Can the NHS learn from US managed care organisations?

Jennifer Dixon, Richard Lewis, Rebecca Rosen, Belinda Finlayson, Diane Gray

A new King's Fund study identifies factors associated with efficient management of chronic disease in the United States

Managed care organisations in the United States have some parallels with primary care trusts in the NHS. A key aim of both is to improve health so that avoidable use of health care is reduced. Managed care organisations have strong inbuilt incentives to manage the care of enrolled patients proactively (box 1). Two studies recently reported that hospital admissions and use of day beds for the population of one managed care organisation, Kaiser Permanente North California, were less than that for a comparable population in the NHS.²⁻³ The findings raised hot debate, and the study by Feachem et al was criticised mainly because of the methods of comparing the US and NHS populations served and costs.⁴ On the assumption that the reduction is real, we examine what factors might contribute and whether the NHS could adopt them.

Background

The Department of Health is already funding two pilot projects modelled on Kaiser Permanente⁵ and another major managed care organisation, United Health Care, in 18 primary care trusts in England.⁶ Nevertheless, there seems to be no consensus about why hospital admission and day bed rates might be lower in managed care organisations or the useful lessons for the NHS.²⁻⁴ We studied how five relatively highly performing managed care organisations organise care for people with chronic conditions, such as asthma, diabetes, chronic obstructive pulmonary disease, and heart failure. We focused on chronic conditions because they are among the costliest to treat in the NHS and the United States,⁷ evidence exists that effective ambulatory care can reduce the risk of inpatient care, and the large variations in rates of hospital admission by primary care trusts suggests that care of patients in the NHS could be better.⁸ The full report is available from the King's Fund.⁹

Study methods

We selected five managed care organisations that served a population of at least 100 000 including people on Medicaid (mainly families on the lowest incomes) and had relatively high scores on performance indicators relevant to chronic disease management (using the Health Plan Employer Data and Information Set¹⁰). Unfortunately, we could not compare hospital admission rates for chronic conditions between managed care organisations because such data are not reported publicly. The organisations selected were Kaiser Permanente (North California), Group Health (Washington State), Touchpoint Health Plan (Wisconsin), Anthem (Connecticut), and Health Partners (Minnesota).

A team from the King's Fund visited each organisation in 2003 to identify the factors associated with good management of chronic disease. The teams

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collected data using semistructured interviews with senior staff, grey literature, visits to clinical facilities, and contacts with practising clinicians. We adapted a framework set out by Ferlie and Shortell¹¹ to group factors that seemed to be associated with success into three domains: the wider environment, the organisational domain, and the clinical process.

Findings

Wider environment

In the wider environment, we found that market pressures on managed care organisations created an important incentive to increase the efficiency and quality of care for people with chronic conditions. Competition between managed care organisations for members (particularly competition for contracts with large employers that are the major purchasers of care) seemed to have more influence on change than competition between providers for contracts with managed care organisations. The need to survive in the marketplace helped to align the objectives between managers and clinicians.

However, when competition for members was intense, it created disincentives to improve chronic disease management and incentives to focus on attracting younger, healthier (and cheaper) members. Thus the market could act as a positive and negative force, and the underpinning values and mission of the managed care organisation was an important mediating factor in improving the quality of care.

Box 1: Functions of a typical managed care organisation¹

- Monitor and coordinate care for an enrolled population for a fixed annual fee
- Monitor and coordinate care throughout the entire range of services (primary to tertiary care)
- Emphasise prevention and health education
- Encourage the provision of care in the most appropriate setting by the most appropriate provider
- Promote the cost effective use of services through various means

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Health Policy, King's Fund, London W1G 0AN

Jennifer Dixon
director

Richard Lewis
visiting fellow

Rebecca Rosen
fellow

Belinda Finlayson
research officer

Diane Gray
visiting fellow

Correspondence to: J Dixon
jdixon@kingsfund.org.uk

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Box 2: Organisational factors encouraging good management

Strategic values that support long term investment in managing chronic diseases

Well aligned goals between physicians and corporate managers in managed care and provider organisations, with a limited set of mutually agreed targets

Investment in information technology systems and attention to accuracy of clinical data

Use of financial incentives to shape clinical behaviour

Evidence of cost effectiveness of better primary care in reducing preventable hospital admissions

Organisational domain

The freedom that managed care organisations had to set their own priorities and the process of setting priorities through negotiation between corporate and clinician managers contributed to good performance. Of particular importance were good, long term relationships between corporate managers and clinical leaders based on trust, shared values, and the desire to integrate primary and specialist care—for example, through shared information systems and clinical protocols.

When managed care organisations worked exclusively with affiliated groups of physicians, the financial incentives for both to improve management of chronic disease were especially well aligned. Attainment was more likely if clinicians in the provider and managed care organisations jointly agreed a limited set of targets. The more organised and cohesive networks of physicians also seemed more willing and able to implement effective chronic disease management than loose networks of solo practitioners. The relationships between doctors (in provider or managed care organisations) and non-clinical managers were strong, although few leadership opportunities existed for other clinical professionals. Finally, a stable population with relatively low annual turnover was also critical to encourage investment in managing chronic disease.

Clinical process

We found widespread use of aspects of the chronic care model, a generic model of care with six elements to help organise better care for people with chronic conditions.¹² Four of the organisations identified patients at high risk of illness and targeted intensive case management at these patients, mainly through nurse-led outreach care. Lower risk patients were offered disease specific proactive management programmes. These included clinical guidelines with prompts to clinicians and patients, information technology based decision support systems for clinicians and patients, patient education and self care, electronic disease registries, and feedback of accurate real time clinical data to physicians on their patients with supportive and regular peer review. There was little focus on social care. With one temporary exception, all organisations had made large investments in case management (which was perceived or shown to be very cost effective) and disease management.

Limitations of study

We did not use a comparison group in our study so we cannot be certain that the factors we have identified are responsible for successful care of people with chronic

conditions. We can claim only that these factors seem to be associated with success. However, our findings are similar to those of other surveys conducted in the United States.^{13–15} Furthermore, we made little attempt to ensure that the populations served by the five managed care organisations were comparable with each other or those in the NHS. We did not assume that care was necessarily better in the United States; we aimed only to identify factors associated with good performance that could be useful to the NHS.

The wider health system environment obviously differs in the United States and the NHS. US health care is well funded but denies universal access; it is competitive, decentralised, and shaped by a multitude of powerful stakeholders. Market pressures exert powerful effects, with healthcare organisations forming and folding constantly. The NHS has grown out of a different social contract; equity, parsimony, and continuity are valued and pursued through central hierarchy and control.

Incentives for innovation

Overall, we were convinced that the incentives arising from market pressures on the managed care organisations (within limits) contributed to the quality of service and the focus on the needs of their members. So what messages are there for the NHS? Primary care trusts have some big advantages over managed care organisations in trying to improve chronic care. They have the benefit of national strategies, implementation programmes, targets, and investment in the shape of national service frameworks^{16 17}; financial incentives to improve care of people with chronic conditions arising from the new general practice contract¹⁸; and generally low patient turnover. But they also have potential disadvantages—minimal incentives to prompt constant innovation and consumer focus or to harmonise the goals of managers and clinicians. Stronger incentives will be needed to prompt more innovation.

Broadly two routes could be taken. The first is to introduce more market incentives for trusts—such as encouraging competition for patients or for contracts from the NHS to commission care. Such a policy would clearly need accompanying regulation to guard against problems such as adverse selection. At present encouraging competition among primary care trusts for patients is risky: trusts are still at an early stage of development, movement of patients between trusts may be insufficient to generate competitive pressure, and the benefits of the current geographical population focus of trusts may be lost. But a start could be made through careful piloting of competition by comparing performance indicators and periodic market testing of management of primary care trusts that perform poorly.

The second approach would be to strengthen non-market financial incentives in the NHS for all relevant parts of the health economy (primary care trusts, general practices, NHS trusts, social care). This provides much scope for creativity, pilots, and local innovation. For example, financial incentives could be introduced that prompted specialists and primary care staff to work jointly to reduce the risk of inappropriate hospital admission. Another example would be to create a joint budget across primary and secondary care for people with chronic conditions, building on current experiments with multispecialty teams.¹⁹

Organisational and clinical factors

The factors in the organisational domain that seemed to encourage good management of chronic diseases (box 2) were perhaps unsurprising. In some ways NHS policy is moving along the same lines. The new general practice contract provides financial incentives for general practitioners to improve care of people with chronic conditions, investment in information technology is ongoing,²⁰ and attempts are being made to develop clinical leadership. But the study highlighted weaknesses in the NHS—such as the frequent dissonance in goals between clinical and managerial staff, the lack of evidence base or a business case for managing chronic diseases, the strong focus of national policy on elective care rather than chronic care; and the lack of (financial) incentives for specialists (or NHS trusts more generally) to help to reduce the risks of admission.²¹

The clearest clinical message for the NHS was the perceived benefits of identifying high risk patients for targeted intensive management. One chief executive of a managed care organisation put it bluntly: "Without case management, we are sunk in the marketplace." Many high risk patients are aged over 65 with multiple chronic illnesses. Primary care trusts need to take the lead on case management, and some have already shown good results, particularly in partnership with social services.²²⁻²³ The cost effectiveness of disease management programmes in the United States is less clear, and more research is needed in Britain. Nevertheless, evidence exists that multifaceted interventions along the lines of the chronic care model are effective.²⁴ Case management needs to be supported by investment in collecting accurate information on patients' use of care and encouraging regular peer review by clinicians.

Conclusion

Our research suggests that the NHS can learn from US managed care organisations on improving care for people with chronic conditions. Primary care trusts, general practices, and NHS trusts could, for example, focus on reducing preventable admissions for people with chronic conditions; align goals of clinical and managerial staff more successfully; pilot risk stratification and case management programmes; and collect accurate information on each case and encourage clinicians to peer review their care.

For the Department of Health, our work suggests the need to evaluate the best way to provide stronger incentives for improving the quality of care of people with chronic conditions. It also needs to consider creating more opportunities for targets to be locally determined between clinicians and managers. More evidence is needed on the best ways to identify high risk patients and the cost and effects of multifaceted management of high risk patients and disease specific management programmes for lower risk patients.

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Contributors: JD has studied and reported widely on health policy issues and has a long research interest in avoidable admissions and US health care. RL has a background in health service management and has studied and reported widely on health policy issues, in particular primary care. RR is a practising general practitioner and a public health physician who has studied and written on policy issues particularly on primary care. BF

Summary points

Competitive pressures between managed care organisations provide an incentive for innovation in management of chronic diseases

Doctors in these organisations have a strong management role

Goals are agreed between clinicians and managers, and financial incentives exist to improve care

All managed care organisations identify high risk patients and target intensive nurse led outreach care to minimise hospital admissions

Multifaceted chronic disease management programmes were used, in which self care and patient education were central features

has written on regulation in health care and workforce issues in the NHS. DG is a practising public health physician with a particular interest in chronic disease management.

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