Looking Westwards

Dr Adam Oliver askes 'can the NHS learn anything from Kaiser Permanente?'

A view, shared by many, is that competition, of one form or another, will improve outcomes and quality within the NHS. Moreover, when one thinks of competition in health care, one may think of the United States, which might, by extension, make one think of Kaiser Permanente. Like the NHS, Kaiser Permanente is essentially a health maintenance organisation (HMO) in that it combines its purchaser and provider arms into a single organisation; indeed, it is one of the largest integrated health service networks in the US. Therefore, following a somewhat circuitous route, we might ask ourselves the question: can the NHS learn anything from Kaiser Permanente? Given the frequent transatlantic visits involving NHS, Department of Health and Kaiser Permanente staff, it seems clear that many people believe that the answer to the above question is affirmative.

Kaiser Permanente is a non-profit organisation, officially founded in 1945, but owing its earlier origins to an insurance consortium formed by several large Californian construction contractors to meet worker compensation claims. It derives its name from the integration of the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals, with independent physicians group practices called Permanente Medical Groups. To the public, the health plan, which provides insurance, and the hospital and medical groups are perceived as a single organisation. Kaiser Permanente doctors are salaried and own shares in the organisation, and specialists cannot work outside the system. The Health Plan has approximately nine million members, about six million of whom are Californian residents, with the remainder scattered across eight other states and Washington DC.

A few years ago, there was a spate of articles that focussed on comparing the NHS and Kaiser Permanente, the most famous (some might argue infamous) of which was written by Feachem *et al.* (2002). Kaiser Permanente is considered to be a 'working class' system; the NHS, as a 'national' system, inevitably covers a wider spectrum of the population, from the very poor to the very rich, which makes meaningful comparisons of the two systems difficult. Nonetheless, Feachem *et al.* made a not inconsiderable effort to control for the different profiles of the two populations, by adjusting per capita costs for age, socioeconomic status, and the fact that the NHS covers the very poor. The authors also adjusted the incomes of Kaiser Permanente doctors down so that they were on a par with those earned in the NHS, under the rationale of equalising input costs across the two systems. This latter adjustment is questionable, because performance may in part differ across the systems precisely *because* of differential salaries.

Be that is it may, the main finding unearthed by the authors was that Kaiser Permanente offered better value for money than the NHS, principally because the use of beds was much higher in the NHS; specifically, the NHS used four times the number of acute beds per 100,000 population per year. These bed use differences, it was argued, were caused by higher NHS admission rates and lengths of stay, although in this respect one ought to tread cautiously, because the NHS may be faced with disproportionately more elderly patients who cannot so easily return home after hospital admission, and NHS data sets do not in any case always distinguish between time spent in acute and community hospitals. Despite the quite legitimate concern that a comparison of the two systems is akin to comparing a strawberry to a banana, it is probably fair to conclude that Kaiser Permanente manages its acute beds relatively well, which is a finding that should not be sniffed at, particularly when it is remembered that hospital stays tend to be the most expensive component of health care systems and that their efficient use may free up considerable resources for other services. Feachem *et al.* attributed Kaiser Permanente's performance in this respect to a number of factors, including good, integrated, co-ordinated care between hospital and outpatient settings,

an impressive use of information technology (including electronic health records), and the pressure to be responsive to patients, or risk losing them to other health plans.

There have been other studies. Ham *et al.* (2003) largely corroborated the Feachem *et al.* study, although they concluded that differences in admission rates are less important than length of stay when accounting for overall differences in bed day use. They also emphasised how well Kaiser Permanente apparently integrates inpatient and outpatient care, how patients are facilitated to return to their home environments (e.g. by being taught how to dress following orthopaedic procedures, and to properly take their medications), and how a greater concentration of specialists and skilled nurses can help people to leave hospital quicker. Ham *et al.* also noted the importance of the threat of exit (i.e. enrolees leaving the plan) serving as a motivator to be responsive to patients, which is something that is mostly alien to the institutional structure of the NHS (and may bring harms in terms of continuity of care, and/or national equity objectives, as well as benefits). Others are less enamoured with Kaiser Permanente. Talbot-Smith *et al.* (2004), for example, claimed that the costs of the system are actually substantially higher than those of the NHS, even though, on the whole, it covers a younger, healthier population.

If we must look westwards from this cold, wet, green and pleasant land, need we necessarily look towards California (leaving aside consideration of some pleasant policy tourism)? We could instead look towards a different type of Kizer – Kenneth Kizer, who, in the mid 1990s led a reform of the US Veterans Health Administration (VHA). The VHA publicly both finances and provides health care for the veterans of the US armed forces. Institutionally, organisationally, and culturally (e.g. with respect to an ethos of public service, and with a traditional absence of demand-side competition), the VHA closely resembles the NHS; more closely, probably, than either resemble Kaiser Permanente. Kizer, by improving planning, performance management, resource allocation and information technology (among other things), oversaw the transformation of the VHA from a widely castigated service, to arguably the best performing sector of American health care (Oliver 2008). Useful lessons might be learnt from the tale of the VHA, but that's another story.

References

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