Education and debate

US and UK health care: a special relationship?

What can the UK and US health systems learn from each other?

Lois Quam, Richard Smith

The NHS and US insurance based health systems seem worlds apart. Despite the differences, each has much to learn from examples of good practice in the other

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

Learning within clinical medicine often spreads rapidly across the globe. Once an innovation—for example, thrombolysis for patients with heart attacks—is accepted, it is likely to be picked up rapidly in most countries. This is because cardiologists travel to world meetings, know each other well, read the same international journals, and are encouraged to innovate by global pharmaceutical companies. In stark contrast, innovations in how care is organised and delivered have rarely spread. We examine why countries have not been good at learning from each other and some of the areas where learning between the United Kingdom and United States could be beneficial.

Barriers to learning

One obvious barrier is that healthcare systems are culturally, politically, economically, and socially bound in a way that cardiologists' interventions are not. This has led some people to believe that international learning is impossible. Another barrier is mutual ignorance. Health systems have become so complex that few people have a deep understanding of more than one system. Who in Britain, for example, could explain with complete confidence the workings of the NHS in England, Scotland, Wales, and Northern Ireland? This inhibits learning not only internationally but also within one nation state.

A more disturbing block to learning is a feeling that to learn from others is a sign of weakness—even failure. We saw some of this perhaps in the hostile reaction to the *BMJ* paper that suggested that Kaiser Permanente might get significantly better outputs than the NHS for roughly similar inputs.¹ There were legitimate reasons for criticising the study,^{2–3} but a much healthier reaction to the paper would have been to look more deeply at Kaiser and try to learn from the opportunity.⁴ It is a demonstration of strength rather than weakness to be open to learning from others.

Most learning, says Peter Senge, inventor of the learning organisation, comes from doing, not simply from reading, observing, or listening; think of learning to tie shoelaces.⁵ This presents another barrier to learning across health systems. Reading an article on

Fig 1 Risk adjusted mortality from cancer against length of stay for institutions in New York State. The size of the circle indicates the number of patients treated

what happens in other countries or visiting for a few days will not be enough—although it may provide a spark, and we concur with W B Yeats that “education is not the filling of a pail but the lighting of a fire.” True learning, says Senge, comes from doing things together and occurs when teacher and learner are in a new place. “By learning you will teach; by teaching you will learn,” says the Latin proverb. “All teach, all learn” is the modern version and implies not a fleeting visit but a joint project. The NHS has examples of the Modernisation Agency working with the Institute for Health Care Improvement in Boston on many projects and of 10 primary care trusts working with the United-Health Group to try to improve the care of frail elderly people. The results are not copies but something new.

Opportunities to learn

We thought it important for this article to have a prelude on learning, but we want now to identify opportunities for transatlantic learning. Although we can

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A list of learning opportunities is on bmj.com

outline opportunities, true innovation will come from joint projects. The box lists some of the examples of learning we considered, but we have space here to consider only four—two in each direction. We've deliberately avoided some of the more obvious learning points—like the new general practitioner contract, the National Institute for Clinical Excellence, the care of patients with long term conditions, and the integration of primary and secondary care in a model like that of Kaiser—which have been well covered elsewhere.^{1 5–8}

Opportunities for the United Kingdom

The Institute of Medicine

Britain would undoubtedly benefit from having an organisation like the Institute of Medicine. Indeed, some prominent figures in British health—particularly Sir George Godber, arguably England's most distinguished chief medical officer—have been arguing this for decades. The Institute of Medicine, which was chartered as part of the National Academy of Sciences in 1970, has huge influence in American health care. Its report on medical error, for example, pushed that long neglected issue to the top of the agenda and had reverberations around the world.^{9 10} In the past year it has produced reports on childhood obesity, health literacy, and the uninsured.

The institute's influence comes from a combination of factors that are not found together in one institution in the United Kingdom:

- It can call on the best and the brightest—It has over 1500 members, all of them distinguished, but anybody can be invited to join a committee producing a report. And people will respond because of the prestige and influence of the organisation
- Members are not all from health care—At least one quarter of members must be selected from outside the health professions, from fields such as the natural, social, and behavioural sciences as well as law, adminis-

Fig 2 Number of procedures against one year survival for centres performing heart transplantation in the United States

tration, engineering, and the humanities. This diverse membership improves the quality of the thinking and the credibility of the reports

- The institute is independent of both government and professional factions
- It has adequate resources to produce high quality reports—Too many British organisations (for example, the Academy of Medical Sciences) lack the resources to do the quality of work that the Institute of Medicine can achieve
- The institute has well designed processes of peer review and for avoiding conflicts of interest. Those who work on reports are not compensated for their work.

All of these ingredients are important, and if Britain had a similar body there might be much less suspicion of science. The quality of public debate on health issues could also be much improved.

High performance, low cost centres for complex procedures

Figure 1 shows adjusted mortality from cancer plotted against length of stay (a surrogate for cost) for institutions treating patients with cancer in New York State in 2000. One institution (the Memorial Sloan-Kettering Cancer Center) stands out with both lower costs and better outcomes, but generally cost and outcomes are not clearly correlated. Higher cost does not mean a better result as it would with wine, cars, or hotels. This finding in health care of no clear relation between cost and outcome is usual; if you were buying care for a population—as primary care trusts do in England—it would seem to make a lot of sense to buy from institutions that have good outcomes and low costs.

Figure 2 shows survival against number of heart transplantations in 139 centres in the United States. Centres doing more operations tend to have better results, and patients are willing to travel for major procedures such as heart transplantation. By creating a network of centres that do more than 15 transplantations a year and achieve one year survival rates above 77.5%, UnitedHealth Networks has increased survival and lowered costs. Similar benefits can be achieved for patients needing other transplant operations and being treated for congenital heart disease, rare and complex cancers, infertility, and extreme prematurity.

Britain tends to have fewer centres doing many of these activities, but combining the production of high

Opportunities for transatlantic learning in health care

What the US might learn from the UK

1. The effectiveness and efficiency of ensuring health care without regard to ability to pay
2. Paying general practitioners for quality and outcomes
3. National Institute for Clinical Excellence—particularly its use of cost utility data to help decide which innovations should be introduced into the NHS, how it incorporates public values into its decisions, and how it is beginning to regulate surgical procedures
4. National Patient Safety Agency—one of few examples of a national programme to make health care safer

What the UK might learn from the US

1. Institute of Medicine—how medicine can speak with one highly respected and well informed voice
2. Building a network of high performance, low cost centres for complex healthcare procedures
3. Getting maximum value for money through knowing much more about the costs and benefits of different procedures
4. Management of patients with long term conditions

The full list of examples considered is on bmj.com

quality data on outcomes and costs with the building of networks could produce better outcomes at lower cost—especially if such networks were European rather than simply British.

Opportunities for the United States

Modernising professional learning

Continuing medical education (CME) in the United States is a multibillion dollar business funded largely by pharmaceutical companies. Much of it comprises traditional forms of education, with “experts” (often funded and even invited by the pharmaceutical companies) giving lectures to non-experts. The result is little learning and no change in practice,¹¹ but physicians need to accumulate “CME points” in order to remain in their specialty practice.

The United Kingdom also has its share of this expensive but largely ineffective enterprise, but it is increasingly recognising that it's possible to do much better. Every doctor in the United Kingdom is now required to have a personal development plan, and this must be built from a “diagnosis” of learning needs. Doctors measure their competencies against those needed for their specialties. The General Medical Council has defined the competencies needed by all doctors,¹² and various specialist groups, including for example, the Royal College of General Practitioners, have defined the extra competencies needed for their specialties.¹³ Professional bodies in the United States have not defined what is a good doctor, but without such a definition it is impossible to know whether professional examinations are measuring what they should be measuring.

Many other tools can be used to identify the learning needs of doctors, including some that are derived from interactions with patients. Once they have identified their needs, doctors in Britain are required to show how they respond to those needs, recognising that there are many different ways to learn and that individual doctors will have different learning styles. A record of their needs and the responses is kept in a personal development plan, which must be presented during the annual appraisal that is now required for all doctors in Britain.

Increasingly, doctors are also encouraged to learn with other professional groups. Multidisciplinary learning has long been praised but hasn't happened much. Now it is beginning to happen. We lack the evidence that this new form of learning will improve patient care, but there are sound educational reasons for thinking that it will be much superior to a diet of lectures from experts.

Using information technology to improve patient care and experience

The Institute of Medicine, which we praised above, advised that moving from a paper to an electronic based system would be the single step that would most improve patient safety.⁹ At the moment, patient records are often not available when patients are admitted for emergency care and are regularly lost in routine care. Furthermore, they are held in multiple places and are disorganised. For patients with long term or complex conditions, it can be impossible to find essential information in the bulging and often disintegrating files.

In addition, health care has heavily underinvested in information technology compared with other enterprises (fig 3). Those who pay for health care have understandably put investment in staff and treatments before investment in technology, but in the long term this is a mistake. Health is a knowledge based enterprise, and yet the knowledge has been disorganised and often inaccessible.

In 2002, a major report on the needs of the NHS over the next 20 years concluded that “without a major advance in the effective use of information and communications technology, the health service will find it increasingly difficult to deliver the efficient high quality service, which the public will demand.”¹⁴ A massive programme—the National Programme for Information Technology—is now under way in England.¹⁵ It is costing more than £6bn (\$11.3bn, €8.7bn), will take 10 years, and aims to link all parts of the NHS so that records will be accessible everywhere and to provide a platform for the employment of increasingly sophisticated information tools.

Unsurprisingly, the programme faces major hurdles, but the first stage of procuring and installing the technology is well under way; the government seems to have used its buying power effectively. The next stage of encouraging people to change the way they work will be both more difficult and more important in terms of delivering value from the investment.

Some parts of the US health system use information technology very effectively, particularly the Veterans Health Administration, but the biggest benefits depend on having information systems that work right across a health system, providing information on patients no matter where they may travel or which doctors or institutions they might use. Groups in the United States have recognised that an improved information technology system may be the “big hope” for improving the quality of health care and slowing the relentless rise in costs. But within the fractured US health system it's hard, perhaps impossible, to find organisations willing to make the huge investment that is needed to “wire the whole system.” If the UK programme can show that substantial improvements can flow from such a major investment, pressure to find a way to do something similar in the United States will grow.

Fig 3 Annual expenditure per employee on information and communication technology in United Kingdom in different economic sectors, 2000

Summary box

Learning across health systems comes mostly from joint projects

The United Kingdom would benefit from having an organisation like the US Institute of Medicine

Europe should consider building a network of high performance, low cost centres to do complex procedures

The United States is wasting large sums on old fashioned continuing medical education, whereas Britain is modernising professional learning

The US would benefit from system-wide information technology such as that being introduced in England

Conclusions

Learning from other healthcare systems is not straightforward, but all systems face the same fundamental problems of quality, safety, access, usability, availability, and affordability—and all perform suboptimally. We see increasing examples of interaction and learning among systems. Such learning will benefit patients.

Contributors and sources: LQ was a Rhodes scholar in Oxford and is now the chief executive of Ovations, which provides services for seniors in the United States. She also worked with Hillary Clinton on the reform of US health care. Formerly a member of the *BMJ* editorial board, she has worked closely with

staff in the Department of Health and the NHS to establish programmes in England. RS was editor of the *BMJ* and chief executive of the BMJ Publishing Group for 13 years. Before becoming the editor he spent a year at the Graduate School of Business at Stanford in California. LQ and RS produced a list of possible options for transatlantic learning, partly through the experience and reading and partly through asking others on both sides of the Atlantic. RS produced the first draft, which LQ then corrected. Both have read and approved the final version. RS is the guarantor.

Competing interests: Both authors are employees of the UnitedHealth Group, which operates predominantly in America but is hoping to develop its business internationally.

- 1 Feachem RGA, Sekhri NK, White KL. Getting more for their dollar: a comparison of the NHS with California's Kaiser Permanente [commentaries by Dixon J, Berwick DM, and Enthoven AC]. *BMJ* 2002;324:135-43.
- 2 Correspondence. Getting more for their dollar: Kaiser v the NHS. *BMJ* 2002;324:1332-5.
- 3 Talbot-Smith A, Gnani S, Pollock AM, Gray DP. Questioning the claims from Kaiser. *Br J Gen Pract* 2004;54:415-21.
- 4 Ham C, York N, Sutcliffe S, Shaw R. Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data. *BMJ* 2003;327:1257-60 (full version on bmj.com).
- 5 Senge P. *The fifth discipline: art and practice of the learning organisation*. New York: Random House, 1993.
- 6 Roland M. Linking physicians' pay to the quality of care—a major experiment in the United Kingdom. *N Engl J Med* 2004;351:1448-54.
- 7 Rawlins MD. NICE work—providing guidance to the British National Health Service. *N Engl J Med* 2004;351:1383-5.
- 8 Murphy E. Case management and community matrons for long term conditions. *BMJ* 2004;329:1251-2.
- 9 Committee on the Quality of Healthcare in America. *To err is human: building a safer health system*. Washington, DC: Institute of Medicine, 1999.
- 10 Committee on Quality of Healthcare in America. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: Institute of Medicine, 2001.
- 11 Davis DA, Thomson MA, Oxman AD, Haynes RB. Evidence for the effectiveness of CME. A review of 50 randomized controlled trials. *JAMA* 1992;268:1111-7.
- 12 General Medical Council. *Good medical practice*. London: GMC, 1998.
- 13 Royal College of General Practitioners. *Good medical practice for general practitioners*. London: RCGP, 2002.
- 14 Wanless D. *Securing our future health: taking a long term view*. London: HM Treasury, 2002. www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm (accessed 14 Feb 2005).
- 15 Humber M. National programme for information technology. *BMJ* 2004;328:1145-6.

A global health equity agenda for the G8 summit

Ronald Labonte, Ted Schrecker, Amit Sen Gupta

The G8 summit in July could be used to enable developing countries to meet the millennium development goals. What should world leaders commit to?

Substantial reversals of the global trend in improvements in health of the past 150 years are now evident in large parts of the developing world, particularly in sub-Saharan Africa.^{w1} In addition to its intrinsic value as a human right,¹ health is an important contributor to economic development.^{2 w2} This creates a compelling case for investing in health, especially since several cost effective interventions are available that can produce rapid and broadly shared improvements in health.^{3 w3}

The international community is committed to the millennium development goals, most of which are closely related to health status or determinants of health. However, much of the developing world will not meet those goals by the designated date of 2015 unless the industrialised world makes major long term commitments to provide new resources.⁴ Because the G8 countries account for roughly half the world's eco-

nomics activity and dominate the decision making processes of the World Bank and International Monetary Fund, appropriate commitment at the 2005 UK summit could turn the page on decades of neglect and fatal indifference.⁵

Health systems and health research

Developmental aid for health totalled \$8.1bn (£4.4bn, €6.3bn) in 2002, the most recent year for which figures are available.⁶ This is a fraction of estimated minimum needs: \$27bn by 2007, \$38bn by 2015.² Of critical importance is support to curb the spread of communicable diseases in sub-Saharan Africa. The G8 must provide a timetable for increasing their financial

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References w1-13 are on bmj.com