

# The state of primary care in the United States of America and lessons for primary care groups in the United Kingdom

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## SUMMARY

*The health care system of the United States of America (USA) is lavishly funded and those with adequate insurance usually receive excellent attention. However, the system is fragmented and inequitable. Health workers often find it difficult to separate vocational roles from business roles. Care tends to focus on the acute rather than the chronic, on 'episodes of illness' rather than 'person-centred' care, on short-term fixes rather than long-term approaches, on scientific/technical solutions rather than discourse or the 'art of healing', and on individual health rather than population health. The majority of US doctors are trained in the 'high-tech' hospital paradigm and there is no equivalent of the United Kingdom (UK) general practitioner (GP), who lies at the hub of a primary health care team (PHCT) and who is charged with taking a long-term view, co-ordinating health care for individual patients, and acting as patient advocate without major conflicting financial incentives. However, primary care groups/trusts (PCGs) could learn from US management and training techniques, case management, NHS Direct equivalents, and the effects of poorly developed PHCTs. PCGs could develop the UK's own version of utilisation management. A cash-limited, unified budget within an underfunded National Health Service poses threats to general practice.*

*In both the USA and the UK, primary care is a prominent tool in new attempts at cost control. PCGs offer the opportunity of better integration with public health and social services, but threaten GPs' role as independent advocates by giving them a rationing role. Managed care has forced a similar role onto our US counterparts with consequent public displeasure and professional disillusion. UK GPs will have to steer a careful course if they are to avoid a similar fate.*

*Keywords: primary care; USA; health care management; primary care groups; primary care trusts.*

## Introduction

I was drawn to the United States of America (USA) for the same reasons as I would have been drawn to Rome if I had lived 2000 years ago. The USA is the most powerful nation on earth, and exerts substantial influences on the United Kingdom (UK) and its health service.<sup>1</sup> Health care systems do not exist in isolation of other systems and a broad understanding of US society seemed essential to understanding its medical system. To achieve this, in April 1997 my family and I set off for California to live as ordinary a life as possible for 15 months.

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This report concentrates on the organisation of health care. It reflects my sabbatical experience at the Department of Family and Community Medicine, the Center for Health Professions, and the Institute of Health Policy Studies in San Francisco. The department offers care to a wide variety of patients, including the under- and uninsured. My status as a Senior Fulbright Fellow also gave me access to physicians and organisations outside San Francisco.

By understanding other systems we gain an understanding of our own. I hope this paper will help readers understand better the US and UK systems. Currently, both countries are tackling cost control and in both countries primary care is in the limelight — via managed care in the US and primary care groups/trusts (PCGs) in the UK.

## The structure and process of US health care

The US has a mixture of privately and publicly funded systems (Table 1). Health insurance premiums are paid in the following proportions: 7% of the population buy their own, 16% have none, 34% is government funded, and 43% is funded by private employers. However, the actual costs of health care provision are divided differently: individuals pay 26%, the government pays 47%, private employers pay only 21%, and 6% comes from non-patient revenues.<sup>2,3</sup> The main publicly funded programmes are Medicare (for the elderly) and Medicaid (for the poor).<sup>4</sup>

One of the most startling observations about US health care is the relative policy vacuum compared with the UK. President Clinton's health plan of the early 1990s attempted to rectify this, but was rejected by Congress. The vacuum has been partially filled by the 'corporatisation' of health care and the development of 'managed care'. Managed care can be defined as: 'any system of health service payment or delivery arrangements where the health insurer attempts to control or co-ordinate the use of health services by its enrolled members in order to contain health expenditures.'<sup>5</sup> Managed care has reduced cost escalation to 'European' levels,<sup>6</sup> at least temporarily.<sup>7</sup> It is often effected by health maintenance organisations (HMOs) that contract with networks or groups of doctors, hospitals, and other providers. Gatekeeping, where primary care physicians control referrals, is a common feature of managed care. Recent trends in US health care have caused much disillusionment among the public and health professionals.<sup>8,9</sup> There are some excellent examples of primary care,<sup>10</sup> but these are not representative. There is no coherent policy for developing a primary care system that is generally dispersed, uncoordinated, and fragile.

## Primary care and the primary care team

Although definitions of primary care that seem familiar to the UK audience have emanated from the US,<sup>11</sup> in practice US primary care is very different from the UK model. The working definition is variable and frequently determined by commercial interests, for example health insurance companies, rather than by negotiation between governments and professions as occurs in the UK. Primary care physicians include family physicians, internists, paediatricians, and sometimes gynaecologists, but

**Table 1.** Statistical comparisons between the US and the UK health care systems.

	US	UK
Total health expenditure per capita per annum <sup>a</sup> (% GDP) in 1996 <sup>6</sup>	\$3708 (14.2)	\$1304 (6.9)
Government health expenditure per head of population per annum in 1996 <sup>4,6</sup>	\$1732	\$1108
Percentage population over 65 years old in 1996 <sup>6</sup>	12.2	15.8
Prescriptions per capita per annum in 1995 <sup>12</sup>	16.6	8.8
Life expectancy (years from birth) in 1995 <sup>6</sup>		
Male	72.5	74.3
Female	79.2	79.7
Infant mortality per 1000 births in 1995 <sup>6</sup>	8.0	6.0
Inpatient hospital beds per 1000 population in (1990) and 1995 <sup>6</sup>	(4.7) 4.1	(5.9) 4.7
Average length (in days) of inpatient hospital stay <sup>b</sup> in (1990) and 1995 <sup>6</sup>	(9.1) 8.0	(15.6) 9.9
Number of physicians <sup>c</sup> per 100 000 population in 1994 <sup>5</sup>	277	174
Number of primary care physicians per 100 000 population in 1994 <sup>5</sup>	73	62
Family physicians/GPs per 100 000 population in 1994 <sup>12</sup>	33	62
Family physicians/GPs average annual net earnings in 1995 <sup>29</sup>	\$124 000	\$80 000
Specialists' annual average earnings in 1995 <sup>29</sup>	\$225 000	\$105 000

<sup>a</sup>Per capita spending is adjusted for purchasing power parities; <sup>b</sup>includes community hospitals, federal hospitals, and psychiatric hospitals; <sup>c</sup>includes training grades.

there is no overarching organisation, such as the Royal College of General Practitioners, which binds them together (Table 1).

Primary care teams are often poorly developed, with practice nurses and physicians' assistants acting as 'hand maidens'. Doctor contact with the community is often minimal; for example, district nursing is usually ordered from an independent agency by telephone. Clinical, as opposed to business information technology, seems surprisingly underdeveloped.

### Hospital versus community orientation

Many US family physicians enjoy treating their patients in hospital and the resulting continuity of care. However, many are also financially motivated and fear that loss of 'admitting rights' would lead to competitive disadvantage. But hospital work is time-consuming, disrupts office routine, requires specialist skills, and is increasingly being passed to 'hospitalists'. These US specialists are not usually based in hospitals but work from offices similarly to private doctors in the UK. They are self-employed and pay hospitals to use their facilities. Hospitalists are a new breed who are hospital-based for at least 25% of their time. They treat inpatients after referral from primary care physicians, each covering a number of specialities. US family physicians spend approximately the same amount of time visiting hospital patients as UK GPs spend home visiting;<sup>5,12</sup> a telling indicator of differing orientations.

Family doctor training programmes in the US are impressively structured and rigorous. The three-year courses are run throughout by family medicine departments that focus on teaching, as opposed to service commitment.<sup>13</sup> Training is usually hospital-based without the benefit of a registrar year spent entirely in the community. It does not, therefore, allow a 'divorce' from the high-tech hospital paradigm and doctors often remain procedure-oriented. Procedure orientation is also reflected in the reduced emphasis on communication and consultation skills compared with the UK; there is no equivalent of the principles developed by Balint and others, and the Family Practice Board Examination contains no video component. Procedure orientation is encouraged by fee-for-service payment systems and financial structures usually determine the quality and content of primary care, at times introducing perverse incentives.<sup>14</sup> For example, fee-for-service payments encourage health checks of unproven value, and the physicians I interviewed offered 45 minutes for a health check, but only 15 minutes for regular appointments. Non-capi-

tated health insurance policies remunerate health checks highly. Capitated policies often ration the number (but not necessarily the content) of health checks; for example, Kaiser HMO patients can wait up to six months for an appointment. In some states, a more structured approach to prevention is gaining ground through federally designed standards called health plan employer data information sets (HEDISs). In these states, employers who subsidise their employees' health insurance have formed into groups and pressed health insurers to adopt these standards.<sup>15</sup>

### Continuity of care

Fee-for-service payments give scant reward for acquiring patients' previous records. In spite of the advent of managed care, the system does not encourage continuous patient records. Competition encourages patients and employers to change health insurers and providers frequently. Continuity of care is often poor, creating weaker doctor-patient relationships and higher costs.<sup>16</sup> Sub-optimal record systems and poor continuity of care encourage the duplication of investigations and expensive procedures. This probably leads to waste, false positives, iatrogenic illness, and inappropriate treatment. Even within mature, progressive HMOs, such as Kaiser, only 30% of patients feel they have a personal primary care physician. Many Americans told me that the lack of a familiar primary care physician raised their threshold for seeking care. Managed care organisations encourage primary care gatekeeping, but between one-third and one-half of patients still refer themselves directly to specialists.<sup>17</sup>

### Quality of care and service

The USA's reputation for quality of service is legendary and well deserved. Customer responsiveness is ingrained in US culture, and, unlike in the UK, there is no muddle between service and servitude. This is partly owing to quality management and training. In the UK, many employees have four to six weeks of annual holiday, whereas in the USA one to three weeks of vacation and three to six weeks of training are more usual.

The standard of clinical care offered by primary care physicians is enhanced by their impressive clinical knowledge and technological infrastructure but compromised by their health care system. There is no uniformity or standardisation in the system. As Americans themselves say, 'If you've seen one HMO, you've seen one HMO.' There is also no obvious denominator population in the US — no equivalent of the GP list. These factors,

together with poor continuity of care, make it difficult to take a preventive or community-oriented approach.<sup>18</sup> Uninsured patients often present with late stage disease that might have been prevented by early intervention.<sup>19</sup> As discussed above, barriers to good health care exist for the adequately insured as well as the under- and uninsured.

### *Trends in the US and lessons for the UK*

The US and the UK health care systems reflect substantial cultural differences and comparisons must be treated with caution. States vary and my experience is of urban and suburban California, which is at the forefront of health care changes. The charity-dominated health culture of the post-war period switched to a for-profit culture after large corporations moved in during the 80s and 90s.<sup>19</sup> Managed care leapt into prominence. Commercial interests and the profit imperatives of the stock market now dominate health care. Employers have joined into purchasing groups to increase their negotiating power.<sup>15</sup> However, much medicine is practised as before, albeit within larger organisations, tighter management, and altered incentives.<sup>14</sup> The stage is now set for the industrial production techniques developed at the turn of the twentieth century by entrepreneurs such as Carnegie and Ford to be translated into medicine.<sup>20</sup> The rest of the developed world has adopted systems of centrally regulated universal care and will be interested to see how this US experiment develops.

The recent US trend towards managed and capitated care seems to be slowing. Many welcomed its ascendance, hoping it would boost primary care. Although primary care has achieved greater prominence, lack of coherent policy has inhibited its development. Managed care and its emphasis on gatekeeping has been a mixed blessing, leaving physicians and the public dissatisfied with many of the constraints imposed.<sup>14</sup> They are also disturbed by financial incentives and other policies that emphasise the physician's role as a rationer.<sup>8,9,14</sup> There is a danger that PCGs could place GPs in a similar position.<sup>21</sup> Strictly cash-limited budgets may force GPs to choose between quality and cost, and PCGs must find ways of balancing these two issues, or risk alienating the public and demoralising the profession.

To control costs, PCGs may be tempted to use US-style 'utilisation management' systems. These monitor the activity of health professionals (profiling) and require them to request prior authorisation before initiating expensive investigations or procedures. Authorisation is usually via telephone through nurses and lay workers who follow computerised protocols. These techniques can reduce inappropriate treatments and gross deviations from accepted practice but their primary concern is cost. In the UK, we have our own variant of utilisation management: hospital specialists who have no pecuniary interest in performing inappropriate procedures vet GP referrals. Some would say that private practice gives specialists an incentive to undertreat NHS patients and prolong waiting lists.<sup>22</sup> PCGs might better ensure that National Institute for Clinical Excellence recommendations are implemented and that specialists are committed to the National Health Service (NHS) and undergo quality review.

Case management may be of greater interest to PCGs.<sup>23</sup> Case managers (usually nurses) track inpatients, especially those needing complex and expensive treatment. They promote efficiency and effectiveness and speed discharge by organising inpatient stays; for example, by ensuring that investigations are done promptly. NHS Direct probably also has US origins.<sup>24</sup> The success of advice lines set up by HMOs has been limited by patient perceptions that they have little local knowledge and are influenced by cost reduction motives.

The separation of primary and secondary care budgets in 1948

is probably one reason for the strength of general practice.<sup>26</sup> There are potential dangers in amalgamating these budgets within PCGs. Media and public pressure to move money from less charismatic primary and preventive care to expensive high-tech procedures of unproven value will probably continue. It will be interesting to see if PCGs can resist this pressure more effectively than their predecessor health authorities. The partial protection or 'one-way valve' negotiated by the General Practice Committee preserves historic cash-limited General Medical Services (GMS) budgets, but is no guarantee of future GMS development or protection from 'capped' prescribing budgets.

Since 1911, GPs have had a statutory social role that their US counterparts never had. Many GPs resent their wider, non-biomedical roles, but it is this ability to straddle the biomedical, the psychosocial, the public health, and the community roles which gives general practice much of its powerbase and popularity with patients. However, these diverse roles are now creating workload problems which are being exacerbated by the demands of PCGs. In recent years, general practice has recruited practice nurses to help cope with new workload. Further expansion of the primary health care team (PHCT) could help GPs cope with new work and increase the quality and breadth of services.<sup>27</sup> But GPs must learn to manage effectively with careful goal-setting, skill-mix analysis, and training programmes. Practice development plans should include attached staff and PCGs could press for GPs to take over their clinical management, leaving employment in the hands of community trusts. PCGs could foster high quality management and training, an area where we could learn much from the USA.

Per capita health spending in the US is three times that of the UK and yet indicators, such as infant mortality rate and longevity, are better in the UK (Table 1). Although there is considerable waste in the US system, the standard of service to patients and the efficiency and common decency with which most insured patients are treated is impressive and in stark contrast to the UK. As a result of long-term underfunding, waiting lists and general standards in many UK hospital departments are nothing less than abysmal. In these respects the UK also compares badly with many EU countries.<sup>19</sup> The government's total control over NHS spending means that underfunding is inherent in the NHS system, in spite of public desires to the contrary.<sup>28</sup> Despite all its strengths, the NHS is in many ways a source of international embarrassment.

General practitioners within PCGs could publicise the effects of rationing and stimulate local debate. This could stimulate public involvement and increase pressure for adequate funding. Primary care has not previously been cash limited and presently shows fewer signs of underfunding than secondary care. It is responsible for around 90% of NHS patient contacts and fortunately most patients have little experience of hospitals. General practice is a 'steam valve' for the NHS and this may be one reason why the public has tolerated the dark side of the NHS. The imposition of further cash limits on primary care could have devastating effects, not just on primary care, but also on the whole NHS.

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