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# Health Reform: Insights from Around the World

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The United States stands at the brink of a historic change that would remove financial barriers to health insurance coverage and ensure access to essential health care services. Enactment of health reform legislation would enable the U.S. to join the ranks of major industrialized countries that offer their people a system of health insurance coverage. Most of the health reform debate has focused on ways to strengthen our uniquely American private-public system of health financing and expand coverage to those who fall through its cracks. Yet, the debate has also been informed by insights gained from health systems in other countries.

## Making Care Affordable

A recent Commonwealth Fund survey of primary care physicians in 11 countries published in *Health Affairs* underscores just how much is at stake. Many of the shortcomings in the U.S. health system revealed by the survey—pertaining to access, quality, health outcomes, and value—would be addressed by the proposals under consideration by Congress.

Almost three of five U.S. physicians (58%) say their patients often have difficulty paying for care. In sharp contrast, about one of four primary care physicians in the other 10 countries say that costs are often an issue for patients. That's largely because most of these countries have a coverage system with benefits designed to facilitate access to essential services and provide financial protection against burdensome medical bills. Countries such as Norway, Sweden, and the U.K. include little or no patient cost-sharing for medical expenses and cap total financial exposure for the year. Some, such as France, base patient cost-sharing on how essential a particular service is for ensuring good health outcomes. Others, such as Germany, use reference pricing for prescription drugs, with patients paying the difference if they prefer a higher-cost but no more effective medication. Germany also limits total out-of-pocket costs as a share of income to 2 percent for the general population and 1 percent for sicker patients. France eliminates cost-sharing for seriously ill patients and those with specified chronic conditions on care plans.

Without a seamless coverage system like those offered in these other countries, many Americans cycle in and out of coverage. Nearly one-third of U.S. adults under age 65 are either uninsured at some point during the year or underinsured, meaning their insurance does not protect them from high medical expenses. Because there is no accepted standard for essential benefits, even the insured can encounter difficulty paying medical bills. Not surprisingly, half of U.S. physicians report that the time they spend helping patients get needed treatment or medications because of insurance restrictions is a major problem. One study supported by The Commonwealth Fund found that physicians spend $31 billion a year dealing with insurance companies. On a per-person basis, the U.S. spends more than twice as much as other countries on the net costs of insurance administration. Varying benefit designs, marketing costs, people churning in and out of coverage, underwriting, and insurance profit margins all contribute to higher overhead costs. A recent McKinsey study estimates that such complexity–including multiple reporting requirements—accounts for some $90 billion per year in excess costs.

Insurance reform is fundamental for access to care and financial protection. It also can serve as a base for a more rational payment system and incentives that reward value, not volume. Coherent prices and payment policies that support

effective and efficient care are critical for markets to work, as is publicly available information that gives patients comparative information on quality and price to facilitate choice and providers data to improve quality and efficiency.

The U.S. stands out among other countries for the high prices it pays for care. All other industrialized countries leverage their purchasing power to negotiate reasonable provider payment rates and prescription drug prices. Unlike countries with multiple payers and competing insurers–such as Germany, Switzerland, and the Netherlands–the U.S. lacks a mechanism to coordinate payment policies to achieve coherent price signals or use group purchasing power. As a result, the U.S. tends to pay higher prices for specialized services, including prescription drugs, particularly brand-name drugs without generic options. A recent McKinsey study found the U.S. pays 50 percent more than other countries for comparable drugs and pays for a more expensive mix of drugs than do other developed countries, leading to total costs per capita that are twice as high as other industrialized nations.

## Improving Primary Care

Also notable are our nation's weak primary care foundation and poor care coordination. Other countries have insurance systems that promote continuity of care and provide a choice among primary care practices in the community. Many encourage or require patients to identify a "medical home"--a practice that will serve as their principal source of primary care and coordinator of specialist care when needed. With modest financial incentives, more than 90 percent of French adults voluntarily choose to sign up with a medical home. In the Netherlands, after-hours cooperatives take over for primary care physicians at nights and weekends, which explains why 97 percent of Dutch primary care physicians report that they have arrangements for after-hours care of patients. By contrast, only 29 percent of U.S. primary care physicians report any arrangement for the care of their patients after hours.

The U.S. relies on market incentives to shape its health care system, yet other countries are much further along in providing financial incentives to primary care physicians aimed at improving quality of care. The U.K. has had substantial success in improving quality of care with its pay-for-performance rewards to primary care physicians. Eighty-nine percent of U.K. primary care doctors report they can receive financial incentives for quality improvement. By contrast, only 36 percent of U.S. primary care physicians report that they can receive financial incentives based on meeting quality targets, delivering recommended preventive or chronic care, or meeting other care goals as of 2009. Incentives and targeted support for primary care in other countries include extra payments to add nurses to care teams, payment for e-mail consultations, and enhanced payments for after-hours care. Providers also receive extra payments for enrolling patients in disease management programs and for offering chronic care services such as patient self-management education. Several countries pay physicians in a way that narrows the spread between primary care physicians' and specialists' income—making a stark contrast to the widening gaps between primary and specialty providers in the United States. Countries that have traditionally paid for care on a fee-for-service basis are increasingly moving toward a mixed payment method, including per-patient monthly allotments for providing access, coordination, teams, and serving as a "medical home" as well as fees for visits or incentives for quality. In most other countries, hospital and inpatient physician services are "bundled" into a single system of payment, either as global fees based on diagnosis or hospital budgets including salaries of physicians caring for hospital patients.

Investing in advanced clinical information systems is instrumental to inform, guide, and drive innovation. Despite its reputation for use of technology, the U.S. lags way behind other countries in adoption of health information technology and creation of health information exchange networks that facilitate access to all of a patient's pertinent medical information for physicians and other health professionals, authorized by patients. In some countries, patients have direct access to their own medical records. Less than half of American primary care physicians report use of electronic medical records, compared with nearly all of their counterparts in the Netherlands, New Zealand, Norway, and the U.K. Other countries have invested to spread the adoption and use of health information technology, with the capacity for information exchange. The wide differences across countries reflect national efforts to standardize and promote use, often with financial incentives. The American Recovery and Reinvestment Act enacted earlier this year should help speed adoption of information technology in the U.S.

Countries are also investing in assessing comparative clinical effectiveness to inform patient and physician decisions as well as pricing and benefit designs. Such assessment promotes innovation and enables reference pricing of medications and brings downward pressure on higher-cost alternatives. In addition, several countries are developing rich comparative information systems on performance. In Germany, peers visit hospitals where the quality of care is substandard and enter into a "dialogue" about why that is the case. The Netherlands and the U.K. are investing in transparency in reporting performance data, including data on patient experiences. In both countries, this information is posted on public Web sites as well as fed back to clinicians. The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

Overall, what most differentiates the U.S. from other countries is the leadership shown by government in setting coherent policies that drive health systems to high performance. This includes setting goals, measuring performance, and rewarding improvement. Over the last decade, a focused strategy and quality outcomes framework have helped transform the National Health Service in England. When other countries rely extensively on markets, government sets market rules in the public interest to focus competition on quality and efficiency and provide information to spur improvement and innovation. In countries with multiple payers and competing insurers, this includes provisions for public and private participation in a common set of policies that work in the same direction.

But today, the national leadership in the U.S. is working to put in place the coverage and delivery reforms that our country desperately needs to ensure the health and economic security of current and future generations. We have the benefit of multiple examples of international strategies as well as care systems in the U.S. that achieve high-quality care at lower costs. We can learn from the experiences of other nations as they continue to innovate to meet current and future needs for accessible, high-quality, and efficient care. By enacting national reforms that take steps to put the United States on a path to a high performance health system, there is the opportunity to reap a high return for the health of the population and the economy.