

Learning from abroad or policy tourism?

INCREASINGLY, as we become more aware of what is going on in other countries, we realise that healthcare systems, although different, are subject to similar forces. The key issues we face are common: how to contain rising costs, improve quality and efficiency, and, in some countries, promote equity. It is natural, therefore, that we should take an interest in how other healthcare systems finance, organise and deliver health care and the relationship this might have with health outcomes and costs.

Major exercises for comparing the performance of healthcare systems have been undertaken. For example, the 2000 *World health report* compared the performance of 191 health systems.¹ This exercise was heavily criticised for the quality of its methodology and its conclusions.² While international comparisons can be useful and prompt critical discussion about health policy, often they are not sufficiently robust to support the flimsy inferences based on them.²

Another exercise that hit the headlines was a comparison between the NHS and Kaiser Permanente, one of the United States' (US') largest non-profit healthcare organisations.³ This paper, which used detailed statistical analysis to claim that the Kaiser system was more efficient than the NHS, prompted a growing love affair by the Department of Health, which sent teams out to study the Kaiser system and has encouraged Kaiser to operate in the United Kingdom (UK). In this issue of the *BJGP* Talbot-Smith and others provide a devastating critique of the inflated claims.⁴

The lesson from this is not that international comparisons should not be conducted, but that it is very difficult to make sensible comparisons between healthcare systems, and that great care should be taken in using such comparisons to make strong statements about their relative performance. Consider how difficult it is, for example, to make sensible comparisons between the performance of hospitals or even individual surgeons. The complexity of systems is much greater and there is even more room for spurious results.

There is great potential value in cross-organisational and cross-national learning. The problem is how to do this scientifically and sensibly. Unfortunately, just as we have seen international comparative analysis fall short of accepted scientific standards, politicians and health policy makers in England are increasingly and uncritically turning to models from overseas in an apparently desperate bid to find simple solutions to complex problems. A phenomenon described by Maynard as 'policy tourism' (A Maynard, personal communication, 2004). However, probably all of us have experienced some disappointment with our overseas holiday purchases, due to three sorts of biases: context bias (the rug that looked lovely in Guatemala but is too bright in Basingstoke), compatibility bias (the machine worked really well over there but I can't get it to work in my living room without buying a whole conversion kit), and the conned-while-abroad or the holiday romance effect (I don't know why I bought that time-share while in Tenerife).

We cannot assume that approaches that worked in one place will work in the same way when transplanted to

another system. A review of quality improvement strategies like Total Quality Management, for example, which worked well in manufacturing industries, found that there was little evidence that they improved quality and performance when applied to healthcare organisations.⁵ Those who engage in simple transplantation of interventions with insufficient regard to system differences, other contextual factors and complexity, have been described as 'ecologically blind transplanters'.⁶ Sometimes, however, policy tourism results in the adoption of strategies where the evidence of benefit, even in the country from which they have been bought or borrowed, is very slim. The introduction of hospital foundation trusts, a system of devolving autonomy to hospitals, was inspired by pilot projects in Spain and other countries that have yet to demonstrate benefit. Even where the evidence in one country is quite strong, further thought might indicate that suitable adaptation and piloting would be needed to see if the results were transferable to the UK.

We need to develop better methods for comparison and technology transfer. Sometimes, system complexity will prevent cross-border transfer.⁶ In other instances the fundamental mechanisms of action will ensure similar outcomes — independent of the context — although probably rarely. Since healthcare systems are like living organisms in which the various agents respond to changes often in unpredictable ways, it is not easy to be certain of the effects of policy initiatives. For example, the introduction of apparently cost-lowering technologies, such as laparoscopic cholecystectomies, unexpectedly resulted in higher overall spending as the threshold for treatment fell and increasing numbers of people, who previously would not have been treated, received the procedure.⁷

It is likely that, for many of the problems faced by our healthcare system, other people have made progress in finding solutions that work in certain contexts. We can accelerate our search for locally effective approaches by learning from, and with, other organisations around the world.⁶ For example, we do have things to learn from Kaiser Permanente, particularly in the way they have invested in a national evidence-based population care management approach for adults with diabetes.⁸ However, we have to be more intelligent in the way we do this. We need to understand better the extent to which others really have implemented effective strategies and the degree to which this is likely to be transferable, and how they will need to be adapted.

We must also resist being seduced into believing that some off-the-peg intervention from one country can be a panacea in another. For example, the Department of Health has invested millions of pounds in buying a chronic disease management programme developed at Stanford University in the US, and which has to be implemented in a prescribed way with little room for local modification. The Expert Patients Programme, which uses self-management training for patients with chronic conditions led by lay people, has been

evaluated in US settings predominantly with self-selected well educated participants.⁹ It is being rolled out nationally before the local evaluation is completed, and despite the fact that initial results from the evaluation suggest poor uptake.¹⁰ More disappointing is that the Department of Health may find that they have bought a time-share when, in fact, there was an equally good cottage around the corner. The Angina Plan, for example, is a UK developed and evaluated self-management programme for people with recently diagnosed stable angina, which is facilitated by a health professional. In a randomised, controlled trial it was shown to reduce frequency of angina by over 40% while reducing physical limitation.¹¹ A community cardiac rehabilitation team at Darlington Primary Care Trust devised an innovative programme using the Angina Plan in a leisure centre, which was a finalist in the recent Department of Health's Health and Social Care Awards, but this has not attracted the sort of attention of the brightly coloured foreign import. Let us learn from abroad, but do it wisely and without forgetting the great resources for effective innovation on our own doorstep.

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Inequalities in access to care for patients with ischaemic heart disease

IN this month's Journal there are three different studies, all about inequalities of care for patients with ischaemic heart disease in general practice. Some results challenge widely-held beliefs and others confirm and underline important problems. So what do these studies tell us? how do they fit in with what we already know? and what questions are left unanswered?

In the first paper, Gill and colleagues report a secondary analysis of questionnaire and interview data from the 1998 and 1999 Health Survey for England.¹ Of the 1123 patients with ischaemic heart disease, over 80% were taking lipid-lowering therapy. Older patients, those from deprived areas, and patients with a myocardial infarction were all less likely to be prescribed lipid-lowering drugs, reaffirming previous work by Reid *et al.*² However, there was no evidence that ethnicity influences uptake of lipid-lowering therapy. Since an earlier study found evidence of poor access to coronary bypass graft for South Asian patients,³ this finding is reassuring.

The next study uses an ecological design to determine the effect of practice-level factors (such as deprivation and ethnicity) on access to care for angiography.⁴ The study examined angiography rates in 143 practices in East London and found no evidence of inequitable access — practices with high proportions of South Asian patients also had higher

rates of angiography. One of the strongest findings was the inverse relationship between angiography rates and distance from centres performing the procedures — practices further away from centres had lower rates of angiography, confirming previous reports elsewhere in the United Kingdom (UK).⁵ Surprisingly, there was no association with deprivation, although the authors suggest that this could be owing to a lack of variation in the sample, which was from an area of high deprivation.

The third paper comes from Italy and uses a large validated computerised database from general practice to report on overall levels of care for patients with angina (excluding those with a myocardial infarction).⁶ The strengths of this study are its analysis of individual patients, drawn from a large population base, and using outcomes that are based on actual prescriptions or readings rather than self report. Three-quarters of patients had a blood pressure value recorded and more than half had poor control. Two-thirds of patients had a cholesterol value and under a quarter had treatments with lipid-lowering drugs. These results are comparable with results for the UK at the same time, showing under-recording.⁷ Their study also confirms other reports of sex inequalities with younger patients and male patients being more likely to be referred and receive some treatments.⁸⁻¹²