



**U.S. Health Reforms to Improve Access, Outcomes and Value: International
Insights and Innovative Policies**

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U.S. HEALTH REFORMS TO IMPROVE ACCESS, OUTCOMES, AND VALUE: INTERNATIONAL INSIGHTS AND INNOVATIVE POLICIES

ORAL STATEMENT AND EXECUTIVE SUMMARY

Thank you, Mr. Chairman and members of the Committee, for the invitation to testify regarding insights for the United States from international experiences with health care system reforms to improve access, outcomes, and value. As the U.S. confronts the urgent need for federal action to expand and improve access and to slow the increase in health care costs for families, employers, and the public sector, we might well ask how other countries insure everyone, achieve outcomes that rival or exceed those in the U.S., and yet spend far less than we do.

The U.S. stands out among wealthy, industrialized nations for: our failure to cover everyone; our expensive, complex, and inefficient insurance system; our fragmented health care delivery systems with weak primary care foundations; our lack of information; and incentives to increase the volume of health services irrespective of quality of care or outcomes. We are the only country with high rates of uninsured and underinsured, where even the insured can face cost-related access barriers and financial stress or bankruptcy if they become sick. Such concerns are “made in America”—that is, virtually all other high-income, advanced industrialized countries have adopted health insurance policies that guarantee coverage for the entire population, access to care, and financial protection, with an emphasis on protecting those individuals who are vulnerable because of poor health or low income. Moreover, they do so at far lower cost, and achieve health outcomes that are often comparable to or better than those in the U.S.

The U.S. leads the world in health spending, with costs projected to continue rising far faster than incomes over the next decade if trends continue. Health care spending, at \$2.5 trillion or \$7,290 per person, already consumes 17 percent of our nation’s gross domestic product (GDP), and it is more than twice what other major high-income, industrialized countries spend. If trends continue, health spending as a percentage of our GDP will likely reach 21 percent by 2020. Compared to other industrialized countries, we spend about twice as much per person. As a share of national resources (GDP), we spend from one-and-a-half to two times as much as other countries—and the gap has been widening since 1980, particularly in the past five years. Relatively higher-cost countries, such as Germany and Canada, have moderated their

spending growth relative to income, while countries with lower spending, such as the United Kingdom, have increased outlays as a matter of deliberate public policy.

As other countries adopt innovative policies to improve performance, incorporate incentives to enhance value, and harness markets and competition in the public interest, we as a nation have opportunities to learn from these international strategies and reforms. The key question confronting U.S. policymakers contemplating national reforms is how to expand coverage to everyone and slow the growth in health care costs while maintaining or improving the quality of care. Looking at other countries, it is clear that each has developed, and continues to develop, its own approach, with policies and health systems evolving from their unique histories and institutions. Similarly, the U.S. will need to craft policies and adapt changes that fit our history, institutions, and values. Still, we can learn from the values and strategies that cut across diverse countries and from examples of incentives, policies, and practices that contribute to higher performance. The international experience provides insight regarding the potential direction and effectiveness of U.S. insurance, payment, and delivery system reforms.

Five lessons from the international experience stand out:

- **Payment Policies: Prices, Purchasing Power, Information, and Incentives**

In addition to its health insurance gaps, the U.S. is notable for paying higher prices than other countries, including very high prices for more specialized care, and for incentives to do more irrespective of value. Unlike other countries with multiple payers and competing insurers—such as Germany, Switzerland, and the Netherlands—we lack a mechanism to coordinate payment policies so that price signals are coherent, or a way to use group purchasing power to move in the same direction. In more monopolized markets, U.S. private insurers often act as price-takers to maintain networks and pass through higher prices, with a mark-up for marketing, administrative costs, and margins. 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., compared with other developed countries, pays 50 percent more for comparable drugs and pays for a more expensive mix of drugs, leading to total costs that are twice as high as expected—amounting to some \$98 billion in excess spending per year.

- **Primary Care: Payment, Incentives, and Infrastructure**

Overall, the U.S. stands out for its weak primary care foundation and poorly coordinated care. Most striking is that other countries have insurance systems that promote continuity in care, including long-term relationships with physicians, and provide the choice of all primary care practices in the community. Many encourage or require patients to identify a “medical home” to serve as their principal source of primary care and to coordinate specialist care when needed. After-hours cooperatives take over for primary care physicians at nights and on weekends in several countries.

Most fundamentally, other countries make primary care financially and physically accessible to their residents. Insurance designs emphasize coverage of primary care with low or no cost-sharing for preventive care and essential medications for chronic illnesses. Such value-based benefit designs provide positive incentives for patients, lower financial barriers for highly effective care, and align patient incentives with efforts to hold clinicians accountable for high-quality, effective care.

The U.S. relies on market incentives to shape its health care system, yet other countries are more advanced in providing financial support and incentives to primary care physicians that target quality of care. Incentives and targeted support for primary care in other countries include: extra payments for adding nurses to care teams, payment for e-mail consults, and enhanced visit payments for after-hours care. Providers receive financial incentives for enrolling patients 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, especially compared to the widening gaps in the U.S. Countries that have traditionally paid on a fee-for-service basis are increasingly moving toward a mixed payment method that includes a per-patient monthly allotment for providing access, coordination, and team-based care and for serving as a “medical home,” as well as fees for visits or incentives for quality.

- **Information Systems to Inform, Guide, and Drive Innovation**

Other countries have made investments to promote the adoption and use of electronic health information technology with the capacity for information exchange. As of 2006, one-fourth of U.S. primary care physician report using electronic medical records, compared with nearly all primary care physicians in the Netherlands, New Zealand, and the U.K. Primary care physicians in other countries also increasingly have health IT featuring an array of functionality, a result of efforts by these countries to build on their IT capacity. When assessed against 14 different functions of advanced

information capacity, one of five U.S. primary care physicians reported having at least seven of the 14 functions, compared with 60 percent to 90 percent of physicians in the Netherlands, Australia, the U.K., and New Zealand. The wide differences reflect these other nations' efforts to standardize and promote use of health IT, often through financial incentives.

- **Comparative Information and Transparency**

In addition to using assessments of clinical effectiveness to inform medical decisions and insurance benefit designs, several countries are developing rich comparative information systems on performance. In Germany, peers visit hospitals whose quality is substandard and enter into a “dialogue” about why that is the case. The Netherlands and the U.K. are also investing in transparency in reporting quality data, including patients' experiences. In both countries, this information is posted on public Web sites and fed back to clinicians. The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

- **Insurance-Related Complexity and Administrative Costs**

As currently structured, the U.S. health insurance system also generates high insurance-related administrative and overhead costs—for insurers as well as for doctors and hospitals. On a per-person basis, the U.S. spends more than twice as much for the net costs of insurance administration. Varying benefit designs, marketing costs, churning in and out of coverage, underwriting, and insurance profit margins also contribute to higher overhead costs. A recent McKinsey study estimates such complexity—including multiple reporting requirements—accounts for some \$90 billion in excess costs each year. And this does not count the internal costs to physician practices in time and staff resources to cope with complex variations.

Conclusion

In summary, several core strategies span diverse countries, although each country has evolved its own approach. These include:

- Coverage for everyone: an explicit national goal and shared value
 - Insurance designs emphasize access, financial protection, and value
 - Insurance provides foundation for payment and system reforms
- Payment policies that emphasize value and use group-purchasing power, and that promote primary care, prevention, and effective care of chronic disease

- System reforms that harness markets and competition in the public interest and provide information to spur improvement performance and innovation
 - Market rules that focus competition on quality and efficiency
 - In multipayer systems, joint efforts to move in the same direction
 - Information systems to inform, guide, and drive change and innovation
- Leadership, goals, and targets
 - In countries with multiple payers and competing insurers, this includes provisions for public and private participation.

Insurance reform is fundamental for access and financial protection. Other countries provide evidence that it also can serve as a base for a more rational payment system and for 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 information. Investing in comparative information and assessment and advanced clinical information systems are instrumental to inform, guide, and drive innovation. These core strategies cut across other countries and have fueled reforms designed to meet the health needs of their populations.

The time has come for the U.S. to move forward on behalf of the health and economic security of current and future generations. We have the benefit of being able to draw from multiple examples of international strategies, as well as care systems here in the U.S. that achieve high quality at lower cost. We can learn from diverse international experiences as nations innovate to provide accessible, high-quality, and efficient care. By enacting national reforms that take strategic steps to put the nation on a path to high performance, we have the opportunity to reap a high return for the health of the population and the economy.

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Thank you, Mr. Chairman and members of the Committee, for the invitation to testify regarding insights for the United States from international experiences in health care system reform to improve access, outcomes, and value. As the U.S. confronts the urgent need for federal action to expand and improve access and to slow the increase in health care costs for families, employers, and the public sector, we might well ask how other countries insure everyone, achieve health outcomes that rival or exceed those in the U.S., and yet spend far less than we do. The U.S. stands out among wealthy, industrialized nations for: our failure to cover everyone; our expensive, complex, and inefficient insurance system; our fragmented health care delivery systems and weak primary care foundation; our lack of information; and incentives that increase the volume of health services irrespective of quality of care or outcomes. We have opportunities to learn from international strategies and reforms as countries adopt innovative policies to improve performance, incorporate incentives to enhance value, and harness markets and competition in the public interest.

Today, I'd like to review what we know about the U.S. health system compared to the health systems of other countries, and then highlight policies and examples of recent innovations that address concerns central to U.S. health reforms. Policies and practices as well as strategic approaches draw from Denmark, France, Germany, the Netherlands, and the United Kingdom. Recent reforms in these countries plus innovative practices illustrate a variety of approaches for addressing the challenge of simultaneously achieving better access, higher quality, and greater efficiency.

The Only Major Industrialized Country Without Universal Coverage, the U.S. Spends Far More on Health Care but Does Not Get Commensurate Return in Value
Currently, 46 million Americans are uninsured and at least 75 million adults and children are without coverage at some time during the year.^{1,2} If trends continue, we could see 61 million uninsured by 2020 (Figure 1).³ Twenty-five million more are underinsured, meaning their coverage leaves them exposed to high medical care costs compared to their incomes when they are sick.⁴ An estimated 42 percent of all adults under age 65 were

either uninsured or underinsured in 2007, before the start of the recession. Insurance is becoming ever-less affordable as premiums have doubled and incomes stagnated: premiums are up by 108 percent since 2000, compared to a 32 percent increase in workers' wages and a 24 percent increase in general inflation (Figure 2). The steady rise in health insurance costs has occurred despite a marked increase in cost-sharing. Rising costs directly contribute to eroding coverage and stress businesses as well as federal, state, and local government budgets. With coverage eroding even for those with insurance, 72 million adults ages 18 to 64 face problems paying medical bills or are paying off past medical debt—including a sharp increase among middle-class families.⁵

Such concerns are “made in America”—that is, virtually all other high-income, advanced industrialized countries have adopted health insurance policies that guarantee coverage for the entire population, access to care, and financial protection, with an emphasis on protecting those who are vulnerable because of poor health or low income. Moreover, they do so at far lower costs and achieve outcomes that are often comparable to or better than those in the U.S.

The U.S. leads the world in health care spending, with costs projected to continue rising far faster than incomes over the next decade, if trends continue. Health spending, at \$2.5 trillion or \$7,290 per person, already consumes 17 percent of the nation's gross domestic product (GDP). If trends continue, health spending as a percent of GDP will likely reach 21 percent by 2020.⁶ Compared to other industrialized countries, we spend about twice as much per person. As a share of national resources (GDP), we spend from one-and-a-half to two times more—and the gap has been widening since 1980, particularly in the past five years (Figure 3).⁷ Relatively higher-cost countries, such as Germany and Canada, have moderated their health spending growth relative to income, while countries with lower spending, such as the U.K., have increased outlays as a matter of deliberate public policy.

With such a high investment, the U.S. should expect to lead on health outcomes and care experiences. Yet we fall short of achievable benchmarks for access, quality, and efficiency.^{8,9} Indeed, on some key indicators we are falling behind, as other countries improve faster.¹⁰ The U.S. is now in last place, behind 18 other high-income countries, on mortality amenable to health care before age 75—in other words, deaths that are potentially preventable with timely, effective health care or early efforts to screen and prevent the onset of disease.¹¹ Although U.S. death rates declined by 4 percent over five years (1997–98 to 2002–03), other countries achieved much faster declines, averaging 16

percent over the same period (Figure 4). The difference between the U.S. and the countries with the lowest mortality rates amounts to 100,000 premature, potentially preventable deaths each year. Within the U.S., mortality rates from conditions amenable to health care—such as diabetes—are higher in states with high uninsured rates, high rates of readmissions to hospitals, and low levels of preventive care.¹² Our infant mortality rates are high and our healthy life expectancy is low by international standards.¹³ U.S. adults are also more likely than adults in other nations to report medical errors, duplicative tests, and care coordination gaps, and to lack rapid access to primary care or care after regular hours without going to the emergency room. These contrasts indicate the U.S. could improve health and promote healthy lives with insurance reforms, a stronger emphasis on prevention and primary care, and health care delivery system reforms.¹⁴

All advanced industrialized countries face rising costs from technological change, including costly new pharmaceutical products, and aging populations with often complex chronic disease. Indeed, the population in most European countries already has the age distribution that the U.S. will experience in 20 years. Nor is the difference in spending attributable to rationing care or shortages of physicians. In fact, the U.S. has lower rates of hospitalization and shorter hospital stays than most other countries and fewer visits to physicians each year.¹⁵

Physician-to-population ratios in the U.S. are also similar to or lower than what they are in other countries. At the same time, more U.S. physicians are specialists and subspecialists.¹⁶ Research both within the U.S. and across countries has shown that health care spending is higher and health outcomes worse when there is a lower ratio of primary care physicians to specialists and a weak, less-accessible primary care foundation.¹⁷

The resulting fragmented, highly specialized U.S. health care system generates poorly coordinated care that puts patients at risk and wastes resources. U.S. payment incentives reward doing more irrespective of health benefits or costs—a recipe for spending more without getting higher value in return. The fractured U.S. health insurance system further erodes performance and undermines efforts to move in a new direction.

The U.S. stands out among other countries in its failure to provide everyone with health coverage, with benefits that ensure access and financial protection. Those with insurance increasingly face high cost-sharing or benefit limits that put them at risk. The fractured insurance system and benefit designs together undermine health system

performance by erecting cost barriers to timely, effective care and weakening primary care. Half of chronically ill U.S. adults report not getting needed care because of the cost—a rate far higher than seen in other countries (Figure 5). And sicker patients in the U.S., whether insured or uninsured, are far more likely to report high out-of-pocket costs (Figure 6).¹⁸ Forty-two percent of chronically ill U.S. adults who were insured all year went without needed care because of the cost. Among all U.S. adults, 30 percent of those with insurance and 34 percent of those without spent more than \$1,000 for the year in 2007—much higher than in any other country.¹⁹

In addition to failing to guarantee financial access to care, the U.S. also fails to ensure accessible and coordinated care. The U.S. stands out for the proportion of its adults who report either having no regular doctor or having been with their physician for a short period.²⁰ This reflects in part high churning in and out of health plans: one third (32%) of U.S. adults changed plans in the past three years, and 14 percent did so more than once in a 2007 cross-national survey. In the U.S., coverage linked to employment, in addition to managed care plans with restricted networks, exacerbates poor continuity of care, since people often need to change physicians when they change jobs or their employers change coverage.

Keys to Reform: Lessons from the International Experience

The key question confronting U.S. policymakers contemplating national reforms is how to expand health insurance coverage to everyone and slow the growth in health care costs while maintaining or improving the quality of care. Looking at other countries, it is clear that each has developed, and continues to develop, its own approach, with policies and health systems evolving from their unique histories and institutions. Similarly, the U.S. will need to craft policies and adapt changes that fit its history, institutions, and values. Still, we can learn from values and strategies that cut across diverse countries and from examples of incentives, policies, and practices that contribute to higher performance. The international experience provides insight regarding the potential direction and effectiveness for U.S. insurance, payment, and delivery systems reforms.

Payment Policies: Prices, Purchasing Power, Information, and Incentives

In addition to its health insurance gaps, the U.S. is notable for paying higher prices than other countries, including very high prices for more specialized care, and for incentives to do more irrespective of value. Unlike other countries with multiple payers and competing insurers—such as Germany, Switzerland and the Netherlands—the U.S. lacks a mechanism to coordinate payment policies so that price signals are coherent, or a way to

use group purchasing power to move in the same direction. In more monopolized markets, U.S. private insurers often act as price-takers to maintain networks and pass through higher prices, with a mark-up for marketing, administrative costs, and margins.

As a result, the U.S. tends to pay higher prices for specialized services, including prescription drugs, particularly brand-name drugs without generic options.²¹ Studies indicate that higher prices plus a more expensive mix of prescription medications have contributed to rapid increases and higher spending per person in the U.S. than in other countries over the past decade (Figure 7). Although in 1995 the U.S. started out near what other countries spend per capita on prescription drugs, by 2007 we were far higher than the next-highest country.

In all countries, advances in medical treatments and technology, including medications, create an upward pressure on costs. Many countries have responded by using group purchasing power and “reference pricing” to moderate increases, particularly where alternatives exist (Figure 8). A recent McKinsey study found the U.S. pays 50 percent more for comparable drugs and pays for a more expensive mix of drugs than do other developed countries, leading to total costs that are twice as high as expected—some \$98 billion per year.²² Other nations’ governments typically either negotiate on behalf of all residents to achieve lower prices or use reference-pricing differentials in insurance designs to drive the market to lower prices.^{23,24} The U.S. also tends to pay specialists more and pay more for surgical devices, such as hip and knee prostheses.²⁵

Increasingly, other countries are assessing comparative information on clinical effectiveness and costs to inform insurance benefit design and develop incentives for markets to work while ensuring access. For example, France covers prescription drugs at multiple cost-sharing levels, with the lowest tier for highly effective medications, including expensive drugs if these are the only options (Figure 9). Germany and Denmark use reference pricing where multiple medications exist in a class—with full coverage at the reference price.²⁶ This practice has helped gain lower prices from manufacturers, with regular updates. In the U.S., private insurers regularly use formularies and vary cost-sharing without disclosing the rationale or underlying prices. However, other countries with independent comparative assessment centers share information with all insurers and make assessments publicly available to physicians and patients, with regular updates.²⁷

Countries with multiple payers, such as Germany, the Netherlands, and Switzerland, have also established mechanisms for paying for care that allow more

coherent policy changes over time. These policies also make it possible to ask what the price is or the total cost of care is for patients and providers. Such information is essential for markets to function. In contrast, prices in the U.S. vary for the same service in the same community by insurer and by hospital, with little rational relationship to resource costs or value and outcomes. Using several state examples, one observer notes the result in the U.S. is “chaos” behind a veil of secrecy.²⁸

Primary Care: Payment, Incentives, and Infrastructure

Overall, the U.S. stands out for its weak primary care foundation and poorly coordinated care.²⁹ Studies indicate that inadequate primary care undermines timely access to care, preventive care, and control of chronic conditions and contributes to the avoidable use of emergency rooms or hospital admissions and readmissions stemming from preventable complications. The contrast between the U.S. and other countries reflects insurance and payment policies, including the relative value placed on primary care, prevention, and promoting health rather than treating disease.

Most strikingly, other countries have insurance systems that promote continuity in care and provide patients with the choice of all primary care practices in the community. Many encourage or require patients to identify a “medical home,” which is their principal source of primary care and is responsible for coordinating specialist care when needed. When U.S. adults are asked whether they would value having a central source of care where the staff knows them and helps coordinate their care, their responses are similar to those of adults in other countries—with 80 percent saying having such a relationship is very important (Figure 10).

Country differences in care arrangements and the relative undersupply of primary care physicians show up in patterns of care. Along with Canada, which also faces primary care concerns, U.S. adults are less likely to report having same-or next-day access to their physicians when sick and are more likely to seek care in emergency rooms (Figure 11). Only one-fourth of U.S. and Canadian adults with chronic illness said they saw their doctor the same day the last time they needed medical attention, compared with nearly half or more in the U.K., New Zealand, and the Netherlands. In contrast, the U.S. has comparatively shorter waiting times for elective surgery or specialists than some other countries, although German and Dutch adults also report rapid access to specialized care in recent surveys.³⁰

U.S. adults are also more likely than those in several other countries to find it difficult to get care on nights and weekends without going to the emergency room. Forty percent of U.S. adults say getting such care is very difficult, compared to less than one of five in several other countries (Figure 12). In the U.S., 59 percent of adults reported going to the ER during the year, often several times.

The contrast with the Netherlands is notable. Just 15 percent of Dutch adults report it is difficult to get care after-hours without going to the emergency room, and Dutch ER use is relatively low. In a 2006 survey of primary care physicians, only 40 percent of U.S. physicians said that they have an arrangement for after-hours care, compared with nearly all primary care physicians in the Netherlands (Figure 13). The sharp differences reflect Dutch payment policies that emphasize primary care, plus recent initiatives that established after-hour cooperatives to provide round-the-clock access.³¹

U.S. patients face a fragmented health care system with often poor care coordination. More things can go wrong when care is provided by multiple parties and coordination is lacking. In a 2008 survey of chronically ill patients in eight countries, U.S. adults were more likely to report medical errors—particularly errors related to incorrect lab and diagnostic tests and delays in hearing about abnormal results (Figure 14). They were also more likely to report duplicative tests and records and test results that were not available at the time of their appointments.³² In a separate survey, nearly half (47%) of U.S. adults reported one of the following experiences in the prior two years: their physician ordered a test that had already been done; their physicians failed to provide important medical information or test results to other doctors or nurses involved in their care; or they did not hear about results of diagnostic tests (Figure 15).³³

The weak U.S. primary care foundation reflects the way we insure and pay for care as well as the way we organize care. A rich array of international policies and reforms aims to strengthen and transform primary care and improve care for those with chronic disease.

Most fundamentally, other countries make primary care financially and physically accessible to their residents. Insurance designs emphasize coverage for primary care, with low or no cost-sharing for preventive care and essential medications for chronic illness. In countries with cost-sharing at the point of care, insurance designs typically limit or cap total cost exposure. France lowers or eliminates cost-sharing for those with low-income, the disabled, and for specific chronic, severe illnesses—especially for chronic care

treatment plans. Germany limits cost-sharing to 2 percent of income for the general population and 1 percent for people with chronic conditions (Figure 16). Denmark and France lower cost-sharing for very effective yet expensive drugs. In effect, these policies strive for value-based benefit designs that ensure access and provide incentives for essential effective care. By providing positive incentives for patients to seek effective care, such designs align patient incentives with efforts to hold clinicians accountable.

Many countries, including the Netherlands, Denmark, and the U.K., encourage or require patients to identify a “medical home,” which is their principal source of primary care and is responsible for coordinating specialist care when needed. Similar to the U.S., Germany and France have historically operated with care systems with self-referrals to specialists. To encourage stronger relationships with primary care providers and enable new payments for accountable primary care practices, France and Germany have recently introduced incentives for both patients and physicians. French and German patients opting to designate a primary care source to coordinate care face lower cost-sharing when they need more specialized care, and their physicians receive extra payments.³⁴

The U.S. relies on market incentives to shape its health care system, yet other countries are more advanced in providing primary care doctors with financial support and incentives targeted on quality of care. Only 30 percent of U.S. primary care physicians report having the potential to receive financial incentives targeted on quality of care, including the potential to receive payment for: reaching clinical care targets, achieving high patient ratings, managing chronic disease or patients with complex needs, providing preventive care, or undertaking quality improvement activities (Figure 17). In contrast, nearly all primary care physicians in the U.K. and over 70 percent in Australia and New Zealand report the availability of such incentives.

The high rates in the U.K. and other countries reflect direct incentives as well as supplemental support for primary care practices. The U.K. General Practitioner Contract in April 1, 2004, provided bonuses to primary care physicians for reaching quality targets, including improved outcomes for chronic disease (Figure 18). Follow-up studies indicate that financial incentives change physician behavior and support improvement.^{35,36}

Incentives and targeted support for primary care in the Netherlands include extra payments to add nurses to care teams, payment for e-mail consults, and enhanced visit

payments for after-hours care. Recent Dutch national reforms blend capitation, fees for consultations, and payments for performance.

The Maastricht Transmural Diabetes Organization in the Netherlands also started a program that offers financial incentives to general practitioners as well as patients to encourage participation in a system of chronic care designed to improve coordination of care and appropriate provision. In 2006, this was adapted to a number of disease management pilots.

In 2000, Germany launched disease management programs and clinical guidelines for chronic care. Providers receive financial incentives for enrolling patients and for offering chronic care services, such as patient self-management education. Early results show positive effects on quality (Figure 19).³⁷ Also, an experiment involving an all-inclusive global fee for paying for cancer care is under way in Cologne.

In addition to a blend of capitation and consultation fees (including fees for e-mail consults), Denmark and the Netherlands have initiated after-hours cooperatives that take over for primary care physicians at night and on weekends. These cooperatives rely on community physicians and nurses to provide off-hours services. A patient's personal physician receives a record of care and contact the next day. Although the Danish and Dutch systems work differently, both are integrated with community practices to provide 24/7 access to advice and care. The Dutch cooperatives are recent, set up by national legislation in 2000/2003 (Figure 20).³⁸ The U.K. and several other countries are also looking to urgent care centers, with efforts to link care through information systems.³⁹

Several countries also pay physicians in a way that narrows income differences between primary care physicians and specialists, especially compared to the widening gaps in the U.S. Denmark may be the extreme, in that it is seeking roughly similar net income levels. Danish specialists are salaried and employed by hospitals; primary care physicians own their own practices.

Countries that have strong primary care foundations, such as the Netherlands and Denmark, tend to pay for care on a per-patient basis, with primary care physicians serving as gateways for referrals to more specialized care. These countries, as well as others that have traditionally paid providers on a fee-for-service basis, are increasingly moving toward a mixed-payment method that includes a per-patient monthly allotment

for providing access, coordination, and team-based care and for serving as a “medical home,” as well as fees for visits or incentives for quality.

These and other payment innovations and infrastructure efforts increase the attractiveness of primary care practice to medical students and support a focus on prevention and population health. In contrast, the U.S. tends to pay mainly for visits or procedures and fails to pay in a way that supports care teams, 24-hour access, time spent with patients, or efforts to coordinate care. Without payment reforms and incentives to strengthen and transform primary care, the U.S. health system is at risk of further weakening an already fragile community care system. Medical students are increasingly choosing to specialize, deterred by the hours, multiple demands, and relatively lower pay of primary care.⁴⁰

Information Systems to Inform, Guide, and Drive Innovation

In the U.S., physicians are highly trained, and hospitals are well equipped compared with hospitals in some other countries.⁴¹ Similar to the U.S., many other countries operate with small physician practices and an organizational divide across sites of care. In fact, fully integrated care systems are rare. To bridge the divide and support clinicians, other countries have made investments to promote the adoption and use of electronic health information technology with the capacity for information exchange. As of 2006, one-fourth of U.S. primary care physicians report using electronic medical records (EMRs), compared with nearly all primary care physicians in the Netherlands, New Zealand, and the U.K. Primary care physicians in other countries also increasingly have health IT featuring an array of functionality, a result of efforts by these countries to build on their IT capacity. When assessed against 14 different functions of advanced information capacity (EMR, EMR access to other doctors, access outside office, access by patient; routine use electronic ordering tests, electronic prescriptions, electronic access to test results, electronic access to hospital records; computerized reminders; prescription drug alerts; prompts for test results; easy to list diagnosis, medications, patients due for care), one of five U.S. primary care physicians reported having at least seven of the 14 functions, compared with 60 percent to 90 percent of physicians in the Netherlands, Australia, the U.K., and New Zealand (Figure 21). The wide differences reflect national efforts to standardize and promote use, often with financial incentives.

An assessment of information systems in 10 countries ranks Denmark at the top, and concludes that countries with a single unifying organization to set standards and be responsible for serving as an information repository have the highest rates of information

system functionality.⁴² Danish physicians, whether seeing patients through the off-hours service or during regular hours, are supported by a nationwide health information exchange featuring a portal supported by government funds and standards set by a nonprofit organization MedCom (Figure 22). The portal is a repository of electronic prescriptions, lab and imaging orders and test results, specialist consult reports, and hospital discharge letters—all accessible to patients and authorized physicians and home health nurses. It captures 87 percent of all prescription orders, 88 percent of hospital discharge letters, 98 percent of lab orders, and 60 percent of specialist referrals. Denmark is rated as one of the best countries on primary care, as measured by high levels of first-contact accessibility, patient-focused care over time, a comprehensive package of services, and coordination of care when services have to be provided elsewhere.⁴³

All Danish primary care physicians (except a few near retirement) are required to have an EMR system, and 98 percent do. Danish physicians are paid about \$8 for e-mail consultations with patients, a service that is growing rapidly. The easy accessibility of physician advice by phone or e-mail together with electronic systems for prescriptions and refills have cut down markedly on both physician time and patient time. Primary care physicians save an estimated 50 minutes a day from information systems that simplify their tasks, a return that easily justifies their investment in a practice information technology system (Figure 23).⁴⁴

Comparative Information and Transparency

In addition to assessing clinical effectiveness to inform clinical decisions and benefit designs, several countries are developing rich comparative information systems on performance. Germany's national hospital quality benchmarking provides real-time quality information on all 2,000 German hospitals, with over 300 quality indicators for 26 conditions (Figure 24). Peers visit hospitals whose quality is substandard and enter into a "dialogue" about why that is the case. Typically, within a few years all hospitals come up to high standards.

The Netherlands and the U.K. are also investing in transparency in reporting quality data, including patient experiences. In both countries, this information is posted on public Web sites and fed back to clinicians (Figure 25). The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

These countries emphasize choice and look to competition as well as collaboration to improve. The combination of payment incentives focused on value,

information, group purchasing power, and insurance for the entire population are systemic policies that seek to make markets work in the public interest.

Insurance-Related Complexity and Administrative Costs

The complex and fragmented U.S. insurance system makes it difficult to bring about such cohesion among payers. In addition, the U.S. insurance system as currently structured generates high insurance-related administrative and overhead costs—for insurers and for doctors and hospitals. On a per-person basis, the U.S. spends more than twice as much for the net costs of insurance administration (Figure 26). Varying benefit designs, marketing costs, churning in and out of coverage, underwriting, and insurance profit margins also contribute to higher overhead costs. In the Netherlands and Switzerland, countries that operate with multiple, competing private insurance plans, insurers average about 5 percent of premiums for overhead and margins, compared to an average 15 percent or more in the U.S.⁴⁵

Studies of insurance-related administrative costs for U.S. health care providers indicate that insurance complexity is also taking a toll on medical practices' time and resources and is driving up their costs as well. Recent studies estimate physician practices spend \$31 billion—the equivalent of 10 to 12 percent of total practice revenue—on billing and insurance-related administrative costs, which include three weeks a year of physician time per practitioner (Figure 27).⁴⁶ Hospitals spend 6 to 10 percent on just these two items of insurance-related administrative activities. If standardization could cut such overhead in half, there would be \$15 billion to \$20 billion in savings per year for physicians and \$25 billion to \$40 billion in savings per year for hospitals.⁴⁷ The recent McKinsey study estimates that such complexity—including multiple reporting requirements—accounts for some \$90 billion in excess costs per year.⁴⁸

Other countries with competing insurers, including Germany, the Netherlands, and Switzerland, have enacted market reforms, including more-standardized benefit designs and a prohibition on health-risk rating, to focus insurer competition on total costs and quality—rather than risk segmentation. The much lower costs reflect simpler design and insurance market mechanisms that make it easy to compare and choose among competing options. All three countries define national core benefits, with insurance designs that ensure financial protection. All require insurers to accept everyone and prohibit premium variations based on health risks. Each has adopted a form of risk-adjustment to avoid penalizing a plan with a reputation for high quality and positive outcomes for sicker patients. In the Netherlands, for example, the risk-fund mechanism

pays a plan more if it attracts older, chronically ill, or otherwise high-health-risk beneficiaries. The risk adjustment can be substantial (Figure 28).

Each of these countries operates a type of insurance exchange that offers a choice of plans. National policies provide market oversight and transparent posting of benefits and premiums that facilitate choice. By simplifying benefit designs and precluding underwriting for health risks, these countries operate with much lower insurance marketing, underwriting, and related administrative costs than in the U.S. In Germany, insurance cards, for example, are bar-coded, which makes it easy to track cost-sharing and facilitates the payment of providers.

Conclusion

We have the world's costliest health care system, yet we fail to provide everyone with access to care—and we fall far short of what should be possible given our health workforce and medical care resources. The good news is there is ample room to improve, and we have international as well as internal examples of health systems and policies that yield equivalent or better outcomes and better experiences at lower cost.⁴⁹

Several core strategies span diverse countries, although each country has evolved its own approach. These include:

- Coverage for everyone: an explicit national goal and shared value
 - Insurance designs emphasize access, financial protection and value
 - Insurance provides foundation for payment and system reforms
- Payment policies that emphasize value and use group purchasing power, and that promote primary care, prevention, and effective care of chronic disease
- System reforms that harness markets and competition in the public interest and provide information to spur improvement performance and innovation
 - Market rules focus competition on quality and efficiency
 - In multipayer systems, joint efforts to move in the same direction
 - Information systems to inform, guide, and drive change and innovation
- Leadership, goals and targets
 - In countries with multiple payers and competing insurers, this includes provisions for public and private participation.

These strategies are strikingly similar to key strategies identified by The Commonwealth Fund's Commission on a High Performance Health System in its call to

action and vision of concrete policies that could move the U.S. in a new, more positive direction.^{50,51}

Insurance reform is fundamental for access and financial protection. Other countries provide evidence that it also can serve as a base for a more rational payment system and for 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 information. Investing in comparative information and assessment and advanced clinical information systems are instrumental to inform, guide, and drive innovation. These core strategies cut across other countries and have fueled reforms designed to meet the health needs of their populations.

Moving forward in other countries required bold action; many of the initial foundation reforms were difficult to achieve politically. But national governments and policy leaders responded to the needs of their populations at historic moments and took action. By covering everyone and incorporating incentives and reforms that focus on value, other countries have continued to invest and innovate to provide access to high-quality, innovative care systems with an emphasis on patient-centered, effective, and efficient care.

There is an urgent need for the U.S. to take bold steps to address the rising costs of health care and to ensure everyone access to care with financial security. We cannot afford to continue on our present course as rising costs undermine federal as well as family and business budgets and put the nation's health and productivity at risk.

The time has come for the U.S. to move forward on behalf of the health and economic security of current and future generations. We can learn from diverse international experiences as nations innovate to provide accessible, high-quality, and efficient care. By enacting national reforms that take strategic steps to put the U.S. on a path to a high performance system, there is the opportunity to reap a high return for the health of the population and the economy.

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FIGURES

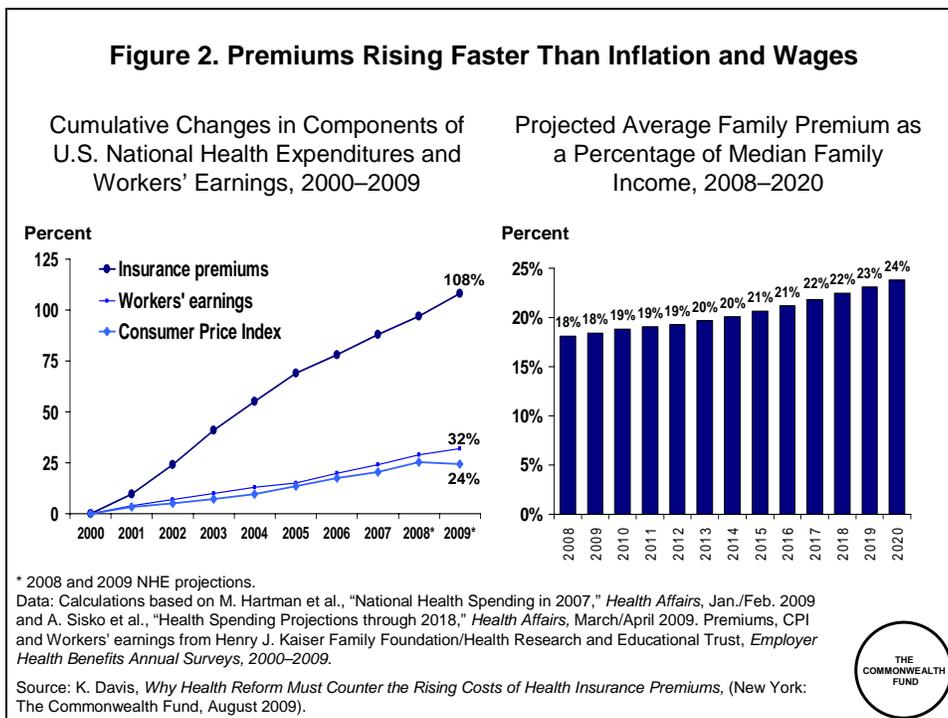
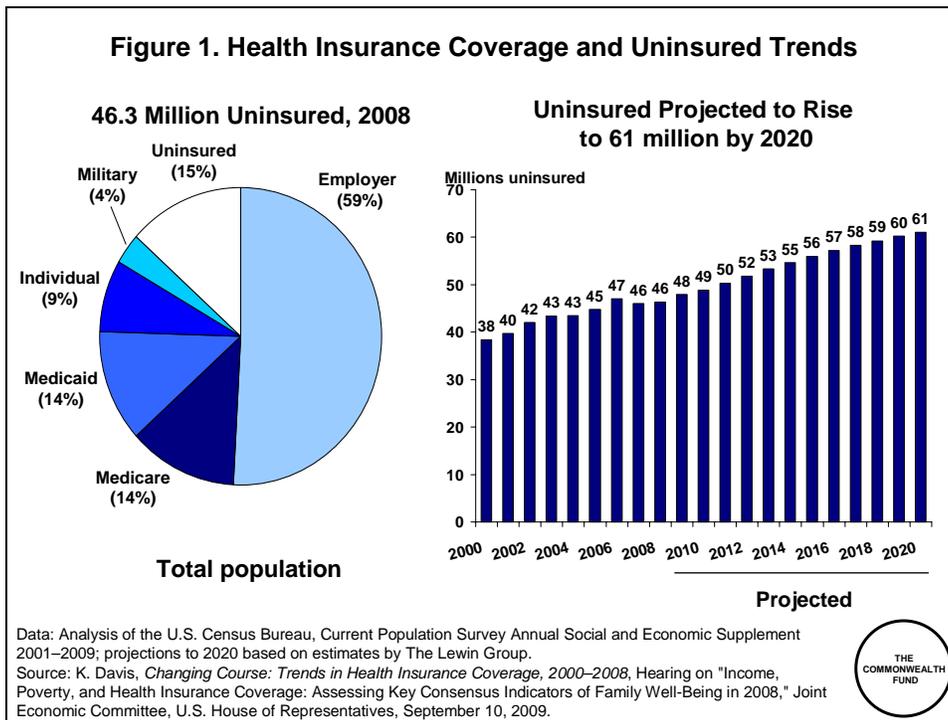
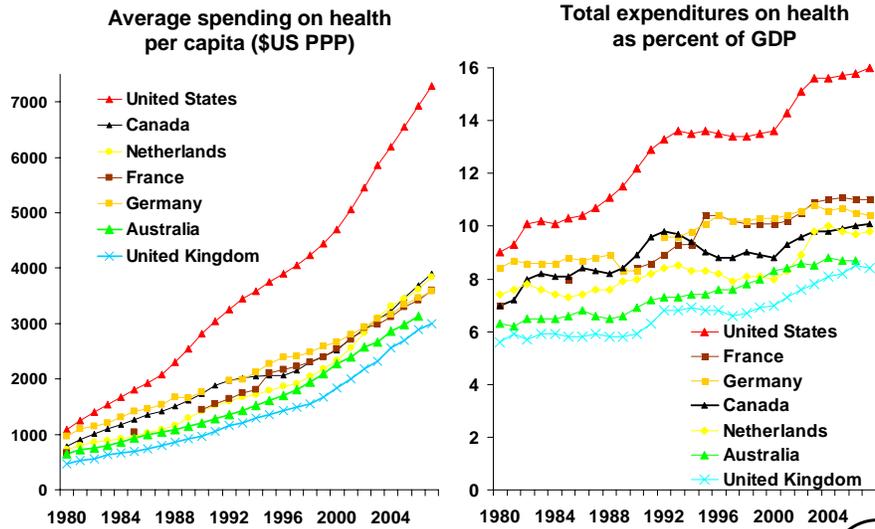


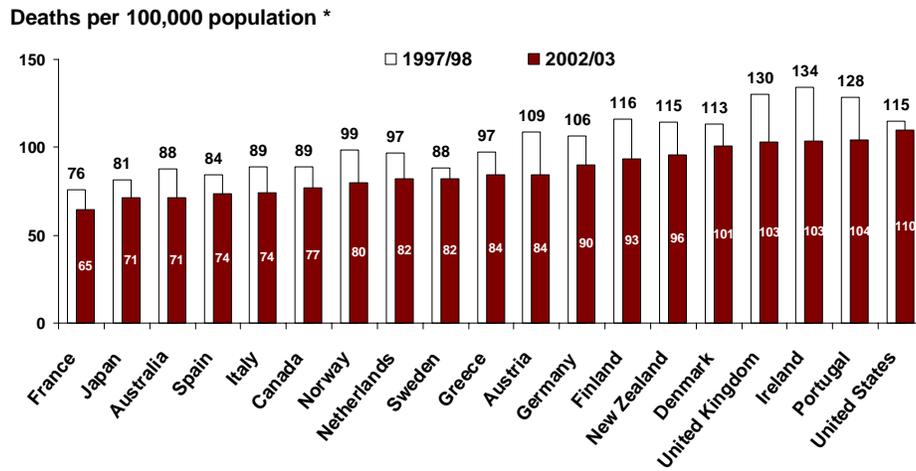
Figure 3. International Comparison of Spending on Health, 1980–2007



Data: OECD Health Data 2009 (July 2009).



**Figure 4. Mortality Amenable to Health Care
U.S. Rank Fell from 15 to Last out of 19 Countries**



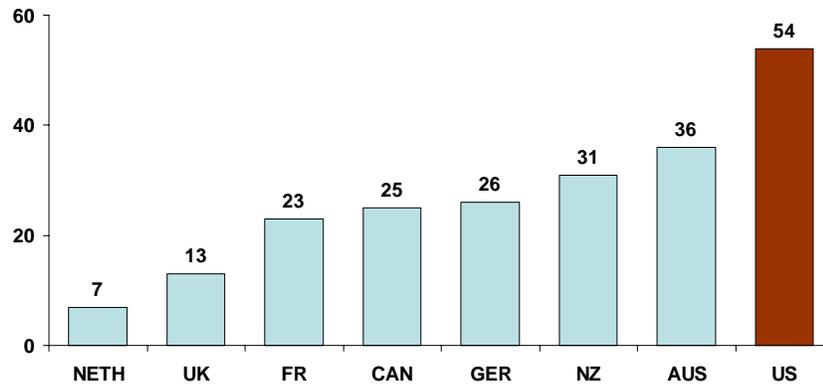
* Countries' age-standardized death rates before age 75; from conditions where timely effective care can make a difference. Includes: Diabetes, asthma, ischemic heart disease, stroke, infections screenable cancer.
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Figure 5. Cost-Related Access Problems Among the Chronically Ill, in Eight Countries, 2008

Base: Adults with any chronic condition
 Percent reported access problem due to cost in past two years*



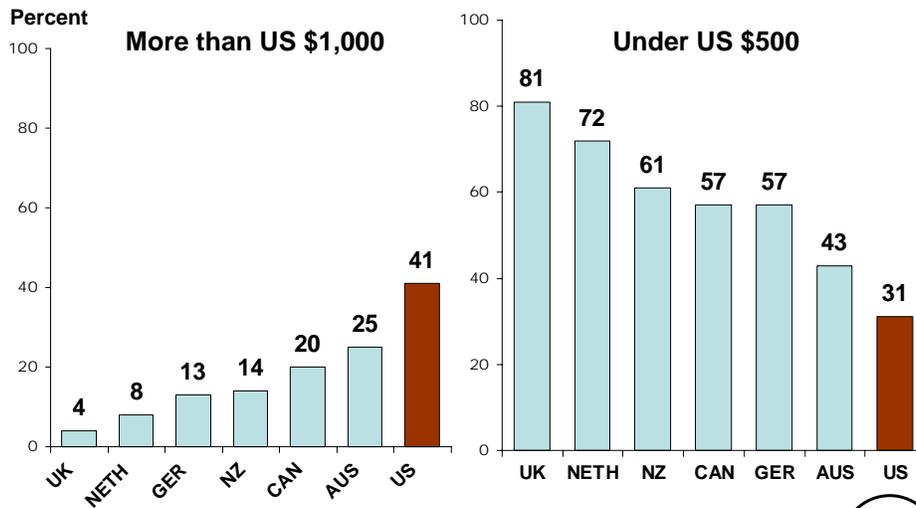
* Due to cost, respondent did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.

Data: The Commonwealth Fund International Health Policy Survey of Sicker Adults (2008).
 Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008," *Health Affairs* Web Exclusive, Nov. 13, 2008.



Figure 6. Out-of-Pocket Medical Costs in Past Year, 2008

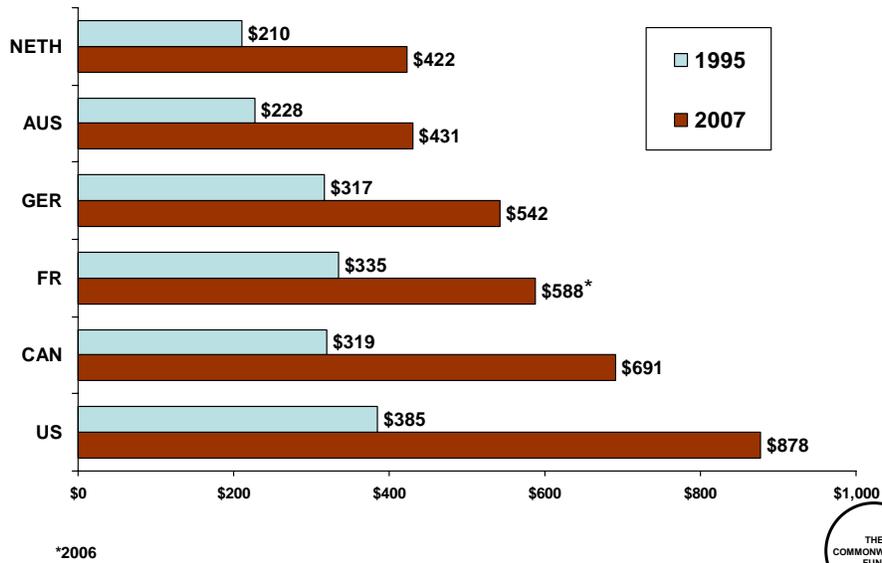
Base: Adults with any chronic condition



Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
 Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008," *Health Affairs* Web Exclusive, November 13, 2008.

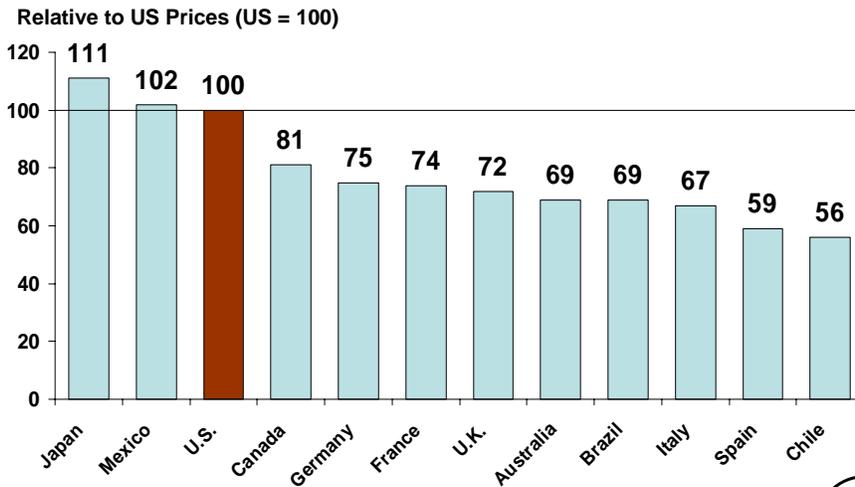


**Figure 7. Pharmaceutical Spending per Capita: 1995, 2007
Adjusted for Differences in Cost of Living**



Source: OECD Health Data 2009.

**Figure 8. Pharmaceutical Price Indices, 2005
Manufacturer Prices at Exchange Rates**



Data: World Development Indicators, 2005; and authors' calculations based on data from IMS Health MIDAS database, 2005.
Source: P.M. Danzon and M.F. Furukawa, "International Prices And Availability Of Pharmaceuticals In 2005," *Health Affairs*, 27, no. 1 (2008): 221-233.

Figure 9. Cost Sharing and Protection Mechanisms for Outpatient Prescription Drugs in Six European Countries, 2008

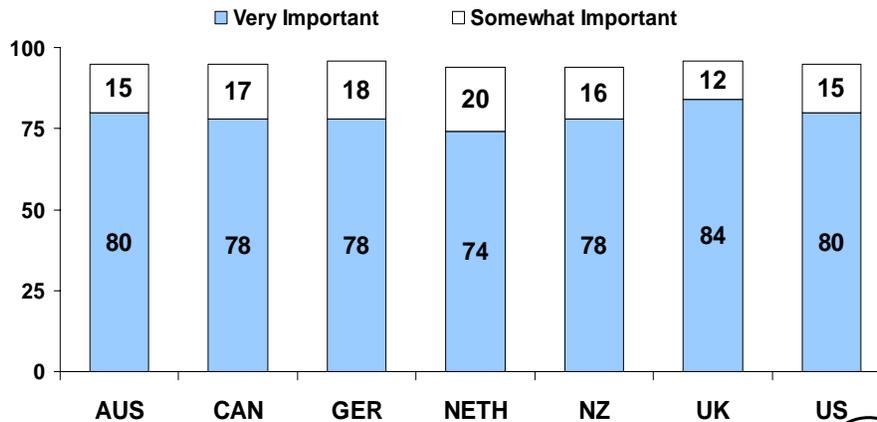
Country	Outpatient prescription drugs	Exemptions	Annual caps on out-of-pocket spending
Denmark	<i>Deductible:</i> DKK520 (\$93) per 12-month period. <i>Co-insurance:</i> varies depending on 12-month drug costs above the deductible; DKK520-1,260 (\$225): 50%; DKK1,260-2,950 (\$526): 25%; >DKK2,950 (\$526): 15%.	Children <18. People with very low income and terminally-ill people can apply for financial assistance. The reimbursement rate may be increased for some very expensive drugs.	<i>Chronically-ill people:</i> DKK 3,805 (\$678).
England	<i>Co-payment:</i> £7.10 (\$10) per prescription.	Children <16, people aged 16-18 in full-time education, people aged 60 or over, people with low income, pregnant women and women who have given birth in the last 12 months; war pensioners, people with certain medical conditions and disabilities, prescribed contraceptives, drugs administered by a GP or at a walk-in centre, drugs for treatment of sexually-transmissible infections.	<i>Annual pre-payment certificate:</i> £102.50 (\$147).
France	<i>Co-insurance:</i> 0% for highly effective drugs; 35%, 65% and 100% for drugs of limited therapeutic value. <i>Non-reimbursable co-payment:</i> €0.50 (\$0.6) per prescription.	<i>Co-insurance:</i> People receiving invalidity and work injury benefits, people with one of 30 chronic or serious conditions (for that condition only), low income people. <i>Non-reimbursable co-payments:</i> Children <18 and low income people.	<i>Non-reimbursable co-payments:</i> €50 (\$66) per person per year for all health care, not just prescription drugs.
Germany	<i>Co-insurance with minimum and maximum co-payment:</i> 10% of the cost of drugs priced between €50 (\$66) and €100 (\$130), with a minimum of €5 (\$6.5) and a maximum of €10 (\$13) per prescription, plus costs above a reference price (about 7% of drugs).	Children <18. No charge for drugs that are at least 30% below the reference price (around 40% of drugs).	<i>For all cost sharing:</i> 2% of household income (1% for chronically-ill people). Household income is calculated as lower for dependants.
Netherlands	None.	N/A	N/A
Sweden	<i>Deductible:</i> SEK900 (\$105) in a 12-month period. <i>Co-insurance:</i> varies depending on 12-month drug costs above the deductible; SEK900-1,700 (\$198) – 50%; SEK1,700-3,300 (\$384) – 25%; SEK3,300-4,300 (\$500) – 10%; >SEK4,300 (\$500) – 0%.	None.	<i>12-month cap:</i> SEK4,300 (\$500).

Source: S. Thompson and E. Mossialos, *Primary Care and Prescription Drugs: Coverage, Cost Sharing and Financial Protection in Six European Countries*, (New York: The Commonwealth Fund, forthcoming 2009).



**Figure 10. Strong Public Support for Having A “Medical Home”:
Accessible, Personal, Coordinated Care**

When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?
Percent very or somewhat important

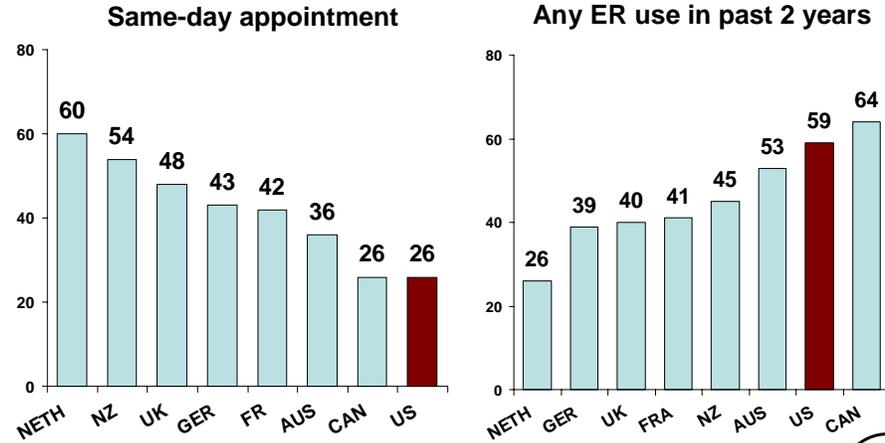


Source: 2007 Commonwealth Fund International Health Policy Survey. C. Schoen, et al. "Toward Higher Performance Health Systems: Adults' Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.



Figure 11. Access to Doctor When Sick or Needed Care, 2008

Base: Adults with any chronic condition
Percent

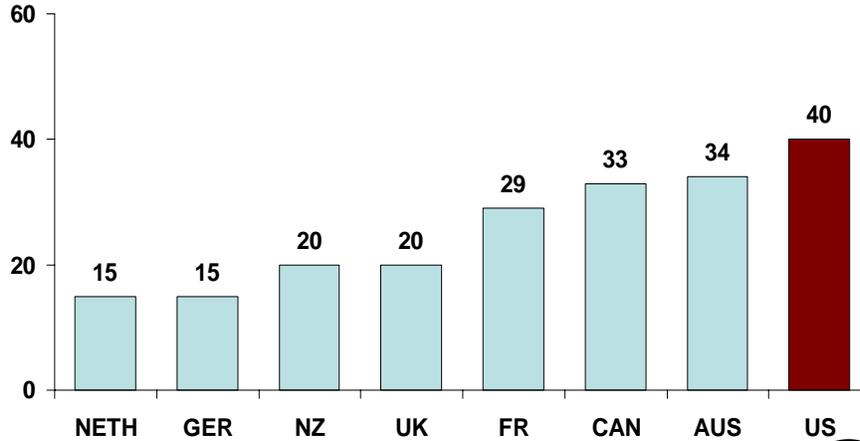


Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.



Figure 12. Difficulty Getting Care After Hours Without Going to the Emergency Room

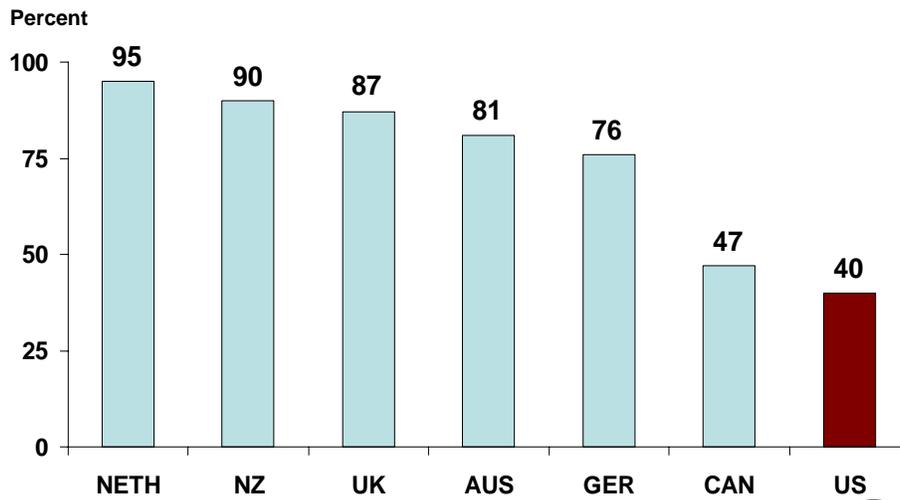
Base: Adults with any chronic condition who needed after-hours care
Percent reported *very difficult* getting care on nights, weekends, or holidays without going to ER



Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.



Figure 13. Primary Care Doctors: Practice Has Arrangement for After-Hours Care to See Nurse/Doctor, 2006



Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
 Source: Schoen et al., "On The Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive, Nov. 2, 2006.



Figure 14. U.S. Chronically Ill Patient Experiences: Access, Coordination & Safety, 2008

Base: Adults with any chronic condition

Percent reported in past 2 years:	AUS	CAN	FR	GER	NETH	NZ	UK	US
Access problem due to cost*	36	25	23	26	7	31	13	54
Coordination problem**	23	25	22	26	14	21	20	34
Medical, medication, or lab error***	29	29	18	19	17	25	20	34

*Due to cost, respondent did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.

**Test results/records not available at time of appointment and/or doctors ordered test that had already been done.

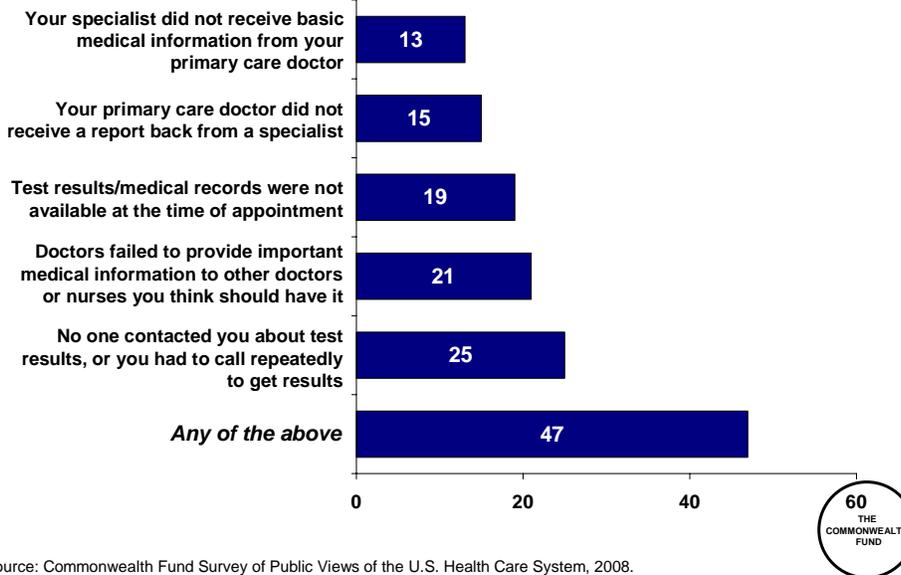
***Wrong medication or dose, medical mistake in treatment, incorrect diagnostic/lab test results, and/or delays in abnormal test results.

Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
 Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.



Figure 15. Poor Coordination: Nearly Half of U.S. Adults Report Failures to Coordinate Care

Percent U.S. adults reported in past two years:



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

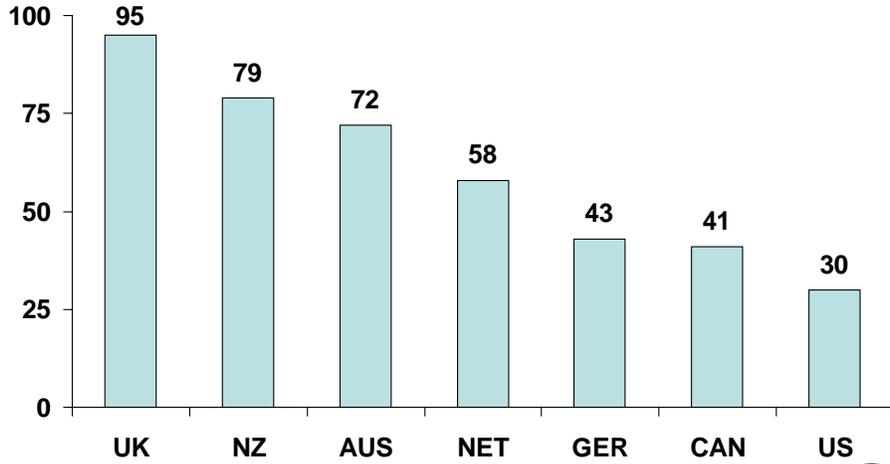
Figure 16. Cost Sharing Arrangements and Protection Mechanisms for Outpatient and Inpatient Care in Six European Countries, 2008

Country	GP visit	Outpatient specialist visit	Inpatient care	Exemptions	Annual cap on out-of-pocket spending
Denmark	None.	None.	None.	N/A	N/A
England	None.	None.	None.	N/A	N/A
France	<i>Co-insurance:</i> 30% with gate keeping or 50% <i>Non-reimbursable co-payment:</i> €1 (\$1.3) per visit	<i>Co-insurance:</i> 30% with gate keeping or 50% <i>Non-reimbursable co-payment:</i> €1 (\$1.3) per visit	<i>Co-insurance:</i> 20%. <i>Non-reimbursable co-payment:</i> €6 (\$21) per day up to 31 days per year.	<i>Co-insurance:</i> People receiving invalidity and work injury benefits; people with one of 30 chronic or serious conditions (for that condition only); low income people; some surgical interventions. <i>Non-reimbursable co-payments:</i> Children <18 and low income people.	<i>Non-reimbursable co-payments:</i> €50 (\$66) for all health care including prescription drugs.
Germany	<i>Co-payment:</i> €10 (\$13) for the first visit per quarter and subsequent visits without referral.	<i>Co-payment:</i> €10 (\$13) for the first visit per quarter and subsequent visits without referral.	<i>Co-payment:</i> €10 (\$13) per inpatient day up to 28 days per year.	Children <18 (all cost sharing) and people who choose gatekeeping (doctor visits).	2% of household income (1% for people with chronic conditions). Household income is calculated as lower for dependants.
Netherlands	None.	<i>Deductible:</i> €150 (\$199) per year.		Children <18, GP services, mother and child care, preventive care dental care for <22.	None.
Sweden	<i>Co-payment:</i> SEK100-150 (\$12-18) per GP visit.	<i>Co-payment:</i> SEK200-300 (\$24-36) per specialist or emergency department visit.	<i>Co-payment:</i> Up to SEK80 (\$10) per day in hospital.	Children <20 in most counties.	Adults: SEK900 (\$109) for health services.

Source: S. Thompson and E. Mossialos, *Primary Care and Prescription Drugs: Coverage, Cost Sharing and Financial Protection in Six European Countries*, (New York: The Commonwealth Fund, forthcoming 2009).

Figure 17. Primary Care Doctors' Reports of Any Financial Incentives Targeted on Quality of Care, 2006

Percent reporting any financial incentive*

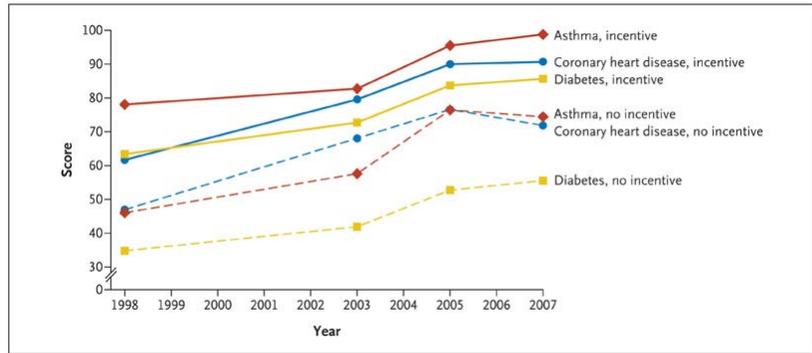


* Receive of have potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or QI activities

Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians



Figure 18. Effects of Pay-for-Performance on the Quality of Primary Care in England



Mean Scores for Clinical Quality at the Practice Level for Aspects of Care for Coronary Heart Disease, Asthma, and Type 2 Diabetes That Were Linked with Incentives and Aspects of Care That Were Not Linked with Incentives, 1998–2007.

Quality scores range from 0% (no quality indicator was met for any patient) to 100% (all quality indicators were met for all patients).

Source: S. Campbell et al., "Effects of Pay for Performance on the Quality of Primary Care in England," *N Engl J Med* 2009;361:368-378.



Figure 19. Disease Management in Germany

- Conditions: Diabetes, COPD, coronary heart disease, breast cancer
- Funding from government to 200+ private insurers (sickness funds)
 - Insurers receive extra risk-adjusted payments to cover patients with these conditions
 - Insurers pay primary care docs to enroll eligible patients into programs & provide periodic reports back to the docs (the closest to coordination)
 - Patients: reduced cost sharing if enrolled
 - Care guideline protocols plus patient education
 - Country-wide evaluation of results

Barmer Ersatzkasse diabetic patients, Type 1 and Type 2	Disease Management Program Participants	Non-participants
n=	80,745	79,137
Hospitalization due to stroke (per 1,000 males)	8.8	12.7
Hospitalization due to stroke (per 1,000 females)	7.8	12.4
Need for amputations (per 1,000 males)	5.6	9.1
Need for amputations (per 1,000 females)	1.8	4.7
At least one eye exam (per 1,000 patients)	780	538

Source: K. Lauterbach, "Population-based Disease Management Programs in the German Health Care System," Presented at The Commonwealth Fund 2007 International Symposium on Health Care Policy, Nov. 1, 2007.



Figure 20. Innovations in Access “After-Hours” Early Morning, Nights and Weekends

- Denmark
 - County wide physician cooperatives with phone and visit center
 - Computer connections to medical records
 - Reduce physician workload
- Netherlands
 - 2000/2003: Cooperatives evening to 8 AM and weekends; Nurse led with physician available
 - House calls for emergencies
 - Reduce physician workload and use of emergency rooms
- United Kingdom
 - Some cooperatives developing; walk-in centers
 - 24 Hour Help Line: NHS Direct
- Australia: After-hours primary care program
- Multiple points of access: email, electronic medical records

Source: Grol et al., "After-Hours Care In The U.K. Denmark, and the Netherlands: New Models," *Health Affairs Web Exclusive*, Nov./Dec. 2006; Schoen et al., "On the Front Lines of Care," *Health Affairs Web Exclusive*, Nov. 2, 2006.



Figure 21. Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Advanced IT Capacity, 2006

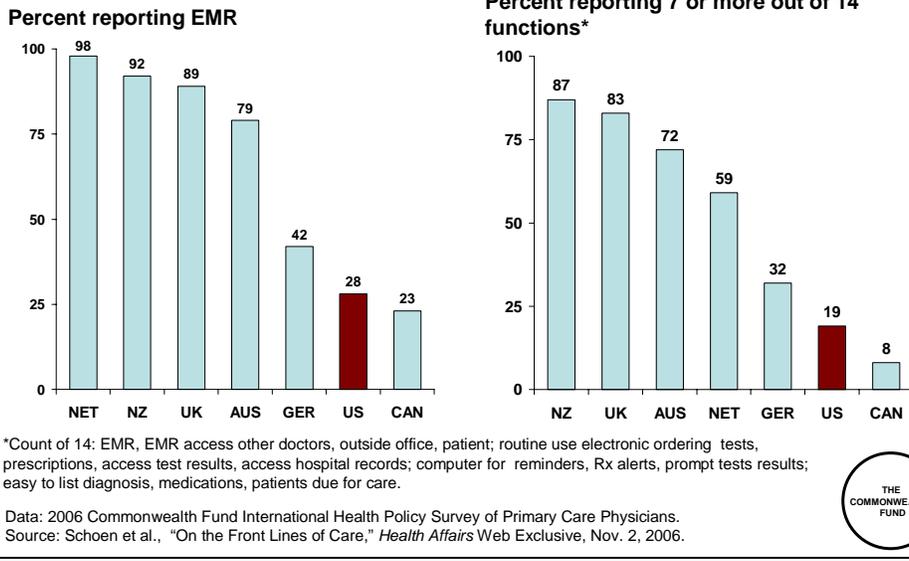
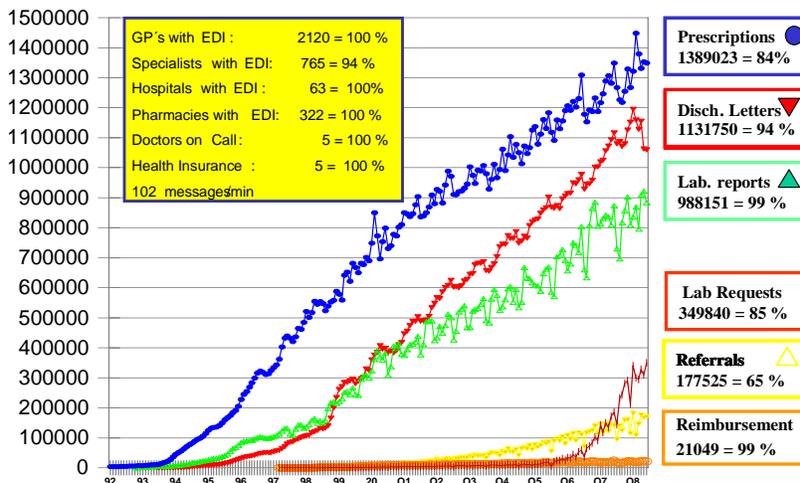


Figure 22. MedCom – The Danish Health Data Network Messages/Month



**Figure 23. Why Invest in E-Health? Registries?
Denmark Physicians and Patients Example**

- **Doctors:**
 - 50 minutes saved per day in GP practice
 - Information ready when needed
 - Telephone calls to hospitals reduced by 66%
 - E-referrals, lab orders
 - Patient e-mail consultation, Rx renewal
- **Patients:**
 - Reduced waiting times, greater convenience
 - Info about treatments, number of cases
 - Patients access to own data
 - Preventive care reminders
 - Information about outcomes

Source: I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.



Figure 24. National Quality Benchmarking in Germany

Size of the project:

- 2,000 German Hospitals (> 98%)
- 5,000 medical departments
- 3 Million cases in 2005
- 20% of all hospital cases in Germany
- 300 Quality indicators in 26 areas of care
- 800 experts involved (national and regional)

Ideas and goals:

- define standards (evidence based, public)
- define levels of acceptance
- document processes, risks and results
- present variation
- start structured dialog
- improve and check

Source: C. Veit, "The Structured Dialog: National Quality Benchmarking in Germany," Presentation at AcademyHealth Annual Research Meeting, June 2006.



Figure 25. Benchmarking in the Netherlands

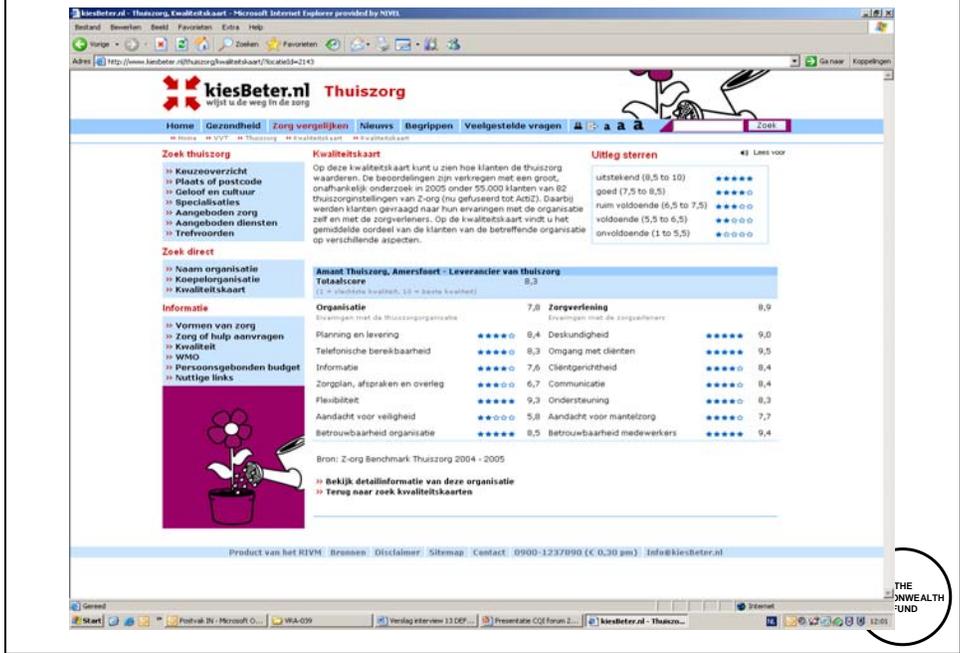
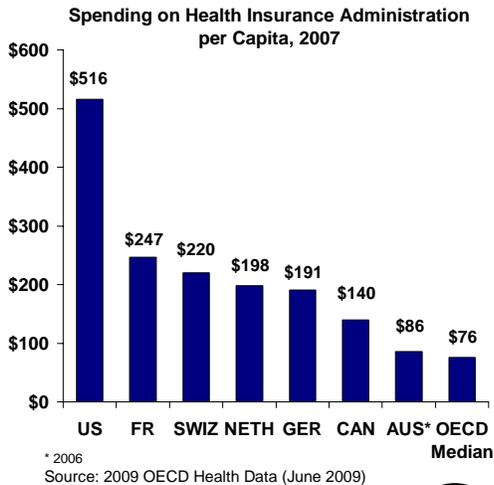


Figure 26. High U.S. Insurance Overhead: Insurance Related Administrative Costs

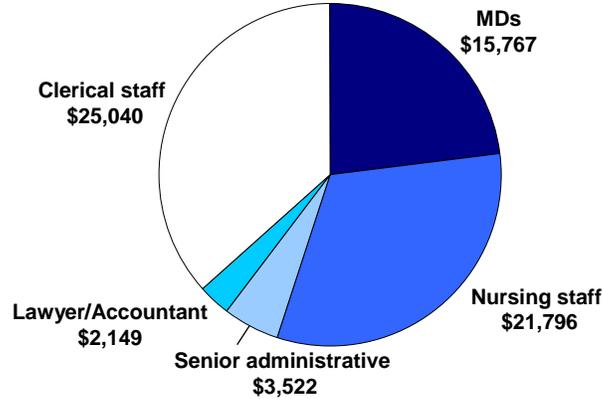
- **Fragmented payers + complexity = high transaction costs and overhead costs**
 - McKinsey estimates adds \$90 billion per year*
- **Insurance and providers**
 - Variation in benefits; lack of coherence in payment
 - Time and people expense for doctors/hospitals



* McKinsey Global Institute, *Accounting for the Costs of U.S. Health Care: A New Look at Why Americans Spend More*, (New York: McKinsey Global Institute, Nov. 2008).

Figure 27. Complexity Drains Resources: Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at \$31 Billion¹

Mean Dollar Value of Hours Spent per Physician per Year on All Interactions with Health Plans



Total Annual per Practice Cost per Physician: \$68,274

¹ Based on an estimated 453,696 office-based physicians.
Source: L. P. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009, w533-w543.



Figure 28. Dutch Risk Equalization System: Calculation of Allocation to Health Plan from Risk Fund

In €s / yr	Women, 40, jobless with disability income allowance, urban region, hospitalised last year for ostéoarthritis	Man, 38, employed, prosperous region, no medication or hospitalisation last year neither any chronic disease
Age / gender	€ 934	€ 872
Income	€ 941	-/- € 63
Region	€ 98	-/- € 67
Pharmaceut. costgroup	-/- € 315	-/- € 315
Diagnostic costgroup	€ 6202	-/- € 130
From Risk Fund	€ 7800	€ 297

Source: G. Klein Ikkink, Ministry of Health, Welfare and Sport; Presentation to AcademyHealth Netherlands Health Study Tour on September 22, 2008, "Reform of the Dutch Health Care System."

