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THE NEW NHS: WHAT CAN WE LEARN FROM MANAGED CARE IN NEW ZEALAND AND THE US?

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On 8 September, 1998, the Health Services Management Centre and the Office of Health Economics co-hosted a seminar on the lessons that could be learned from the managed care experience in New Zealand and the US for the development of The New NHS in England. The following leading policy analysts and public servants from the three countries gave presentations:

Alain Enthoven, Professor of Management, Graduate School of Business, Stanford University, California, US

Chris Ham, Director, Health Services Management Centre, University of Birmingham, UK

Lorraine Hawkins, Health Economist, The World Bank, Washington DC, US

Michael Powell, Professor of Health Management and Director, Centre for Research in Health Services and Policy, University of Auckland, New Zealand

Jonathan Shapiro, Senior Fellow, Health Services Management Centre, University of Birmingham, UK

Clive Smee, Chief Economic Adviser, Department of Health, UK

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Executive Summary

- The integration of health care is the defining theme of policy developments in the UK, US and New Zealand. The common element between the three countries has been the development of multi-practice and multi-professional groups in primary care settings.
- International learning has become commonplace and has accelerated the introduction of innovations in the UK.
- The ability to learn from international experience, however, requires careful consideration since the particular historical, social and cultural context of each health care system differs. Whilst there is great value in international comparisons, implementing overseas innovations should only be considered where a conscious effort is made to identify their relevance to domestic issues allied to a process of evaluation.
- As the UK moves towards an integrated health and social care system organised around primary care-based organisations, policy makers will have a lot to learn from the experience of integrated care organisations in the US and New Zealand. Common features between all of these approaches include capitated primary care networks, the devolution of financial and clinical responsibilities, and the development of public/private partnerships.
- Learning can also be transferred in the organisational process/management techniques area. For example, in determining measures of quality of outcome and patient experiences.
- New Zealand and the US can also learn from the UK. For example, the development of Health Action

Zones and long-term service agreements relates closely to the New Zealand experimentation with integrated care pilots.

- In conclusion, different countries need to develop flexible health care systems with the ability to adapt

to changes in medical technology and economic and social conditions. Learning from international experience, through the sharing of information on areas such as best clinical and management practice, is important in this process.

AMERICA'S EXPERIENCE WITH MANAGED HEALTH CARE AND MANAGED COMPETITION

Alain Enthoven

Alain Enthoven said that every country's health care system is very much an intimate product of its society, its history, its culture, and its economic and political systems. Transporting one country's health care system to another is, therefore, problematic and calls into question the value of international comparison. However, he argued that one could examine other countries' systems and gather useful insights that might be transposed to one's own. For example, American Health Maintenance Organisations (HMOs), adopted the idea that every enrolled member should have a primary care physician – an idea taken from Britain.

Enthoven showed how health care in the US has been going through a rapid transformation from unmanaged care, in which there are no systematic links between insurers, providers and doctors, to managed care. The underlying motivation for this transformation was the lack of financial constraints

within the unmanaged health care system and the subsequent medical cost inflation associated with it (see Box 1). National health expenditures in the US, for example, grew rapidly from 5.1% of GDP in 1960 to 12.2% in 1990 and to 13.6% in 1993. The percentage of people without health insurance has also increased from 15.2% of the non-elderly in 1988 to 17.4% in 1995.

Managed care

Enthoven explained that managed care is different from the traditional US model in that the health care organisation or the insurance carrier selects providers for quality and for willingness to co-operate with utilisation management, cost containment measures and quality assurance activities. Managed care includes:

- utilisation management programmes, such as

Box 1 *Main contributors to medical cost inflation in the US*

- Fee-for-service payment meant providers had the incentive to over-treat patients to realise greater income.
- The US Government's programmes Medicare (for retirees and the disabled) and Medicaid (for the poor) were frozen into the fee-for-service indemnity model because of the political power of doctors.
- Lack of cost sharing meant that insured patients had no reason to be concerned about the cost of what they were receiving.
- For large numbers of Americans the employer paid the whole health insurance premium so the employee had no idea what it cost, and no direct reason to care.
- Employer contributions to health insurance were tax free without limit to the employee, creating an incentive for employees to take compensation in the form of health cover rather than cash.
- Absence of utilisation management or quality controls.

encouraging doctors to develop joint practice guidelines;

- prior authorisation and concurrent review of hospitalised cases;
- negotiated fees rather than fee-for-service;
- quality management, such as measuring outcomes and patient satisfaction.

Two kinds of managed care in the US were highlighted: the Preferred Provider Insurance (PPI) model and the HMO.

PPI is a minimal form of managed care which usually involves an insurer who selects providers for quality and willingness to co-operate within the PPI's management system. The insurer then negotiates prices with them, creates incentives for the consumers to go to those providers, and undertakes utilisation management and quality management. PPI was pioneered in California in the early 1980s, gaining considerable leverage over physicians and reducing treatment costs. For example, California Blue Cross, one of the largest carriers, reduced orthopaedic surgeons' fees for hip replacements from \$4,602 to \$2,380 between 1994 and 1998.

The more inclusive form of managed care is the HMO, the principle of which is the provision of comprehensive benefits. Thus, HMOs cover physician, hospital, laboratory and pharmacy costs, generally with minimal payments by the patient at the point of service. In addition to being responsible for the provision of care, the HMO is also at risk for the cost of care since it must deliver to patients within the overall cost envelope determined by the total income derived from insurance premiums.

One of the most significant differences between the HMO and PPI models is the health maintenance philosophy as opposed to the casualty insurance philosophy. The casualty insurance philosophy is to insure patients against high cost events. However, this system creates an incentive to make what could be low cost events into high cost events, since doctors would hospitalise their patients for diagnostic tests because they are insured if they are in hospital and not insured otherwise. The PPI model prevents this by requiring authorisation of non-emergency hospitalisations. The HMO model encourages patients to present early with symptoms and to have screening tests since the philosophy is to catch symptoms early and treat them more effectively at less cost. Enthoven argued that HMOs have thus been a step towards an integrated health care system.

Integrated care

Enthoven identified seven integrations of health care (Box 2). The first integration is financial responsibility and care delivery, where the providers are funded on the basis of pre-paid capitation. That gives the providers a defined budget within which to work and incentives to treat patients in the most cost-effective way since no more money can be made by providing unnecessary extras.

Second, integration of providers and populations, brings in the notion of population based medicine since there is an incentive for screening and to find preventive measures.

Third, comprehensive integrated services involve the development of inpatient care whilst maximising opportunities for more satisfying and economical care by also supporting the patient in the home.

The fourth integration, of doctors and hospitals, is manifest in keeping patients out of hospital, or in shortening their hospital stays, which are both important economies in health care. Physicians in integrated HMOs, such as Kaiser Permanente, have an incentive to integrate in this way since they share the net income of the hospital such that they are rewarded if they use the hospitals more economically.

Hospital systems are also being integrated. In Sacramento (California), for example, seven non-profit hospitals have joined into one hospital system, resulting in reduced duplication of management tasks and clinical provision.

The integration of doctors with other professionals occurs, for example, where primary physicians share the same offices and quarters with specialists and other therapists. This results in closer partnership and improved continuity and economy of care. This form of integration is also associated with making increasing use of nurse practitioners, often in

Box 2 *Enthoven's seven integrations of health care*

- Financial responsibility and care delivery
- Providers and populations
- Comprehensive integrated services
- Doctors and hospitals
- Hospital systems
- Doctors and other professionals
- Information

partnerships with doctors, helping, for example, to smooth referral patterns so that appropriate referrals are made and inappropriate referrals are avoided.

The final aspect of integrated care is integrated information where comprehensive, electronically storable and retrievable, medical records are linked with encounter data and with the laboratory and pharmacy, so that if a patient shows up anywhere in the system, the provider caring for him can call up this information. Experience in the US suggests that this final integration is far from being achieved, however.

Managed competition

Enthoven argued that US experience of managed competition reveals that effective purchasing has been difficult to achieve. It was believed that a competitive market and informed patients who made choices would be enough to make the system work. However, creating these conditions involves a lot of information gathering, and is progressive and long-term. A key problem has been getting consumers to become interested in choosing a more cost-effective health care system. Enthoven argued that, to achieve this, it is necessary to create price elastic demand so that the insurance carrier faces the prospect that raising prices will lose customers whilst lowering prices will attract customers. Enthoven argued that a multiple choice of plan would help achieve this aim since consumers would be able to make informed decisions based on cost and coverage as well as having information on quality, methods of operation and the like.

“US experience of managed competition reveals that effective purchasing has been difficult to achieve ... A key problem has been getting consumers to become interested in choosing a more cost-effective health care system.”

Alain Enthoven

A side-effect of having competing health insurance arrangements is the problem that the easiest way to prosper has been by selecting the healthy and avoiding the sick. Enthoven argued that a number of measures can be used to avoid such problems:

- risk adjusted premiums that reflect diagnostic history and likely expenditure;
- standardise coverage contracts;
- permit no exclusions from coverage for pre-existing conditions, of the type that have occurred in the traditional commercial insurance model;
- focus on consumer protections such as: dispute resolution processes; limits on doctors' financial incentives; confidentiality of doctor/patient communications; defining emergencies for coverage purposes; and curbing deceptive practices.

Enthoven showed that HMO membership in the US has grown about 12% per year during the 1990s to cover 80 million people by 1998. As a consequence, the percentage of the population receiving the traditional fee-for-service indemnity model of health care fell from 71% in 1988 to just 18% by 1997. Health insurance premiums have also flattened out, helping the percentage of GDP spent on health care in the US to stabilise at 13.6%. Hospital systems have been consolidating by cutting overheads and capacity, and managed competition has exposed the surplus of specialist physicians in some areas such that there has been a geographical redistribution of doctors to practice in under-doctored places.

More recently, however, there has been the start of a managed care backlash. Physicians have been angered over their loss of authority, autonomy and income, whilst many insured consumers, who previously had their health care paid for by their employers, see managed care as leading to a loss of benefits. The basic problem is that it has been very difficult for the American people to accept the idea that there can be limits on their use of third party payer medical care.

FROM COMPETITION TO COLLABORATION: TOWARDS MANAGED CARE IN NEW ZEALAND?

Michael Powell

The political and health system context

Michael Powell highlighted the importance of the changing political context in New Zealand for the development of its health care system. In 1993, a new government in New Zealand introduced a radical health policy shift through the introduction of an UK-style internal market. However, by 1996, public and political opinion had moved against the market principles of the reforms since they had failed to achieve health outcome and financial goals. During 1996, political changes heralded a more collaborative model involving a re-centralisation of funding arrangements and the encouragement of joint ventures and collaborations between service providers.

The formation of Independent Practice Associations (IPAs)

IPAs are groups of professionally-managed general medical practitioners (GPs) that developed from the 'bottom-up' during the 1990s in response to the 'marketisation' of health care. Approximately 70% of GPs in New Zealand are members of IPAs, providing them with a strong industry presence in health care. Most IPAs have been given budgetary control for pharmaceutical and laboratory services, but their desire to hold budgets to purchase secondary care has gained little support from the central Health Funding Authority (HFA) which is unconvinced about the merits of devolved budget-holding.

Service integration

Powell argued that the health care agenda in New Zealand has most recently been dominated by the central strategic objective of 'seamless' care. The central objectives have been:

- to achieve cost-effective care by reducing duplication of services, encouraging providers to consider the marginal costs and benefits of alternative care options, and reducing opportunities for cost-shifting behaviours;
- to improve health care for consumers through better continuity of care and a greater mix of services;
- to align clinical and financial incentives;
- to move financial risk down to providers through capped budgets.

No one model of integration has been centrally imposed and ten National Integration Pilot Projects have been funded to enable research on the costs, benefits and risks of integrated care. The demonstration projects are intended to build the funder's skills in contracting and the providers' experience of managing integrated care arrangements. Approved integrated initiatives include projects for children's health, people with chronic conditions, primary care services for Maoris, and the development of integrated care organisations encompassing both primary and secondary care.

Risks in the development of integrated care

Powell argued that it is critical that the funder undertakes a series of careful experiments to test integrated care concepts before decisions are made on rolling out integrated care across New Zealand. The risks are considerable and the benefits are as yet unproven. For example, getting financial incentives wrong and having an inadequate regulatory framework could provide opportunities for undesired consequences such as 'cream-skimming', the process of active discrimination against high-cost patient groups.

"It is critical that the funder undertakes a series of careful experiments to test integrated care concepts before decisions are made on rolling out integrated care across New Zealand. The risks are considerable and the benefits are as yet unproven"

Michael Powell

The potential creation of integrated provider monopolies raises questions about maintaining consumer choice and the ability to extract efficiency gains. The worry was also expressed that the set-up and administrative costs of integrated care systems would outweigh potential gains.

From integrated care to managed care?

Powell suggested that the movement towards integration in New Zealand foreshadowed a bigger move towards a managed care health care system. In particular, the integration theme appears to be moving from the margins to the core of government policy. Significant steps have included: a shift in funding from public providers (hospitals) to 'Independent Service Providers' (private); continuing experimentation with integrated care projects; and

proposals to integrate all primary and secondary services based on capitated funding. However, whilst the focus on integrated care may lead to the further evolution of the New Zealand health system towards managed care, Powell counselled that recent trends were the outcome of more than a decade of experimentation, change and development. He argued that the political climate in New Zealand was such that there could be a change in government leading to a reversal of current policy trends in health care.

INTEGRATED CARE: THE NEXT BIG IDEA FOR THE NHS?

Chris Ham

Chris Ham argued that Mrs. Thatcher's reforms of the NHS in 1991 shifted the balance of power within the health service to give more influence to primary care. This fundamental shift was manifest in developments such as fundholding and GP commissioning and the separation between purchaser responsibilities and providers. These developments helped to empower entrepreneurial doctors, nurses and managers, increasing the influence of those in primary care over the commissioning of secondary care.

Ham showed how the landscape of primary care had changed out of all recognition in the last eight years. Whereas the term primary care once described the single-handed or group practice, it increasingly encompassed organisations of far greater diversity. Innovations included multifunds, total purchasing pilots, locality commissioning groups and out of hours co-operatives. Ham argued that the importance of such new primary care organisations is that they involve networks, helping to break down the isolation that characterised primary care in the NHS in the past. The development of primary care organisations encouraged practices to come together, provided a basis for peer review and promoted joint working with other agencies. Such organisations have had an impact, not just on the commissioning of secondary care from a primary care base, but also on primary care provision itself – a wider range of services being delivered in GP practices as primary care and community services have more effectively integrated within these organisations.

Ham argued that integrated care is the defining theme of recent NHS white papers but that little within these policy documents explained how to achieve it or what integrated care should look like in practice. Most recent policy has attempted to take forward some of the positive changes of Mrs. Thatcher's reforms while making alterations to those aspects not acceptable to the new Labour government – for example, maintaining the principle of GP influence over commissioning but through a more collective approach.

“Integrated care is the defining theme of recent NHS white papers.”

Chris Ham

The development in England of Primary Care Groups (PCGs) and the more radical Primary Care Trusts (PCTs) is the organisational product of Labour's reforms. Ham argued that both PCGs and PCTs are embryonic HMOs since their features mirror those characteristics of managed care organisations in the US that were described by Alain Enthoven:

- the emphasis on primary care rather than specialist care;
- having a responsibility for an enrolled population;
- giving priority to prevention of illness and to patient education because there is a clear financial incentive as well as a professional incentive to do that;

- making greater use of different kinds of staff and of the opportunities that are available for staff substitution – for example, using nurses and nurse practitioners rather than doctors;
- reviewing variations in clinical practice and promoting greater use of clinical guidelines.

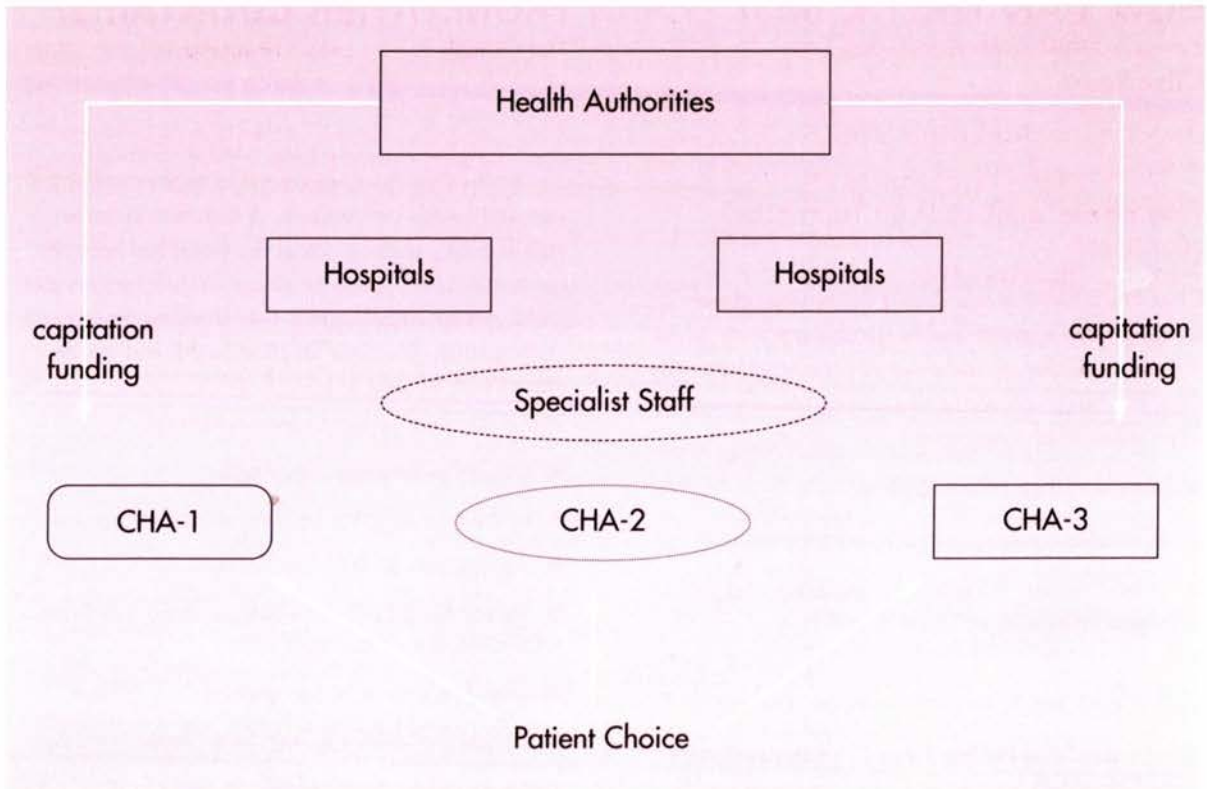
The potential for further integration between general practice and specialist medical practices is an important development since, in the UK, there has been a traditional divide between general practice (which is typically based out of hospital) and specialist medicine (which is based in hospital). In parts of the US, the development of multi-specialty groups has been encouraged such that GPs work alongside paediatricians, gynaecologists, geriatricians and other specialists in a community/primary care setting. Moreover, GPs themselves have further developed their specialist skills, perhaps to take referrals from other GP colleagues rather than to refer patients directly to hospital. Ham argued that PCGs, covering between 50,000 and 250,000 patients, will encourage service integration developments because of their size in a way that previous innovations, based around a practice population of typically 10,000, never could because it was often not economical, appropriate or efficient to achieve a high level of integration between medical specialties.

Challenges for the integration of health care in the UK

Ham set out the challenges faced by the UK government in making integration work. In particular, he argued that the innovators and entrepreneurs nurtured through fundholding should not be discarded in a policy environment emphasising equity and fairness. The importance of the health authority role in setting standards and improving quality in primary care, and in holding primary care organisations accountable for their performance, was also stressed. Managed care initiatives in the US created strong financial incentives for doctors to review their clinical performance but often in a way which had an adverse effect on equity and access to care. To ensure such problems do not materialise in the UK, health authorities ought to become the guardians of patients' interests.

Ham argued that the prognosis for the UK was a shift away from a primary care-led NHS to an integrated care system inclusive of different stakeholders leading to a more balanced view of how health and social care should be taken forward. A possible future for the NHS, as shown in Figure 1, involves the emergence of Community Health Agencies (CHAs) which focus on communities and populations and on the social care and public health agenda as well as the health service

Figure 1 A possible future for the NHS?



agenda. As recent innovations show, the initial focus is likely to be on the integration of primary medical care and community health services. Over time, however, it is possible that the budget for patient care will be directly managed with the integration of purchasing and provision. Ham commented that this prognosis has parallels with international experience, particularly HMOs in the US and IPAs in New Zealand, the common feature being the emergence of capitated primary care networks and the devolution of financial and clinical responsibility.

Ham argued that one of the consequences of recent innovations in the UK is a strong movement towards horizontal integration in many different contexts, for example between secondary care providers leading to a process of trust mergers. Vertical integration, for example between hospitals and primary care organisations, remains less well developed.

Several key operational challenges emerge in the transition to a more integrated system:

- developing a robust resource allocation formula;

- managing risk in organisations with a small population coverage;
- developing the management capacity to support developments;
- creating incentives for those involved, especially GPs;
- creating patient choice where, at present, primary care organisations in the UK are geographical monopolies.

Whilst such challenges exist, Ham counselled that one must not forget some of the strengths that exist in the UK in helping the transition. There are strengths in the registered list that GPs have (the continuity of care between patients and family doctors) and, in recent years, the ability to innovate and test out different models. It should also be acknowledged that a large number of the features of integrated care already exist. Delivering the future is partly a question of building on the strong base that already exists and continuing to offer scope for innovation, but it also depends on ensuring that standards at the bottom of the range are raised, particularly in primary care.

HOW CAN THE UK BEST LEARN FROM OTHER COUNTRIES?

Clive Smee

Why do we want to learn from other countries?

Clive Smee felt that one should be cautious about learning from overseas and be particularly wary of the danger of picking up ideas out of context. However, there is a range of reasons why policy-makers want to learn from other countries:

- to expand their policy options;
- to reinforce existing policies and preferences;
- to help prepare for a new environment – e.g. the emphasis on quality in The new NHS.

What can we learn from other countries?

Smee argued that the last 10 to 15 years have seen a globalisation of ideas about all the aspects of health

care and health care systems. A common element within policy-making across the world has been the examination of approaches taken in different systems and a greater consciousness that all countries have fairly similar objectives for their health care systems and so may be able to learn from one other. Areas in which learning has been gleaned include:

- medical technology, e.g. Viagra;
- health care systems, e.g. financing arrangements;
- policies, e.g. on long term care;
- organisational processes/management techniques, such as the use of managed care;
- emerging pressures, e.g. quality;
- reform processes, e.g. ‘big-bang’ versus evolution.

Learning can be transferred most easily in the

organisational processes/management techniques area. Experience of using measures of quality of outcome and patient experiences can also be transferred fairly easily. However, we should be concerned about different contexts and values that may limit the relevance of other countries' experiences.

How might we increase appropriate learning from overseas?

Smee argued that rather than ad hoc importation of interesting, but potentially damaging, ideas from abroad, the first task is to understand what the

problems are in the home nation health system and what solutions or alternatives would provide us with an answer. Hanging international ideas, like Christmas tree decorations, on the NHS may not necessarily be either useful or relevant. International learning can only be relevant where a conscious effort has been made to identify its relevance to domestic issues.

Smee warned that appropriate learning also requires better evaluative data and that if lessons from overseas are to be examined there is an incentive to develop a more evaluative approach to health care policies and systems and to encourage international networks

Box 3 Summary of common challenges and key differences in approach by UK NHS and US managed care

Challenge	US managed care approach	UK NHS approach
How much management is enough?	<ul style="list-style-type: none"> • Competitive professionalism 	<ul style="list-style-type: none"> • Centrally imposed economy
Encouraging the right amount of care	<ul style="list-style-type: none"> • Personal financial incentives • Advanced information systems 	<ul style="list-style-type: none"> • Tight and aligned budgets • Supply controls • Opportunity-cost-conscious providers
Reducing care variations	<ul style="list-style-type: none"> • Micro-management • Guidelines with financial incentives 	<ul style="list-style-type: none"> • Professionalism/clinical governance • Central guidelines and monitoring
Monitoring quality and outcomes	<ul style="list-style-type: none"> • Fee-for-service data sets • Advanced information systems 	<ul style="list-style-type: none"> • Population-based data sets • Matching purchaser responsibilities
Improving integration of care	<ul style="list-style-type: none"> • Organisational innovation 	<ul style="list-style-type: none"> • Coordination rather than competition • Coordinating PCGs
Managing patient expectations	<ul style="list-style-type: none"> • Co-payments • Information/education for self-care 	<ul style="list-style-type: none"> • Low public expectations • Cautious GPs
Improving care of the elderly and disadvantaged	<ul style="list-style-type: none"> • Experimentation in face of new challenge 	<ul style="list-style-type: none"> • Long experience with serving poor and elderly
Focusing on health of populations	<ul style="list-style-type: none"> • Piloting outcome-based payment systems 	<ul style="list-style-type: none"> • Public health and population-based screening programmes • Purchasers with geographical responsibilities
Funding costs of teaching and research	<ul style="list-style-type: none"> • Philanthropy of (non-profit) HMOs • Cross-subsidisation 	<ul style="list-style-type: none"> • National top-sliced levies • Level playing field
Controlling overall costs	<ul style="list-style-type: none"> • Tools of micro-management • Competition 	<ul style="list-style-type: none"> • Budget caps • Controls on supply

addressing these issues. An example is the Hospitals in Europe Link for Infection Control through Surveillance (HELICS) which has built up comparative data on hospital infection rates throughout Europe enabling examination of relative performance.

“Hanging international ideas, like Christmas tree decorations, on the NHS may not necessarily be either useful or relevant.”

Clive Smee

Smee argued that a number of common challenges existed in every health care system yet have been addressed in different ways by different countries (see Box 3). A comparative examination of the impact of these different approaches would be a useful way to begin answering which approaches appear most effective and why. For example, in managing patient expectations, the US led the way on information and education for self care, an idea that has been imported into the UK through NHS Direct – one of the fastest transfers from one side of the Atlantic to the other.

How can inappropriate learning be avoided?

Smee argued that the problem being addressed in one country is often similar to, but not the same as, the problem that needs to be addressed in another. This does not mean that learning from other countries' solutions is impossible, but it does mean that often 'solutions' were used in another country to address a different problem. For example, diagnostic related groups (DRGs) in the US have been used mainly as a cost-control device, whilst in the UK, through mutation to healthcare resource group (HRG) reference costs, the approach has been used as a mechanism for promoting incentives for efficiency in hospitals.

Smee also counselled that different countries have differing values and organisational arrangements. For example, it is often said in the UK that learning from

New Zealand is appropriate because its context is similar. However, the values and the organisational arrangements are substantially different in many ways – for example, the primary care system in New Zealand, with no patient lists, is very different. One has to be very careful, therefore, about seeking to learn from other countries without first understanding contextual and environmental differences.

Probably the most important point to make is whether there is evidence to suggest that ideas that are being marketed by other countries, particularly the US, are cost-effective or implementable. Ideas now travel so rapidly that if you wait until you can answer yes to such questions the idea in question has probably gone out of fashion. However, it is a real concern that innovations are often implemented without first being evaluated.

How important is learning from other countries?

Learning from other countries is extremely fashionable but there are other sources of policy ideas that could be used in a more systematic way:

- greater introspection;
- better understanding of outlying practice;
- examining the approach of other public departments, such as education, to similar events, such as a purchaser-provider split and league tables of provider performance;
- analysing the private and voluntary sectors to fashion ideas for health care.

International learning has accelerated the introduction of innovations in the UK but the ability to learn from others should not be exaggerated. The great value of international comparisons is the opportunity to identify different ways of doing things. However, one must evaluate them, since those who promote them may not be evaluating them in a way that we find acceptable. Expectations should also be kept low since one model will not fit all. Although there is some convergence in thinking, attempting to identify 'the model' for delivering health systems which will work in all kinds of situations is fruitless.

COMPARING HEALTH CARE IN THE UK AND NEW ZEALAND

Loraine Hawkins

Loraine Hawkins agreed with Smee's call for caution in the use of international comparisons. In particular, comparisons between New Zealand and the UK often failed to understand the historical and cultural context and the impact these have on developing the right kind of health system.

The rationale for learning between the UK and New Zealand is based on similarity in institutional history, particularly the following:

- national health systems founded in similar circumstances;
- funded by general taxation ;
- committed to the principle of access to care being independent of the ability to pay;
- GPs acting as gatekeepers to specialist care;
- largely cash-limited health budgets.

However, there are a number of important differences in the New Zealand system to take into account:

- public hospitals were funded by the Department of Health but were a form of local government agency (a funder/provider split) until 1993;
- primary care is private and, until recently, mainly on a fee-for-service basis;
- the service is only free for maternity care, hospital care and for young children's visits to doctors;
- there is greater pluralism in financing - 77% comes from public sources in two streams: through the Ministry of Health and a social insurance scheme that pays for accident-related care;
- a greater number of non-governmental providers of health care, including Maori organisations.

Health care reforms in New Zealand and the UK in the 1980s and 1990s both included forms of purchaser/provider splits and fundholding. However, this similar language disguises fundamental differences in operational terms. In New Zealand, the purchaser/provider split did not create a UK-style funder/provider relationship and self-governing hospitals with greater autonomy. Instead, a regional tier of funders was introduced that increased central control and reduced hospital autonomy. In the case of primary care, New Zealand always had a free market with little regulation or accountability, and with associated cost containment problems through fee-for-service subsidies. In the UK, reform issues were concerned with greater responsiveness to patients and giving GPs influence over secondary care. Thus, in the UK, reformers were interested in using GPs as agents of patients in relation to secondary care, whereas in New Zealand most interest was in trying to bring maverick GPs into the public health system.

Whilst both countries experimented with GP budget-holding there were a number of key differences in the approach (see Box 4). Hawkins argued that the caution in New Zealand about GP purchasing helped to avoid the controversy about two-tier waiting times and GP management costs that bedevilled the UK fundholding system. Moreover, the New Zealand approach avoided a clash over GP power relative to other primary care staff such as nurses and practice-attached midwives. On the other hand, UK GPs have had more leverage over hospitals for service changes.

A further illustration of the differences in primary care between the two countries is that 95% or more of a GP's income in the UK is derived from public sources

Box 4 *New Zealand and UK approaches to GP budget-holding*

New Zealand GP budget-holding

- Large IPAs are paid 50-70% of savings they make on national drugs and diagnostic budgets;
- GPs do not purchase or commission services in secondary care;
- Local contracts for primary care development.

UK fundholding schemes

- Fundholding practices keep 100% of drugs bill and other savings, but 'bank' with health authorities;
- Fundholders can purchase a range of hospital and health care services, including non-elective services;
- National contract for the provision of General Medical Services.

whereas not much more than one third comes from health authorities in New Zealand. The majority of GPs' income in New Zealand is paid via a combination of direct patient fees (about 30%), private medical insurance (13%), and the remainder coming from the social insurance agency that purchases accident-related care. Thus, in New Zealand, GPs are probably more accountable to patients directly than they are accountable to health authorities.

Access to primary care also differs. The number of GPs per thousand population is a little higher in New Zealand, though the distribution in the two countries is similar (ranging from 0.5 to 0.9). New Zealand, however, has more than double the number of practice nurses, who also enjoy enhanced responsibilities (e.g. fielding patients' clinical inquiries). Hawkins explained that the difference was almost certainly due to the availability of a practice nurse subsidy in New Zealand. She argued that responsiveness to patients was better in New Zealand since no patient has difficulty finding a GP of their choice nor has to wait up to a week for a consultation. Hawkins also revealed that New Zealand employed far more pharmacists – around 0.7 per thousand population compared to 0.2 per thousand in the UK.

Relative to the UK, however, Hawkins argued that the New Zealand primary care system was deficient in certain areas. In particular, she argued that New Zealand had some catching-up to do in areas such as information and computerisation; performance in achieving immunisation and screening targets; and feedback on prescribing activity and use of diagnostics.

In terms of the integrated care agendas for change in the two countries, Hawkins argues that there is some overlap:

- moving towards a proactive model of primary care which is population-focused, with greater planning on how best to meet the health needs of the population;
- improving equity of resource allocation to populations;

- developing larger and more multi-disciplinary primary care teams;
- co-ordinating/integrating primary care practice with community health services and co-ordinating health services with social services;
- performance measurement.

Hawkins argued that there was scope within these common agendas for exchanging relevant experiences and for developing similar techniques. For example, in terms of the broader agenda of service integration, the UK's experience of Health Action Zones and the development of long term service agreements relates closely to the New Zealand experimentation with integrated care pilots.

Hawkins stressed, however, that differences between the UK and New Zealand contexts limit the extent of joint learning. One important difference is that in the UK the development of PCGs has employed a model of geographic monopolies aligned with local government authorities, whereas in New Zealand primary care monopolies are unlikely since GP-led commissioning is not supported by policy makers. A further difference in New Zealand is that a strong Maori health care system exists that requires the provision of different services for its population. Perhaps most fundamentally, GPs and patients in New Zealand do not value a national health care model quite as much as those in the UK, primarily because the UK model would inhibit traditionally valued freedoms.

Hawkins concluded that differences between the health care systems of New Zealand and that UK were worth exploring. In particular, the development of PCTs in the UK had potential lessons for New Zealand as a model for how primary care can be integrated at delivery level with community health services. Hawkins also argued that New Zealand could learn from the UK's innovations in measuring primary care performance. Conversely, the development of integrated care organisations in New Zealand was argued to be of relevance to the UK, particularly developments in public/private partnerships.

CLINICIANS MANAGING CARE: THE FUTURE FOR THE NHS?

Jonathan Shapiro

Jonathan Shapiro examined the role of the professional in health care and argued that it needed to change since a number of generic problems existed in health care systems as a consequence of professional dominance and autonomy.

- Demand outstripping supply. Health care professionals tend to drive up demand for care by utilising new technologies as they emerge; for example, within hospitals, by developing new techniques and using the most modern equipment. However, fuelled by public expectations, governments in general are unwilling to pay more money for such activity and hence demand outstrips supply.
- Authorities have been unable to manage doctors. Consultants (medical specialists) have traditionally been very independent within the hospital sector. In particular, their clinical freedom has traditionally been sacrosanct, with few questioning clinical practice. Authorities have been administrative rather than managerial and their decision-making power over consultants has been very limited.
- Governments cannot manage doctors. Medical opinion has a strong hold on public opinion, with doctors enjoying the high moral ground, making it difficult for governments to control medical opinion. Managing doctors also implies restrictions, and any thought of restricting medical professionals' activities tends to be seen as rationing.

Can clinicians manage themselves?

One of the underlying tenets of the UK reforms of the 1990s was to put GPs onto the purchasing side of the equation to make them more aware of the financial consequences of their actions. There was a very marked change in culture with incentives becoming financial, in particular the ability for savings to be reinvested into services. However, financial incentives in the internal market, and contracting in particular, were not in themselves very effective tools for achieving service changes in the acute sector.

Perhaps a more important result of the reforms was that the consultant/GP relationship changed from 'parent/child', through 'sibling rivalry', to a more 'adult' relationship, with the GP having considerably more power in negotiations.

Over time, the culture appears also to have changed into a more professional one based increasingly on quality rather than purely on cost.

In future, a major change will be the move towards true professional clinical governance with collective responsibility between doctors and a range of other stakeholders including nurses and the public. Such a system requires a culture shift amongst existing professionals towards power sharing. However, once achieved, such a system would be very robust.

In delivering such a future, Shapiro gave four warnings:

1. politics and health care do not mix well, yet in every country the political context is an important factor;

"It has to be acknowledged that professionals will always play the system. If it's a good system they will play it well, but if it's a bad system they will just play it to meet their own ends."

Jonathan Shapiro

2. the link between care purchaser and service provider, whether it be centralist or devolutionist, has consequences since it has to be acknowledged that professionals will always play the system. If it is a good system they will play it well, but if it is a bad system they will just play it to meet their own ends;

3. large organisations always seek structure. PCGs, for example, have been developing structures before understanding the functions they will need to perform. The paradox is that large organisations and structural solutions usually do not work in health care;

4. the role of the consumer is likely to remain tokenistic. As George Bernard Shaw said: 'all professions are conspiracies against the laity'.

REFLECTIONS ON THE DAY

Alain Enthoven

Enthoven reflected on the fact that a common experience in New Zealand and the UK was the undertaking of a great deal of restructuring in the last ten years. He was impressed with the level of innovation, variety and diversity of prototypical schemes implemented in the search for a more effective health care system. Enthoven argued, however, that one should not be attempting to think of the ideal concept for a health care system. He argued that there is no one health care model, but perhaps a set of principles that underlie an ethical welfare system which then allows local sensitivity both in terms of service delivery and culture.

“There is no one health care model, but perhaps a set of principles that underlie an ethical welfare system which then allows local sensitivity both in terms of service delivery and culture.”

Alain Enthoven

Enthoven argued that the presentations had shown that there are so many important and conflicting factors – from professional values to patient values and from technology to economics - that no complete theory would be able to reveal the best way to organise things. Instead, he argued that it was important to develop a flexible health care system with the ability to adapt to changes in medical technology and economic and social conditions.

Enthoven concluded that there was great value in the process of Darwinian learning – learning through experience – and of empowering people in the field by devolving the responsibility of resources to managers and to let them develop solutions that will be adaptive to their particular circumstances. Lessons could also be learned from the experiences of health care innovations in different countries. By sharing what is going on, so you can actually learn from each other, whether it is about information, or best clinical practice, best management practice or best cultural practice.

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