

Education and debate

Making the NHS more like Kaiser Permanente

Donald Light, Michael Dixon

The NHS needs to break down the barriers between primary, secondary, and tertiary care

The US health maintenance organisation Kaiser Permanente has been highlighted as a successful model of integrated, cost effective care. A key policy of the NHS and other health systems is to learn from this model. However, the changes being made by the English government overlook the key features that have enabled Kaiser to develop and implement its clinical and operational programmes. We examine the importance of integrating clinical governance as well as collaborative contracting in achieving integrated, patient centred services.

Comparing the NHS and Kaiser

In a highly influential article, Feachem and colleagues compared the costs and performance of the NHS with those of Kaiser Permanente in California. They concluded that Kaiser provided much better value, largely by using only a third of the acute bed days used in the NHS.¹ Several serious criticisms were levelled at the methods used, but even if they are taken into account, the Kaiser system has much lower hospital admissions and shorter lengths of stay, especially for serious illnesses.

Ham and colleagues carried out a more methodologically sound and detailed study of the Kaiser system.² The data show such a much higher rate of hospital admission in the NHS for bronchitis and asthma and for angina pectoris. However, the admission rates for acute myocardial infarction, heart failure, and urinary infection were so much higher in Kaiser than the NHS that specialists in the two systems could be practising different types of medicine. Nevertheless, the overall question is how do doctors in Kaiser Permanente achieve such low rates of hospital admission and lengths of stay? Ham and colleagues point to several factors in the Kaiser system:

- Integration of funding with provision of service
- Integration of inpatient care with outpatient care and prevention
- Focus on minimising hospital stays
- Teaching patients how to care for themselves
- Emphasis on skilled nursing
- Patients' ability to leave for another system if care is unsatisfactory.

These are important factors from which the NHS can learn, although the NHS also integrates funding

with service, strives to minimise admissions and lengths of stay, and has worked hard to develop a strong primary care system dedicated to prevention.

This assessment, however, overlooks the core drivers behind Kaiser's concerted effort to minimise bed days by emphasising prevention, early and swift interventions based on agreed protocols, and highly coordinated services outside the hospital. These drivers are its clinical governance structure and its culture. Also overlooked are the ways in which recent NHS reforms take the NHS further away from the kind of integrated clinical governance that has allowed Kaiser to achieve its cost effective, integrated services.

Organisational history and culture

Before drawing possible lessons from Kaiser for the NHS we need to recognise the differences between how the two systems developed. The Kaiser system developed as a more cost effective, integrated approach to keep workers healthier and treat their problems before they become ill and have to pay to see a doctor.³⁻⁵ Its prepaid, fixed budget design aroused fierce opposition from the county, state, and national medical societies. They even barred Kaiser doctors from existing facilities so that Kaiser had to build its own hospitals and become a self contained delivery system with its own full time doctors, nurses, and staff. Thus Kaiser recruited—and still does—clinicians who believe in wellness and a whole systems approach to health care and who embrace team based treatment.

By contrast, Anuerin Bevan had to cobble together with deep compromises the fiercely independent consultants, general practitioners, and their professional societies, who were ready to keep the NHS from happening.^{6,7} The result was a segmented financial and organisational system that is still evident despite sweeping efforts to integrate its parts.

Fiscal and clinical governance by doctors

Besides recruiting doctors who believe in keeping patients healthy and uniting under circumstances of adversity, Kaiser Permanente is organised so that all doctors from primary, secondary, and tertiary care share the budget and responsibility for all care. This

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arrangement has required generalists and specialists to resolve their differences and figure out ways to minimise costly hospital services and maximise cost effective services. True clinical governance also results in recruiting and training managers who share the same goals.⁸

Ham, in his report on lessons from Kaiser Permanente, identifies the resulting emphasis on self care and shared care, the emphasis on prevention and early intervention, the active management of patients, and the priority of keeping patients out of hospital.⁹ These result in keeping patients with chronic problems healthier, treating them close to home, and holding costs down. But Ham leaves out the key to how all this is achieved: a true partnership of all doctors (and why not nurses too?), holding the entire budget and managing clinical services. The problem with the current NHS reforms is that a “them and us” structure, reified in budgetary and pay arrangements, will frustrate efforts to provide better and quicker care for less cost through integrated care.

Another important lesson underlying the Kaiser model of truly integrated commissioning is that it does not commission hospital care specifically. What it commissions is specialty care, often by nurses. The specialty teams then decide what hospital services they need to contract for and what social or community services are needed to help patients stay out of hospital. At its core, a hospital consists of nursed beds and a collection of costly technical facilities. But magnetic resonance imaging and other capital intensive services, emergency care, and day surgery can be part of the hospital or not. Specialty clinics can be attached or not. Specialists might conclude that it is most convenient and cost effective to have most equipment, suites, and laboratories all in one place called the hospital, or they may not.

A core problem with primary care trust commissioning is that the central government has locked in the current hospital centric arrangement. This is the latest in a pattern of cycles and upheavals of top down reforms since 1990 by ministers who have never run a health service and are not accountable for the costs or dislocations that result. Ministers and civil servants decide how resources will get allocated, get it wrong,

create new corrective measures (such as elective surgical centres funded by top slicing primary care trusts) that adversely affect the organisations on which they were superimposed, then create corrections to the corrective measures, and so forth. Patients get frustrated and periodically have the chance to throw out a set of politicians, only to get another set that start another cycle of complexifying reforms. Clinicians try to cope as one ministerial initiative follows on top of another.

The root lesson from Kaiser Permanente is that clinicians need to run the health service—all of them together—with shared bottom line responsibility.¹⁰ The primary and secondary doctors at Kaiser have decided that the most cost effective way to allocate their shared budget in an era of sophisticated speciality medicine is to have patients diagnosed and treated in multispeciality health centres where primary care teams work, lunch, and socialise with specialty nurses and doctors, laboratory and imaging technicians, and with the pharmacy team. Patients choose their own primary care doctor, but rapid referral and assessment to the more common specialties and testing is on site. Recently, this arrangement has been further integrated by a shared electronic data system.

Internal schisms still plague the NHS

The NHS is also developing more integrated care by creating primary care trusts and devolving an integrated budget to them. But inside the so called integrated budgets, consultants and acute trusts remain separate and deeply protected from the radical implications of a true partnership in commissioning. Doctors are becoming alienated and disengaged; yet successful reform depends on their full engagement.^{11 12-13} Silo health care still remains, as do the government contracts that effectively serve as licences to set up private practices based on doctors’ NHS affiliations, networks, and waiting lists.¹⁴ As John Yates put it with Biblical reference, one cannot serve two masters, especially if the second master is one’s own pocketbook.¹⁵ Kaiser doctors work only for Kaiser, but then Kaiser pays market rates for its clinicians.

Table 1 Summary of basic differences between Kaiser Permanente and NHS

	Kaiser Permanente	NHS
Governance	Doctors design and run services and determine how the budget is spent	Complex, contradictory mix of central directives, local executives, and “clinical governance”
	(Could include nurses)	Managerial hierarchies by sector (Does include nurses)
Financing	Population based integrated budget	Largely service based segmented budgets, set primarily by central directives inside a so called integrated budget
	It’s doctors’ money	It’s not anyone’s money
	Everyone on salary, with small, team based bonus for meeting performance targets	Most on salary, with varying reward structures; general practitioners contract independently
Organisation	No building up private practice on KP base	Consultant incentives to build private practice on NHS base
	Own facilities, hospitals	Own facilities, hospitals
	Large outpatient centres with multispecialty teams, laboratories, equipment	Small general practices with other services elsewhere or available by arrangement
Role of specialists	Many specialists practise at centres or in the community	Most specialists practise at hospitals
	Design interface with primary care, guidelines, protocols, patient pathways	Largely run their specialty clinics as they see fit
	Delegate to nurse specialists	Some delegation
	Involved early and more often; more specialists	Referrals arranged at arms length weeks later; fewer specialists
	Less use of hospitals	More use of hospitals
	Fewer admissions, rapid discharge	More admissions, slower discharge

The current English reforms will encourage further privatisation and may further entrench the divide between primary and secondary care. Primary care trusts will try to bridge this divide with care pathways and specialty networks, but few primary care trusts are yet able to use them effectively.¹⁶ Their commissioning skills will be tried to the full and may even be undermined as acute trusts become increasingly independent and locally powerful foundation trusts. Celebrating excellence is fine, but there may be dangers in lionising acute trusts before primary care trusts have been able to develop their commissioning teeth. These problems tend not to be mentioned in policy reports on the NHS.^{2 10}

The NHS is set up so that inefficiencies and waste are taken out on patients: fewer get treated, more wait, or treatment is thinned out. By contrast, inefficiencies and waste affect the budgets of all Kaiser doctors, who share incentives to treat patients early and quickly. The new general practice contract is moving closer to a Kaiser model, but the new consultant contract moves specialists away from it by locking consultants into a financial fiefdom rather than a clinical commonality. The concept of foundation hospitals, aside from concerns of privatisation, locks in hospitals and locks up much of the NHS budget. This is the opposite of what is needed to develop clinically integrated services that reduce the amount spent on hospital based care. The table summarises the basic differences between Kaiser Permanente and the NHS.

Collaborative contracting

If the NHS is to achieve Kaiser-like integrated care centred on patients near their homes rather than in hospitals, it needs to move towards "collaborative contracting." Such contracting is the most promising way to develop integrated care and to reduce the duplications, inefficiencies, and unnecessary referrals that consume so much of primary care trusts' budgets.¹⁷ Collaborative contracting and budgets would shift the focus from the needs of hospitals to the needs of patients. It would put consultants back in control of their services, with the charge to organise them in the most clinically integrated way. In the Kaiser system, clinicians manage themselves. They are the managers—the solution to another troubling problem exacerbated by a design flaw in the current reforms to modernise the NHS.

Collaborative contracting also holds the key to bringing down waiting times. Reductions in waiting times result from setting up criteria for referral, training the primary care team to diagnose and treat more problems on the spot, providing specialty back up, educating patients about the choices they have for treating their problem, and reconfiguring services. Current waiting times are the product of the existing system that maximises the number of patients referred across organisational and fiscal divides and that rewards consultants for having long waiting times. Removing the divides and perverse incentives, and the waiting times will largely disappear.

If the aim is integration with a primary care focus, one solution might be to increase the numbers of consultants holding contracts with primary care trusts, especially if they developed a whole system clinical governance structure like Kaiser Permanente. Alterna-

Summary points

The NHS is trying to learn how to provide integrated cost effective care from the Kaiser Permanente system

Current financial and organisational structures militate against true integration

Doctors from primary, secondary, and tertiary care should be given joint responsibility for managing clinical services

Commissioning of health services needs to become less hospital centred

tively, primary care trusts might become health trusts,¹⁸ responsible for commissioning health services for a geographically based population; these services could be provided by integrated primary-secondary centres. This would build on the Kaiser model and extend it to a whole population, not unlike Scottish health boards. With the elimination of trusts and trust boards, Scottish boards are moving towards a single integrated service overseen by trans-specialty clinical teams and trans-sector management teams.¹⁹ The health trust model would integrate public health with clinical medicine and enable the NHS to tackle causes of illness in the community.

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