

# Reply to 'Questioning the claims from Kaiser'

TALBOT-SMITH *et al*<sup>1</sup> claim that our paper, published over 2 years ago in the *BMJ*,<sup>2</sup> has 'become important in UK government policy making'. It is gratifying for us to learn this and we will return to the reasons why it might be so.

We find the refutations relating to different populations, currency conversion, use of National Health Service (NHS) data, and degree of integration to be unconvincing. Many of the difficulties inherent in such analyses, and the data deficiencies, were recognised in our original paper.<sup>2</sup> Other issues were responded to in our reply to the *BMJ* correspondence.<sup>3</sup>

This critique by Talbot-Smith *et al* adds nothing new to this debate and, disappointingly, provides no alternative analysis leading to more robust conclusions. More worryingly, Talbot-Smith *et al* introduce new confusions and factual errors. Space does not permit a full treatment of these, but we offer some examples: the Kaiser Permanente benefit package for seniors is confused with the proposed new federal Medicare drug benefits; gross measures of health status (for example, standardised mortality rates) are equated uncritically with utilisation of healthcare services; our targeted comparison between the NHS and Kaiser is confused by frequent comparisons between the NHS and the overall US healthcare system; contrary to the assertions by Talbot-Smith *et al*, it is of course necessary to adjust both for the fact that the US dollar and the pound sterling are different currencies and for the fact that a standard basket of goods has a different price in the two economies; it is suggested that the deficiencies in Organisation for Economic Cooperation and Development (OECD) data may invalidate our conclusions on bed days, yet these conclusions have been more than confirmed by another study using NHS data.<sup>4</sup>

Finally, a number of the adjustments recommended in Table 2 make no sense. For example, why would one adjust waiting times to see a specialist by the number of specialists? Kaiser waiting times are shorter partly because they employ more specialists per unit of population, and this is achieved at a cost that is not much higher than the NHS.

Other authors have chosen a more rigorous and analytical approach to examining the contrasts between the NHS and Kaiser. Two recent publications are noteworthy.

Ham *et al*<sup>4</sup> conducted a detailed study of '... inpatient admissions, lengths of stay, and bed days in populations aged over 65 for 11 leading causes of use of acute beds'. They compared the NHS to Kaiser and the US Medicare programme. They found that overall bed day use for these causes in the NHS is 3.5 times higher than Kaiser's. They conclude 'The NHS can learn from Kaiser's integrated approach, the focus on chronic diseases and their effective management, the emphasis placed on self-care, the role of intermediate care, and the leadership provided by doctors in developing and supporting this model of care'. Ham *et al* also conclude that '... the most distinctive feature of the Kaiser model is the way in which it integrates care'. They go on to elaborate three important aspects of integration:

- Integrating funding with provision of care and aligning incentives with physicians so that they have '... an interest in minimising hospital stays because they share responsibility for the success of the programme.'
- Integrating inpatient care and outpatient care enabling patients to move easily between hospitals and home, or into intermediate care facilities. An important aspect of this is that consultants work alongside general practitioners in multispecialty medical groups and do not have an incentive to admit patients to hospital.
- Integrating prevention, diagnosis, treatment, and care. Particularly for chronic diseases, care is delivered through reliance on evidence-based clinical guidelines and is actively managed.<sup>4</sup>

In another recent study not cited by Talbot-Smith *et al*, Light and Dixon also examine factors that may explain differences in utilisation of hospital beds between the NHS and Kaiser.<sup>5</sup> They conclude that the core drivers in Kaiser's ability to minimise bed days and focus on '... emphasising prevention, early and swift interventions based on agreed protocols, and highly coordinated services outside the hospital' are its clinical governance structure and its culture. They contend that the '... recent NHS reforms take the NHS further away from the kind of integrated clinical governance that has allowed Kaiser to achieve its cost-effective, integrated services.'

In short, serious work that has followed our original paper has tended to confirm rather than undermine our broad conclusions. Analyses will constantly improve and better data will be brought to bear. So far, this process affirms that there are striking performance differences between the NHS and Kaiser from which the NHS may be able to learn. We welcome and encourage further rigorous work that will shed more light on this important subject.

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