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US and UK health care: a special relationship?

Moving towards true integration

Richard G A Feachem, Neelam K Sekhri

Considerable action will be needed to get maximum benefits from the lessons learnt about integrated health care

This is the last in a series of articles in which we asked experts in UK and US healthcare systems to identify opportunities for learning between the two countries

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Any comparison between the UK and US healthcare systems as a whole will inevitably conclude that the high costs and the lack of universal coverage in the United States make it extremely unattractive from any European perspective. Indeed, the United States can learn a great deal from the United Kingdom about the provision of universal access to health services at a much lower cost by reforming its health financing system. In the other direction, much has been gained in recent years from examining parts of the US experience and exploring how they might, with appropriate adaptation, be of benefit in the United Kingdom. Some of the lessons could be taken further.

Lessons from managed care

Our comparison between the US managed care organisation Kaiser Permanente and the NHS generated interest, debate, and subsequent studies.[1] Several visits by ministers, managers, and clinicians have followed to see what might be learnt from US healthcare organisations. Interestingly, the increased international interest in Kaiser and similar systems has also stimulated debate about the possibilities of extending this model more broadly within the United States.[2]

We identified several factors that might explain performance differences between Kaiser and the NHS, and other researchers have investigated these in more detail.[3] The most important of these, in our view, was achieving true integration, a view subsequently supported by Light and Dixon among others.[3–5] This integration has several components, including:

- Integration of services through the continuum of care to ensure that patients are treated at the most appropriate level of care and that their journey through the system is as rapid and efficient as possible
- Integration of clinical expertise such that all specialties, including primary care, are equal members of a multispecialty team and jointly control financial resources
- Financial integration so that all parties in the system (primary care doctors, consultants, and hospitals) are jointly responsible for a single bottom line. This ensures that available resources are spent most effectively to achieve healthcare outcomes
- Integration of leadership and management to ensure partnership between clinical governance and administration in achieving shared goals
- Integration of culture and vision within a single organisational structure dedicated to providing high quality, cost effective care.

The old NHS was a fragmented financial and organisational structure with deep divides between primary care, consultants, and hospitals. The new NHS reforms have been motivated by a desire to increase integration and strengthen the role of primary care. These are laudable goals. The foundation of the new arrangements is the creation of primary care trusts, through which about 80% of NHS funding is already flowing.[6]

Recent commentary has focused on experience in implementing the primary care trust model, and the picture is mixed.[6] Virtual integration has clearly been increased by creating long term contractual arrangements between the primary and secondary levels. Although the nature of the divide between primary and secondary care has changed, it has not narrowed. Indeed, the divide seems to have become entrenched; the powers of primary care have been strengthened through the creation of trusts at the same time as increasingly autonomous and powerful foundation hospitals have been created. In addition, the relation between primary and secondary care has moved from informal and, at times, indifferent, to formalised purchaser-supplier contracting that often pits one against the other (as in Bradford[7]).

Narrowing the divide

If the NHS wants to realise the performance enhancements that true integration has brought to organisations such as Kaiser, narrowing and bridging the current divide between primary and secondary care is essential. Broadly speaking there are three ways to move in this direction:

- Hospital trusts can expand outwards and downwards;
- Primary care trusts can expand outwards and upwards; or
- New vertically integrated organisations can be created.

LUCY NICHOLSON/AP

Patients in Kaiser Permanente benefit from fully integrated care

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Summary points

US managed care organisations show the benefits of full integration

Recent reforms in the NHS have changed but not narrowed the divide between primary and hospital care

The NHS should experiment with true integration for one or more geographically defined populations

The United States has something to teach us about what doesn't work in this arena. US hospitals have experimented with backwards integration, buying primary care practices and expanding their range of ambulatory services. The results have not been promising.[8] The motivation for hospitals is, typically, to protect their income by maximising use of hospital services. This is precisely the wrong objective for any integrated healthcare system, which depends on keeping people healthy and out of hospital.

Some primary care trusts have explored closer collaborative links with hospitals—for example, through pooling resources, establishing shared incentives to keep patients out of the hospital, and joint chronic disease management initiatives.[9] They could go further and expand to include hospital services. However, this requires considerable capital, which primary care trusts would find hard to mobilise, as the US experience shows.[10] In addition, without consultants as equal and committed members of the group, it is difficult for primary care doctors to control the use of hospital services, which are the key cost drivers in any healthcare system.

This leaves one option: to create vertically integrated organisations responsible for the entire continuum of care of a geographically defined population. The Department of Health would fund these organisations through a capitated sum. Such a reform would require substantial changes to the autonomy and contracts of both consultants and primary care doctors, changes that are sure to be fiercely resisted. For example, as with Kaiser, all doctors would be dedicated to the organisation and would be unable to have private practices. At the same time, compensation and benefits would have to reflect fair market rates.

The good news is that it is much easier to establish this level of integration in the United Kingdom than it is in the United States. Unlike the United States, the United Kingdom enjoys a cohesive, single payer system in which health workers and patients are accustomed to managed access to specialty services. The philosophy and approaches of Kaiser, which were branded communist in the United States in its early days, are regarded as desirable and commonplace in Britain. The obvious downside is that a single integrated organisation might have a monopoly in a particular area and therefore the benefit of a strong competitive environment would be lost.[11]

Feasibility

To make a national change to such a new system is not possible, or perhaps even desirable. However, this is something that can be achieved incrementally. As Berwick has suggested,[5] one region could be selected in which all healthcare related funding and assets are pooled and brought under shared clinical and administrative governance. This new organisation would be responsible for managing the health care of the population in its region for a negotiated per capita sum. In exchange, it would be accountable for the delivery of a variety of public health, clinical, and service performance targets. Financial and other incentives could further enhance performance.

The potential benefits from such a bold experiment in public policy greatly outweigh the risks. Why not give it a try?

Contributors and sources: RGAF and NKS have a longstanding interest in comparative health policy. NKS has worked in managed care in the United States and advised on health care policy, finance, and delivery in several countries.

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One hundred years ago

Insanity and murder

There is an uncomfortable feeling that in trials for murder, when the plea of insanity is raised for the defence, the legal proceedings are not of so complete and satisfactory a nature as they are in other classes of cases. For instance, in trials in the Admiralty Court in which technical questions concerning navigation arise there are special nautical experts, known as "assessors," to assist the formation of judgements by the Court. But in the complicated question of the mental state of the prisoner it is in most cases left to the defence to initiate and sustain arguments as to unsoundness of mind, and it is only after the trial, and when the verdict of the jury has been given, that the medical advisers of the Crown are asked their opinion. The judge in a naval court is not considered competent to decide the question as to whether the helm should have been put to port or to starboard, but he is allowed to be the unaided arbiter of the most difficult problems in psychological medicine. (*BMJ* 1905;i:142)