

## Guest editorials

# What can we learn about quality of care from US health maintenance organisations?

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For many unreconstructed champions of a national health service, one of the more disconcerting policy developments of the last couple of years has been renewal of interest in North American 'managed care'. Two health maintenance organisations (HMOs) – United Healthcare and Kaiser Permanente – are working closely at the government's behest with several primary care trusts (PCTs).<sup>1</sup> Much of the interest in US-managed care relates to evidence of reduced length of stay for elective procedures and global cost containment.<sup>2</sup> Yet haven't we been told for years that the US healthcare market is inequitable (45 million uninsured and rising) and inefficient? Of course, respond the apologists, we are not about to import their system wholesale (notwithstanding new Labour's injection of more competition through Foundation Trusts). So what can we in the NHS learn from managed care organisations (MCOs) in the United States about how to improve quality of chronic disease management here in the NHS?

The following features appear to distinguish chronic disease management in highly performing MCOs.<sup>3</sup> Firstly, the values of the organisation as reflected in mission statements and strategic documents show a surprisingly high preventive orientation. They understand the need to target patients before they appear at the clinic door and much is invested in detailed risk stratification on enrolment. These values are reinforced through strong clinical leadership. Health plan business managers foster trusting relationships with their physician providers but both sides are aware of the financial bottom line.

Unsurprisingly, in a system without registered practice populations, the importance of adequate investment in information technology and management is constantly reasserted.<sup>4</sup> This goes beyond the maintenance of disease registers to desktop systems that 'make effective choices easy choices'. Detailed quality assurance audits on different subgroups at risk provide performance data to clinical teams and individuals. Chronic disease management has to be underpinned by evidence-based guidelines from which clinical standards are developed. Guidelines

and target standards of care are embedded electronically. Registry screens typically highlight outstanding tests required by the guidelines and prompt clinicians to check whether a patient's test results fall into the target range. Much of this will become routine as the new GP (general practitioner) contract is implemented, but it is the systematic nature of data collection and analysis across large populations of enrollees that impresses the UK visitor.

A universal element of chronic disease management is the use of risk stratification to determine the intensity of clinical involvement with individual patients. Patient education starts at the point of diagnosis through one-to-one sessions with a clinician, written materials and access to web-based patient education facilities. Well-controlled patients without complications receive only regular check-ups and education materials. Poorly controlled patients and those with complex co-morbidities receive more intensive care from case managers and specialist physicians. Routine service delivery is largely nurse-led with telephone-based case management and the use of specialist nurses for more complex tasks. Case managers, typically nurses with additional training in chronic disease management, tend people with poorly controlled disease or complex co-morbidity, identifying and chasing up patients not following treatment and monitoring regimes.

Other accoutrements of managed care designed to minimise use of the secondary sector include utilisation review, the use of integrated care pathways designed to ensure earlier evidence-based treatment, pre-referral authorisation and readier access to specialists in primary care.<sup>5</sup> Physicians commonly work in multi-specialty groups located in the same health facility, sometimes sharing a budget. This structural and financial integration aligns the incentives between family physicians and specialists, particularly around chronic disease management, where the work of one group directly impacts on that of the other.

Striking the right blend of external (financial) and internal (professional) incentives is no more or less of a challenge in the US.<sup>6</sup> Physicians are subject to

performance management and financial incentives, paid either directly to individual doctors (up to 20% of base remuneration depending on the MCO), or to whole medical groups. Performance is assessed on the basis of agreed quality indicators, patient feedback surveys and peer appraisal. Much is made on this side of the Atlantic of how such data can be used to profile physicians and facilitate the hiring and firing of poor performers. In reality, physician turnover in the best MCOs is low and managers strive to form creative partnerships with their providers.

What does all this mean for the NHS? Taken separately the different elements described above hardly sound revolutionary; taken as a whole they provide distinctive strategic and operational coherence.<sup>7</sup> The strongest message for the NHS concerns the importance of closer integration between hospital and community-based services, using intermediate care and the active management to reduce lengths of hospital stay. We need to set the right balance of incentives for chronic disease management. The US experience suggests that financial incentives work best where clinicians' interest has been engaged through the perception of impact on quality of care.<sup>8</sup> Significant incentives for chronic disease management in the new GP contract are a new departure. However, incentives that promote integrated primary and specialist care are largely absent.

The importance of culture and context in influencing the behaviour of users and clinicians cannot be underplayed. While NHS funding mechanisms remain fundamentally unaltered, the claims that PCTs are moving to become 'UK-style HMOs' are overblown.<sup>9</sup> The case for markets and greater contestability of PCT management as a spur to quality improvement is not yet won, but beacons of best practice 'across the pond' nevertheless provide pointers to our future. The challenge, as ever, is to identify and assimilate that most effective practice.

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