Lessons for Reform From Our Colleagues Abroad

BY JANE M. ANDERSON

Contributing Writer

WASHINGTON — Analysis of other countries' health care systems has pointed out what might work—and what won't work—in efforts to reform the U.S. system.

At the annual meeting of the American College of Physicians, ACP senior vice president of governmental affairs and public policy Robert Doherty outlined seven key lessons the college learned in looking closely at health care systems around the globe:

► **Lesson No. 1.** Global budgets and price controls can restrain costs, but they can also lead to negative consequences. Canada, Germany, New Zealand, Taiwan, and the United Kingdom all use global budgets, Mr. Doherty said. In the United Kingdom, for example, annual per capita health expenditures totaled $2,546 in 2004 versus $6,012 in the United States that year.

Nevertheless, global budgets do not provide incentives for improved efficiency unless the annual expense budget is reasonable and the target region is small enough to motivate individual providers to avoid the overuse of services, he said.

► **Lesson No. 2.** Societal investment in medical education can help achieve a well-trained workforce that has the right proportion of primary care physicians and specialists and is large enough to ensure access, he said.

Many countries finance medical school education with public funds, so that students pay little (as in the Netherlands) or no (as in Australia, Canada, France, Germany, Japan, and Switzerland) tuition and typically are responsible only for books and fees, the ACP reported earlier this year in a position paper, "High-Performance Health Care System with Universal Access."

In contrast, the average U.S. tuition in 2005 was $20,370 for public medical schools and $38,190 at private medical schools, according to the paper. As a result, 85% of graduating medical students begin their careers with substantial debts.

► **Lesson No. 3.** High-performing systems encourage patients to be prudent purchasers and to engage in healthy behavior, Mr. Doherty said. "Patients need to have some stake in the system themselves," he said. For example, in Belgium, France, Japan, New Zealand, and Switzerland, patients share costs with copayment schedules based on income, and that can help restrain costs while ensuring that poorer individuals have access, he said.

In addition, incentives to encourage personal responsibility—such as those found in Australia, Belgium, Japan, and other countries—can be effective in influencing healthy behaviors.

► **Lesson No. 4.** The best payment systems recognize the value of care coordinated by primary care doctors, Mr. Doherty said. Effective payment systems provide adequate payment for primary care services, create incentives for quality improvement and reporting (as in Belgium and the United Kingdom), recognize geographic or local payment differences (as in Canada, Denmark, Germany, and the United Kingdom), and provide incentives for care coordination (as in Denmark and the Netherlands), he said.

In Denmark, for example, primary care physicians receive a capitated payment for providing care coordination and case management by telephone or e-mail, in addition to receiving fee-for-service payments for office visits.

► **Lesson No. 5.** High-performing systems measure their own performance. Countries such as Australia, New Zealand, and the United Kingdom, along with the U.S. Veterans Health Administration, have implemented performance measures linked to quality, he said.

► **Lesson No. 6.** High-performing systems invest in health information technology, and have uniform billing and lower administrative costs, Mr. Doherty said. The adoption of uniform billing and electronic processing of claims—as has been done in Germany, Canada, and Taiwan, among others—improves efficiency and reduces administrative expenses, he said.

Denmark, Taiwan, and the Netherlands have interoperable health information infrastructures that incorporate decision-support tools. "Systems like these will enable physicians to obtain instantaneous information at the point of medical decision making and will enhance electronic communications among physicians, hospitals, pharmacies, diagnostic testing laboratories, and patients."

► **Lesson No. 7.** High-performing systems invest in research and comparative effectiveness. Insufficient investments in research and medical technology result in reliance on outdated technologies and medical equipment, and delay patients' access to advances in medical care, he said. This has occurred in Canada and the United Kingdom, according to the position paper.

The goal in applying these lessons should be to identify approaches that the evidence shows are more likely to be effective and determine if they can be adapted to the unique circumstances in the U.S., Mr. Doherty said. ■

LAW & MEDICINE

Has the Time Come for Universal Coverage?

With Sen. Edward M. Kennedy (D-Mass.), a staunch supporter of patient rights and health care, now battling brain cancer, the subject of health care in our nation becomes all the more poignant. In a two-part series, we will consider this important issue.

Our present health care system is broken, and we need an updated model. A March 17, 2008, Fortune magazine article reported that the United States now has 47 million uninsured residents, and that, according to the Department of Health and Human Services, health care expenditures will double by 2017, to $4.3 trillion. And even though the United States is the richest country in the world, the World Health Organization recently ranked it 37th in terms of health care quality and fairness.

BY MILES J. ZAREMSKI, J.D.

Health care is a top-tier issue for our presidential candidates. The American electorate demands change in the health care system. This time, whoever takes the Oval Office must ensure that change comes about so that all Americans are provided adequate health care at affordable prices.

The first question to be answered is: Should all Americans be entitled to health care? It is a simple question but one that has produced debate, because we as a nation have never considered health care to be a right. Should it be? If it should not become a fundamental right, should some Americans—such as children—have health insurance coverage guaranteed to them?

The permutations are many, but there is only one right and fair choice: All Americans, including those taking overt steps to become citizens, should be provided health care. This is necessary for many of the same reasons that led to Medicare's passage in 1965: The crisis is as widespread and pervasive today as it was in the years preceding Medicare's enactment, and some type of relief is warranted on a national level, but for all U.S. citizens—not just for seniors.

Who should pay for that care is an important issue, but the answer to this question should not be the engine that drives the car. Instead, we should declare that all Americans should have access to health care, and then figure out a way to achieve that goal.

The two major-party presidential candidates, Sen. John McCain (R-Ariz.) and Sen. Barack Obama (D-Ill.) have very different approaches to the problem. Sen. McCain declares himself to be a free-market guy, believing that governmental intervention proposed in Democratic plans would be shackled with "inefficiency, irrationality, and uncontrolled costs." A fundamental principle of his plan is that no American should be required to buy health insurance.

As noted in the Fortune article, Sen. McCain says his plan would "tax employer-sponsored health insurance, and use the money to provide tax credits (up to $5,000) for individuals and families to shop for coverage on their own," thereby "forcing insurance companies to compete head-to-head for customers" and ostensibly lowering prices. He has also proposed a creation of a Guaranteed Access Plan to help ill and high-risk patients—who otherwise would find coverage very expensive or impossible to buy—obtain "coverage of last resort." He also would not require insurers to sell policies to those with preexisting medical conditions. His message makes for nice sound bites but the devil, as always, is in the details.

The underpinning of McCain's plan involves the elimination of the tax break that employees now receive when their employer provides their health insurance. The employee would have to pay tax on the cost of an employer-provided plan for that employee or his family. With the federal dollars saved by eliminating the tax break, McCain would provide a $2,500 federal tax rebate for individuals and $5,000 per family that could be used toward the purchase of private health care policies. Sen. McCain expects that this would result in many fewer people opting for employer-sponsored health benefits.

In addition, Sen. McCain would allow the individual to purchase the health plan that best fits his or her stage in life, allowing insurers to offer an array of plans, with various benefits, copays, and deductibles. As one writer has observed, however, the downside is that "he risks leaving the poor and sick behind" (although one McCain lieutenant says the tax credit would be increased for that patient population).

Sen. Obama describes his plan as providing affordable and portable health coverage for all and lowering costs by modernizing the health care system. Specifically, he would require that no American be turned away from any insurance plan because of an illness or a preexisting condition. Americans would receive benefits similar to those that Sen. Obama and other members of Congress receive through the Federal Employees Health Benefits Program. He also calls for a National Health Insurance Exchange to assist individuals who wish to purchase a private insurance plan.

Employers that do not offer or make a "meaningful" contribution to the cost of quality health coverage for their employees would be required to contribute a percentage of payroll toward the costs of a national plan, although some small employers would be exempt from that requirement. Parents would be required to provide coverage for their children.

For physicians, Obama's plan would strengthen comparative effectiveness research by establishing an independent institute to guide reviews and studies, giving physicians and patients up-to-date clinical information. Another part of his plan would strengthen antitrust laws to prevent insurers from overcharging physicians for their malpractice insurance and would work to improve systems that eliminate errors in patient care and safety. Again, nice bullet points, but crafting all his points into a workable solution for a majority of Congress will take some doing. ■

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