

On the Limits of Expanding Health Care Reform: Chronic Care in Prepaid Settings

MARK SCHLESINGER

*Center for Health Policy and Management,
John F. Kennedy School of Government,
Harvard University*

HEALTH MAINTENANCE ORGANIZATIONS (HMOs) have become the medical elixir of contemporary health policy. Once advocated primarily by socially concerned physicians and reform-minded academics, the benefits of prepaid health care are now extolled by policy makers of every political persuasion (Iglehart 1982). HMOs have become popular among investment analysts, who believe that "HMO companies will represent one of the most attractive opportunities for health care investment for the next 3-5 years" (Santry 1984, 1), as well as among hospital administrators who see them as a means of securing a stable population of patients (Hadley and Feder 1984; Moore 1985)

The enthusiasm for HMOs is understandable. Investors see an industry predicted to increase its revenues four-fold by 1990, policy makers an answer to the looming dilemma of how to control health care costs without seriously restricting access or reducing the quality of care (Santry 1984). The benefits of prepaid care are perceived as so large that the focus of policy debates has shifted from the question of whether to encourage the spread of prepayment to the question of how to ensure that particular segments of the population are expediently enrolled in prepaid plans. Attention has been particularly focused on

groups now receiving care under publicly financed programs. These include the elderly, covered under Medicare, and the seriously mentally ill, whose care is largely financed by a combination of state and federal funding.

Policy makers have long favored encouraging the enrollment of elders in HMOs: "The Nixon, Carter and Reagan administrations have all expressed support for proposals that would encourage HMOs through incentives to enroll more Medicare beneficiaries and for the elderly to seek out such plans" (Iglehart 1982, 454). During the first two years of the Reagan administration there was a flurry of legislative activity; some half-dozen bills were introduced in Congress creating various types of "voucher plans," programs under which Medicare recipients would use a voucher of fixed value to purchase access to a year's worth of medical services. All three of the major Medicare reform proposals produced in the past two years—the Reagan administration's plan, the Bowen Commission proposal, and the Kennedy-Gephardt bill—incorporate vouchers.

Medicare's use of prepaid plans has lagged behind these expectations. Though doubling between 1979 and 1984, enrollment in HMOs is still under three-quarters of a million beneficiaries. Recent reforms and renewed public enthusiasm, however, have led to predictions of rapidly accelerated growth in the near future. The governor of Massachusetts, for instance, recently announced plans to enroll up to a third of all elders in that state in HMOs (Iglehart 1985).

Support for prepaid care for the seriously mentally ill is of more recent vintage. Calls for experimentation with prepaid arrangements have appeared with increasing frequency in the academic literature over the past several years (Talbot 1985; Mechanic 1985; Sharfstein 1982; Meier 1981). Recent proposals for reform of the mental health systems in several states, including New York and Tennessee, incorporate capitation arrangements of one form or another.

The notion of extending prepaid arrangements beyond privately insured groups thus seems to be gaining intellectual momentum. It is a reform that is easy to understand and relatively easy to encourage through public policy. The widespread enthusiasm for this concept, however, can easily mask our very limited experience with prepaid care for groups other than those which are relatively young and healthy. Care for the elderly and the mentally ill, in particular, has one important common characteristic: a substantial portion of the illness in each group is chronic (Meier 1981; Pegels 1980). Most of the

documented past "successes" of HMOs, though, involve the reduced utilization of acute health care, particularly hospitalization (Luft 1981).

Can we expect the benefits of prepayment to extend to the care of the chronically ill? Proponents of the expanded use of HMOs believe this to be true, but these claims are more often based on hypotheses than evidence. This article will suggest, in contrast, that many of the claims made for the efficacy of HMOs in caring for patient populations with a substantial level of chronic illness are overstated and that the limited evidence that does exist raises more doubts than hopes about the potential of prepaid care for such populations. These conclusions raise questions about a number of current policies. They also suggest some directions for future reform better designed to adapt the general principle of prepayment to the health care needs and utilization of specific populations.

The Promise of Prepayment for the Chronically Ill

Proponents of HMOs argue that, in general, prepayment makes providers more cognizant of the costs to society of illness. Prevailing fee-for-service arrangements are thought to foster excessive utilization, to leave providers and patients insensitive to the costs of treatment, and to encourage a myopic perspective on the provision of care. In contrast, prepayment is believed to discourage utilization above professional norms, to encourage providers to seek the least costly settings for treatment, and to put a higher perceived value on prevention as a way to decrease future costs.

More specifically, prepaid chronic care is predicted to have three major advantages over existing fee-for-service arrangements in that it: (1) reduces existing biases toward institutional care, (2) induces coordination of what is now a fragmented care-delivery system, and (3) promotes the use of preventive care. The statements of these advantages in caring for both the elderly and mentally ill have been remarkably similar.

Reducing Institutionalization

There is a clear bias in existing public and private insurance coverage of chronic illness toward institutional settings. This creates financial incentives for both patients and providers to arrange for inpatient

treatment. In caring for the elderly, providers face limited coverage by Medicare and Medicaid for home health services (Pegels 1980; Morris and Youket 1981; Farrow et al. 1981). Coverage for mental health care under both private insurance and Medicaid programs is significantly more restricted for outpatient than inpatient services (Muszynski, Brady, and Sharfstein 1983; American Hospital Association. Advisory Panel on Financing Mental Health Care 1973).

It is argued that shifting to prepayment will eliminate or at least reduce this bias. In the care of the elderly it is expected that "the capitation plan creates incentives for the proper placement of institutional patients and would prevent, alleviate or retard the use for inpatient care when the services could be provided less expensively at home" (Winn and McCaffree 1979, 189). Similarly, for mental health care it is claimed that "underfunded alternatives such as day treatment and psychosocial rehabilitation would be financed more adequately within fixed budgets as programs consolidated and focused on cost-effective approaches in the community" (Sharfstein 1982, 469).

Coordination of Services

Chronic illness often has social as well as medical repercussions which require a range of health and social services (Butler and Newacheck 1981). Individuals seeking care are faced by "a myriad of agencies and programs" with inadequate information to choose the best source of care (Sharfstein 1982, 469; LaVor 1979; Greenlick et al. 1983). Under these conditions, illnesses often go untreated (Morris and Youket 1981), are treated in inappropriate settings (Coleman 1982), or are dealt with in such a discontinuous fashion that the quality of care is significantly reduced (Meier 1981; Morris and Youket 1981).

The proposed solution to this problem is typically two-fold: integrate services under a single agency (Callahan 1981; Budman 1981) and provide the chronically ill with case managers to guide them through the service delivery system (Freedman and Moran 1984; Sharfstein 1982; Beatrice 1981). It has been argued that providing care through HMOs accomplishes both these goals. Since they are responsible for a range of services, HMOs are thought to have incentives to coordinate care. For the mentally ill, this is predicted to lead to "carefully coordinated collaboration between primary care providers and mental health professionals" (Meier 1981, 128), in part because individual

providers have little personal financial incentive to “hang on” to a particular patient, allowing patients to be shifted from one provider to another in a timely fashion (Budman 1981). Prepayment is also believed to create incentives for the HMO to prevent inappropriate, and excessively expensive, utilization by providing case management (Bonanno and Wetle 1984).

Preventive Care

Prepayment is thought to produce incentives to intervene early to deal with chronic illnesses before they create more serious consequences (Budman 1981; Sharfstein 1982).

The HMO's incentive structure may also encourage the substitution of earlier, less expensive, less technology-intensive interventions (e.g., ambulatory, preventive) for later, more expensive, more intrusive care (e.g., acute hospitals, nursing homes); this feature is likely to be particularly beneficial for older patients, whose decreased reserves and likelihood of compromising illnesses often result in less than optimal outcomes from late, heavily intrusive interventions (Bonanno and Wetle 1984, 42).

These potential advantages are understandably attractive to policy makers. Prepayment seems to offer the best of all possible worlds: the potential for saving money by shifting care to less costly settings and preventing debilitating illness while simultaneously improving the quality of care by reducing inappropriate institutionalization, better matching of providers' capabilities and patients' needs and reducing the need for overly intrusive treatments. Given policy makers' concerns over the rising cost of health care for the elderly (Ginsburg and Moon 1984) and the mentally ill (Sharfstein, Muszynski, and Myers 1984), there is likely to be increased political pressure to expand HMO enrollment for these populations in the near future.

The Promise of Prepayment Reexamined

It appears that at least some of the advocates of a broadened role for prepaid care operate under the mistaken belief that “a basic premise of the HMO is that maintaining health is cheaper than treating more

serious illness" (Budman 1981, 111). Given the acronym, it is understandable that prepaid plans are often equated with "health maintenance." In fact, though, prepayment simply serves to make providers more sensitive to costs of illness and treatment. To the extent that this makes providers' choices more responsive to the costs of illness faced by society as a whole, prepaid care should be more compatible with socially valued goals than are other forms of reimbursement.

In many cases, however, the costs faced by providers when making treatment decisions (or the costs faced by a group health plan as a whole when allocating the budget among departments) will be quite different from the costs borne by society. When the costs of future illness to the plan or the individual provider are higher than those borne by society, one would predict that too much care—compared to the socially optimal level—will be provided. When the costs faced by plan or provider are less, then too little care will be delivered.

Chronic illness appears to fall into the latter category. Individual providers and the plan as a whole will undervalue society's costs from chronic illness for two reasons. First, the costs of chronic illness faced by providers exclude the significant costs borne by family members or other individuals (Freedman and Moran 1984; Weisbrod 1983; Morris and Youket 1981; Wetle and Evans 1984; Somers 1982). For example, a recent study based on the 1982 National Long-Term Care Survey found that between 80 and 85 percent of all home care received by impaired elders came from spouses, children, or other relatives (Manton and Liu 1984).

Second, many of the costs of chronic illness can be shifted out of the HMO to publicly financed and operated systems of care. Plan members who become seriously—and potentially expensively—mentally ill can be "dumped" to community mental health centers and state psychiatric hospitals (Meier 1981). Similarly, costs of care for the seriously ill elderly can be shifted to Medicaid by placing enrollees in a nursing home (Triegeer, Galblum, and Riley 1981).

Economic incentives, of course, are not the only factors influencing treatment and resource allocation decisions. Professional standards obviously play a major role. Here too, however, characteristics of chronic illness are likely to leave patients with these conditions "short-changed." There exist few professional norms for treating either the chronic illnesses of the elderly (Farrow et al. 1981) or those of the mentally ill (Sharfstein, Muszynski, and Myers 1984; U.S. Office of

Technology Assessment 1980). Treating chronic illness of either sort ranks low on the hierarchy of professional prestige for providers (Farrow et al. 1981; Pollack 1979; Sapolsky 1977; Greenblatt 1975). Under these circumstances, it is likely that efforts to keep costs within a prepaid constraint will disproportionately "squeeze" the budgets for departments of mental health and long-term care in HMOs.

This congruence of economic and professional incentives will lead prepaid plans significantly to undersupply care for the chronically ill relative to the social optimum. Unfortunately, since we have no way of establishing what the appropriate amount of chronic care should be, it is impossible to test this hypothesis directly. The amount of chronic care provided by HMOs is so small, however, that it is virtually certain that the hypothesis is correct.

This can be seen most clearly in the limited coverage of chronic illnesses in HMOs. The authors of a recent survey found that "typically HMOs impose limitations on psychiatric care that are as severe as the weakest psychiatric coverage of conventional plans" (Sharfstein, Muzynski, and Myers 1984, 180). These restrictions are often targeted at the chronically ill: "Certain psychiatric services are routinely excluded in HMOs as not a covered benefit; the relevant phrase usually reads 'conditions which are chronic or not likely to respond to short-term treatment'" (Bonstedt and McSweeney 1985, 5).

Although current coverage seems quite limited, coverage would be even less in the absence of legal requirements; prior to the passage of state and federal legislation requiring minimum mental health coverage such care was typically provided by prepaid plans only under the provisions of special riders (Budman 1981; Levin and Glasser 1979). Studies of chronic care for elder-plan members reveal equally severe restrictions on coverage:

Present HMOs do not offer very extensive long-term care benefits to their enrolled population. For example, only one-third of 18 HMO arrangements offered any extended care facility benefits; in all cases this benefit was of limited duration, less than four months. . . . Other benefits, such as services in the home, are similarly limited (Winn and McCafree 1979, 186).

Enrollees in prepaid plans may also face various types of nonfinancial rationing, such as long waits for appointments or moral suasion by providers and administrators to reduce "unnecessary" utilization (Luft

1981). The more severe the budget constraints are on the HMO as a whole or a particular department, the more utilization will be constrained by these measures. Because chronic care lacks professional prestige, departments offering such services are most likely to bear the brunt of budget pressures. For example, a study of mental health utilization in prepaid settings, conducted by Sharfstein, Muszynski, and Myers (1984), concluded that year-to-year variations in utilization were in large part caused by changing budget constraints in the plans.

The combination of restricted coverage and rationed care probably constrains the delivery of care for chronic illness in prepaid settings to levels below those that are socially desirable. Similarly, the incentives produced by prepayment may create a number of other undesirable outcomes. Consider, for example, the three proclaimed advantages of shifting care of the chronically ill into HMOs.

Reduced Institutionalization

HMOs are predicted to reduce institutionalization by avoiding the biases currently embodied in fee-for-service insurance arrangements. Certainly this holds true for hospitalization. Studies of Medicare beneficiaries enrolled in prepaid plans indicate that HMOs can be as successful at reducing their rate of hospitalization as with younger enrollees (Weil 1976; Greenlick et al. 1983).

Treatment of the chronically ill, however, creates special problems for the HMO. On the one hand, there is a perception of an almost unlimited demand for chronic care with little ability to constrain utilization through professional norms (Sharfstein, Muszynski, and Myers 1984; Lave 1985). This concern is based in large part on the expectation that formal services substitute for care which is currently provided through family and other acquaintances (U.S. General Accounting Office 1981). One recent review article, for example, concluded that "the expense of substituting formal for informal services" was a major reason that past expansions of home-based and community-based services had not reduced health care costs (Lave 1985, 20). On the other hand, the budgets for chronic care in HMOs may often be squeezed down by competition from other departments.

Under these conditions, it becomes necessary for the HMO to restrict utilization of services for the chronically ill. A common approach is to impose copayments, particularly on the utilization of outpatient

care. In fact, surveys show that cost sharing for mental health care in HMOs is as large or larger than that in fee-for-service insurance (Sharfstein, Muszynski, and Myers 1984). This cost sharing often takes the form of ceilings on coverage, limits which have the greatest impact on the chronically ill (Levin, Glasser, and Roberts 1984; Levin and Glasser 1979).

These forms of cost sharing create exactly the incentives toward institutionalization that HMOs were expected to avoid. A recent review of mental health care in prepaid settings concluded, for example, that "the national average HMO mental health inpatient utilization rates are far in excess of what they should be" (Boaz 1985, 1). Similarly, a comparison of Medicare expenditures in seven prepaid group plans and fee-for-service control groups found that, controlling in a regression model for age, sex, and locational differences in the population, enrollees in HMOs had a higher rate of institutionalization in nursing homes and lower utilization of home health services than did the comparable control group (Weil 1976).

Coordination of Services

Prepayment is thought to promote continuity of care by (1) providing the HMO with an organization-wide incentive to integrate services and (2) eliminating the incentive for providers to retain patients to maintain revenues, thus increasing timely transfers of patients between primary care providers and specialists. The experience of the initial Medicare/HMO demonstration projects indicates that prepayment can induce physicians to consider more carefully the options for managing patient care (Iglehart 1985). The benefits of these incentives, however, are to some extent mitigated or offset by the other incentives and constraints facing providers in HMOs.

In many cases, it is assumed that the primary care provider, typically a physician, will be the principal source of coordination and case management in the HMO (Budman 1981). Using the physician in this role, however, is problematic for several reasons. First, physicians tend to be more interested in acute care and therefore may devote less time and attention to the coordination of services for the chronic patient (Farrow et al. 1981; Pollack 1979). Second, case management requires input from the patient and careful communication from the provider (Beatrice 1981). Sharing of information between provider

and patient, however, is perhaps the single aspect of the care delivery process that HMOs perform most poorly, relative to fee-for-service arrangements. A review of studies on this topic concluded:

Overall, the evidence strongly supports the view that PGP [prepaid group practice] enrollees are less happy with doctor-patient communication. There is more dissatisfaction with the amount of information given the patient than with the physician's willingness to listen. This is consistent with the general view that PGP physicians have less time and are not as warm toward their patients (Luft 1981, 272).

Third, because HMOs commonly restrict coverage of extended care, they are forced periodically to refer enrollees with chronic illness to other providers, disrupting continuity of care and weakening the effectiveness of case management programs within the plan. A recent analysis of coverage for chronic mental illness in HMOs concluded, for instance, that limiting benefits, as many plans do, creates a pool of enrollees "whose care becomes discontinuous every time they have to be hospitalized outside of the HMO system" (Bonstedt and McSweeney 1985, 6).

Finally, for the same reasons that one provider in an HMO would willingly transfer a patient to another, there are few incentives under prepaid plans for providers to exert themselves to maintain contact with patients. Under these circumstances, chronic patients may well slip through the cracks in the system, disrupting any attempts to coordinate care. A study of one HMO, for example, found that almost 40 percent of the mental health care episodes in the plan were terminated by the patient before the provider thought it appropriate. The researcher concluded that "a high dropout rate and a relative lack of special efforts by the staff to prevent dropping out may be seen as logical weak spots to be expected in a prepaid health system" (Spoerl 1974, 59).

Prevention of Chronic Illness

HMOs are thought to emphasize prevention as a way of reducing the costs of future illness. As noted above, however, the adoption of services in the HMO depends on the future costs faced by the plan or by the individual provider, not by society as a whole. To the

extent that the costs of future chronic illness are borne by family members or the publicly financed institutions, the HMO has less financial incentive to provide an adequate array of preventive services. Unfortunately, many of the preventive interventions for chronic illness fit this pattern. A study of hypertension screening and treatment, for example, found that reductions in future medical costs represented on average only 15 percent of the monetary value of the social benefits from controlling hypertension (Stokes and Carmichael 1975). It is thus not surprising that the few studies which have examined the provision of preventive care for the elderly report no differences in the amount of prevention between prepaid and fee-for-service settings (German, Skinner, and Shapiro 1976).

In addition, studies of the provision of preventive services in general in HMOs have concluded that such services are made available only if there is fairly clear evidence that they are cost effective to the plan (Luft 1981). There may be many chronic illnesses for which no preventive services meet this criteria. Certainly, this seems to be the case for mental health care; for many chronic illnesses there is currently no effective preventive approach, for others there is virtually no data with which to assess the cost effectiveness or efficacy of potential preventive interventions (Lemkau 1982; Plaut 1980; Swift 1980). Thus, in the absence of additional evidence of the efficacy of preventive care, there seems little reason to expect prepaid plans to pour resources into these services.

Prepayment: Promises and Policies

The evidence presented in the last section suggests that prepayment will not necessarily lead to more adequate or cost-effective care for populations with substantial chronic illness. Prepayment may, in fact, lead to less suitable care for these diseases than under current fee-for-service arrangements. While we still know too little about the ways in which HMOs deliver these services, and while there is undoubtedly much variation among HMOs, existing evidence does make it clear that public policy that simply encourages the extension of prepaid care to broader populations may require further refinement. This conclusion holds implications for a variety of proposed policy reforms, including Medicare voucher plans and schemes to restructure state mental health care systems.

Prepayment and Current Proposals for Health System Reform

Medicare Voucher Plans. Proposals to increase enrollment in HMOs have been a part of every major Medicare reform package developed during the past several years. There can be little doubt that expanding enrollment offers some important benefits to both the Medicare program and enrollees, including significant reductions in the cost of hospital care and expanded coverage of services (Weil 1976; Greenlick et al. 1983). In addition, by allowing beneficiaries to choose among plans, a voucher system allows them to select the plan that covers the services they value most highly (Iglehart 1985). The evidence presented in the last section, however, suggests that these benefits may be purchased at the cost of less-adequate care for chronic illnesses.

Proponents of voucher plans contend that competition among HMOs provides a safeguard against reductions in quality of care: “[I]f one assures that every family has the purchasing power to buy membership in a good plan and a free choice among competing plans, organizations that make a practice of underserving members will not last long” (Enthoven 1978, 720). However realistic this claim is in general, competition does not seem a very convincing safeguard for the chronic care of the elderly.

Experience indicates that elders are often ill-equipped to assess choices among health insurance policies and health care providers. Competition has not protected elders from unscrupulous practices by insurers selling “Medi-gap” policies to supplement Medicare coverage. A survey conducted by the Federal Trade Commission estimated that one-quarter of the supplemental policies purchased in the mid-1970s were completely worthless since they simply duplicated existing coverage (Pegels 1980). Competition did not safeguard quality in the nursing home industry; the unregulated care provided in these institutions was often abysmal (Vladeck 1980).

The choice among prepaid plans is considerably more complicated than the purchase of either Medi-gap policies or nursing home care. This complexity raises additional questions about the extent to which competition limits reductions in the quality of care (Luft 1984; Friedman, LaTour, and Hughes 1983). Moreover, elders choosing among HMOs are likely to be less concerned about the coverage of chronic than acute illnesses. For example, a survey of some 2,000 elders found

that the decision to enroll in an HMO was less sensitive to variations in long-term care than to restrictions in utilization of either hospitals or physicians (Friedman, LaTour, and Hughes 1983). This is particularly true for mental health care, since many elderly attach a social stigma to using mental health services (U.S. General Accounting Office 1982). Elders from minorities are least likely to be informed about the availability of and options for long-term care services (Holmes, Teresi, and Holmes 1983).

For this reason, older Americans receive less mental health care than do younger cohorts, although the prevalence of mental illness rises with age (U.S. General Accounting Office 1982). This pattern occurs with both prepaid and fee-for-service care. A study of mental health care in HMOs found that individuals over the age of 65 had an average number of visits per enrollee less than half that of those under 65 (National Institute of Mental Health 1980).

To the extent that elders undervalue coverage for chronic illness, a competitive voucher system can be expected to reduce progressively the provision of such care in prepaid settings. As plans compete to attract enrollees, they will shift resources out of chronic care into those types of services that induce enrollment. As competition increases over time, the magnitude of this shift will grow as well. Pressures to reduce chronic care will be exacerbated by the provisions of many of the proposed voucher plans. These generally include arrangements to squeeze additional efficiency from HMOs by progressively reducing the capitation rate for Medicare beneficiaries (*Medicine and Health/Perspectives* 1981a, 1981b). Given the preferences of both potential enrollees and the medical profession, it seems likely that services for the chronically ill bear the brunt of cost-saving measures.

In addition, because prepayment is based on the average cost of elders in the community, participating HMOs have a financial incentive to screen out Medicare beneficiaries whose care will be more costly than average. Since elders with chronic illness are almost invariably more expensive to treat, they will likely face the greatest barriers to enrollment and, once enrolled, the greatest pressure to disenroll (Long, Settle, and Link 1982). Although Medicare regulations forbid practices by plans which would lead to selective enrollment or disenrollment, such prohibitions are extremely difficult to enforce, because they require monitoring of both the ongoing relationship between enrollees and

the plan as well as the advertising and marketing strategies employed by participating HMOs.

Given these limitations, it is not surprising that evidence is already accumulating that selection of enrollees is occurring. The inspector general of the Department of Health and Human Services has reported evidence of Medicare beneficiaries being pressured to disenroll from some prepaid plans (Iglehart 1985; Stickney 1985). Studies of several of the Medicare prepaid care demonstration projects indicate that favorable selection occurred at a number of sites (Eggars and Prihoda 1982; Luft 1984). As plans become more experienced and sophisticated in their marketing techniques, they will undoubtedly become more adept at this preselection.

Reforming State Mental Health Care Systems. Although most states began to deinstitutionalize the mentally ill over twenty-five years ago, many are still struggling with ways to develop a rational and efficacious system of community-based services (Mollica 1983; Rich 1982). Recently, there has been growing support for plans in which a single organization is given responsibility for delivering all state-financed services in an area (Mechanic 1985). The Massachusetts Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts, for example, recommended in 1981 that the state explore using:

. . . the form of a prime performance contract to a public or private entity at the catchment area level. A performance contract specifies an agreement for the planning, development and delivery of the entire range of needed mental health services to a catchment area population.

The perceived advantages of this approach are identical to those predicted for providing mental health care under any sort of prepaid arrangement: economies from consolidating financing with a single agency, flexibility in better reallocating resources to meet "client need," and rationalizing the system-wide allocation of resources (Massachusetts Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts 1981). Undoubtedly such a system offers important advantages over the rather disorganized and fragmented system that has evolved piecemeal in many states (Mollica 1983). Again, however, one must be equally cognizant of the incentives

which may alter the public mental health care system in potentially undesirable ways.

Publicly operated mental health care facilities treat a mix of chronically and acutely ill patients (Talbot 1985; Foley and Sharfstein 1983; Massachusetts Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts 1981). Some of these patients require hospitalization, others are capable of living in the community. Some, such as long-term residents of state psychiatric hospitals, have costs of care and living which are borne fully by the public mental health care system. Others, such as the homeless mentally ill, create costs borne largely by society as a whole (Bachrach 1984; Lamb 1984).

A shift to a prepaid, capitated system of care creates a number of incentives for provider agencies that appear troubling. First, adopting a capitated approach shifts resource-allocation decisions away from state legislatures, where they are currently based, to the agency level (Dorwart, Schlesinger, and Pulice 1986). Historically, much of the political support and public funding for the chronically ill has been based on legislative initiative (Foley and Sharfstein 1983). At the agency level, the cost-saving incentive produced by prepayment, coupled with professional norms favoring care for acute illness, are likely to draw resources away from treatment of the chronically mentally ill.

Second, the need to restrict spending on outpatient services will likely promote institutionalization for the long-term mentally ill. This runs counter to the professional consensus that many, though not all, of these patients can be better served by an enriched set of community-based services (Gruenberg 1982). Third, there will be a tendency to divert resources away from those individuals whose costs of illness were borne principally by the society at large, such as the homeless mentally ill. This is precisely the group, though, that is now perceived to be most in need of additional services (Lamb 1984; Bachrach 1984).

Adapting Prepayment to the Needs of the Chronically Ill

In spite of the aforementioned shortcomings, prepaid health care does offer a number of advantages over other payment systems. It produces strong incentives to control costs. By predetermining a level of annual revenues for each enrollee, it stabilizes the budgets of individual

providers and overall program expenditures. In so doing, it promotes more effective planning and resource allocation as well as probably creating a greater willingness to experiment with innovative services. Under some prepaid approaches—such as the Medicare HMO program—enrollees are permitted to choose among providers, allowing them to select the one offering coverage which best fits their needs and concerns.

These are important advantages. To preserve them, without unduly risking the welfare of the chronically ill, better ways must be found to adapt the prepaid model to the care of such enrollees. More specifically, methods must be developed to eliminate or offset the three factors identified above which cause prepaid plans to behave in socially undesirable ways: (1) differences between the costs of chronic illness borne by the plan and the costs borne by society as a whole, (2) an undervaluation by providers and patients of the benefits of the coverage for and treatment of chronic illness, and (3) incentives for prepaid plans to shift atypically expensive individuals to other systems of care.

Because we have only limited experience of the chronically ill in prepaid plans, much of the discussion of options for reform must be speculative. Nonetheless, there appear to be a number of ways in which the three problems identified above can be directly and effectively addressed. Each approach, however, has drawbacks as well.

Equating the Costs Faced by Prepaid Plans and Society. Currently, many of the costs of chronic illness are borne by a patient's family or society as a whole. Prepaid providers would deliver the appropriate amount of care for such illness if these costs were internalized. There exist two methods for doing this.

First, prepaid providers could be required to bear some or all of the nonmedical costs of chronic illness. For the chronically mentally ill, agencies might be asked to pay for housing for patients living in the community. For the elderly, a broader mandate could bring under one agency the responsibility for supplying both health and social services. Various forms of this strategy have been proposed in the academic literature—labeled Social/Health Maintenance Organizations (S/HMOs) or Local Area Management Organizations (LAMOs)—and there are ongoing demonstration projects to evaluate the feasibility of the S/HMO model (Diamond, Gruenberg, and Morris 1983; Ruchlin, Morris, and Eggert 1982; Iglehart 1985).

These agencies combine public funding for health and social services into a single per capita rate. It is anticipated that, in addition to

providing incentives for the appropriate care of the chronically ill, this approach can also take advantage of the opportunity for substitution between health and social services:

Home health, personal care and social services are likely to increase due to improved systems controls in the S/HMO. . . . Of various long-term-care reforms currently under consideration, the S/HMO offers the strongest possibility of centralized controls over patient management, and hence may offer the greatest potential for efficiency and cost savings (Diamond and Berman 1981, 209–10).

Although this approach holds promise, it seems likely to be limited in several ways. First, because medical care is often considered more prestigious than social services, combining the two under a single budget may simply replicate what many view as past mistakes made under Medicare and Medicaid: a “medicalization” of care involving “steadily tilting toward medical spending and away from spending for other social purposes” (Butler and Newacheck 1981, 67; Farrow et al. 1981). This problem may be partially alleviated by requiring that nonphysician case managers determine the use of services—as do the ongoing S/HMO demonstration projects—but the medical profession may still dominate and distort the overall allocation of resources made within the agency (Majone 1984).

Second, under prepayment, resources will be allocated for social services—within the bounds of professional norms—only to the extent that they affect the future costs of the prepaid plan. If most of the costs of inadequate social services are still borne by enrollees or their families, rather than formal providers, there will be too little financial incentive for providers to deliver an adequate level of social services. To increase this incentive, government must be willing to accept the added costs of paying for this care. In an era of constrained public budgets, this seems unlikely.

These limitations lead some observers to favor a second, more regulatory, approach. Prepaid plans could be required to cover particular services and to deliver an appropriate level of services to their enrollees. Violating these standards would result in legal and financial penalties which would make the costs to the provider of undersupplying services closer to those for society as a whole.

Requiring that at least some additional nonmedical services be covered by plans would increase the use of these services and likely

stimulate innovations in their delivery. Broader mandates, however, also have important liabilities. In prepaid systems which allow enrollees to select among plans, mandates force greater uniformity on the system, greatly reducing the benefits of choice.

Perhaps more important, it may prove extremely difficult to implement such mandates. It is one thing to require that prepaid plans cover a service, it is another to assure that such service is actually provided to enrollees in the plan. There currently exists no professional consensus on what constitutes appropriate access for many health and social services, particularly those for the chronically ill (Friedman 1984). In the absence of such standards, regulatory mandates inject the government into an ill-defined area, potentially disrupting relationships between providers and patients and probably leading to a proliferation of regulations and intervention.

Having providers face the true societal costs of chronic illness will clearly lead to more appropriate care in prepaid settings. To do this, providers must be given incentives to offer a broader array of services. For services for which there exists a reasonably well-defined professional consensus on appropriate standards for care, it may be most feasible simply to mandate coverage. Where consensus is absent, as it will be for much of the care for chronic illnesses, it may prove more practical simply to combine public funds for health and social services under a single per capita payment to one provider agency. Unless, however, these public funds pay for a substantial portion of the social costs of chronic illness, a prepaid agency will still undersupply care for the chronically ill. Nor do either of these strategies overcome problems of biases which lead providers and patients to undervalue these services.

Promoting More Accurate Assessments of the Benefits of Care for the Chronically Ill. Exacerbating the problems caused by inappropriate incentives is the tendency of health care providers to consider it more prestigious and satisfying to treat acute rather than chronic illness. Coupled with the cost-saving incentives produced by prepayment, these beliefs can create strong pressures to shift resources away from long-term care.

To the extent that such biases are the result of misinformation, they can be redressed by requiring special continuing education programs for care-givers (Besdine, Levkoff, and Wetle 1984; Wetle and Levkoff 1984). There is also evidence linking providers' attitudes to the type

of professional training that they have received. Studies indicate that nurses and social workers are more comfortable working with the chronically ill than are physicians (Wetle and Levkoff 1984; Lutsky 1980). More balanced treatment decisions and resource allocations may thus result if prepaid agencies are required to employ a number of different professions and to provide specific services—such as interdisciplinary health assessments—which make use of their talents (Besdine, Levkoff, and Wetle 1984).

While these strategies may mitigate problems caused by biased perceptions, they will clearly not eliminate them. Moreover, biases among providers are compounded in prepaid systems which allow enrollees to select the prepaid plans and choose among coverages. The observed tendency of potential enrollees to undervalue long-term care services creates competitive pressures to reduce the coverage and provision of this type of care.

Again, to the extent that this undervaluation results from misinformation, it can be addressed in several ways. First, much as the Food and Drug Administration requires labeling of nutritional information on prepared foods, prepaid plans could be required to inform potential enrollees of the expected use of various chronic and acute care benefits. Under Medicare's HMO program, for example, the Health Care Financing Administration could determine, for elders of different ages, the expected use of a standardized set of services, including various types of long-term care. Participating HMOs could be required to include this list—identifying clearly those services which they did and did not cover—in all of their marketing material.

Although such information would undoubtedly lead to better-informed decisions, many potential enrollees would likely remain confused by the array of options which they faced. It thus seems important that any prepaid system that allows for a choice of plans also provide an institutional mechanism to aid beneficiaries in this selection. Similar problems in the nursing home industry have led to the creation of ombudsmen under the auspices of the federal Administration on Aging and a number of states (Newcomer, Benjamin, and Estes 1983; U.S. Administration on Aging 1982). Although these agencies are perceived to have had only a moderate impact on the long-term care system, they clearly provide an important point of contact and information for the recipients of services.

Limiting Cost Shifting by Prepaid Plans. To the extent that per

capita payments are based on the average cost of treating patients, prepaid providers have an incentive to seek enrollees with below-average costs and avoid those with above-average costs. More often than not, the chronically ill will fall into the latter group. If it were possible to adjust payment rates to reflect more accurately the expected resource use of individual enrollees, this problem would be avoided. Given current knowledge, however, only crude adjustments are feasible and these may create more difficulties than they resolve (McClure 1984).

Under these circumstances, other reforms may be required. Consolidating health and social services within a single prepaid plan—as in the S/HMO and LAMO models—will limit cost shifting by eliminating alternative programs to which the chronically ill might be “dumped.” The broader the coverage, the less cost shifting is likely to be a concern.

However, when enrollment in a prepaid plan is voluntary, as under the current Medicare program, significant problems may remain. Prepaid plans will profit to the extent that they are able to channel expensive chronically ill beneficiaries back into the fee-for-service system. To avoid such selection strategies, it has been proposed that, in the future, Medicare shift from voluntary to mandatory HMO enrollment (Friedman, LaTour, and Hughes 1983). Mandatory enrollment guarantees that program costs will not increase due to favorable selection of enrollees by prepaid plans and concomitant shifting of high-cost elders to the fee-for-service system.

On the other hand, mandatory enrollment has a number of drawbacks. It forces elders into a system of care that has incentives which may lead—in spite of the reforms discussed here—to inadequate treatment of the chronically ill. Surveys suggest that a number of elders would strongly resist being required to use prepaid plans (Freidman, LaTour, and Hughes 1983). Finally, mandatory enrollment does not eliminate problems caused by selection. Prepaid providers would still have an incentive to select the least expensive enrollees; elders who are unusually sick and costly to care for would thus have trouble finding sources of care. Plans which enroll a disproportionate number of such elders would find their costs exceeding their revenues and would, if this continued, be forced to close. A mandatory prepaid system in which there is a large variance in the costs of health care among enrollees could thus be rather unstable (McClure 1984).

Conclusion

It has long been recognized, by both researchers and HMO administrators, that prepayment does not remedy all the ills of the health care system. Less understood, however, are the ways in which the limitations of prepaid care compound for particular types of enrollees, such as those with prevalent chronic illness. Policy makers, moreover, appear less cognizant of the limitations of prepayment. Public policy in the United States is often based on a quest for social panaceas. We discover institutional forms that work well for specific purposes and proceed to heap upon them all the unresolved social problems of the day. This creates something like a Parkinson's law for institutions—additional responsibilities are added until the organizational form rises to a level of social incompetence. This seems to be the case for prepaid plans under current public policy.

As the population of this country ages, the prevalence of chronic illness will continue to rise. With appropriate care, it should be possible to develop methods for successfully integrating prepaid care for acute and chronic illness within a single organization. Simply lumping the two types of services together within a capitated system, however, is not likely to be one such method. Prepayment no more guarantees social welfare than do fee-for-service arrangements; policies must be designed which adapt the general concept of prepayment to the particular needs and capabilities of the chronically ill. This will require a better understanding of how payment incentives affect the actions of providers and patients. It will also probably require more extensive government regulation and modification of the basic model of prepaid care. Many of the proponents of prepayment may well feel uncomfortable with such intervention, but it seems a necessary prerequisite for meeting the heterogeneous needs of potential patients.

References

- American Hospital Association. Advisory Panel on Financing Mental Health Care. 1973. *Financing Mental Health Care in the United States*. DHEW pub. no. (HSM) 73-9117. Washington.
- Bachrach, L. 1984. The Homeless Mentally Ill and Mental Health Services: An Analytical Review of the Literature. In *The Homeless Mentally Ill*, ed. H. Lamb, 11-54. Washington: American Psychiatric Association.

- Beatrice, D. 1981. Case Management: A Policy Option for Long-term Care. In *Reforming the Long-term-care System*, ed. J. Callahan and S. Wallack, 121–62. Lexington, Mass.: Lexington Books.
- Besdine R., S. Levkoff, and T. Wetle. 1984. Health and Illness Behaviors in Elder Veterans. In *Older Veterans: Linking V.A. and Community Resources*, ed. T. Wetle and J. Rowe, 1–34. Cambridge: Harvard University Press.
- Boaz, J. 1985. Managerial Criteria for Evaluating a Mental Health Service: Part I. *HMO Mental Health Newsletter* 1:1–2.
- Bonanno, J., and T. Wetle. 1984. HMO Enrollment of Medicare Recipients: An Analysis of Incentives and Barriers. *Journal of Health Politics, Policy and Law* 9:41–62.
- Bonstedt, T., and J. McSweeney. 1985. Interpretation of Psychiatric Exclusions in HMOs. *HMO Mental Health Newsletter* 1:5–8.
- Budman, S. 1981. Mental Health Services in the Health Maintenance Organization. In *Linking Health and Mental Health*, ed. A. Broskowski, E. Marks, and S. Budman, 103–14. Beverly Hills: Sage.
- Butler, L., and P. Newacheck. 1981. Health and Social Factors Relevant to Long-term-care Policy. In *Policy Options in Long-term Care*, ed. J. Meltzer, F. Farrow, and H. Richman, 38–77. Chicago: University of Chicago Press.
- Callahan, J. 1981. Single Agency Option for Long-Term Care. In *Reforming the Long-term care System*. ed. J. Callahan and S. Wallack, 163–84. Lexington, Mass.: Lexington Books.
- Coleman, J. 1982. Health/Mental Health Integration. In *Public Mental Health: Perspectives and Prospects*, ed. M. Wagenfield, P. Lemkau, and B. Justice, 209–26. Beverly Hills: Sage.
- Diamond, L., and D. Berman. 1981. The Social/Health Maintenance Organization: A Single Entry, Prepaid Long-Term-Care Delivery System. In *Reforming the Long-term-care System*. ed. J. Callahan and S. Wallack, 185–218. Lexington, Mass.: Lexington Books.
- Diamond, L., L. Gruenberg, and R. Morris. 1983. Elder Care for the 1980s: Health and Social Service in One Prepaid Health Maintenance System. *Gerontologist* 28:143–54.
- Dorwart, R., M. Schlesinger, and R. Pulice. 1986. Privatizing Public Mental Health: The Case of Purchase of Service Contracting in Massachusetts. *Hospital and Community Psychiatry* (in press.)
- Eggars, P., and R. Prihoda. 1982. Pre-enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in "At-Risk" HMOs. *Health Care Financing Review* 4:55–73.
- Enthoven, A. 1978. Consumer-choice Health Plan. *New England Journal of Medicine* 303:709–20.
- Farrow, F., T. Joe, J. Meltzer, and H. Richman. 1981. The Framework

- and Directions for Change. In *Policy Options in Long-term Care*, ed. J. Meltzer, F. Farrow, and H. Richman, 1-37. Chicago: University of Chicago Press.
- Foley, H., and S. Sharfstein. 1983. *Madness and Government: Who Cares for the Mentally Ill?* Washington: American Psychiatric Association.
- Freedman, R., and A. Moran. 1984. Wanderers in a Promised Land: The Chronically Mentally Ill and Deinstitutionalization. *Medical Care* 22 (suppl.):S1-S60.
- Friedman, B., S. LaTour, and E. Hughes. 1983. A Medicare Voucher System: What Can It Offer? Paper presented to the Conference on the Future of Medicare, sponsored by the Committee on Ways and Means, the Congressional Budget Office, and the Congressional Research Service, Washington, November 29-30.
- Friedman, E. 1984. Can "Essential Services" Be Defined? *Hospitals* 58:105-8.
- German, P., E. Skinner, and S. Shapiro. 1976. Ambulatory Care for Chronic Conditions in an Inner-city Elderly Population. *American Journal of Public Health* 66:658-66.
- Ginsburg, P., and M. Moon. 1984. An Introduction to the Medicare Financing Problem. *Milbank Memorial Fund Quarterly/Health and Society* 62:167-82.
- Greenblatt, M. 1975. Psychiatry: The Battered Child of Medicine. *New England Journal of Medicine* 292:246-50.
- Greenlick, M., S. Lamb, T. Carpenter, T. Fischer, S. Marks, and W. Cooper. 1983. Kaiser-Permanente's Medicare Plus Project: A Successful Medicare Prospective Payment Demonstration. *Health Care Financing Review* 4:85-97.
- Gruenberg, E. 1982. The Deinstitutionalization Movement. In *Public Mental Health: Perspectives and Prospects*, ed. M. Wagenfield, P. Lemkau, and B. Justice, 209-26. Beverly Hills: Sage.
- Hadley, J., and J. Feder. 1984. Troubled Hospitals: Poor Patients or Management? *Business and Health* 1:15-19.
- Holmes, D., J. Teresi, and M. Holmes. 1983. Differences among Black, Hispanic and White People in Knowledge about Long-term Care Services. *Health Care Financing Review* 5:51-67.
- Iglehart, J. 1982. The Future of HMOs. *New England Journal of Medicine* 308:451-56.
- . 1984. HMOS (For-Profit and Not-For-Profit) on the Move. *New England Journal of Medicine* 310:1203-8.
- . 1985. Medicare Turns to HMOs. *New England Journal of Medicine* 312:132-37.
- Justice, B. 1982. Primary Prevention: Fact or Fantasy. In *Public Mental*

- Health: Perspectives and Prospects*, ed. M. Wagenfield, P. Lemkau, and B. Justice, 209–26. Beverly Hills: Sage.
- Lamb, R. 1984. Deinstitutionalization and the Homeless Mentally Ill. *Hospital and Community Psychiatry* 35:899–907.
- Lave, J. 1985. Cost-containment Policies in Long-term Care. *Inquiry* 22:7–23.
- LaVor, J. 1979. Long-term Care: A Challenge to Service Systems. In *Reform and Regulation in Long-term Care*, ed. V. LaPorte and J. Rubin, 16–64. New York: Praeger.
- Lemkau, P. 1982. A Conceptual Model of Prevention. In *Public Mental Health: Perspectives and Prospects*, ed. M. Wagenfield, P. Lemkau, and B. Justice, 195–208. Beverly Hills: Sage.
- Levin, B., and J. Glasser. 1979. A Survey of Mental Health Service Coverage within Health Maintenance Organizations. *American Journal of Public Health* 69:1120–25.
- Levin, B., J. Glasser, and R. Roberts. 1984. Changing Patterns in Mental Health Service Coverage within Health Maintenance Organizations. *American Journal of Public Health* 74:435–58.
- Long, S., R. Settle, and C. Link. 1982. Who Bears the Burden of Medicare Cost Sharing? *Inquiry* 19:220–38.
- Luft, H. 1981. *Health Maintenance Organizations: Dimensions of Performance*. New York: John Wiley.
- . 1984. On the Use of Vouchers for Medicare. *Milbank Memorial Fund Quarterly/Health and Society* 62:237–50.
- Lutsky, N. 1980. Attitudes toward Old Age and Elderly Persons. *Annual Review of Geriatrics* 5:287–336.
- Majone, G. 1984. Professionalism and Nonprofit Organizations. *Journal of Health Politics, Policy and Law* 8:639–59.
- Manton, K., and K. Liu. 1984. The Future Growth of the Long-term Care Population. Paper presented at the Third National Leadership Conference on Long-term Care Issues, Washington, March 7–9.
- Massachusetts. Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts. 1981. *Mental Health Crossroads*. Boston.
- McClure, W. 1984. On the Research Status of Risk-adjusted Capitation Rates. *Inquiry* 21:205–13.
- Mechanic, D. 1985. Mental Health and Social Policy: Initiatives for the 1980s. *Health Affairs* 4:75–88.
- Medicine and Health/Perspectives*. 1981a. HMOs: One Way Out of the Medicare Dilemma? 35(August 17):1–4.
- . 1981b. Medicare Vouchers: Competition, Round One. 35(September 21):1–4.

- Meier, G. 1981. HMO Experiences with Mental Health Services to the Long-Term Emotionally Disabled. *Inquiry* 18:125-38.
- Mollica, R. 1983. From Asylum to Community: The Threatened Disintegration of Public Psychiatry. *New England Journal of Medicine* 308:367-73.
- Moore, W. 1985. CEOs Plan to Expand Home Health, Outpatient Services. *Hospitals* 59:74-77.
- Morris, R., and P. Youket. 1981. The Long-term-care Issues: Identifying the Problems and Potential Solutions. In *Reforming the Long-term-care System*, ed. J. Callahan and S. Wallack, 11-28. Lexington, Mass.: Lexington Books.
- Muszynski, S., J. Brady, and S. Sharfstein. 1983. *Coverage for Mental and Nervous Disorders: Summaries of 300 Private Sector Health Insurance Plans*. Washington: American Psychiatric Press.
- National Institute of Mental Health. 1980. *Use of Health and Mental Health Outpatient Services in Four Organized Health Care Settings*, series DN, no. 1. DHHS pub. no. (ADM) 80-859. Washington.
- Newcomer, R., A. Benjamin, and C. Estes. 1983. The Older Americans Act. In *Fiscal Austerity and Aging*, ed. C. Estes and R. Newcomer, 187-206. Beverly Hills: Sage.
- Pegels, C. 1980. *Health Care and the Elderly*. Rockville, Md.: Aspen Systems Corp.
- Plaut, T. 1980. Prevention Policy: The Federal Perspective. In *Prevention in Mental Health: Research, Policy and Practice*, ed. R. Price, R. Ketterer, B. Bader, and J. Monahan, 207-36. Beverly Hills: Sage.
- Pollack, W. 1979. *Expanding Health Benefits for the Elderly*. Vol. 1: *Long-term Care*. Washington: Urban Institute.
- Rich, R. 1982. Comparing States' Mental Health Policy Processes. Paper presented at the Conference on Chronic Mental Patients in the Community, Stanford University, December 3-4.
- Ruchlin, H., J. Morris, and G. Eggert. 1982. Management and Financing of Long-term-care Services. *New England Journal of Medicine* 306:101-5.
- Santry, B. 1984. *The HMO Industry*. New York: Alex. Brown and Sons, Inc.
- Sapolsky, H. 1977. America's Socialized Medicine: The Allocation of Resources within the Veterans' Health Care System. *Public Policy* 25:359-82.
- Sharfstein, S. 1982. Medicaid Cutbacks and Block Grants: Crisis or Opportunity for Community Mental Health? *American Journal of Psychiatry* 139:466-70.
- Sharfstein, S., S. Muszynski, and E. Myers. 1984. *Health Insurance*

- and Psychiatric Care: Update and Appraisal*. Washington: American Psychiatric Press.
- Somers, A. 1982. Long-term Care for the Elderly and Disabled. *New England Journal of Medicine* 307:221-26.
- Spoerl, O. 1974. Treatment Patterns in Prepaid Psychiatric Care. *American Journal of Psychiatry* 131:56-59.
- Stickney, J. 1985. Two Cheers for HMOs. *Money* 14:155-64.
- Stokes, J., and D. Carmichael. 1975. *A Cost-benefit Analysis of Model Hypertension Control*. National High Blood Pressure Education Program. Bethesda, Md.: National Heart and Lung Institute.
- Swift, C. 1980. Primary Prevention: Policy and Practice. In *Prevention in Mental Health: Research, Policy and Practice*, ed. R. Price, R. Ketterer, B. Bader, and J. Monahan, 207-36. Beverly Hills: Sage.
- Talbott, J. 1985. The Fate of the Public Psychiatric System. *Hospital and Community Psychiatry* 36:46-50.
- Treiger, S., T. Galblum, and G. Riley. 1981. HMOs: Issues and Alternatives for Medicare and Medicaid. In *Health Care Financing: Issues*. HCFA pub. no. 03107. Washington.
- U.S. Administration on Aging. 1982. *The Long-term Care Ombudsman Program*. Washington.
- U.S. General Accounting Office. 1981. *Medicare Home Health Services: A Difficult Program to Control*. Pub. no. HRD-81-155. Washington.
- . 1982. *The Elderly Should Benefit from Expanded Home Health Care but Increasing These Services Will Not Insure Cost Reductions*. Pub. no. GAO/IPE-83-1. Washington.
- U.S. Office of Technology Assessment. 1980. The Efficacy and Cost Effectiveness of Psychotherapy. Background Paper no. 3 to *The Implication of Cost-Effectiveness Analysis of Medical Technology*. Pub. no. OTA-BP-H-6. Washington.
- Vladeck, B. 1980. *Unloving Care*. New York: Basic Books.
- Weil, P. 1976. Comparative Costs to the Medicare Program of Seven Prepaid Group Practices and Controls. *Milbank Memorial Fund Quarterly/Health and Society* 54:339-60.
- Weisbrod, B. 1983. A Guide to Benefit-cost Analysis, as Seen through a Controlled Experiment in Treating the Mentally Ill. *Journal of Health Politics, Policy and Law* 8:808-45.
- Wetle, T., and L. Evans. 1984. Serving the Family of the Elder Veteran. In *Older Veterans: Linking V.A. and Community Resources*, ed. T. Wetle and J. Rowe, 231-60. Cambridge: Harvard University Press.
- Wetle, T., and S. Levkoff. 1984. Attitudes and Behaviors toward Elder Patients in the V.A. System. In *Older Veterans: Linking V.A.*

and Community Resources, ed. T. Wetle and J. Rowe, 205-30. Cambridge: Harvard University Press.

Winn, S., and K. McCaffree. 1979. Issues Involved in the Development of a Prepaid Capitation Plan for Long-term Care Services. *Gerontologist* 19:184-90.

Address correspondence to: Mark Schlesinger, Center for Health Policy and Management, John F. Kennedy School of Government, Harvard University, 79 Kennedy Street, Cambridge, MA 02138.