ACHIEVING INTEGRATED CARE. LESSONS FROM THE US AND THE UK TO IMPROVE QUALITY AND AFFORDABILITY IN HEALTHCARE
In this paper, the authors suggest that the respective healthcare reform processes in the UK and the USA, although moving in opposite directions, are converging onto a similar model which represents a greater sense of balance between clinician and patient and between state and individual. The UK offers relevant experience from previous successes and failures in addressing the healthcare challenges which the US system is now facing, and the US offers comparable experience and learning to those leading the next stage of UK reform.

In particular, as each system strives for better clinical outcomes and more efficient use of resources, we see considerable value to both, from adoption of the model for Accountable Care Organisations. This paper explores our reasons for optimism in such a solution and poses a few questions to those involved in system development on both sides of the Atlantic.

In keeping with our values of integrity and excellence, Matrix and Optimity have taken reasonable professional care in the preparation of this paper. Although we have made reasonable efforts to obtain information from a broad spectrum of sources, we cannot guarantee absolute accuracy or completeness of information/data submitted, nor do we accept responsibility for recommendations that may have been omitted due to particular or exceptional conditions and circumstances.

INTRODUCTION

In July 2010, the UK Coalition Government set out its new vision for the NHS in its White Paper “Equity and Excellence: Liberating the NHS”. The White Paper sets out the Government’s commitment to choice, improved outcomes, subsidiarity and efficiency, and how this might be achieved through a radical overhaul of commissioning and contracting. The new NHS will see a greater involvement of patients and public: “no decision about me without me”; and greater choice of care and provider. Local communities, explicitly empowered by the concept of ‘Big Society’, will have a greater voice and involvement in improving the wider determinants of health. Health care commissioning will be led by groups of GPs with provider contracts designed to reward quality and efficiency.

Equally transformational have been the health care reforms in the US, enacted in March 2010. Designed to increase access to health insurance coverage, and to reduce costs and bureaucracy, the legislation sets out a comprehensive programme of reform to be enacted in the US over the next four years.

One such reform involves an interesting new contracting model between the payers and providers of healthcare. Under the legislation, providers to Medicare are able to form “Accountable Care Organisations” (ACOs). The ACO concept involves providers sharing the responsibility for achieving quality health care goals for a defined patient population, whilst at the same time sharing financial savings which can be achieved from more efficient, integrated, care management. Integrated within the ACO concept is a “Medical Home”, which is to reimburse the primary care physician to better coordinate and manage all aspects of patient care. This model is not dissimilar to the Integrated Care Organisations piloted across the UK following Lord Darzi’s NHS Next Stage Review.

The current reforms in the UK and the US are each designed to address shared challenges, namely to improve quality, reduce cost and increase efficiency in the healthcare industry. This paper explores the practical lessons that can be shared as the reforms are implemented.

THE ISSUE

Almost since the inception of the NHS, successive governments in the UK have reshaped the NHS through reform processes designed to address the need to invest, redress inequities, and create a performance-driven
regime which rewards improvements in services. Following the introduction of the “internal market” in the early 1990s, the focus of the past ten years has been to improve processes (especially regarding access to services, e.g. reducing waiting times), before beginning to tackle the patient experience and quality of outcomes, especially in the dominant diseases such as cancer, heart disease and mental health. The next stage of reform is about minimising the role of government, giving the public the levers to ensure that the care provided is driven by their experiences and expectations, and giving clinicians responsibility for responding to this agenda by strengthening quality and outcomes.

The gap between the UK health service and those operating in other comparable nations has narrowed significantly. The UK can now demonstrate clear accountabilities, much improved facilities and processes, a strong improvement agenda, and an emphasis on equity. Nevertheless, there remains an imbalance between the influence of management and clinicians, and an inadequate focus on the customer service culture required for the NHS to be truly patient focused.

In contrast, the US market has been shaped by market forces and especially the competitive pressures exerted on insurers by their need to attract and retain member volumes. Services are invariably clinically led and driven by the customer culture. The market is strongly shaped by the high value placed on personal health by those who are willing and able to pay a premium for quality, with the net result that healthcare is about twice as expensive per capita in the USA as anywhere else, accompanied by faster rising costs as people demand investment in the best innovations. Provision for the most disadvantaged and elderly is made through Medicare and Medicaid. However, between 40 million and 50 million people currently fall outside the reach of this high quality, expensive system, or are picked up by the safety net system, where provision is inevitably limited. The system has high levels of waste and inappropriate treatments, driven by the strong influence of a demanding public, and incentives designed to manage risk through active intervention.

So the challenges can be summarised by:

- the UK system seeking to retain the gains from reform, whilst shifting the levers from centralised performance management into patient pull and clinician push, strengthening the focus on outcomes, experience, quality, safety and efficiency;
- the US system seeking targeted government intervention to rebalance the system, increase the number of people with health insurance, raise overall outcomes and quality, whilst curbing costs.

In their own way, each is seeking to find a new balance between government regulation and market forces, shifting responsibilities to strengthen the levers to accelerate change in the chosen direction.

The ACO model has been proposed in the US as a way of delivering the improvements in efficiencies and quality that federal government is demanding. It could also provide a way for the UK to facilitate the vision for more clinician-led decision-making as set out in ‘Liberating the NHS’.

ACHIEVING INTEGRATED CARE

Creating a system which facilitates the delivery of more integrated care is the key challenge for both the US and the UK. The two fundamental ingredients which can drive improvement in healthcare are reduction in errors/failsures by eliminating system boundaries, and the reduction in variation by tighter process control. Both are key drivers for integration.

In the US, the ACO concept enables the coordination and engagement of multiple health care professions across different institutional settings and specialities. It seeks to align information, decision making, and financial incentives, to improve outcomes and reduce costs. Creating a whole system accountability reduces the perverse incentives which favour the maintenance of the fragmented status quo, even where that status quo sustains ineffective care and inefficient deployment of resources.

In the UK, the development of care pathways commissioning; and the integration of acute and community providers; represents a similar desire to provide seamless, effective care to patients who need the services of multiple care professionals.

---

7. Integrated Care – attraction or distraction, David Welbourn, National Association of Primary Care Journal, special edition, March 2009
There are a number of thematic areas which will become key issues and challenges, both in the implementation of ACOs in the US and the implementation of the GP-based commissioning in the UK. Key challenges include:

- Meaningful and informed choice.
- Patient and carer engagement, including self management of chronic conditions.
- Reimbursement models that promote coordinated care and drive efficiencies, i.e. best practice tariffs and pathway tariffs, money ‘following the patient’; the use of quality and outcome measures to inform reimbursement decisions and drive improvement such as disincentives for ‘Never’ events.
- Legislation and regulation to prevent anti-trust and non-competitive behaviour.
- Managing risks within the system.
- Transformation of complex legacy information technology systems to support risk-based administration rather than traditional fee-for-service processing.
- Management of the changes to governance structures to ensure appropriate control between primary care, specialist, and acute care providers.

Underpinning all of these themes is the need for high quality information tailored to numerous audiences to drive accountability and promote innovation and improvement.

There are a number of thematic areas which will become key issues and challenges, both in the implementation of ACOs in the US and the implementation of the GP-based commissioning in the UK. Key challenges include:

PATIENT CHOICE

There is an inherent tension between unfettered patient choice (of each provider of each aspect of care throughout an entire care pathway) and the development of care pathways’ commissioning. A similar tension exists within the ACO model in the US, with the risk that it could be perceived to limit choice in a traditionally consumer-driven market. CMS has indicated that patients will remain free to use non-ACO providers, and payments for services by both ACO and non-ACO providers will be continue to be made on a fee-for-service basis. A possible delivery model in the UK could be that patients are presented with a choice of an integrated care plan coordinated by a consultant of the patient’s choosing, or a more bespoke solution in which overall care is more fragmented, but individual steps may be more targeted from numerous providers, some of whom may be more specialist. Patients will need meaningful and accessible information provided to help them make the trade-offs between their choices.

PATIENT AND CARER ENGAGEMENT

Liberating the NHS embeds the concept of “no decision about me without me” as the standard for patient and carer involvement. This requires a transformation in how information is presented to patients, including:

- Access to care records which can be shared with providers and practitioners at will8.
- Transparent information about the performance of provider organisations and individual clinicians.
- Information about treatment options.
- Support for self-management of chronic conditions.
- Transparency in the governance of health care organisations.

The US health reform agenda requires a similar step-change in the use of information to empower patients, and the new legislation places patient choice at the heart of the drive to reduce costs and improve quality, patient safety and outcomes. The ACO model is dependent on the portability of electronic patient records to ensure that information can be shared between multiple providers in near-to-real time. As part of the Medical Home Concept, primary care physicians require this data in order to effectively manage all aspects of care. There is a similar drive to empower patients with knowledge about their treatment plans to promote self-management of long-term conditions.

REIMBURSEMENT MODELS THAT PROMOTE COORDINATED CARE AND DRIVE IMPROVEMENTS AND EFFICIENCIES

Both the UK and US governments have signalled their commitment to the use of

---

8. Ultimately this means that the patient must own their own health record – a step which has not yet been taken in the UK, but is embraced in many healthcare regimes.
Significant information technology changes will need to occur, specifically in areas of accounting general ledger, decision support systems (i.e., to support clinical pathways), business and data informatics, and revenue cycle management.

GOVERNANCE
Reform to policy and regulation, and geographical considerations such as primary care provider density and overlapping care delivery areas will drive increased organisational changes in governance. Delivery systems will grapple with challenges such as:

- Organisational structure (patient requirements, provider requirements, organisational structure requirements, etc.)
- Legal structure that aligns to regulation for market conduct, any willing provider laws, and member choice.
- Governance model

Delivery systems are already grappling with whether a staff model organisation vs. a partnership model of independent primary care providers can best address integration, quality, and revenue sharing requirements. Up front due diligence in assessing and determining the most appropriate governance model is critical to ensuring providers are able to weather the transformation (i.e., short-term revenue disruption), align provider expectations, and maintain compliance in an evolving regulatory environment.

WHAT CAN THE US AND UK LEARN FROM EACH OTHER?
How can the lessons of the last several years’ reform in the UK help inform the US as it moves to a more active role for the government in the regulation of healthcare, and how can the best experiences from the US of a market-driven system help shape the shifting accountability away from government control in the UK?

LEGISLATION AND REGULATION TO PREVENT ANTI-TRUST AND NON-COMPETITIVE BEHAVIOUR
The move towards GP based commissioning in the UK will have profound implications for governance structures for GP Consortia, in terms of ensuring transparency in the separation of commissioning and provider functions, and ensuring fair competition in the tendering of services according to an ‘any willing provider’ principle. Similarly, the development of ACOs in the US will almost certainly require further legislation to overcome current issues around anti-trust legislation, while ensuring that the market is still fair and competitive. This is a shared challenge that arises in a health system transformation process aimed at producing greater clinical integration and greater levels of information about the quality and cost of care.

TRANSFORMATION OF COMPLEX INFORMATION TECHNOLOGY FINANCIAL AND PROCESSING SYSTEMS
Care delivery systems have evolved to capture, code, and invoice based on services rendered. Supporting care delivery financial accounting systems have supported cost accounting methodologies, rather than actuarial models of risk managed care and outcomes. In the US, primary physician practice management systems adoption and use is a new trend. However acute care providers have evolved complex legacy systems that are often difficult to upgrade and/or change.

reimbursement models that reward improved clinical and quality outcomes, and incentivise efficiencies in the delivery of care. Likely payment structures in the UK include pathway tariffs which would include re-ablement and post-discharge support, including social care, home adaptations and extracare housing. Another proposed model is that of the ‘best practice’ tariff which would reimburse providers according to the costs of excellent care rather than average price. There are also plans to link quality measures to payment arrangements, including the leveraging of fines for ‘Never’ events such as wrong-site surgery.

Similarly, the US reforms place greater emphasis on the use of financial incentives to improve quality and clinical outcomes. The ACO model is intended to support the use of full or partial capitation payment, or bundled payments to incentivise efficiencies in the delivery of care.

9. The Government has signalled its intention to put such consortia on a statutory footing, details for which are eagerly awaited.
10. In the US, this will need to encompass both federal and regional regulations.
LESSONS FOR THE USA - HOW CAN GOVERNMENT INVOLVEMENT IMPROVE QUALITY AND DECREASE COSTS?
Over the past twenty years the UK’s NHS has been in a state of continual reform, focusing initially on structural and transactional reform of the management of care, and shifting more recently to a focus on driving clinically led and evidence-based reforms in the delivery of care. There are clear lessons to be learnt from the successes and failures of various NHS reform initiatives in terms of introducing mechanisms which motivate providers to concentrate on quality and outcomes, the introduction of Payment by Results and the Quality Outcomes Framework to support transactional reform, and the reform of monitoring bodies to minimise bureaucracy in the administration of performance management efforts. Particularly relevant to the US are the UK’s experiences of:
• Transitioning away from activity-based reimbursements.
• Realigning clinical and financial decision-making.
• Forming public-private partnerships (in the context of medical homes).
• Integrated care pathway development and associated challenges.
• Use of data to report meaningful quality metrics.
• Providing adequate patient access to appropriate care.
Key to the US in terms of learning from the UK experience is understanding the hierarchy of reforms. In the UK, reform has focused on all aspects of the system- including demand-side, supply-side, transaction and management reform.
By implementing these foundational reforms the NHS is better positioned to focus on a clinician-led approach to improving the delivery of care according to evidence-based guidelines.
Throughout the reform period, the UK has placed emphasis on capturing system-wide data on activity and performance in a coherent approach which allows meaningful benchmarking and comparison at several levels. This creates the competitive drivers for hospitals to accelerate their improvement to be high in the league tables. A single agency (the Health and Social Care Information Centre) is responsible for defining and capturing this data and making it available for research and comparison purposes. Crucial to the evolution of this, has been the shift from purely process-based data (e.g. waiting times) towards meaningful outcome data (such as that related to cancer and cardiovascular diseases).

This has helped to overcome some of the tensions between clinicians and managers that measurement can create. Equally crucial has been the recognition that the burden of data collection must be proportionate. More value must be created from the use of the data, than is spent in collecting data for bureaucratic ends.

LESSONS FOR THE UK - HOW CAN CLINICALLY-LED DECISION-MAKING IMPROVE THE PATIENT EXPERIENCE?
There are specific health conditions where the provision of timely care of high quality can significantly impact the cost of care. The integrated delivery of health and social care can significantly improve outcomes for patients with complex and chronic long-term conditions such as diabetes by preventing acute exacerbation of the condition, leading to admissions and unnecessary complication. It is in this context that a model such as the ACO has the potential to deliver the vision outlined in Liberating the NHS. Implementing an ACO model would bring together a range of providers into a structured care pathway with clear visibility and management from end to end. Providers enjoy a clear model for shared savings if they are able to deliver coordinated care that meets clinical standards and creates efficiencies within the system through clinical integration supported by effective information sharing. There are lessons from the US in relation to choice, competition, incentivisation, governance, data protection and data sharing that could inform the development of a model specific to the UK context.

RECOMMENDED PREREQUISITES FOR IMPLEMENTING AN ACO MODEL
• The current model of service delivery had traditionally been an acute provider with responsibility for ensuring a coordinated care pathway across the continuum of care.
• There are long standing partnerships between health and social care.
• GPs do not have the specialist clinical expertise or managerial skills required for effective commissioning.
Framework provides basic quality metrics that could inform financial incentives.

Similarly, Stroke care or Diabetes care could provide interesting opportunities for testing innovations to improve clinical quality and gain increases in efficiency in the delivery of care.

HOW IT WOULD WORK IN PRACTICE:
For an ACO model to be applied to a particular patient pathway, it would require a collaboration of GP consortia with a large population base. A small population base would not provide a sufficient risk pool to be financially viable, and would create inefficiencies of scale.

Each of the GP consortia would pool their budgets, and allocate this to a clinical lead, most likely based in an acute setting. Some of the pooled budget could be retained to provide a fund to reward the ACO for meeting defined targets related to quality. The clinical lead would then be charged with negotiating sub-contracts with a holistic range of community-based and hospital-based services. The clinical lead would have a responsibility to provide a choice of services to patients, and to ensure that the care pathway included access to social care such as housing-related support. The sub-contracting relationships would explicitly set out each

The mental health pathway is frequently at the forefront of forging new ways of working, with breakthroughs in multi-disciplinary team working, and strong liaison across community and hospital-based care. Because the structural foundations are already broadly in place, the mental health care pathway provides an ideal environment in which to develop innovative financial reimbursement models to reward providers for delivering integrated high quality care for their patient populations. Mental Health Services are already integrated Trusts, and it has been recognised that GPs are often not deeply knowledgeable about the care needs of mental health patients.

The financial structures are evolving, with the development of care clusters and tariffs. The Mental Health National Service Framework provides basic quality metrics that could inform financial incentives.

The table below summarises the likely prerequisites for successful implementation of an ACO model.

---

11. In the UK, mental health is often treated as a Cinderella aspect of healthcare, and this valuable pioneering work is not often recognised, amongst providers of either primary or acute physical care.
Can financial incentives overcome the traditional professional siloes that currently prevent integration of care?

How should the costs of capital improvement programmes be shared amongst providers within an ACO?

How should local authority budgets (such as housing-related support) and healthcare budgets be pooled effectively?

How should non-public funds (such as charitable donations) be accounted for?

How can the US develop a budgetary process which adequately reflects deprivation, demographics, geography and other population-based determinants of ill health?

CONCLUSION
We have argued that the respective healthcare reform processes in the UK and the US, although moving in opposite directions, are converging onto a similar model which represents a greater sense of balance between clinician and patient, between state and individual and between rights and responsibilities. The UK offers relevant experience from previous successes and failures in addressing the healthcare challenges which the US system is now facing, and the US offers comparable experience and learning to those leading the next stage of UK reform.

In particular, as each system strives for better clinical outcomes and more efficient use of resources, we see considerable value to both, from adoption of the model for Accountable Care Organisations. We have explored our reasons for optimism in such a solution and pose a few questions to those involved in system development on both sides of the Atlantic.

QUESTIONS FOR CONSIDERATION:
• How well can ACOs respond to the needs of patients with co-morbidities or other complex needs?
• How can an ACO prohibit ‘cherry-picking’ of patients or failure to provide adequate levels of care?
• To what extent can an ACO provide true choice while ensuring economies of scale?
• Over what time period should outcomes be measured?

12. We are assuming that provision for Specialised Commissioning for rare and expensive conditions will be managed outside an ACO model, as at present.
13. For discussion of some of the issues with budget allocation formulae, see Research into diseconomies of scale in delivering health and social care in rural areas, Matrix Insight, report produced for the Cabinet Office Social Exclusion Task Force (SETF), July 2009.