International health policy: common problems, alternative strategies

K Davis

Cite this article as:

Health Affairs 18, no.3 (1999):135-143
doi: 10.1377/hlthaff.18.3.135

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/18/3/135.citation

For Reprints, Links & Permissions : http://content.healthaffairs.org/1340_reprints.php

Email Alertings :
http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe : https://fulfillment.healthaffairs.org
International Health Policy: Common Problems, Alternative Strategies

A multinational symposium allowed analysts and officials to compare notes on their common ground and to debate solutions to problems in their health care systems.

by Karen Davis

Health care systems in the five major English-speaking countries—Australia, Britain, Canada, New Zealand, and the United States—all have undergone significant change in the past decade, often precipitating dissatisfaction from the general public and the medical professions. Officials in most of these countries seem to be regrouping—modifying reforms and strategies and reaching out to forge consensus and shape broader coalitions for change. There is a growing view that attempts to curb health spending either have gone too far or need to be balanced with attention to quality improvement.

The common themes emerging from a recent Commonwealth Fund–sponsored international health policy symposium, from which several papers in this volume are drawn, include (1) how best to integrate health services, (2) the uses and limits of financial incentives for health care providers and patients, (3) the potential of better information in monitoring and improving health system performance, and (4) trends in health insurance coverage. Despite the unique features of the U.S. health care system, the experiences of other countries can help the United States to assess the relative effectiveness of its current course, can suggest approaches that might improve the performance of the U.S. health care system, and can raise cautions about potential challenges and pitfalls.

Integration Of Health Services

Health care is costly in any industrialized nation. In the 1980s and early 1990s slowing the growth of total health care spending was a predominant concern. Health policy was driven in most countries...
by governmental budgetary pressures and a desire to control rising tax burdens. Although U.S. employers and policymakers have been encouraged by the slowdown in health care costs, international data do not provide any evidence that the United States is slowing its spending relative to other countries. In the 1990s U.S. per capita health spending grew at about the median rate for industrialized nations and more quickly than spending in Canada or the United Kingdom. Health spending as a percentage of gross domestic product (GDP) stayed constant in the 1990s in Canada as a result of stiff governmental budgetary measures. 1

For the United States, these comparisons spell both good and bad news. On the positive side, they suggest that measures to control health spending—whether legislative changes to programs such as Medicare and Medicaid or market-driven approaches such as employers’ shift to managed care—have not been excessive but, rather, are roughly in line with changes in other countries. On the negative side, they provide no evidence that domestic strategies are working better than methods used by other countries.

Although total spending remains a potent issue, concern has recently shifted in several countries to changing delivery systems to provide care at lower cost. Integration of health care services is viewed as a strategy for substituting less costly ambulatory care for hospital care and for better disease management, including patient education and prescription drugs that prevent episodes of acute illness requiring hospitalization.

Since hospital care is the most costly segment of the health sector, countries are seeking ways to shift care out of the hospital. Canada has established regional authorities responsible for a broad array of services (not including physician services and prescription drugs), resulting in significant hospital closures and bed reductions in some provinces. But to be truly effective, authorities will need broader responsibility for physician services.

Several Australian state governments have adopted American-style diagnosis-related group (DRG) prospective payment methods to shorten hospital stays. Other countries rely more heavily on direct controls on health care use, typically resulting in long waiting times for elective surgery. Although effective, these strategies have their shortcomings. The Commonwealth Fund 1998 International Health Policy Survey found, for example, that 58 percent of British patients wait longer than one month for nonemergency surgery, compared with 12 percent of U.S. patients. 2 Public backlash in New Zealand has led to the development of “booking systems” with explicit criteria for services established in cooperation with the medical profession.
Canada has aggressively pushed outpatient or day surgery: 70 percent of all surgery in Canada is day surgery, compared with half of all U.S. surgery. Both of these rates are considerably higher than in the United Kingdom. The decline in Canadian public satisfaction with the health care system and perceived quality of care in the 1990s suggests that day surgery and shorter hospital stays may be leading to discomfort or anxiety among patients and increased burdens on families.

The United States does have the lowest rate of hospital utilization. The U.S. rate of 1.1 inpatient hospital days per capita is well below the median for industrialized countries and the national rates for Australia (2.2), Canada (1.9), and the United Kingdom (1.7). Where the United States rate seems high is in cost per day of care and number of hospital employees per patient. The U.S. system is clearly more technology intensive, featuring, for example, more magnetic resonance imaging (MRI) machines and computed tomography (CT) scanners and providing more bypass operations, cataract surgeries, and joint replacements per capita than other countries.

Other countries avoid high costs per day of care and excessive use of expensive technology through direct measures. Hospitals typically are subject to tightly constrained global budgets, and capital outlays for major equipment or facilities must be approved by governmental authorities. In some countries the numbers of surgeons and other specialist physicians are directly controlled.

Financial Incentives

**Physicians.** Some interesting recent innovations include giving primary care physicians a financial incentive to manage the total care of patients more economically. British reforms in the early 1990s included general practitioner (GP) fundholding, through which GPs received capitated payments to cover their own services and services (such as surgery) “purchased” for their patients. GP fundholding is now being phased out and replaced by primary care groups. At their most advanced level of development, groups of approximately fifty primary care physicians will receive the entire allocation for their patients’ health care and will purchase all services, including hospital care, through the group. New Zealand has been moving in a similar direction: Under a system called “budget holding,” groups of physicians will assume the financial risk for providing a broad array of services.

These trends have direct relevance to the United States, where physicians have formed associations to negotiate capitated managed care contracts. Primary care physicians may receive capitated pay-
ments for their own services, plus a bonus if funds set aside for specialty care are not exhausted. Medicare now permits managed care plans established by physicians and hospitals—provider-sponsored organizations (PSOs)—to participate. State Medicaid agencies are beginning to consider direct contracting with provider groups, especially as for-profit managed care plans pull out of the program. Sharing experiences across countries may clarify the administrative, financial, and quality implications of these new arrangements.

**Prescription drugs.** Another recent trend common to most industrialized nations is the rapid growth in prescription drug spending. This upward shift has been particularly marked in the 1990s: Between 1992 and 1996 per capita drug spending rose by 41 percent in Australia, 31 percent in the United Kingdom, and 23 percent in the United States. This change is partly attributable to the movement of patient care out of the hospital. A patient hospitalized for four days typically receives a variety of medications during that time, which are counted as part of hospital spending. If the same patient receives outpatient surgery instead, the medication costs are counted as pharmaceutical spending. The implications touch on more than accounting: Unlike hospital expenses, drugs often must be paid for directly by patients.

New drugs for conditions ranging from human immunodeficiency virus (HIV) infection to heart disease also have driven up costs. Yet these more effective drugs often extend life expectancy, prevent hospitalizations, and avert the need for surgical interventions. U.S. managed care plans tend to encourage pharmaceutical use as part of sound disease management.

The U.S. and Canadian governments have balked at covering prescription drugs despite the financial burden they pose for chronically ill patients. Medicare does not routinely cover prescription drugs, although one survey found that more than three-fourths of beneficiaries have ongoing medication requirements. In Canada prescription drugs are not routinely covered as part of basic benefits, but provinces typically offer subsidies for the elderly and the poor. Ironically, the segments of the U.S. population most in need of prescription drug coverage—the elderly and disabled—do not receive it, although the healthier working population often gets it through employer-sponsored plans. Australia has instituted a number of innovations to hold down rising drug costs, including patient cost sharing, incentives to use generic drugs, and negotiating prices with suppliers. As a result of this last tactic, drug prices in Australia are only about 50–60 percent of world prices.

**Capitation.** Although capitation encourages substitution of
lower-cost alternatives, it also can create excessive incentives to reduce utilization. Conference participants discussed a partial capitation or blended payment system as a way of balancing incentives for too little and too much care. Some countries such as the United Kingdom have a mix of capitation and fee-for-service (FFS) payment for primary care physicians. Most U.S. physicians receive some income from capitation contracts and some income from FFS payment, but neither managed care plans nor physicians typically receive a blended payment for services provided to patients.

Government officials from participating countries also stressed the need for collaboration rather than confrontation with the medical profession and for devolving greater responsibility to physicians. Particularly in the United Kingdom and New Zealand, earlier reforms that had a more confrontational approach with the medical profession have encountered considerable resistance. Trying to move forward, they are seeking a more collaborative relationship. Trust does not occur overnight, and wariness is still dominant on both sides.

**Information And The Quality Of Care**

The preoccupation with containing health care spending has led to some public backlash and a growing fear that quality of care is being compromised. These concerns are most marked in countries that have recently instituted stringent cost containment measures, such as Canada and New Zealand. Growing queues in the United Kingdom are a particular source of public debate. Restrictions by U.S. managed care plans have prompted concerns about getting access to specialist and emergency care.

Concern about quality has triggered interest in developing better health information systems. Health care professionals and consumer advocates would use information to demonstrate that budget cuts have been too severe and to counter further pressure to downsize hospital capacity. Others see information systems as a way of helping to prevent medical errors, quickly locating medical record information, making state-of-the-art diagnosis and treatment information available to practicing physicians, and coordinating care and flow of medical information among various providers and settings.

Ministers of health see information systems as a way of monitoring quality across health care providers, motivating excellence in care and adoption of best practices. Report cards, including clinical quality and information on patients’ experiences with care, can be used to reward responsive health systems and providers. Benchmarks on cost and quality of care can be the basis for stimulating improvement, raising standards, and advancing practice. Information systems also can provide better information to patients—
“Other countries are beginning to experience a crack in social solidarity and a potential breakdown of universal coverage.”

example, on scheduling of surgery and other specialized procedures. Making rationing decisions “transparent” could lead to greater accountability and acceptance of systems as fair and equitable.

In market-based health care systems such as the U.S. system, information is viewed as helpful to decision making by patients and purchasers. Families can use information on managed care quality and provider performance to choose plans and physicians that are right for them. Some employers use accreditation by the National Committee for Quality Assurance (NCQA) and Health Plan Employer Data and Information Set (HEDIS) data as a basis for selecting plans offered to employees. Increasingly, patients are turning to the Internet to obtain information about their medical conditions and treatment alternatives.

Managed care plans also increasingly require sophisticated information systems, not only for administrative purposes but also to monitor providers’ practice profiles and patterns of care. Chronic disease management to ensure compliance with prescription drug therapy and avoid costly hospitalization requires better information systems. Some health plans and physicians are using electronic communication to answer patients’ inquiries and triage care. Others have sophisticated reminder systems to help physicians and patients adhere to preventive care protocols.

Information systems also can be used to improve payment methods under government programs. Case-mix measurement and adjustment of capitation rates for the health risk of enrolled populations can reward managed care plans that serve chronically ill patients. Government financial officials see information systems as a way of identifying inappropriate or unnecessary care and ways to achieve additional savings without adversely affecting quality of care. In a time of tight budgetary resources, information on the value of health care interventions and outcomes is important in making the case for additional resources.

Conference participants called for international collaboration to standardize measures, facilitate cross-national research on quality of care, and promote cross-national learning about model information systems. Most countries have responded—through either governmental or private efforts—by developing methods to measure and monitor the quality of care. The United States has led the way in defining both patient-centered measures, derived from patient sur-
veys, and clinical measures. HEDIS now functions as a yardstick for managed care plans' quality. Medicare is requiring standardized information on patient satisfaction (Consumer Assessment of Health Plans, or CAHPS) and quality of care (Medicare HEDIS) as a way of facilitating beneficiaries' informed decision making among Medicare managed care plans through an open-enrollment process. Some state Medicaid programs are moving in this direction as well.¹⁵

British conference participants indicated that they are adopting a version of HEDIS to monitor quality of care in their country as well. The British National Health Service (NHS) has contracted with Picker Europe—a joint venture of the Picker Institute and the Swedish firm BURE—to conduct patient-centered care surveys in British hospitals. The United Kingdom also is establishing an Institute on Clinical Effectiveness. A commission on health improvement is addressing issues such as treatment of cancer, cardiac care, mental health care, diabetes care, and care of the elderly. Britain, Canada, and other countries have put increasing emphasis on "evidence-based medicine" and other efforts to promote improved clinical quality, while New Zealand has worked with clinicians to develop clinical guidelines and identify best practices. Cross-national studies could reveal important lessons regarding the effectiveness of such efforts in improving the quality and responsiveness of care.

**Health Insurance Coverage And Satisfaction**

The United States is the only major industrialized nation that does not provide universal health insurance coverage. The growing number of Americans without health insurance is the dominant concern in discussions of health care access in this country. A 1997 survey found that lack of coverage was systematically related to access problems, including difficulty in obtaining needed care, postponing care, and not receiving high-quality care.¹⁶ The United States stands alone in looking to incremental steps, such as the recently enacted State Children's Health Insurance Program (CHIP) and possibly future steps to expand coverage to parents, to close gaps in coverage.

It is striking that other countries are beginning to experience a crack in social solidarity and a potential breakdown of universal coverage. As governmental spending on health care has tightened, there is a growing desire for supplemental insurance by the middle class to assure that their families can get high-quality care. Australia and New Zealand both count on substantial private health insurance to reduce pressure on public hospitals and public budgets. Prescription drugs are not covered in the Canadian system, leaving
those without private insurance coverage for drugs increasingly vulnerable as prescription drug costs rise rapidly.

Health care is central to individual health and well-being; therefore, when people become dissatisfied with their health care system, governments must take notice. Issues that prompt widespread public dissatisfaction include high out-of-pocket costs for patients, difficulties in getting access to care, and the perception that care is poor or inadequate. The Commonwealth Fund 1998 International Health Policy Survey found high levels of discontent in both the United States and New Zealand, where almost a third of patients said that they would favor a complete rebuilding of their health care system.\(^7\) Their dissatisfaction seems to be linked directly to high medical bills—an acute problem for the 15 percent of Americans with no insurance and for the many working families whose coverage is inadequate. In New Zealand very unpopular user charges for hospital inpatient and outpatient services were imposed in 1993 but subsequently withdrawn.\(^9\) By contrast, only 14 percent of Britons believe that their health care system needs extensive reform.

Achieving popular reform is often elusive. After failing to reach consensus on an approach to universal health insurance coverage in 1994, the United States has turned instead to more modest incremental reforms. Responsibility for health care costs is a constant source of tension between the national and state or provincial governments in Australia and Canada.\(^9\) Conflict between the medical profession and public officials over reforms in the United Kingdom and New Zealand in the early 1990s have led to more collaborative and conciliatory approaches in recent reforms.\(^20\)

One obstacle to change is disagreement over fundamental strategies. Some advocates favor a market-oriented approach, tempered with financial incentives to use health care resources more economically. Others endorse equity and social solidarity as guiding principles, emphasizing the public provision of care along with decentralized decision making and accountability mechanisms. Yet the concerns being debated and the choices being considered are similar in many ways, even in radically different health care systems. Building on this rich foundation of common goals and diverse experiences could open new opportunities for each health care system to develop better, more efficient services.
NOTES
4. Ibid.
18. Poutasi, “Costs, Quality, and Equity.”
20. Le Grand, “Competition, Cooperation, or Control?” and Poutasi, “Costs, Quality, and Equity.”