Gatekeeping in Health Care

Quite a number of German politicians, health insurers and experts see and herald the gatekeeping system as quality enhancing and a panacea for cost containment. A study recently carried out by the Center for Hospital Management (CKM) as part of the institute’s international benchmarking project of health care systems and care provider organisations concludes differently.

Gatekeeper systems in each of the countries reviewed were found without exception to impede rather than enhance care coordination and decreasing the cost of care. The study also found that patients and doctors generally do not like gatekeeping. Particularly “one-man-band” primary care practices perceived gatekeeping as problematic. Apart from costing doctors time and money, an increasing concern is the scope of medical knowledge physician are required to master. The number of patients a doctor is seeing is on average not only of greater age these days, but usually comes with a host of comorbidities. As a result physicians have less time available to diagnose and to visit their patients in hospital. For example in the US the number of patients visited by their respective family doctor has gone down dramatically over the last 20 years, i.e. from about 12 patients per day to only 2 patients per day. Less visits also meant that quality of care was compromised.

It was also found that there are gatekeeping systems like for example in the US which incentivise medical practitioners for delaying the referral of patients to hospital as long as possible. This has led physicians to keep and treat more difficult cases ambulatory instead of an early referral to hospital. Figures for the period 1978 to 1997 reveal physicians wrote up 11 referrals from a total of 12 patients seen in 1978 compared with only one written up referral by 1997.

Britain’s National Health System (NHS) requirement of gatekeeping has had different but also mainly negative ramifications. The NHS suffering from chronic underfunding ever since its inception was subjected to the GP Fundholder concept by the Thatcher government in the late eighties. The concept was designed to have collectives of primary care physicians as “gatekeepers” compete with NHS hospital Trusts (care providers) for care provision “bought” by the Health Authorities (purchaser). The “added” competition was meant to help contain costs and cut waiting lists. However, the “cherry picking” of patients by the GP Fundholders quickly starved NHS Trust of badly needed finance, which in turn led to even longer waiting times, rationing of certain procedures as well as exacerbating an already precarious shortage of nursing staff. Nurses were found to switch to much better paid jobs at Fundholder practices.

The Netherlands have experienced similar gatekeeping effects like those in Britain. The majority of Dutch physicians consider authorisation of specialist visits as time consuming and costly. The prevailing attitude among Dutch physicians is that gatekeeping is demoralising and frustrating. They feel they have been denigrated to administrators of the system. This has led to the peculiar situation that mostly only Dutch female doctors can be found these days to uphold the function of gatekeeping and that strictly only on a half-day basis.

Generally speaking, gatekeeping can be blamed for diminished care provision of the population. Preventative measures and health screening are two areas where the system’s shortfall is most obvious and noticeable. Mammography is an example in case. As wastefulness is a problem with gatekeeping so is communication between gatekeeping groups and specialists/hospitals. While communication is of utmost importance, gatekeeping policies may not be an effective way to promote it. For an integrated care provision system to be clinically and administratively fully effective and efficient it should embrace an information network reaching from the electronic patient file at the core to the latest telemedicine technology helping to put specialists at the patient’s bed-
The findings of CKM’s investigation confirm that traditional gatekeeping systems lack the necessary attributes to meet the demands of a health care system that is supposed to deliver high quality care at low unit costs.

As a result of another CKM study of 3 gatekeeping systems (US and Germany) the institute has devised a modified gatekeeping system (depicted below) largely overcoming the weaknesses of the current systems. The CKM gatekeeping model is based on the assumption that “traditional” gatekeeping is losing out to innovative developments in the market place such as “medical competence centres”, polyclinics and the intensification of ambulatory care capabilities at hospitals. The IHBF-Expert Round, part of CKM’s international benchmarking project of “Best Practices” in secondary care, evaluated world-wide gatekeeping policies and unanimously concluded that from the “screeners” point of view gatekeeping is only ever going to succeed if it will consider strategies to promote care co-ordination while simultaneously freeing patients and care givers from ineffective bureaucratic procedures.

**The Blunt End: Risk Management through Failure Mode and Effects Analysis (FMEA)**

What constitutes a “sharp end” is something Pamela Smith knows very well in her role as co-ordinator of the “Sharp Teams” at the Lakeland Regional Medical Centre, Lakeland, Florida, USA. According to risk managers, the “sharp end” signifies those undesirable incidents which result in permanent injuries: a needle breaks off injuring the patient; a switched x-ray film leads to a wrong diagnosis and incorrect treatment, the wrong limb is amputated or a life-saving medication is wrongly administered causing death.

Sharp end incidents are by nature catastrophic: people are injured, property destroyed, massive financial losses incurred. But disaster management at the “sharp end” is reactive and aims to limit damage. Much more effective than “management at the sharp end” is that at the “blunt end” as most catastrophes usually have some tell tale precursors and those who recognise these early warning signals can undertake timely and targeted protective measures. These days hospital managers have well tried and tested risk management tools and techniques at their disposal for the prevention of risks. One of these tools is the Failure Mode and Effects Analysis (FMEA) routinely applied in other high safety-oriented industries such as the aeronautics or automobile industries. First applied in engineering, FMEA is a powerful quality method that helps in a highly structured approach to identify and counter weak points in the early conception phase of products and processes. Thus avoiding the occurrence of any future fault in the respective product, process or service.

The two major FMEA applications are:

- For products and services. Here FMEA is used in the context of new work procedures (e.g. surgical techniques) or the introduction of new services (e.g. introduction of a hospitalist system for providing care to older patients; the introduction of a new range of meals).
- For processes. Here FMEA is used for early detection of risks as a result of restructuring a new work flow (e.g. introduction of HIS/RIS/PACS) and to proactively counter such risks.

At Lakeland Regional Medical Center (USA) the FMEA is successfully employed in risk management. Prof. von Eiff explained the FMEA methodology and communicated his experiences with it in the automotive industry, where the method originated and was first used.

**The objectives of FMEA:**

- Identify potential types of faults and errors and potential sources of failure,
- Evaluate and prioritise the consequences of mistakes for customers,
- Determine the possible factors which favour the occurrence of mistakes,
- Device monitoring techniques to detect mistakes prematurely,
- Device measures for permanently eradicating mistakes and improving quality.

**The benefits of FMEA are:**

- To be prepared for possible faults and their effects,
- To systematically combat faults within the processes, and to reduce faults and prevent them occurring in future.
For risk management to be an effective quality method organisations have to nurture and promote a culture of openness that encourages to talk freely about past mistakes, the fear of risks and how to improve performance.

But here’s the crux: In 1984 as AUDI faced accusations of "unintended acceleration" in one of its models, one part of the investigation was that all FMEA cards for the respective model were examined. Fortunately the investigation gave the company a clean bill of health since the cards gave no hint that this possible fault had been known. However, the emotionally led discussions that ensued in the American public around this perceived "fault" cost AUDI dearly in terms of downturns in its sales, which took many years to reverse. A hospital were it to adopt the FMEA system, and using it as a tool for learning, could in case of a serious incident produce its own proof of guilt or innocence. Yet learning should always be first and foremost and have priority over achieving transparency about causes of incidents. But if organisations prefer a "name and shame" culture at the expense of a "learning from mistakes" one they will never achieve developing a "learning risk culture".

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**FMEA for In-patient Rehabilitation Process**

Failure-Mode-and-Effects-Analysis Table. FMEA tables are used to recognize and rank potential failures and the effects of failures, to identify actions that could eliminate or reduce the chance of the failure recurring and to document the process.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Potential Failure Mode</th>
<th>Potential Effects of Failures</th>
<th>S</th>
<th>E</th>
<th>V</th>
<th>Potential Causes of Failures</th>
<th>O</th>
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<th>Current Design Controls</th>
<th>D</th>
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<th>R</th>
<th>P</th>
<th>N</th>
<th>Recommended Actions</th>
<th>Responsibility Target for Completion</th>
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<tbody>
<tr>
<td>Proadmission Assessment</td>
<td>Confusion on Part of Team</td>
<td>Less Available Resources</td>
<td>2</td>
<td>Inaccurate Data</td>
<td>Missing Data</td>
<td>Miscommunication</td>
<td>Unnecessary Data</td>
<td>5</td>
<td>Informal “Gotcha”</td>
<td>“Victim”</td>
<td>4</td>
<td>Marketing Meeting</td>
<td>4</td>
<td>40</td>
<td>Educate Staff in use of quality concerns and collect actual data</td>
<td>2 Weeks, Clinical Department Managers</td>
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<td>Wrong Treatment</td>
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<td>Condition not monitored (Unidentified Problem)</td>
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<td>Initial Assessment or Admission</td>
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**Legend:**

- **SEV**: Severity Rating for each potential effect of the failure
- **OCC**: Occurrence Rating = probability of occurrence of a potential cause
- **DET**: Detection Rating = for each design control the effectiveness of the procedure is rated
- **RPN**: Risk Priority Number = overall potential effect on patients; sets priorities on which to work first.

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**Learning from "Down Under"**

Alison Stalley, Commissioning Co-ordinator at the St. Vincent’s Hospital Toowoomba, Australia, a benchmark partner hospital in the IHBF project, followed an invitation to visit Krankenhaus Düren another partner hospital, whilst attending one of the project’s bi-annual fora. The Düren Management Team used the opportunity of Alison’s visit to quiz her about and learn from her extensive experience with the Australian DRG system, a derivative of which German care providers are meant to adopt on a voluntary basis in 2003 before becoming mandatory in 2004.

The Australian Government introduced the DRG system into their healthcare system in 1992. Taken advantage of this head start Peter Neumann, CEO of the Krankenhaus Düren, and his team gained valuable insight from Alison.
about the dos and don’ts of a DRG system and its ramifications on the entire organisational structure and development of care givers. CEO Peter Neumann finds the IHBF-network extremely useful commenting "The direct and personal learning experience from someone having years of experience with reimbursement based on DRG classification has been most helpful for us in respect of preparing ourselves for DRG D-day." Alison, glad to have been of help, comforted her German colleagues with:

"Don't worry, initially we went through the same feelings of panic, frustration, doubts and sometimes chaos, but you'll come through alright."

**Statements from the Project Partners**

"Using the intercorporate comparison as an instrument for dialogue and learning from best practices requires new, also for many politicians unusual communication and learning habits.*  

*Horst Seehtner, Member of the German Parliament and former Minister of Health"

"The true meaning of benchmarking is to learn from others and to bring ideas into the business and as such benchmarking is an active process of discovery and a desired activity provided with the proper instructions and support that signifies a commitment to the process by top management."

*Wilhelm Schleibach, International Business Development, CKM, London, UK*

"In an era of increasing health care costs and problems everywhere the IHBF stands for worldwide communication and solving problems by learning from each other. There is currently considerable big interest in optimising medical-workflow, introducing clinical pathways, controlling expenses, as well as paying attention to the patients' needs and wishes. To connect both, often controversial positions, IHBF helps us to find a clear way to be prepared for the future developments on a high professional level."

*Thomas Krammer, Senior Medical Officer, Medical Controlling, Quality Management, St. Franziskus-Hospital, Münster, Germany*

"The development of international best practice standards for hospitals as we move further in the 21st century is the goal of the IHBF. The forum allows physicians and healthcare leaders to discuss common problems and solutions in the context of cultural understanding. In addition, we have been able to share best practices, both clinical and administrative, bringing this information back to our own system. Participating in the IHBF has been a pleasure for me and an honor for the MemorialCare system. I look forward to the future of this organization. It has the potential to influence the practice of hospital medicine worldwide."

*Clyde E. Wesp, Medical Director, Best Practices, Memorial Care, Huntington Beach, USA*

"The central problem for all health systems is comparative measurement of quality - vital to this process is the existence of reliable international benchmarks against which individual managers, as well as whole health services, can judge their performance."

*Tim Kelsey, CEO DrFoster, London, UK*

**The Value of Benchmarking**

The intercorporate comparison proved in many different areas of industry and public organisations to be a helpful instrument to facilitate customer orientation, efficiency and transparent leadership. The International Hospital Benchmarking Forum which is organised by the CKM under the auspices of Professor Wilfried von Eiff brings together innovative examples of best practices in lively debate. The network has moved beyond the boundaries of purely specialist dialogue and become a reform workshop for the health care systems and hospital sectors of all those countries involved. Beyond the debate concerning practical examples, it can justifiably be claimed that the demands made and the solutions proposed have repercussions that go beyond hospitals as such.

*Reinhard Mohn, Founder of the Bertelsmann Foundation, Member of the Executive Committee of the Board of the Bertelsmann Foundation, Germany*