suffered tax trouble and collapsed. However, Dr. Schaffer says, the company is optimistic about its remaining project in Brazil, as well as those in

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Around the World

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Mexico, Japan, India and Western Europe.
What feature of managed care do other
countries want most? Automated record-
keeping systems that closely track spending
and monitor the quality of doctors' care. But
information systems are expensive and dif-
ficult to set up even in the U.S., let alone in
a developing nation like Poland, where doc-
tors who use computers must spend week-
ends trying to get them to work.

A more readily achievable goal is the de-
velopment of "clinical guidelines"—road
maps on how to best treat an illness, using
expert advice and up-to-date studies. Mill-
iman & Robertson, a San Francisco com-
pany that supplies guidelines to U.S. health
plans, has developed a network of 30 firms
around the globe to spread the technique.

One country that wants to use clinical
guidelines to reduce the wide variation in
doctors' practice is Germany, which has a
national insurance system run by not-for-
profit "sickness funds." But Christoph
Straub, an official at the fund VDAK in
Siegburg, says doctors balked at using
guidelines—a problem, since the funds
can't legally drop any doctors from their
network. So the funds are playing hardball.
Beginning next year, Dr. Straub says, doc-
tors will have part of their pay withheld un-
til the end of the year to make sure they're
obedient, and if they're not, they'll lose the
money.

New Zealand likes the notion of practice
guidelines, but aims to make them more
palatable by involving local doctors, nurses
and patients in drawing them up, says
Pieter Deppeing, professor of health man-
agement at the University of South Wales,
Sydney, Australia.

Another common feature of U.S-style
managed care—the "gatekeeper" system,
in which patients must see their family
doctor to get authorization for tests or spe-
cialists' referral—is a monumental bust
in Germany, according to Dr. Straub. Pa-
tients in VDAK refused to go through a
gatekeeper, he says, even when offered $60
a year to do so.

The gatekeeper system works well in the
United Kingdom's public health service, but
what's missing is management flexibility to
shift money from one program to another,
says Alan Maynard, editor of Health Eco-
nomics magazine in York, U.K. People who
need a cataract removal or joint replacement
must wait a year or more, he says, while
money is wasted somewhere else.

Squeezing excess medical services and
hospital beds out of the health system, an
aim of managed care in the U.S., would also
be useful in Eastern Europe and the former
Soviet Union, says Paul Lenz, chief execu-
tive of ABC Medcover Holdings BV, a
health-care provider in Warsaw. Those re-
gions tend to have twice as many hospital
beds and doctors per capita as in the U.S., he
says, but the hospitals are badly deterior-
aed and ill-equipped. Doctors' and nurses'
pay is so low, he adds, that some of them
supplement it by taking bribes for preferen-
tial treatment.

Managed care's emphasis on prevention
would be useful in many African coun-
tries, where rates of AIDS and other infec-
tious diseases are among the highest in the
world, and delegates from South Africa,
Uganda and Botswana have appealed to
multinational insurers to help them.

Poverty is no disqualifier for interna-
tional insurers' investment. Prathap