US and UK health care reforms: reflections on quality

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When I was invited to reflect on the effect of recent reforms on quality of health care in the NHS I originally planned to review progress during the four years of my time in the UK on a few key factors which contribute to or hinder quality health care. As I write this, I have been in the US for about eight weeks, working at the national level on health care reform policy and how to change government agencies so that they can facilitate a new approach to health care delivery and financing. Perhaps linking my observations of changes in the UK with changes that we are contemplating here in the US will raise some issues about the potential impact of change on quality of health care in both countries.

About three months into my stay in early 1990, there seemed to me several aspects of care that offered the most stark contrasts between the US and UK health systems. Four of these are especially important to quality: access, the size and shape of the health care system, primary care, and standard setting. Changes in each in the UK during the first years of the reform process and a few comments and contrasts with the US health system reveal, to me, some good news and some bad news for quality.

Preserving access to health care
The first step to quality health care for people in any country is access – that is, their ability to get health care when they need it. The most dramatic difference between the US and UK has historically been the strong cultural value in the UK for social equity. In the health sector this has led to universal financial access to a publicly financed and accountable health care delivery system. There is a strong contrast between this approach and the apparent conflict of values between equity and individuality that has been the stronger force in US culture in general and in US health care culture in particular. The health care system in the US, which is predominantly private, has guaranteed the individual’s right to consume as much health care as he or she can afford, even if it means some will be denied access except in cases of extreme need.

Preserving the guarantee of equal financial access to the NHS has been a point of debate in the UK during much of the past four years of change brought about by the reforms. Generally, those favouring a one class system have won these debates, as politicians have retreated from proposals (whether explicit or leaked) for copayments and increased reliance on the private sector. However, few can deny the power of the GP fundholding scheme and the reality that there is a policy gap through which the government has, either by choice or by default, failed to address the fact that some people now have a “fast track” to specialty consultation and hospital admission for elective surgery, and this has created differential access within the NHS.

Another challenge to the notion of equal access in the reforms has been how to address the issue of rationing or priority setting – not the fact that it happens, the waiting lists attest to it – the fact that with limited funds the pressures increase for explicit, publicly accountable decision making about the criteria for what services will be provided and to whom. Again, the fact that the government has chosen not to take this on nationally, preferring to leave decision making to local purchasers or providers, may further put the opportunity for equity across the UK at risk.

Here in the US, for the first time, there is actually a debate on new configuration for the health care delivery system in a context in which politicians of both liberal and conservative persuasions are, for the first time, rarely questioning the assumption that there should be universal access. This is such a radical shift for the US that if we can add access to health care as a right of citizenship as one outcome of the health care reforms it will be a major achievement. Ironically, in the US the fear that universal access may reduce the benefits to some has led to a policy decision for a national definition of the benefits package that will be covered under the health reform programme. The same political reluctance to make hard choices that has led to avoidance of an explicit definition in the UK has in the US led to such a rich package of benefits that some question its affordability, but the potential for equity in the US will be vastly increased if some version of it can be sustained through the debate.

Clearly, a concern for access and an equitable accountable definition of the services...
to which the citizen/patient has a right must be fundamental to any quality delivery system.

Size and shape

The second concern for the functioning of any health care system is its size and shape. This has been an area of considerable change in the UK in the past four years and will be a focus of attempts at change in the US reforms. The essence of change in the UK has been a move from a more centrally administered command and control system to one in which authority and responsibility for purchasing has been devolved to districts and providing has been devolved to trusts. Probably no one imagined the pace of change that would accompany the development of trust providers when the possibility of trust status was first announced. With trusts having their own boards and charged to steer their own course within a contracting framework, the diversity and heterogeneity of the UK system has been increased dramatically. It will be virtually impossible to pull back from this level of decentralised authority and responsibility.

Again, this has implications for quality. On the one hand, local initiative to innovate and shape the approach to, and responsibility for, standards of health care are encouraged; on the other, decentralisation opens the door for considerable variability in quality without a national framework for standard setting (see below).

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In the US reform programme, the challenge is developing an organisational approach that can help to rationalise and increase the coordination of what many have felt is a “terminally” heterogeneous and decentralised system. In a sense, because of the lack of control across the system, the US has long had a national set of standards for hospitals, enforced through a non-governmental organisation, the Joint Commission for the Accreditation of Health Care organisations (JCAHO). Although initially a fully voluntary system, in recent years a provider organisation’s ability to meet these standards has been tied to receiving federal payment under the Medicare system, and many other insurers have followed this lead. There are concerns that the “snapshot” approach to JCAHO inspections has not been conducive to continuous improvement, and it will be reconsidered in the context of reform.

One thing is very clear, it is much easier to let go of administrative and managerial control (as in the UK) than to try and rein in independent payers and providers. In either scenario a mechanism for quality assurance must be developed that balances the need for accountability with the actual levers available to achieve it within the size and structure of the health care system.

Strengthening primary care

A third area of obvious contrast between the US and UK is that of primary care. The British system of GPs and community based health and social care has long been an international model. With only 10–15% of all visits to GPs resulting in a referral to a specialist or hospital, primary care serves as an important triage system as well as providing a valuable locus for comprehensive and coordinated care. With the exception of the GP fundholder approach, the reforms have not focused adequate attention on funding and further development in primary and community care, especially when contrasted with the resources and national focus given to the trusts. There was, as I left, considerable dissatisfaction being expressed by GPs and concern that while the NHS policy was calling for movement of services out of hospital and into the community, the actual resources, both human and financial, to support the developments needed in the community based infrastructure are not there.

Although we argue that GPs in the UK under-refer and in that sense may not be providing the best quality of care, the open access system in the US, where patients self refer directly to specialists and hospitals, has resulted in documented evidence in study after study of between 20 and 30% of unnecessary care, some of which is actually harmful to the patient. Clearly the development of an effective primary and community care system is a major part of the US reform and will not be easy to accomplish. The preservation and strengthening of the UK primary care system must be a greater focus for all those concerned with quality.

Setting and maintaining standards

The last issue for my “retrospective” is standard setting. Firstly, let me define my terms. The notion is that providers are held to a standard that is explicit (whether developed by them or others) and open to public scrutiny. The degree of public scrutiny and by which public is always an issue. At the beginning of the NHS reforms there was clearly considerable resistance to medical audit among doctors even though the programme predated the reforms. There was near unanimity that the information to be gained from whatever audit was done would be for doctors’ eyes only. When I first arrived, even the mere mention of words like accreditation or some kind of external quality assurance scheme was seen as unacceptable to the profession or, at the very least, creeping bureaucracy. This attitude has changed considerably during the past three years.

Several things have influenced this change. First has been the gradual realisation that purchasers will not be able to take the full responsibility for standard setting and quality
assurance. Their role will become more advanced, but purchasers will never have the staff for adequate monitoring. Clearly, purchasers have become better at collecting information about the quality of their providers and, increasingly, are making that information available to GPs as the proxy for patients. Many are beginning to develop ways of giving it to patients themselves. The realisation is also increasing that in a market driven system financial incentives can skew the decision making over use of resources. There is thus a serious question whether either party with a vested interest in the financial transaction – purchaser or provider – can be neutral in the issue of quality and best represent patients’ interests.

There is increasing willingness, indeed eagerness, among providers to participate in the voluntary King’s Fund organisational audit or the BS 5750 standard setting process. The King’s Fund has recently been asked by purchasers to develop an “audit” process for their organisations. All of this is evidence of a commitment to quality and the potential role of a third party in reviewing it. The support of the NHS Management Executive for TQM models and the increasing visibility of the interdisciplinary approach to clinical audit, recently supported in a jointly published document on clinical management by the Royal College of Nursing, BMA, British Association of Medical Managers, and Institute of Health Service Managers will continue the momentum for greater openness in quality assurance efforts that may lay the final foundations for creative “third party” models.

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Adopting clinical practice guidelines based on effectiveness and outcomes research should also be an important factor in quality assurance in the future in the UK, owing to traditional concerns for appropriate use of resources in a financially constrained environment. The current NHS Management Executive investments must be sustained and increased and the process for effective dissemination and adoption of clinical guidelines explored carefully.

On the ground, however, there is still a tremendous gap, even in technical understanding of and support for medical and clinical audit, as well as other approaches to publicly accountable quality assurance, and this must be overcome. Journals such as this one clearly show the interest in and commitment to doing so. There is a real opportunity to develop an approach to quality assurance that is both positively develop-

mental and accountable in the UK since there is little negative history to prejudice the direction of this development. It is an exciting opportunity.

US reforms

As the US embarks on reform, the issue of standard setting and the approach to be used for quality assurance is a focus of debate. Because past accreditation and quality regulation processes have been so tied to either strategies for cost containment or the “bad apple” approach, with an eye to preventing malpractice, there is considerable emotion about further national standard setting. The Clinton approach includes the idea of a national quality management programme that would develop and promulgate national standards for health plan performance. Health plans would have a “quality report card” that would include not only structural standards – that is, the names of hospitals and doctors included in the plan and the doctors’ credentials – but outcomes data and patient satisfaction information. The goal is for such a report card to be available to all so that people can select the plans in their area on the basis of better information. Because the availability of choice is a fundamental aspect of the reform, patients will be able to choose among plans and change plans annually if they are dissatisfied.

There is also considerable emphasis in the US reforms on the use of outcomes and effectiveness research, with incentives such as “presumptive innocence” in the face of malpractice claims for doctors who use clinical guidelines. It will be interesting to see whether the kinds of fundamental change in the nature of the financial incentives previously promoting unlimited treatment by doctors in the US will lead to greater interest in use of these approaches. The kinds of data systems needed to manage such a change, as well as the desirability of applying national standards locally, are already being debated; because there is a different history in the US, some national standards are likely.

The other interesting feature of the Clinton proposals is the strong commitment to public education and sharing of data about health care providers and the quality of services as fundamental to any quality assurance approach. If this emphasis survives the Congressional discussion and debate, it could fundamentally change the role of the citizen/patient in the health care transaction. Americans have always been much more assertive consumers of health care services than their British counterparts, but often the basis for these choices has been superficial attention to hotel services or responses to aggressive marketing programmes by providers. This may change.

While many purchasers in the UK are attempting to present better information to those living in their localities, a more concerted effort to include the public in quality assurance and measurement approaches is needed at all levels. Again,
because this development is starting on relatively neutral base, there is a real opportunity to assure that the basis for public participation in health care decision making in the UK is substantive.

This brief discussion of what may appear to be rather broad health policy issues may seem somewhat distant from the day to day realities of delivering quality clinical care. Perhaps this is the main message from my reflections on the UK and the US: it must be clear that those of us concerned with quality have to maintain such a broad perspective. We must analyse the potential impact on quality of all policy decisions affecting our health care system if we are truly to assure quality patient care.