TPG International Health Academy

London, England Executive Trade/Study Mission

September 8-13, 2012

Executive Summary

For a number of years, the United States has been embroiled in a debate on how to address healthcare in a more cost efficient manner while achieving high quality results. Interestingly, activities associated with health reform are not just occurring in the U.S., but around the world. In September 2012, 30 U.S. healthcare executives traveled to London, England with the TPG International Health Academy (TPG-IHA) Executive Trade/Study Mission to meet with experts from within the British healthcare system. The purpose of this educational mission was not only to gain an understanding of their healthcare system, but to learn new and innovative ideas that can be transferred back to their own organization. In the course of the week, many of the myths that exist about healthcare in the UK were dispelled.

The group discovered that many of the issues and challenges that exist in the U.S. are similar to those in England. TPG-IHA is pleased to share this executive summary that focuses on highlights of the mission. The executives that attended the educational mission have received comprehensive session summaries.

Organizational Structure of Healthcare within England

All citizens of the UK are provided with universal coverage, free at the point of delivery, through the National Health Services. This universal coverage is financed through taxation. There is private medical insurance within the UK which does offer increased choice of providers and hospitals, access to some elective procedures, various "hotel services" while hospitalized, decreased waiting time for services and access to additional pharmaceuticals. Until recently, waiting times were a major reason for those who could afford it to purchase private health insurance. As waiting times have decreased the desire for private health insurance has waned. Today, most citizens in the UK do not opt to pay for private insurance. However, there is some belief that if healthcare services are decommissioned (decreased) in order to meet financial constraints and to help reduce the 20 billion pound budget deficit, that there will again be greater desire for private insurance.

One of the linchpins of the UK's National Health Service (NHS) system and their healthcare overall is the commissioning of services. This entails strategic planning, procuring, monitoring and evaluating healthcare services. Much of this activity is done on an annual basis and therefore does not include long term vision or planning.

The organizational structure associated with payment and oversight is changing. Family doctors will be leading the geographically organized commissioning boards that will be responsible for public health of their population which includes purchasing and overseeing health services in their area.

Healthcare Finance

Most of the healthcare in the UK is financed through taxes. Spending decisions are much more centralized in England where the English treasury and various national departments (such as NHS) meet to set annual budgets. This contrasts with the U.S. healthcare budgets where the only area in which the federal government has authority over healthcare spending is with government-funded programs such as Medicare and Medicaid.

Similar to the U.S., England has increasing healthcare costs that are believed to be unsustainable. Healthcare expenditures have sharply increased in the UK: 55 billion pounds in 2001 versus 126.6 billion pounds in 2012 (9.6% of the UK GDP). Like here in the U.S., the question of value of money spent continues to be asked. Unlike here where this has created a situation with significant cost shifting to the healthcare consumer, there are few healthcare consumer out-of-pocket costs associated with UK healthcare services. Another difference between the U.S. and the UK is in the lack of finger pointing or politicizing of these issues. Instead the UK focuses on a national effort to meet the goal of reducing healthcare spending by 20 billion pounds by 2015. The English understand the need for healthcare cost containment but they are adamant about finding cost savings through efficiencies rather than in cuts or disruption in services.

A number of the speakers felt that the cost goals could be met by changing the skill mix of those professionals within the healthcare system, change the role of patients in order to better engage them in their own health and determine the most cost-effective means of using technology. This discussion struck a very common chord with our U.S. delegates. A cost reduction initiative is being addressed through the Quality, Innovation, Productivity and Prevention Program (QIPP), also known as the “Nicholson Challenge”.

Access to Care

Every patient in the UK is registered with a primary care physician, known as a General Practitioner (GP). The role of the GP is to oversee the care that the patient receives. The GP also acts as a clearing house for specialty care that a patient may need. Unfortunately, as it is here in the U.S., there are more specialists than primary care providers. This situation is unlikely to change as only about 2% of physicians are entering primary care in the UK. The U.S. and the UK share the same understanding that there is probably greater need for primary care providers. GPs in the UK are self-employed. This is different than consultants (specialists) who

are employees of the NHS. Providers can work in both the private and public sector. A large majority of specialists have some activity within the private sector.

Most of the primary care that the British receive, including diagnosis, testing and treatment, are done by trained nursing staff, utilizing standardized guidelines. Those patients who need additional services beyond the capabilities of the treating nurse are then referred to their GP.

A common criticism about the English healthcare system is the lack of access to needed care. Whether it is access to pharmaceuticals as in the case of oncology medications, access to technology such as radiologic studies or long waiting times to see doctors, the ability to obtain necessary care has been challenging. Over the last few years England has made a focused effort in addressing the issues of access, especially waiting times. Times have recently been reduced to the goals of 18 weeks for non-critical care and 2 weeks for cancer care.

Hospitals

Most of the hospitals are state-owned, autonomous and self-governing. Budgets are balanced annually. This creates a challenge around long term strategy or investments. There are a few hospitals that are privately-owned and although the care given is similar to the publically-owned hospitals, the private hospitals do offer greater "creature comforts". Most of the private hospitals do have contractual agreements with the NHS although the majority of their revenues are accrued from private insurance. For the most part, there is little competition between hospitals as patients tend to receive care from the hospital in their "neighborhood". This is changing slowly.

One area of financial pressure on hospitals centers on the increasing number of older seniors in the hospitals. Many of these people are not in need of acute care but are being hospitalized due to the cost structure of healthcare for the elderly. Patients pay nothing while in the hospital but have increased out-of-pocket financial responsibility when taking up residence in long term residential care.

Pharmacy

Pharmaceutical coverage and costs are handled at a national level in the UK. The foundation of this activity is through the National Institute for Health and Clinical Excellence (NICE). This organization was created in 1999 to evaluate the value of NHS services. Care is evaluated against evidence-based guidelines in order to identify those services that will receive NHS coverage. Coverage decisions are based on a cost/quality adjusted life years (QALY) analysis. The cost portion of the equation is negotiated between the pharmaceutical manufacturer and the government – in this case "the sole Payor" of healthcare for the country. In the United

States, we have many “Payors”, each of whom negotiates their own cost structure with the pharmaceutical manufacturers.

Once NICE makes a coverage decision and the government determines a cost structure for the medication, utilization tools are put in place to control the use of the medication to assure appropriate prescribing. The use of the most cost-effective medications is done through pre-authorization, step therapy, medication switching and patient and provider education. Similar to most of the healthcare the British receive, there is currently no patient financial responsibility. During the mission, there was discussion that co-payments of some sort were inevitable, but the timing remains unclear.

Utilization

As was stated above, healthcare cost cutting initiatives within the UK are focused more on efficiency of care than utilization of care. For the most part, there are fewer concerns regarding overutilization as a cost driver than in the United States, with the exception of overutilization of hospital admissions, readmissions and over reliance of Emergency Department services. Initiatives that look at alternative sites of care and easier access to primary care co-located with Emergency Departments are being tried in an attempt to lower these high cost sites of care and refocus the services to lower cost and acuity sites when appropriate.

Quality

Over the last few years, the quality movement has begun to take hold. There are a number of initiatives and organizations within the UK that address quality of care. In addition to their well-known focus on pharmaceutical coverage, NICE is also responsible for national quality standards, generating approximately 150 such standards. Another organization leading the quality agenda within the UK is the Health Foundation, a charitable organization that supports safety and quality within the NHS. Much of the work that this organization does is focused on safety within the country’s hospital systems.

Today, hospitals in the UK tend to follow their own guidelines but this is beginning to change as standardized guidelines are being mandated nationally. Hospitals have begun to utilize best practices and have initiated programs to look at “never events” associated with care. Centers of excellence are becoming more prevalent in both the United States and the UK. The UK-utilized Academic Health Science Network and the Centers of Excellence are responsible for identifying and driving best-in-class services.

Local commissioners will have the responsibility at looking at the quality data in their area and setting goals for quality improvement that addresses their specific gaps. The domains or areas

of focus for the quality and outcomes framework are very similar to our areas of focus. These include: 1) clinical effectiveness, 2) patient safety, and 3) the patient's experience. Quality initiatives are also beginning to take place in the ambulatory setting. The UK is utilizing such a framework as the foundation of their clinical activities. This program looks to reward (compensate) high quality care that GPs deliver to their patients in specified disease states. This payment methodology is a change from the previous payment model which was based solely on activity-based payment. This new payment method is similar to "pay-for-performance" methods being deployed in the U.S.

As a means to address the UK's 20 billion pound deficit, the QIPP program discussed above also looks to address quality shortcomings. It is suggested by those that created this program that improvements in quality will result in the necessary reductions in cost and therefore address the financial shortfall. Unfortunately, it is considered by some that this program's primary focus has been diverted from quality improvement to solely a financial savings initiative.

The overall "quality movement" is not as strong in the UK as it is in the United States. Similar to the U.S., silos exist within the British healthcare system which creates gaps in information sharing and issues associated with quality of care. There have been discussions on how to improve the integration of care across providers. Several examples were provided describing incidents in local communities bringing about change to a broader constituency. For example, the result of the *The Bristol Inquiry* created an environment for looking at outcomes in an unbiased manner and as well as being transparent about areas for improvement.

Data

In order to assess both quality and the cost of healthcare the UK and the U.S. have both realized the need to collect data, especially from primary care providers. Both countries have also found that collecting this information can be a challenge.

Like the U.S., a great deal of money has been spent with varying degrees of success in access to and use of data collected. Patient level information is lacking due to the structural model of the UK health system. It is believed that the top five therapeutic conditions consume approximately 50% of the healthcare budget. As in the United States, variation also occurs within the UK healthcare system, but due to lack of good data, this variation is not well understood or documented. Historically, getting data from GPs has been difficult. More recently, data has been a bit more forthcoming as physicians are being paid for the collection and sharing of the data. Providers can increase their salaries by up to 20% for this activity.

We heard from several speakers that the collection and sharing of clinical information is quite limited in the UK. The government attempted to put in place a national IT system, which unfortunately after much time and expense, was discontinued in 2011. This has created a

situation where the IT system varies across the country. Even in those areas that have reasonable systems in place, silos remain. Communications between the GP, the specialist and the hospital is relatively limited despite there being quite robust databases utilized within the primary care practices. The type and format of these databases varies considerably across primary care groups. There is also some hesitancy by some groups to utilize these patient-centered databases due to changes that have to be made within the medical practices. For the most part, a patient's information does not follow them from inpatient to ambulatory or from one physician to another. If communication does occur, it is most often done through letter format due to overarching privacy concerns. There are a number of areas of the country that are attempting to remedy this problem.

Innovation

Where most of the innovation conducted here in the U.S. is done at a local level, in the UK it is done in a top down manner with central bodies charged with innovation. This creates a challenge to implement and disseminate innovative solutions in a broad-based manner across England. New technologies such as Telehealth and home monitoring are beginning to be utilized. However, as with electronic medical records and patient-focused databases, funding for these types of activities are limited as monies are allocated on an annual basis with little long-term planning taking place.

Aging and Chronic Conditions

Chronic illness has become a significant focus in the UK, similar to the U.S. The British healthcare system has begun to recognize that it is not well prepared to address many of the facets of chronic illness. Many of the educational and support programs found within the U.S. (such as disease management) are rarely utilized within the UK. They are also beginning to place greater emphasis on prevention through public health campaigns. One such campaign, "Change for Life", encourages both adults and children to adopt healthy lifestyles. Results of this initiative are unclear. Another area of focus is smoking cessation. To date, the UK has been less successful than the U.S. in creating legislation to help to curb tobacco use within the country. Overall, England, like the U.S., struggles with getting their citizens to actively engage in their own health.

Aging is also an area of concern and increasing focus in the UK. As the average age is increasing, greater levels of care and resources are utilized. Senior care (social care) is operated and paid for by local governments. The British are working to rationalize care for the aged in a way that best utilizes existing resources in order to achieve higher quality care within the financial framework that exists. This continues to be a challenge.

Conclusion

Although the financing and organizational structure of healthcare is quite different in the UK then the U.S., many of the challenges remain similar. Costs are rising, while chronic conditions and aging populations will require the healthcare system -- providers and healthcare consumers alike-- to act differently in order to achieve the quality and cost goals that both countries are looking to achieve. It is clear that information sharing across continents will help both countries to achieve a cost-efficient, quality-based system.

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TPG-IHA (www.tpg-iha.com) develops and conducts educational programs in countries outside the United States for senior healthcare executives.