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Book review

# Across the pond—lessons from the US on integrated healthcare

*Richard Gleave*
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*Across the Pond*, authored by Richard Gleave, former fellow of the Commonwealth Fund Harkness/ Health Foundation, and published by the Nuffield Trust, explores integrated care in the US and suggests lessons for the UK's health system. This monograph, which is based on first-hand observations, includes four case studies of integrated-care networks in the US (Kaiser Permanente Colorado and Northwest, the Geisinger Health System in rural, northeastern Pennsylvania, and Health Partners in Minnesota). These case studies offer valuable insights to policy-makers and managers who wish to implement effective integrated care. Comparing integrated care in both countries, Gleave uncovers useful lessons with regard to: (1) governance, (2) risk management and use of incentives, and (3) integrated health information technology.

Historically, different forces have driven integrated care in the UK and the US. In the UK, integrated care operates primarily through a 'single-payer' system. It is based on a market-oriented model of purchaser and provider designed to improve network and system efficiency. By contrast, integrated care in the US has developed primarily as a response to the potentially perverse effects of incentives in the health insurance market and fragmentation in the delivery system. It is often closely associated with managed care, which covers a broad range of care models. The two leading models are health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs are based on 'vertical integration,' while PPOs favor 'virtual integration.' Vertical integration is associated with 'closed systems,' where hospitals, physician groups, and insurance companies are fully interrelated and only members of the health plan can access the delivery system. HMOs are often integrated systems of physician groups, hospitals and insurance companies, but can also maintain collaborative arrangements with hospitals that are 'outside' the system. A PPO is a 'virtually integrated system' with a 'provider network' whereby an insurance company has established a cooperative agreement with hospitals and physician groups regarding payment levels and reimbursable health care services for subscribers. Physicians and hospitals may treat patients from a number of health insurance plans with a variety of agreements.

Gleave has observed innovations in America that can spell success for the NHS. He makes a distinction between integration at the micro (patient and family) and macro (system) levels and argues for their closer alignment. He emphasizes integration components and their importance in the current debate in the NHS: (1) GPs and psychosocial professionals with primary health care teams; (2) primary health care teams with other community-based health professionals; (3) community-based teams with social care; and (4) health and social care team with hospital specialists. A major challenge for professionals, teams, and organizations in implementing integrated care is working across boundaries. Strong accountable governance structures, which develop through sound clinical leadership and robust management practices, appear to be critical to the level of integrated care achieved. They are responsive to local diversity and grounded in a culture that promotes integrated care delivery. Medical groups and pay-for-performance schemes that foster integration and quality of care are also key features of integrated care development, even if research has not conclusively established their superiority over standard practices. Gleave also notes that while Health Partners utilized the approach of withholding marginal payments to improve patient safety, within the Kaiser Permanente system wherein risk is internalized, all of the regions preferred service management approaches and performance management approaches in seeking to improve patient safety.

Payment incentives designed to align provider and patient behavior with quality care issues are critical to the development of integrated care. Innovative and sophisticated payment schemes that take into account patient profiles, performance indicators, and satisfaction metrics have emerged in different mixtures in various health delivery systems in the US. Payment incentives focus on the productivity and value of the entire care pathway, bundling all professional contacts irrespective of the health care provider who sees the patient. Payment incentives also try to balance 'risk minimization' (which is related to vertical integration),

and 'risk-sharing' (associated with virtual integration). Capitation funding such as the HCCs (180-hierarchical condition category), which is presented as an innovative payment scheme that promotes care integration and quality, could be adopted in the UK. Gleave also endorses robust internal management systems, for example, primary care trusts (PCTs) which ought to focus on managerial accountability in dealing with issues that range from external purchasing to internal quality of care.

Another lesson from the US involves the deployment of effective integrated health information technology (IT), developed as a performance management tool. IT, which is viewed as a transformational tool for improving care delivery, can provide an interactive portal for patients, encouraging self-care, and streamlining communications between providers and consumers.

Gleave's report suggests that socioeconomic and political incentives—important change drivers for promoting integrated care—are lacking in the US. Much greater amounts are spent in the US than in the UK on administration (primarily administration and billing). However, integrated care mainly through HMOs greatly reduce administration and billing costs although they may also be construed as limiting consumer choice. To preserve consumer choice in future integrated health care networks in the UK, patients may be allowed to select their general practitioner or decide on the care pathway they will follow. Challenges are also expected in the provision of prevention, primary care and rehabilitation services to specific clienteles. The 'spirit of innovation' in the US and 'vital building blocks of organizational success (i.e. excellent physicians, passionate administrative leaders supported by sound management infrastructure)' are viewed as a 'fascinating learning laboratory' for reforms in the UK and encourage experimentation.

While *Across the Pond* offers valuable recommendations for enhancing integrated care in the UK, the report does have certain limitations. There is too little detail regarding basic funding streams and organization in the four case studies presented here. The monograph would have been enhanced with the inclusion of more concrete examples in support of the points Gleave makes. Finally, it should be noted that even 'closed plans' are not entirely closed as they may serve patients through the federal Medicare and/or the federal/state Medicaid programs.

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