

Primary Care in the United Kingdom and the United States

Are There Lessons to Learn From Each Other?

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Present health care system reforms, such as the rapid growth of managed care in the United States and the introduction of general practitioner (GP) fundholding in the United Kingdom, have some striking similarities. These similarities are particularly evident in primary care. Yet, the health care delivery systems in the United States and the United Kingdom are so different that some policymakers claim that comparisons between the 2 systems are almost impossible to make.

DIFFERENCES BETWEEN THE UNITED KINGDOM AND THE UNITED STATES

Health care systems in the United States and the United Kingdom differ from each other in the following respects:

- Under the National Health Service in the United Kingdom, coverage is universal (ie, no one is uninsured), financed through general taxation, and free at the point of service. Coverage in the United States is predominantly employer-based (ie, many individuals are uninsured) and financed from private insurance, with variable deductibles and co-payments.¹
- In the United Kingdom, the proportion of public funding for all health services is about 90%, whereas in the United States it is 40% to 50%.²
- In the United Kingdom, the health care system is based on primary care, whereas in the United States the system is dominated by specialty and tertiary care, although recently there has been a shift toward primary care. According to Starfield,³ the United Kingdom has the highest primary care score (1.7) of 10 Western industrialized countries, while the United States has the lowest (0.2). To calculate a "primary care score," Starfield assigned numerical weights to 11 characteristics of pri-

mary care: 5 described the health care system and 6, the characteristics of practice most relevant to primary care. The system characteristics included (1) the type of system; (2) the type of physician who provides primary care; (3) the financial access to health services; (4) the percentage of active physicians who are specialists; and (5) the income of primary care physicians relative to specialists. The 6 practice characteristics included (1) the degree to which the primary care physician serves as the first contact for care; (2) the longitudinality of the relationship with a practitioner over time; (3) the comprehensiveness of services provided; (4) the coordination of care; (5) the extent to which care is family centered; and (6) the community orientation of care.

- In the United Kingdom, the GP rarely sees a patient in the hospital, whereas in the United States most primary care physicians have and use hospital admitting privileges.⁴
- In the United Kingdom, there is a limited role for the for-profit sector, whereas in the United States the health care sector is increasingly dominated by for-profit corporations.⁵
- The consequences of these differences are also well known. In the United Kingdom, the entire population (58 million) is covered for health care but only 7% of the gross national product is used for health care.⁶ In the United States, although more than 14% of the gross na-

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tional product is spent on health care, about 40 million Americans lack health insurance at any given time, and as many as 50 or 60 million are without it at some time during a calendar year.⁷

SIMILARITIES BETWEEN THE UNITED KINGDOM AND THE UNITED STATES

Despite the differences between the 2 health care systems, when it comes to primary care, many of the problems encountered by primary care physicians on both sides of the Atlantic are similar. These problems include the following:

- Low prestige and lower income relative to specialists. In the United Kingdom, the income differentials between the GP and the specialist are much less dramatic than in the United States and originate from the specialist's ability to earn merit awards and engage in private practice.⁸ In the United States, the fees and incomes of primary care physicians are substantially lower than those of specialists.⁹
- General practitioners in the United Kingdom are limited to practice in ambulatory settings. When patients of general practitioners require hospitalization, their care is turned over to the consultant specialist.¹⁰ In the United States, although primary care practitioners admit patients to hospitals, they often lose control of their patients' care when they refer the patients to specialists.^{3(pp91-107)}

CHANGES IN PRIMARY CARE IN THE UNITED KINGDOM AND THE UNITED STATES

Primary care has been in transition in both countries during the past 5 years. In the United States, primary care physicians, who have traditionally functioned as conduits to specialists, are taking on many of the gatekeeper functions of the British GP, largely as a result of the spread of managed care.¹¹ In the United Kingdom, GPs are enlarging the scope of their gatekeeper functions through a reform called GP fundholding. Initiated in 1990, GP fund-

holding gives participating GPs the authority and the budget to contract for specialist services, elective inpatient surgical procedures, and community-based services for patients on their list.¹² This reform allows the GP greater control over health services offered to patients and provides the GP's practice with a larger proportion of health care resources.¹³

In October 1996, a new government white paper titled *Choice and Opportunity*¹⁴ encouraged GPs to develop innovative models of health care delivery, stepping beyond the GP fundholding paradigm. Partnerships between GPs, including salaried options for GPs and contracts with nonphysician professionals, were cited as examples. Light¹⁵ calls this a movement from "managed competition" to "managed cooperation."

Primary care physicians in the United States, who have traditionally been compensated by fee-for-service payment, are increasingly accepting capitation payments for patients enrolled in health maintenance organizations. Indeed, a 1995 survey¹⁶ found that primary care physicians in 56% of network or independent practice association-model managed care plans were paid on a capitated basis, as were those in 34% of group- and staff-model health maintenance organizations and 7% of preferred provider organizations. As more GPs in the United Kingdom become fundholders and more primary care physicians in the United States accept capitation, both groups seem to be moving toward each other in function and payment.

CONVERGENCE OF THE 2 SYSTEMS

Current reforms have led to changes in primary care practice in each of the 2 systems. In the United Kingdom, fundholders are trying to get their patients treated by specialists more quickly,¹⁷ while in the United States managed care organizations give primary care practitioners strong incentives to restrict patients' access to specialists' services.

As a result of these primary care reforms, primary care practitioners

in both countries have seen their power increase relative to that of specialists. In the United Kingdom, fundholding GPs have acquired greater bargaining power vis-à-vis specialists, who are being forced to become more sensitive to National Health Service patient needs.¹⁸ For instance, fundholding GPs can negotiate shorter waiting times for their patients seeking elective surgical procedures. In the United States, primary care physicians are the "hot-ticket item" in most regions of the country. Even specialty-dominated delivery systems, such as academic health centers, are demanding more primary care physicians. In both the United Kingdom and health maintenance organizations in the United States, the gap between the earnings of primary care practitioners and those of specialists has narrowed.¹⁹ In general, there is an enhancement in the prestige of the primary care practitioner.

PROBLEMS ENCOUNTERED

However, reforms in the health care systems of both the United States and the United Kingdom have not been without problems for primary care practitioners. General practitioner fundholding in the United Kingdom and managed care in the United States have led to an increased amount and complexity of administration and paperwork.²⁰⁻²² In both countries, there are mounting pressures to select patients based on the level of risk, favoring healthy patients vs sick ones.^{23,24} Although in the United States the pressure to select patients based on the level of risk is most obvious at the point of entry to the managed care organization, when primary care physicians take on total capitation, these pressures can be experienced on the individual physician level. For instance, capitated primary care physicians have powerful incentives to encourage sick patients to disenroll from their practices. As the demand increases to control costs by reducing services and referrals, there is also an increased conflict for the physician between patient needs and physician income.²⁵ As some observers²⁶ have remarked, "Capitation-plus-bonus payments can turn

primary care gatekeepers into gate-shutters [withholding specialty, ancillary, or hospital services in order to augment personal income], undermining the trust between physician and patient.” Furthermore, there is a lack of coordination and integration of primary care and community health services in both countries,^{27,28} although community outreach and the care of people in the home is a much more common feature of primary care in the United Kingdom.

The shape of future developments in primary care practice can also be discerned from the approaches adopted by a small but significant number of innovators. In the United States, risk-sharing contracts between primary care physicians, hospitals, and health maintenance organizations and other insurance companies are being developed.²⁹ Groups of primary care practitioners who accept full capitation for their patients, including payment for specialist services, acute inpatient care, and prescription drugs, are less prevalent but likely to attract increasing numbers of physicians in the future.³⁰

In the United Kingdom, multifunds and total fundholding are being developed. Multifunds group individual GP fundholders together into consortia, thus enabling smaller practices to exercise more control over the purchase of specialist and elective inpatient surgical procedures. Furthermore, total fundholding, which has already been piloted in 51 practices nationwide, is intended to widen the scope of fundholding to include most acute inpatient services.^{12(p13)}

However, there are problems inherent with total fundholding in the United Kingdom and total capitation in the United States. First, both total fundholding and total capitation increase primary care practitioners’ exposure to financial risk. However, this risk is considerably smaller in the United Kingdom where GP fundholders are not at personal financial risk and are protected against excessive financial risk by stop-loss provisions per patient, in which any additional costs are incurred by the National Health Service.³¹ Second, both total fundholding and total capitation increase the

pressure to form ever-larger groups of practitioners to distribute risk and share computer software programs and information technology, resulting in more bureaucratic administrative structures.^{18(p318)} In addition, both total fundholding and total capitation move the assumption of rationing decisions from the governmental or company level to the level of the individual practitioner, exacerbating conflicts between patients and physicians and accelerating the potential for patients’ distrust.

Finally, total fundholding and total capitation can polarize the primary care practitioner community, pitting fundholders against nonfundholders in the United Kingdom³² and stimulating potential conflicts between capitated primary care physicians and salaried physicians in the United States, such as those employed in community health centers or the clinics of teaching and public hospitals. There is increasing concern that GP fundholders in the United Kingdom and capitated primary care practitioners in the United States are more likely to cater to a higher-income, healthier patient population than nonfundholding GPs in the United Kingdom and salaried primary care practitioners in the United States. General practitioner fundholders and capitated primary care physicians are also likely to practice in more affluent, suburban areas, as opposed to inner-city or rural neighborhoods.^{12(p10)} These and other factors are encouraging 2 separate and unequal systems of health care.

LESSONS TO BE LEARNED

In conclusion, although the health care systems in the United Kingdom and the United States are different, recent reforms in primary care in both countries share some remarkable similarities. Conventional wisdom would say that the United States has been the major source for lessons learned in the United Kingdom and that the United Kingdom has contributed little to health care reform in the United States. But this opinion ignores the following lessons offered by the United Kingdom:

- The value of a primary care-oriented health system. It is the primary care characteristics of the health care system in the United Kingdom that contribute to its popularity and effectiveness (ie, it is the GP who offers first contact, family-centered care based on a longitudinal relationship over time with access to comprehensive benefits and coordination of care). The United States appears to be learning this lesson as managed care spreads from the suburbs to the specialty-oriented academic health centers using the primary care model.
- The importance of universal coverage. In the United Kingdom, the principle of universal coverage has resulted in remarkable loyalty to a health care system that costs one half of that in the United States and has no uninsured people.
- The feasibility of primary care capitation in a universal tax-financed single-payer health care system. The obsession with the Canadian model by single-payer advocates in the United States has led to the impression that a tax-financed, universal coverage health care system needs to be based on a fee-for-service approach.³³ The National Health Service model in the United Kingdom should be reexamined as an alternative to the for-profit managed care model emerging in the United States.
- The potential benefits of separating ambulatory care from inpatient care. The GP focus on outpatient and community-oriented care, with specialist dominance in the hospital inpatient service in the United Kingdom, needs more careful exploration. With the advent of the “hospitalist”³⁴ role in the United States, some physicians are beginning to look at this aspect of the health care system in the United Kingdom.

However, the United Kingdom can also learn lessons from the United States beyond the managed care model. Health care systems that rely on for-profit delivery systems result in unequal access to care. They encourage risk selection by health plans and even by individual providers, which results in divergent interests

between sick patients and healthy patients and frequently pits one group of providers against another.

There are many other lessons that can be learned by comparing the health care systems of the United States and the United Kingdom. This article calls attention to the recent reforms in primary care in both countries as a first step in such a dialogue.

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Clinical Pearl

Selenium

Selenium supplementation did not protect against common skin cancers but was associated with lower rates of cancer at several other sites. (*JAMA*. 1996;276:1957-1963.)