Lessons from a Sabbatical:  
What the British Healthcare System Can Teach Us about Safety, Quality, Access, Primary Care, and Rationing

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Life in the UK: Some General Observations

- London’s an amazing city, and English towns are lovely and charming
- People in the UK are extraordinarily nice and open, in an understated British sort-of way
- It’s near impossible to open a UK bank account
- Meals in London cost the same as in SF… but then you have to multiply by 1.5!
- Rupert Murdoch owns both of their political parties (vs. only one of ours)
Basics of the UK Health System

- Tax-funded system (NHS) owns hospitals, employs docs (except GPs)
- Nearly complete separation of community-based primary care/public health and hospital-based specialty care
- Relatively small private insurance system mostly for amenities, shorter queues
- System is quite centralized; frequent efforts (inc. contentious one today) to decentralize
  - Hint: they usually fail
“The survival of most NHS commissions resembles that of patients with certain metastatic cancers.”

*Nigel Edwards, The King’s Fund*
My Agenda

- Hospital care in the UK: moving from specialists to generalists, slowly
- Primary care in the UK: a system that works
- US vs. UK approach to safety and quality
  - Checklists and IT as illustrations of the risks of too much central control
- NICE and an explicit approach to rationing
- General lessons from two healthcare systems
Patient with acute illness (from ED or outpatient practice)

PCP Oversees Hospital Care (with some exceptions, such as MI and stroke), lots of consultation, specialists frequently took over

Post-Discharge Care by PCP and/or Subspecialist (hospital or community-based)

Inpatient Subspecialty-based Firm (i.e., no role for GP or hospital-based generalist)

Post-Discharge Care by GP and/or Hospital-based Subspecialist
Patient with acute illness (from ED or outpatient practice)

**Hospitalist’s Role**
- Overall responsibility for hospital care (always includes step-down unit, often includes ICU), with consultants as needed
- May be teaching or non-teaching service
- Usually includes co-management of surgical patients
- Often includes overnight coverage
- Patients followed until hospital discharge

**Acute Physician Role**
- Care of acutely ill patients for first 48-72 hours (with consultants as needed), includes teaching
- May include some surgical and stepdown patients
- Usually does not include ICU or overnight care
- 50% of pts discharged from hospital from AMU, rest leave AMU for inpatient subspecialty firms

**Post-Discharge Care by PCP and/or Subspecialist**

**Post-Discharge Care by GP and/or Subspecialist**
Key Issues in Hospital Care

- US & UK grappling w/ role of acute generalists
- In US, huge reservoir of general internists, coupled with fluidity of market, facilitated fastest growing specialty in US history
  - ~35,000 hospitalists in US today
- In UK, new specialty catalyzed by a rule (4-hour ED stay limit); required NHS support, training slots, modifying specialists’ contract
  - ~750 acute physicians in UK today

Wachter RM, Bell D. Renaissance of hospital generalists. *BMJ* 2012
Primary Care in the UK

- Only one type of PCP: GPs
- Independent practitioners (own their own practices, not NHS employees)
- Spectacular primary care access
- Strict gatekeeping: no direct specialty access
- “Most GPs don’t know where the hospital is”
- Approximately 50-50 GP/specialist ratio
- Powerful incentives on quality/safety
### GPs Track Metrics in Real Time

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<td>Smoking status &amp; advice</td>
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I’m the main breadwinner in my family

James’s wife is a colo-rectal surgeon

Dr. James Morrow
Cambridge area GP
The US Approach to Safety/Quality Problems

- Quality/safety movements launched by reports by IOM (a non-govt. organization)
- Accreditors/standard setters got into act (Joint Commission, ACGME, the Boards)
- Funding through AHRQ, foundations
- Medicare ultimately promoted the safety/quality agenda via reporting, now $s
- Limited overarching federal agenda/control
Three Examples of Different Approach: Checklists, HIT, NICE

- The checklist story: entrepreneurial, change-oriented research yields striking benefit in US
  - Could it have happened in the UK?
- HIT: the top-down, “efficient” NHS program was a fiasco
  - Will the market-oriented US approach do better?
- NICE: UK makes resource allocation decisions with mature equanimity
  - In US, discussion is a divisive and painful failure
The Checklist: A Bottom-Up Innovation in US

- Dr. Peter Pronovost develops checklist for CLABSI (evidence->bundles->checklist)
  - Tries it at home (Johns Hopkins): it works
  - Puts together a state-wide study in Michigan
  - Demonstrates effectiveness in NEJM study

- Popularized in article, book by Atul Gawande, extended to surgery (WHO surgical checklist)

- Diffuses through US, with govt support
Arrives in UK via NHS Mandate
Arrives in UK via NHS Mandate

“Another top-down mandate.”

One UK surgeon

Organisations are required to:
- Ensure an executive and a clinical lead are identified in order to implement the surgical safety checklist within the organisation.
- Ensure the checklist is completed for every patient undergoing a surgical procedure (including local anaesthesia).
- Ensure that the use of the checklist is entered in the clinical notes or electronic record by a registered member of the team.
Each Nation’s Top Safety Researchers

Dr. Peter Pronovost

Prof. Charles Vincent
MD vs. PhD Researchers in Safety/Quality: What it Signifies

- Little UK tradition of MD engagement in safety/quality
  - Few paths/role models in academia
  - "Safety is a bunch of government rules, enforced by the managers"

- A vicious cycle
  - Top-down leads to learned helplessness among providers, which leads to more top-down…
The HIT Story

- Each country wants to promote HIT adoption
  - UK: centrally-run program to wire NHS hospitals, 12 billion pounds invested
    - Result: very efficient failure
  - US: much slower process: “meaningful use” standards, incentives for users
    - Result: very slow success (he says hopefully)
NICE was founded in 1999, mostly to address inequities in coverage decisions.

Reviews evidence on new drugs/devices.

Citizens Council helps set policy on tough issues.

Approval threshold ~ $30,000 per QALY.
  - Approximately 2/3rds approved, 15% rejected, rest “optimized”.

Remarkably uncontroversial…
“The man on the street gets it. [The public knows] that there is a finite amount of money. And politicians get it as well — they know that someone is going to have to make these tough decisions, and they’d rather it be us than them.”

Sir Michael Rawlins, NICE Chairman

Quoted in www.wachtersworld.org, “Saying ‘No’ While Being NICE”
NICE and Death Panels

- NICE: mature, transparent process to determine which services NHS will cover based on evidence-based review of cost-effectiveness

- US: one line in 1000-page health reform bill discussed paying doctors to counsel patients about EOL care
  - Immediately caricaturized as “death panels” by Sarah Palin, others
  - Funding stripped, conversation stilled
Countries Have Typical Patterns When Faced With Tough Problems

- Like people, nations have default cultures, structures, and instincts that cause them to approach big problems in predictable ways.
- Also like people, important to understand this so as to compensate for potential blind spots.
- US and UK are quite different in these instincts.
Myers-Briggs on US vs. UK

- US: Individualistic, entrepreneurial, rejects central authority, worships markets, tolerates wildly disparate outcomes
  - Leads us to reject central solutions/rules, create structures/policies that promote individual initiative
  - Maddeningly slow, messy, non-linear but may end up with more durable and flexible answers

- But slow pace of progress is creating pressure for more prescriptive solutions
UK’s Culture and Instincts

- UK: More communal, accepts central authority and prescriptive solutions (with British irony), a bit uncomfortable with disparate outcomes
  - More linear: instinct is to fix problems with a centrally supplied rule/policy
    - Facilitated by NHS structure and small size of country
    - More efficient, but may efficiently get to wrong solution

- Leads to instinctive embrace of resource limits/rationing, and emphasis on access/primary care
  - “You people can’t say ‘no’ to anything”
One Final Observation About UK Health System...

- 30-50 million uninsured
- Zero uninsured
Out-of-Pocket Spending and Problems Paying Medical Bills in Past Year

More than US $1,000 in out-of-pocket costs

Serious problems paying or unable to pay medical bills

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries
Outcomes: Mixed, But Certainly Not Substantially Worse in UK

- Life expectancy almost exactly the same in US and UK
- Mortality of “illnesses amenable to healthcare”: about 5% worse in US than UK
- Diabetes LE amputation rate: significantly higher in US than UK
- Breast cancer 5-year survival rates: better in US than UK

Source: Commonwealth Fund
Every system struggles with developing solutions to fundamental, knotty problems
- Centralization vs. local autonomy
- “The market” vs. other drivers of change

How we address them is markedly influenced by our culture, history, and available tools

We have lots to learn from each other
- And we are heading in each other’s direction

Ultimately we have the same goal: value
The *Other* Value of a Sabbatical