



## **A FIVE-NATION HOSPITAL SURVEY: COMMONALITIES, DIFFERENCES, AND DISCONTINUITIES**

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May 2004

**ABSTRACT:** This companion report to the most recent [Commonwealth Fund International Health Policy Survey](#) discusses the views of hospital leaders from five different nations<sup>1</sup> regarding the organization of their nations' health care systems. Of the five nations surveyed—Australia, Canada, New Zealand, United Kingdom and United States—all but the U.S. have centralized health care systems and a relatively small private hospital sector. These four countries have increasingly decentralized health care decision-making and provided more power to regional authorities to allocate health care funds. The extent of the commitment of these nations to quality and safety had a large effect on the hospital executives' evaluations. The nursing shortage among affluent nations has eased, due to the policy of recruiting from third world nations. It will be important to observe the effects of changes in the balance between inpatient and outpatient care, and private and public funding in the coming years.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

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## EXECUTIVE SUMMARY

The 2003 Commonwealth Fund International Health Policy Survey found that the ability of hospitals and hospital executives to serve the needs of patients continues to be a major concern of elected representatives, citizens and health care professionals. Compared to the U.S., hospital administrators in Canada, New Zealand, Australia and the U.K. are more satisfied with their systems, but are struggling with greater financial challenges, capacity shortages and inadequate facilities.

Australian efforts to improve the quality of care are comparatively recent, and implementation of national policies remains far from complete. Australian executives, especially those in private hospitals, are more likely than colleagues in other Commonwealth countries to report concerns about losing patients to other hospitals and freestanding health care facilities.

Canada is emerging from a period of fiscal constraint that has seriously affected its hospitals. Canada presents the picture of a publicly governed system in severe financial trouble, struggling with limited capacity and uncertain of its future.

In New Zealand, recent increases in government spending have been preferentially directed towards primary care and public health investments as well as to the hospital sector. New Zealand hospital administrators report the shortest emergency room waits, the absence of diversions, the shortest waits for discharge from the hospital and the greatest facility in communicating with community physicians at the time of discharge.

In governance, the United Kingdom's health care system is almost certainly the most centralized of all the sampled countries. U.K. hospital administrators were less likely than colleagues in any other Commonwealth country to report deficits or losses, and were relatively optimistic about their ability to maintain current services going forward. In general, the U.K. data suggest a system that, while plagued with performance problems, has generated optimism for its ability to improve both in meeting demand for services and in quality and safety.

With its predominantly private and decentralized system, the United States stands apart. Perhaps the most important trend in the U.S. has been the retreat of managed care and a reassertion of the historical authority enjoyed by providers of service, who have been able to increase prices and collections from third parties in recent years. Financially, U.S. hospitals are clearly secure. U.S. hospital executives are most concerned with

competition for patients. Malpractice concerns and competition probably explains the reluctance of U.S. executives to release quality data.

The satisfaction of providers and users of care with their national systems does not correlate with national spending levels or with measures of system responsiveness, such as waits for elective care. A common theme among the Commonwealth countries has been an effort to decentralize and integrate their health systems by pushing authority and accountability for health care spending closer to the site of care. Respondents also reported striking agreement across hemispheres and continents that the nursing shortage, which was predicted to be intractable, has eased at least temporarily.

The next few years will provide an important test of the ability of single-payer systems to meet the increasing demands of their populations for elective care. In the end, each system must find its own way toward balancing efficiency and equity in its hospital sector, its health system and its society in general.

# **A FIVE-NATION HOSPITAL SURVEY: COMMONALITIES, DIFFERENCES AND DISCONTINUITIES**

## **INTRODUCTION**

The most recent Commonwealth Fund International Health Policy Survey provides a rare glimpse of the health care systems of five (predominantly) English-speaking countries from the perspective of hospital administrator reports. Though perhaps less important than they once were, hospitals and their administrators remain critical actors in all modern health care systems, and their ability to serve the needs of patients continues to be a major concern of citizens, elected representatives and health care professionals. The survey results thus provide a critical learning opportunity.

Blendon and his colleagues have reviewed the major findings of the survey.<sup>1</sup> Our goal in this companion paper is to provide a perspective on those findings and to extract lessons and questions that may inform the decisions of private managers and public officials in the participating countries. In the course of preparing the paper, we have conducted interviews and focus groups with hospital leaders and received comments from policy experts in each nation. We are grateful for their generosity in sharing their time and views. We first ask, country by country, how recent developments in national health care systems may be reflected in the survey findings. We then explore overlapping issues that may provide opportunities for learning across national boundaries.

## **METHODS**

Subsequent to the Commonwealth Fund's 2003 five-nation survey, The Health Research and Educational Trust (HRET) listened to two focus groups of administrators from hospitals, health care systems and district health boards. Representatives from Australia, Canada, New Zealand and the United States received a summary of the survey's results and were asked to react to the findings. Audience remarks were also solicited after a presentation of the findings at the 2003 Health Forum Leadership Summit. Finally, a subsequent set of in-depth interviews was conducted with chief executive officers and policy leaders in Australia (3), New Zealand (2), Canada (1), the United Kingdom (1) and the United States (2).

In all our comments, we recognize the limitations of the data.<sup>1</sup> The leaders of large institutions like hospitals are very familiar with certain issues, such as the financial status of their institutions. But with respect to other matters, such as the attitudes and behaviors of their physicians, they may fall prey to the optimism that is probably an occupational hazard for any health care leader managing a large organization in a challenging

environment. Furthermore, in systems that depend upon public sector policies for their wellbeing, surveys such as this offer an opportunity to make points with governmental officials, which could influence responses. At best, therefore, we can offer tantalizing hints about the deeper meaning of the survey results.

### **THE WITHIN-COUNTRY PERSPECTIVE**

All modern health care systems are grappling with certain common challenges, and the survey focused on these themes. In reviewing reports from hospital leaders in each country, therefore, we first review major recent developments relevant to those themes and then explore what the data reveals about the effects of these shared challenges, and the programs aimed at addressing them.

In particular, we review the context and data of the following issues:

1. How is each health care system organized and governed, and what major changes have occurred in their organization and governance?
2. What are the prevailing trends in the finances of each health care system?
3. What are the prevailing trends in the capacity of the nation's health care system generally, and its hospital sector in particular?
4. What efforts have been made to improve the quality and safety of care in each country?

Given the space limitations, our treatment of each of these questions is necessarily brief.

#### **Australia**

The Australian health care system consists of a partnership between its national government and its eight states and territories. Public hospitals in Australia are partially funded by both the national government (the Commonwealth) and their respective state or territory. The Commonwealth's agreement with public hospitals is described in the Australian Health Care Agreement (AHCA), negotiated every five years to secure access for the community to free public hospital services. Federal authorities also commit funds in return for the states' agreeing to pursue stated national priorities. The current AHCA covers 2003–08 and continues to focus on access for indigenous peoples, safety and quality, mental health and palliative care, as well as an initiative to improve the discharge process and transitions from inpatient care through step-down care and rehabilitative care services.



One important organizational characteristic of the Australian health care system is the existence of a comparatively robust (for a Commonwealth country) private health care system, with both private hospitals and ambulatory surgical centers. Recent tax law changes and premium incentives have encouraged the purchase and retention of private health insurance. In 2001, private health care spending accounted for about 30 percent of total national health care expenditures. In distinct contrast to the United States, however, there is virtually no employer-based health insurance in Australia.<sup>2</sup> As noted in the companion piece by Blendon and colleagues,<sup>1</sup> Australia has begun to imitate the United States in another dimension: the increasing frequency of malpractice claims against providers, and sharp increases in malpractice premiums,<sup>3</sup> perhaps exacerbated by the bankruptcy crisis of a major malpractice carrier.

Financially, the Australian health care system has experienced comparatively rapid growth over the past decade. National health care spending increased by 3.9 percent annually, compared to an OECD median of 3.1 percent ([Exhibit 1](#)). Hospital spending per capita in 2001 was close to the OECD median at \$811,<sup>4</sup> as was overall health care spending per capita in 2001 ([Exhibit 2](#)). Nevertheless, as is true in most of our sample countries, the number of acute hospital beds per capita fell during this period from 4.4 per 1000 population in 1991 to 3.8 in 1999 ([Exhibit 3](#)).<sup>5</sup> Reductions in inpatient capacity occurred exclusively in the public sector; the number of beds in private hospitals steadily increased over this period, and in 2001–02 accounted for 35% of total beds.<sup>6</sup>

Australians have shown substantial interest in quality of care, and especially in medical errors. However, national efforts to improve the quality of care are comparatively recent, and, our interviews suggest, implementation of national policies remains far from complete. The Australian Council for Safety and Quality in Health Care, established in 2000, has been extremely effective at building consensus with the states and territories about priority areas. It is currently working on developing national centers and centralized mechanisms for accreditation and standard setting.<sup>7</sup> Australians have invested heavily in an outpatient electronic medical record, although their inpatient information technology has progressed far less rapidly.

Several of the findings in the Commonwealth Fund Survey seem to reflect these characteristics and developments in the Australian health care system. As might be expected in a system with rapidly growing real expenditures, 60 percent of Australian hospitals reported that they were either profitable or breaking even. However, as might be expected in a system with an important private sector, there were differences in financial health between hospitals of differing ownership: only 19 percent of public hospitals

reported a surplus or profit, compared with 61 percent of private institutions. Furthermore, 74 percent of public hospitals reported that they lacked sufficient finances to maintain current levels of service, compared to 29 percent of private hospitals ([Exhibit 4](#)). Our interviews suggest that these financial concerns persist despite efforts by public hospitals to shift care from hospital-based outpatient clinics to physician offices, and the largest increase in health spending (6%) between 2000–01 and 2001–02 since 1992.<sup>8</sup> These findings suggest that important differences may be emerging in the financial health and potential future capacity of private and public systems in Australia.

The presence of a growing private health care system may also be apparent in two other findings from Australia. Australian executives, especially those in private hospitals, are more likely than colleagues in other Commonwealth countries to report concerns about losing patients to other hospitals and freestanding health care facilities. This worry is shared by 63 percent of private hospital executives, but only by 29 percent of public hospital executives ([Exhibit 4](#)). Care is increasingly provided in same-day or ambulatory settings, and progressively more complex care is being delivered in ambulatory settings.<sup>2</sup> Moreover, because public hospitals are paid according to volume, they also compete for privately insured patients for dollars from other sources, and our interviews suggest that competition for these patients is increasing. Growing numbers of privately insured patients, as well as expanded options for receiving care, may explain why Australian hospital executives are reporting shorter waits for elective care than are hospital executives of most other Commonwealth nations. Balanced against this benefit are questions that pervade mixed public and private systems. Will the private sector tend to attract healthier and more profitable patients, leaving the public sector to care for sicker, more costly, and less financially attractive citizens? Will under-investment in public hospitals by reluctant taxpayers lead to systematic differences in the availability of technology and amenities in public and private systems? So far, our interviews suggest that these issues have not emerged explicitly in the Australian context. If anything, sicker patients have tended to purchase private insurance and patronize private institutions, and there have been concerns about quality of care (lack of round the clock physician coverage, for example) in private institutions. The Australian hospital system clearly provides a fascinating example of attempts to inject a private initiative into a predominantly public system and merits observation as it evolves over time.

## **Canada**

In Canada, the provinces and territories have the responsibility to design and deliver their own health care programs and systems, and the Canadian federal government has enacted the Canada Health Act, legislation that sets principles for health care services. The

Canadian federal government provides funds to the provinces and territories to help support their respective health care systems. Unlike Australia, all the Canadian provinces except Ontario have created sub-provincial regional health authorities that have powers to move resources between different health care sectors. Also unlike Australia, Canada's private health care delivery is modest. Hospitals, though many are privately owned, are mainly in the not-for-profit sector, fully funded by government, and commonly referred to as "public hospitals." There are few investor-owned hospitals. User fees for medically necessary physician and hospital services are prohibited by the Canada Health Act, with federal funding withheld from the province or territory as a consequence of the violation of the Act.<sup>9</sup>

Canada is emerging from a period of fiscal constraint that has seriously affected its hospitals and all other aspects of its system. After years of public discussion and debate, the Romanow report and the more controversial Kirby report were published in 2002. Both recommended increased federal funding for health care and identified targeted areas for investment. After a long period of very slow growth in the 1990s,<sup>4</sup> the share of Canada's GDP devoted to health rose dramatically in 2000 and 2001, and health care spending per capita was well above the OECD median in 2001 ([Exhibit 2](#)). In contrast, from 1991 to 2001, real health spending per capita grew only 2.1 percent ([Exhibit 1](#)), and hospital beds per 1000 population fell to 3.3 during the 1990s, well below the OECD median of 3.8 ([Exhibit 3](#)).<sup>5</sup> Hospital admissions were 99 per 1000 population in 1999, compared to an OECD median of 154.<sup>5</sup> Canada has also experienced no growth in its physician supply during this period, unlike most of the other countries in our sample ([Exhibit 5](#)). In 2000, the federal government agreed to increase support for provincial health care spending by \$21.5 billion over the subsequent five years, and in 2003 agreed to add an additional \$31 billion to that figure. In the midst of this reinvestment in Canadian health care, however, the SARS epidemic pounded Canadian hospitals, exacerbating resource shortages and capacity problems. Our interviews suggest that SARS is directly responsible for large hospital deficits in Ontario and Toronto, in addition to having a profound effect on hospital staff satisfaction, especially for nurses in Toronto and Ontario. The SARS epidemic was just beginning to recede when our survey was fielded and may have affected responses.

Findings of the five-nation survey seem to reflect the Canadian context in a number of respects. From a financial perspective, Canadian hospital executives report considerable anxiety, with 70 percent reporting a loss or deficit and 81 percent saying that their current finances cannot sustain their current levels of service. Given these financial difficulties, the contraction in hospital capacity, and the lack of a private sector alternative,

Canada's capacity to provide elective and non-elective services is also constrained. Canadian executives were most likely (44 percent) by a wide margin in our sample to report increased waiting times for elective surgery in the previous two years and to report that the state of their ICUs, operating theatres and emergency rooms was fair or poor.<sup>1</sup> The extent to which increasing outpatient surgeries will serve to offset inpatient demand remains to be seen.

Given the power of local authorities to redistribute resources and coordinate care, one might have expected Canada to do relatively well in managing interfaces between services. However, according to the hospital executives we surveyed and our interviews, Canada does no better, and perhaps somewhat worse, than other Commonwealth countries in managing waits in emergency departments, avoiding emergency room diversions, facilitating discharges or communicating with community physicians after discharge. This may result from the fact, cited by Detsky and Naylor, that local authorities have varied considerably in their success at integrating services at the local level.<sup>2</sup>

Finally, Canadian hospital executives tend to have the least favorable view (comparable to the U.S.) of government's effectiveness in intervening to improve the quality of care. Whether this reflects a general skepticism of government, or a particular conclusion based on the low priority assigned to this problem at the current time in Canada, is difficult to say. This lack of emphasis may explain in part why Canadian hospitals are less likely than those in several other sample countries to have policies requiring patient notification of medical errors.

In general, the Canadian responses to the Commonwealth Fund Survey present the picture of a publicly governed system in severe financial trouble, struggling with limited capacity and uncertain of its future. The recent decision to augment funding for Canada's system is clearly justified in light of our hospital survey data. Our findings raise the question of whether the governing structures at provincial and local levels will be able to use those funds to create a coordinated and integrated health care system.

### **New Zealand**

The New Zealand health care system shares many similarities with the Australian. Like Australia it is predominantly publicly funded, but also relies on private health insurance, which is purchased by about one third of its population.<sup>10</sup>

The New Zealand health care system has been reorganized with almost every change of government. Most recently, in 2001 the country divided its health care system

into 21 District Health Boards (DHBs) that are funded by the central government's Ministry of Health on a population basis. Like Canadian regional health authorities, the DHBs have the power to allocate local funding across health sectors to meet the goals of New Zealand's Health Strategy.<sup>11,12</sup> However they are limited by strict national policies and guidelines. DHBs purchase services from private providers and own and operate public hospitals. Historically, New Zealand has heavily supported its primary care sector, and recent increases in government spending have been preferentially directed towards primary care and public health investments as well as to the hospital sector.

Over the last decade, New Zealand's per capita spending on health care grew at 3.3 percent annually ([Exhibit 1](#)), and this does not include a decision within the past year to allocate a total of one-fifth of government spending to health care (including public health). Physician to population ratios have been increasing at a comparatively rapid rate (compared to other Commonwealth countries) of 1.6 percent annually ([Exhibit 5](#)).

New Zealand's quality-of-care and safety efforts are nascent, and compared to other Commonwealth countries, lack national leadership. Current national efforts involve standard setting and credentialing. However, the National Health Committee's 2002 report, *Safe Systems Supporting Safe Care*, is viewed as a step towards developing a national quality improvement strategy.

New Zealand's preferential investment in primary care and public health may in part explain New Zealand hospital managers' reports of losses and deficits that exceed Canada's (82 vs. 70 percent). As noted by Blendon and colleagues, the strength of the primary care system may explain why New Zealand hospital administrators report the shortest emergency room waits, the absence of diversions, the shortest waits for discharge from the hospital and the greatest facility in communicating with community physicians at the time of discharge.<sup>1</sup> Investments in non-hospital resources may pay off in reduced delays at the interfaces between health sectors.

Hospital leaders in New Zealand report waits for elective procedures that are in the mid-range compared to other Commonwealth countries. However, our focus groups and interviews suggest waits may be longer than these numbers suggest, for the authorities just increased the time that individuals must wait before they can be added to the formal waiting list. One informant, though, expressed surprise at the lengthy reported waits for breast biopsies because of recent governmental efforts to improve care of this and other women's health problems. Moreover, our interviews suggest that care provided in private facilities has helped ease waiting times.

Altogether, New Zealand data suggest that its hospitals may face financial and capacity constraints almost as severe as Canadian hospitals, but this reflects a conscious decision to emphasize out of hospital care rather than, as in Canada, the underfunding of the entire health care apparatus. Furthermore, investments in non-hospital services and public health are paying off in terms of increased efficiency in the emergency room and in the discharge processes of hospitals. Whether the effectiveness of these investments may also reflect better local governance by DHBs than by Canada's regional health authorities is an interesting question worth pursuing in more detail.

### **United Kingdom**

A number of salient trends in the areas of governance, financing, quality and safety deserve emphasis in understanding reports by hospital administrators from the United Kingdom. In governance, the United Kingdom's health care system, and especially its hospital sector, is almost certainly the most centralized of all our sample countries. However, starting with the conservative governments of the 1980s and early 1990s, and continuing through recent Labor regimes, the U.K. has been attempting to decentralize the National Health Service through a variety of devices. Most recently, these have included the creation of hospital trusts, local health authorities and primary care trusts run by physicians. The private hospital sector and private health insurance are less developed in the U.K. than in Australia.

Historically the U.K. invested less in health care as a percent of GDP than any other sampled country, and waits for elective surgery had become a major political issue, resulting in recent increases in funding for the NHS. The NHS specifically targeted additional investments towards opening 100 new hospitals and increasing the number of beds in existing hospitals, modernizing GP physician offices, updating information systems, and investing in more consultants, GPs, nurses and therapists.<sup>13</sup> The additional funding is aimed at both short-term reductions in waiting times, and longer-term reinvestments in physical and human capital. The pressure to reduce waiting times has resulted in the publicly funded use of excess capacity in private sector hospitals and the practice of even sending patients abroad for surgery.

The U.K. health care system has a very strong but still evolving emphasis on improving quality and safety. This was prompted by celebrated scandals within the NHS, which responded by creating new governmental structures to improve quality and safety. These agencies are responsible for providing technical assistance in local quality improvement activities (Modernization Agency), for setting national guidelines concerning

evidence-based medicine (National Institute for Clinical Excellence), and for collecting quantitative measures of hospital performance (Commission for Health Improvement).

Survey results provide an interesting perspective on these major developments and characteristics of the British health care system. Perhaps reflecting recent and anticipated infusions of new funds, U.K. hospital administrators were less likely than colleagues in any other Commonwealth country to report deficits or losses, and were relatively optimistic about their ability to maintain current services going forward. Despite absolute waits for elective care that were the longest in our sample, U.K. executives were most likely by a wide margin (86 percent) to report that waits had become shorter in the last two years. The one exception to the generally longer waits perceived in the U.K. was the wait for breast biopsies. This may reflect the success of a government effort launched in 1999 specifically to reduce waits for this procedure.<sup>14</sup> In the U.K., as in Canada, performance lagged at the interface between the hospital and the surrounding health care system, with long emergency department waits, long waits for discharge and long delays in getting information to community physicians after discharge.

U.K. administrators did not report concerns about losing patients to competitors, which may reflect the comparatively small size of the private hospital sector and the need to reduce waiting lists by all available means. Furthermore, our sample of U.K. hospitals did not include any private institutions, which may have been more sensitive to such competition.

In the areas of quality and safety, a generally optimistic pattern emerges in the data. U.K. administrators are mostly comfortable with the idea of releasing data on quality performance, are more likely than other Commonwealth executives to report that they have policies requiring disclosure of errors to patients (74 percent) and believe that they have effective programs for addressing medical errors (91 percent). They also believe that their physicians support efforts to reduce medical errors (89 percent) and are most likely in our sample to express a positive view of governmental efforts to improve quality of care (75 percent).<sup>1</sup>

In general, the U.K. data suggest a system that, while plagued with performance problems, has generated optimism (at least among hospital administrators) for its ability to improve both in meeting demand for services and in quality and safety. Whether this optimism will prove justified is, of course, unclear. In this regard, there is an intriguing contrast between the moods of respondents in the U.K. and Canada. Despite commitments by the government in both countries to markedly increase funding,



Canadian respondents continue to suffer financially and believe that their performance is deteriorating, while those in the U.K. take a brighter view. This is especially surprising since absolute hospital performance in the U.K. is no better, and perhaps worse, than in Canada. Health care spending per capita was only \$1992 in the U.K. in 2001 compared with \$2792 in Canada ([Exhibit 2](#)).<sup>4</sup> Nevertheless, growth in U.K. health care spending (4.1%) far outpaced Canada's during the 1990s ([Exhibit 1](#)). It remains unclear whether Canadian pessimism reflects delays in the arrival of new monies to Canadian hospitals, or is a temporary effect of the SARS epidemic or the lack of a quality and safety thrust in Canada (which may provide a sense of professional purpose). Or perhaps some other consideration is the cause.

### **United States**

With its predominantly private and decentralized system, the United States stands apart from the other countries in our sample. From an organizational standpoint (one hesitates to use the term governance), perhaps the most important trend has been the retreat of managed care and a reassertion of the historical authority enjoyed by providers of service, who have been able to increase prices and collections from third parties in recent years. As a result of this and other long-standing forces, such as the openness of U.S. markets to new technologies, spending has exploded again in the U.S. Double-digit rates of increase in health spending contrast with increases in the consumer price index of 1–2 percent. Though real health spending grew at annual rates of only 3.1 percent in the U.S. from 1991–2001 ([Exhibit 1](#))—less than the U.K., New Zealand and Australia—this number does not adequately capture the experience since 2000. Nor does it adequately reflect the fact that the U.S. spends far more than other nations in both absolute terms ([Exhibit 2](#)) and as a percent of GDP on health care (13.0 percent of GDP in 2000 compared to 9.1 percent in Canada, the next highest within our sample).<sup>5</sup>

Interestingly, despite heavy spending on hospitals and other care ([Exhibit 6](#)), the hospital infrastructure in the U.S. is no larger than in other sample countries. Beds and admissions per 1000 population in 2000 were 3.0 and 118 respectively, below the OECD median, Australia and the U.K. ([Exhibit 3](#)).<sup>5</sup> Anderson and colleagues have suggested that higher U.S. spending may not reflect a larger number of services to U.S. patients, but higher health care prices and provider incomes.<sup>15</sup>

Though its impact is unclear, the quality and safety movement of the late 20th and early 21st century was born in the U.S. and has received considerable emphasis through variably coordinated activities on the part of public and private actors. The Institute of Medicine's landmark reports have received wide publicity, and hospital accrediting



agencies, such as the Joint Commission for the Accreditation of Health Care Organizations and the National Committee for Quality Assurance, have given increasing attention to quality. Employers and other purchasers have banded together in nascent coalitions, such as the Leapfrog Group and the Pacific Business Group on Health, which have focused the attention of some health plans and hospitals on quality and safety goals. Medicare has begun publishing data on quality outcomes for health plans, nursing homes and home health agencies, and plans to do so in the future for hospitals. Incentives in the recently enacted Medicare prescription drug legislation may accelerate public reporting of hospital quality data. An important inhibitor of some types of progress in the quality area is the highly problematic malpractice climate in the U.S., which discourages the sharing of quality information both within and outside institutions.

Responses from hospital executives reflect these various forces and raise some intriguing questions. Financially, U.S. hospitals are clearly more secure than those in any other sample country, with 71 percent reporting a profit, and only 30 percent concerned about maintaining current levels of service. U.S. executives are also the most confident of the quality of their internal plant, with only single-digit numbers reporting that intensive care units, operating rooms or diagnostic facilities are fair or poor.<sup>1</sup>

Not surprisingly, given the highly private and competitive system in which they work, U.S. hospital executives are most concerned with competition for patients. Their greatest worries pertain to freestanding centers, which may reflect recent efforts by specialists and specialty hospitals to create facilities that care for highly profitable orthopedic and cardiac patients.<sup>16</sup>

Given that the size of the U.S. hospital sector is no larger on a population basis than in other surveyed countries, and admission levels are comparable, it may seem surprising at first glance that waits reported by U.S. executives are minimal compared to those reported by Commonwealth countries. This may reflect several factors: the fact that the uninsured and underinsured demand less elective care; the larger proportion of specialists among U.S. physicians who actually perform elective care; the prevalence of outpatient and freestanding surgical facilities that reduce the need for inpatient care; the allocation of more resources within hospitals to profitable elective care; and the increased efficiency that results from competition for new patients.

In the areas of quality and safety, U.S. executives paint a mixed picture, but one that suggests a modest impact from the quality movement. American hospital leaders report a high prevalence of policies to inform patients of medical errors. This reflects an

accrediting requirement that hospitals have such policies. However, focus groups and interviews suggest that patients are rarely informed when errors occur. U.S. executives are confident of their ability to learn about and manage errors, but again, interviews suggest that this opinion is overly optimistic. The combination of malpractice concerns and competition probably explains the clear reluctance of U.S. executives to release quality data. True to the general attitude of U.S. citizens toward government, hospital leaders in the U.S. are least likely to regard government interventions to improve quality as effective (40 percent compared to 75 percent in the U.K. and 68 percent in Australia).<sup>1</sup>

Consistent with underlying trends in the U.S. health care system, the survey of hospital executives paints a picture of a hospital sector that is doing comparatively well financially, is confident of the quality of its physical plant, and is meeting demands for service with comparative effectiveness. The hospital sector's ability to meet such demands with an infrastructure that is comparable in size to other countries that are struggling to do the same is worth additional study. Our data also suggest that U.S. health care executives are aware of the pressures for quality improvement, but may be overly optimistic about the progress they have been able to make on their own toward quality and safety goals.

## **THE CROSS-COUNTRY PERSPECTIVE**

The first thing that stands out in looking across countries in our sample is, of course, that the United States is in so many ways incomparable. Its system is so different, its spending levels so high, its decentralization and privatization so extreme, that it truly marches to a different drummer. We may have more to learn, therefore, by comparing the five countries to one another. Nevertheless, in certain specific instances, looking across all five countries produces stimulating insights and questions.

### **The Satisfaction Paradox**

Past Commonwealth Fund Surveys have repeatedly shown that the satisfaction of providers and users of care with their national systems does not correlate with national spending levels or with measures of system responsiveness, such as waits for elective care. This survey of hospital executives again confirms this finding, but may make the case even more dramatically than previous studies. Even this sophisticated group of hospital executives apparently divorced their daily experience—financial difficulties, waits for service, concern about inadequate infrastructure—from their global satisfaction with their health care system ([Exhibit 7](#)). Some of our interviewees and focus group participants half-jokingly suggested that non-U.S. respondents may have been expressing a kind of obstinate national pride in their universal coverage systems and were unwilling to concede any ground to a chaotic and unjust U.S. framework. Some of our U.S. respondents

speculated that one of the reasons for unhappiness among U.S. executives was that they are constantly forced to make ethically troubling decisions concerning patients who can't pay. Whatever the precise explanation for the survey findings, they continue to suggest that the values expressed in the structures of health systems can powerfully affect providers' satisfaction with those systems.

### **Experience with Decentralization**

A common theme among the Commonwealth countries in our sample has been an effort to decentralize and integrate their health systems by pushing authority and accountability for health care spending closer to the site of care. The Canada, New Zealand and U.K. systems have been most explicit about this effort. There are striking similarities in particular between the Canadian regional health authorities and New Zealand's District Health Boards. The United Kingdom has not created comparable integrating authorities at the district or regional level, but has placed considerable purchasing authority in its new primary care trusts. The process of decentralization and the associated aggregation of spending authority at local levels for many lines of service, both inpatient and outpatient, create the potential to integrate care across sectors of the health care system, to make handoffs more efficient, and to allocate resources optimally in communities.

A survey of hospital executives is probably not the best way to assess the impact of these changes, but as noted previously in this paper, some telltale indicators emerge. Particularly interesting is the efficiency of the New Zealand health system in avoiding delays at the interface between hospital and community care: with the shortest emergency room waits, the quickest discharges and the most efficient communication between hospitals and outside physicians. Canadian and U.K. executives report much more frequent problems at these interfaces. The differences cannot be explained simply by the level of investment in outpatient care, since Canada invests a larger proportion of its GDP in health care than New Zealand, and has a comparable number of physicians and more visits per capita. It is perhaps simplistic to single out the administrative structure of the health system as the cause of these performance differences across countries. But the differences do raise the question of whether other systems can learn from the way in which New Zealand manages its health care resources at the local level.

### **Quality and Safety**

The emphasis on quality and safety varies across the countries in our sample, and our data suggest that national commitments to these goals matter, at least in reports from hospital executives ([Exhibit 8](#)). The contrast is perhaps most evident in the experiences of Canada and New Zealand on the one hand, and the U.K. on the other. In the U.K., quality and

safety have become national priorities and the National Health Service has invested heavily in them. Canada and New Zealand have not yet made a comparable commitment at the national level. U.K. executives are more likely to report policies in place to report medical errors, are more optimistic about dealing with medical errors (perhaps unrealistically), and are more positive about the government's role in quality and safety. Of course, optimistic executives do not make hospitals safer, but at a minimum, our data suggest that a concerted national quality effort in a centralized health care system can capture the attention and even the approval of hospital managers.

The reported U.S. experience with quality and safety may suggest at the same time that government involvement is not necessary to promote consciousness of quality and safety among hospital executives. U.S. hospital managers are comparable to those in the U.K. in their estimate of their institutions' ability to manage safety problems, their physicians' willingness to cooperate, and the frequency with which they have policies requiring that patients be informed of errors. Our interviewees and focus groups suggest the need for caution in interpreting reports from U.S. hospital administrators prone to see the bright side of their hospitals' performance. Nevertheless, it will be instructive to watch the objective progress of the U.K. and U.S. in striving to improve quality. They are attempting to reach the same goal through dramatically different methods, one based on public investment and regulation and the other heavily dependent on market forces.

### **The Nursing Crisis**

Our respondents reported striking agreement across hemispheres and continents that the nursing shortage, which was predicted to be intractable, has eased at least temporarily. Respondents in different countries report widely varying approaches to dealing with their shortages, but all seem to have worked ([Exhibits 9](#) and [10](#)). The Achilles heel of these approaches, both ethically and practically, may be the heavy reliance of nations outside North America on recruitment from other countries. The availability of trained personnel in the developing world is limited (though that could change), and in any case, taking them away from much needier populations is an ethical concern. Nevertheless, the disappearing nursing shortage in the developed English-speaking world suggests that we should always be cautious in predicting the end of nursing as we have known it. Its intrinsic satisfactions and economic rewards have a way of confounding doomsayers.

### **CONCLUSION**

As is so often the case with research, and especially surveys, the Commonwealth Fund International Health Policy Survey of hospital executives is in many ways as notable for the questions it raises as for the conclusions it reaches. Its conclusions are nevertheless

instructive. Compared to the U.S., executives in other sample countries are more satisfied with their systems, but are struggling with greater objective problems: financial challenges, capacity shortages and inadequate facilities. Canada stands out as a particularly troubled system that has not yet responded to long overdue investment in its improvement. Since all these countries are increasing the funding of their systems, it will be instructive to see if the gap in performance with the U.S. narrows over time, and if Canada in particular can reverse an apparent decline. The next few years will provide an important test of the ability of single-payer systems, however variously organized they are, to meet the increasing demands of their populations for elective care.

A notable question in this regard concerns the U.S. hospital sector and why it seems to do better in managing patient demand with an infrastructure that is comparable in numbers of beds and admissions and has shorter lengths of stays. The answer may be as simple as the reliance on out-of-hospital elective procedures or a larger number of operating rooms and specialists per capita. However, there may be opportunities to learn from this cross-national comparison.

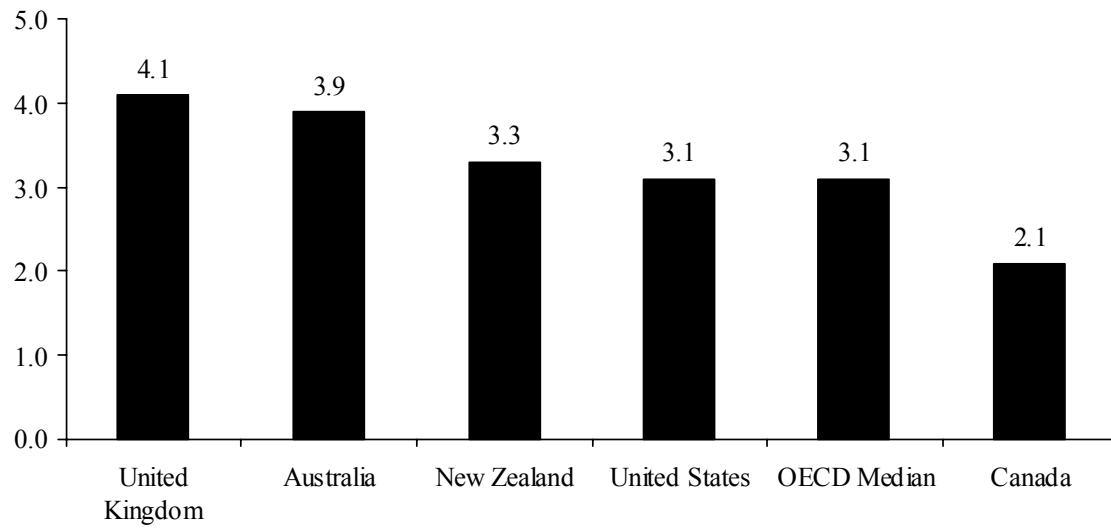
In the end, of course, each system must find its own way toward balancing efficiency and equity in its hospital sector, its health system and its society in general. The Commonwealth Fund's international health policy surveys continue to offer a glimpse of the international struggle to juggle these often-conflicting priorities.

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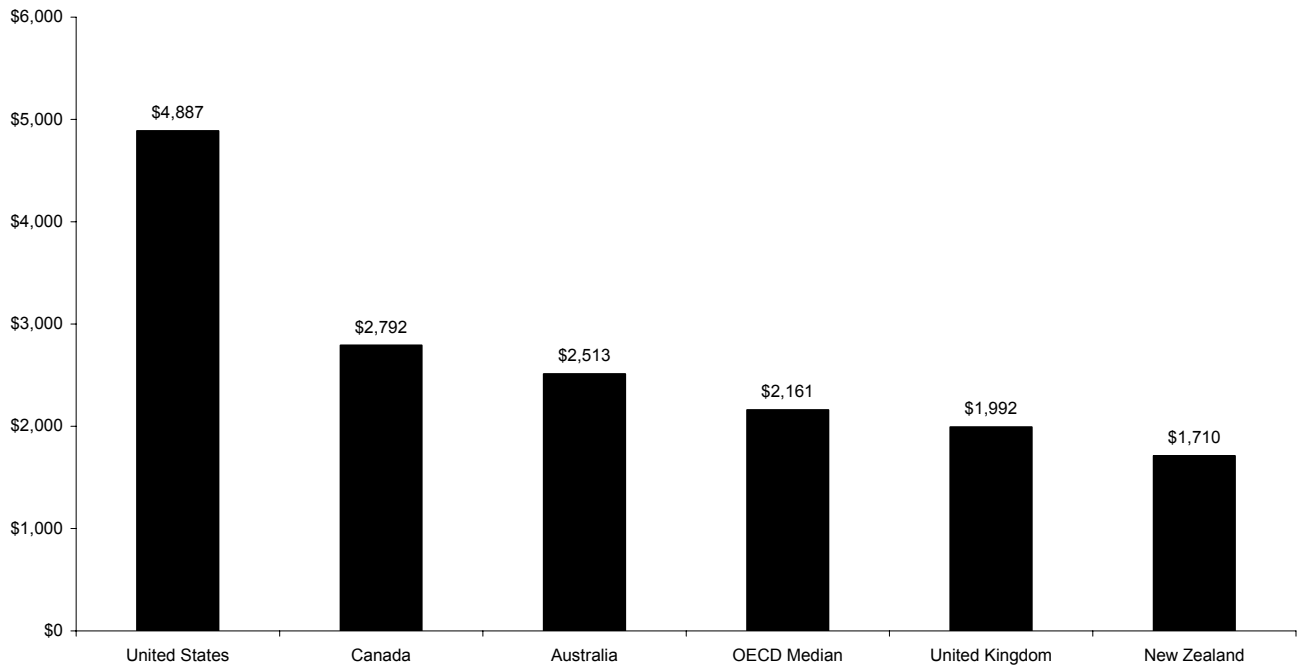
**Exhibit 1. Average Annual Growth Rate of Real Health Care Spending per Capita Between 1991 and 2001**



Source: OECD Health Data, 2003.

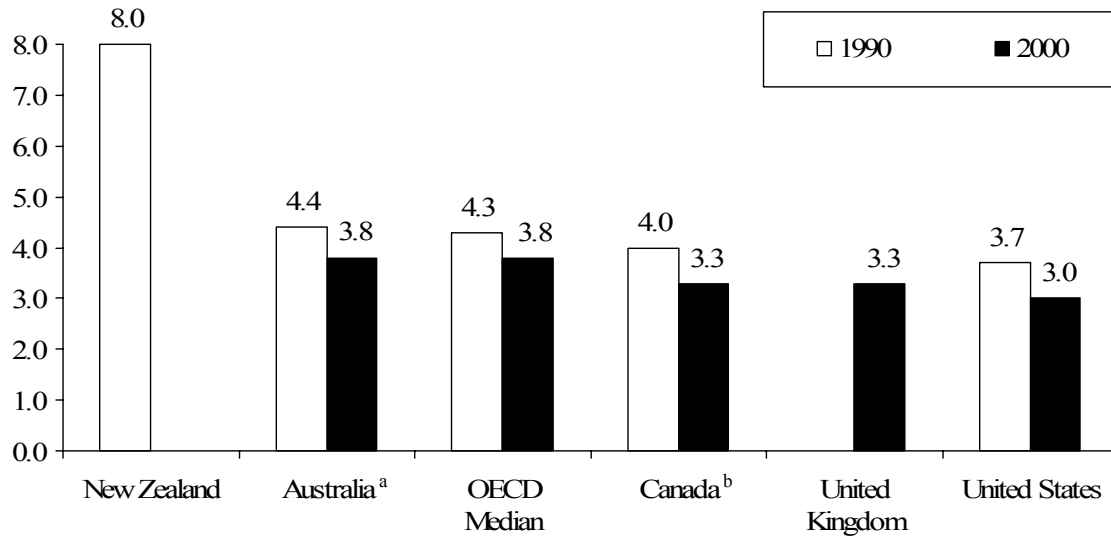


**Exhibit 2. Health Care Spending per Capita in 2001,  
Adjusted for Differences in the Cost of Living**



Source: OECD Health Data, 2003.

### Exhibit 3. Number of Acute Care Hospital Beds per 1,000 Population



<sup>a</sup> 1991–1999

<sup>b</sup> 1990–1999

Source: G. F. Anderson, V. Petrosyan, and P. S. Hussey, *Multinational Comparisons of Health Systems Data*, 2002 (New York: The Commonwealth Fund, October 2002).

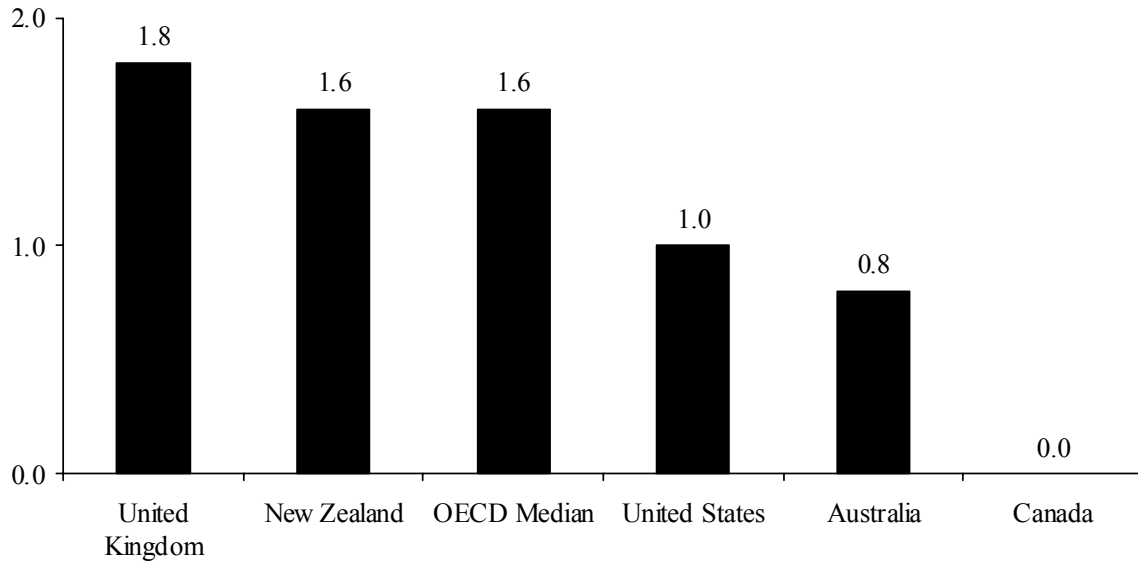
**Exhibit 4. Australian Hospital Executives' Evaluations of  
Public Versus Private Hospitals**

	<b>Total</b>	<b>Public</b>	<b>Private</b>
<b>In the Past Year:</b>			
<b>Had a surplus or profit</b>	<b>35%</b>	<b>19%</b>	<b>61%</b>
<b>Broke even</b>	<b>25</b>	<b>31</b>	<b>16</b>
<b>Had a loss or deficit</b>	<b>40</b>	<b>50</b>	<b>24</b>
<b>Current Financial Situation:</b>			
<b>Insufficient to maintain current levels of service</b>	<b>57%</b>	<b>74%</b>	<b>29%</b>
<b>Allows for some improvements*</b>	<b>11</b>	<b>2</b>	<b>26</b>
<b>Waiting Times for:</b>			
<b>Breast Biopsy – 3 weeks or more for 50-year-old woman with ill-defined mass</b>	<b>15%</b>	<b>19%</b>	<b>3%</b>
<b>Hip Replacement – 6 months or more for 65-year-old man</b>	<b>39</b>	<b>52</b>	<b>0</b>
<b>Competition in Next Two Years:</b>			
<b>Very or somewhat concerned about losing patients to other hospitals</b>	<b>42%</b>	<b>29%</b>	<b>63%</b>

\* Does not include percent reporting sufficient to maintain current levels of service.

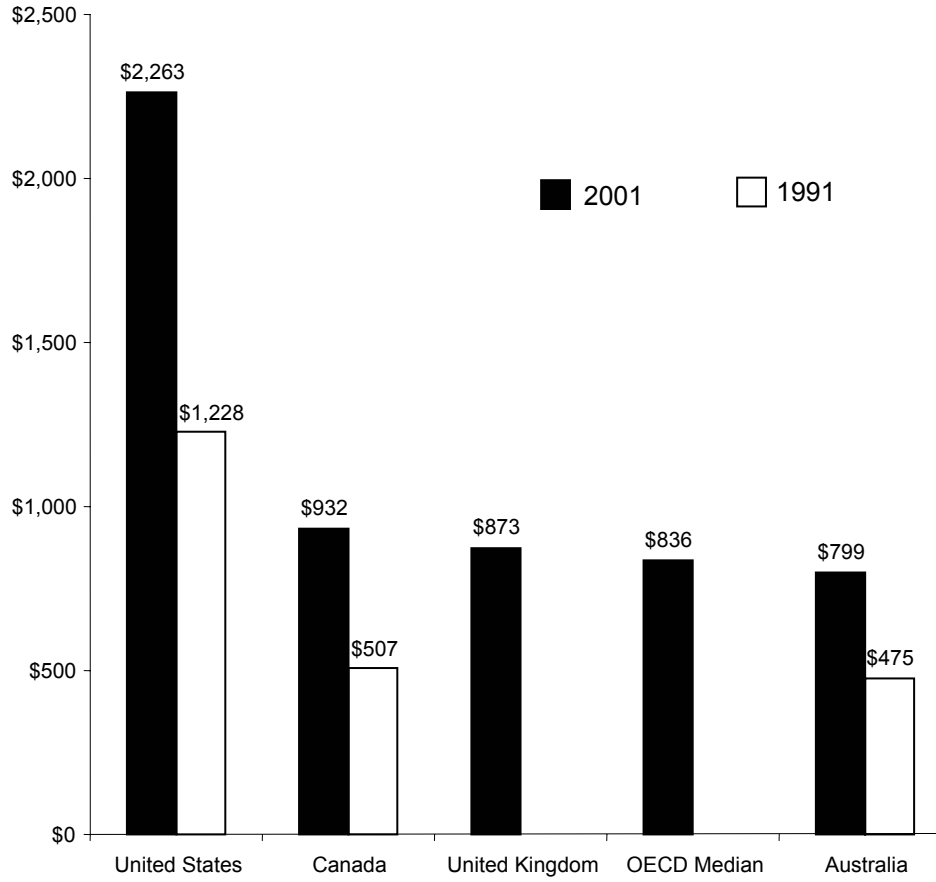
Source: R. J. Blendon, C. Schoen, C. M. DesRoches, R. Osborn, K. Zapert, and E. Raleigh, "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey," *Health Affairs* 23 (May/June 2004): 119–35.

**Exhibit 5. Average Annual Growth Rate in Physicians  
per Capita, 1991–2001**



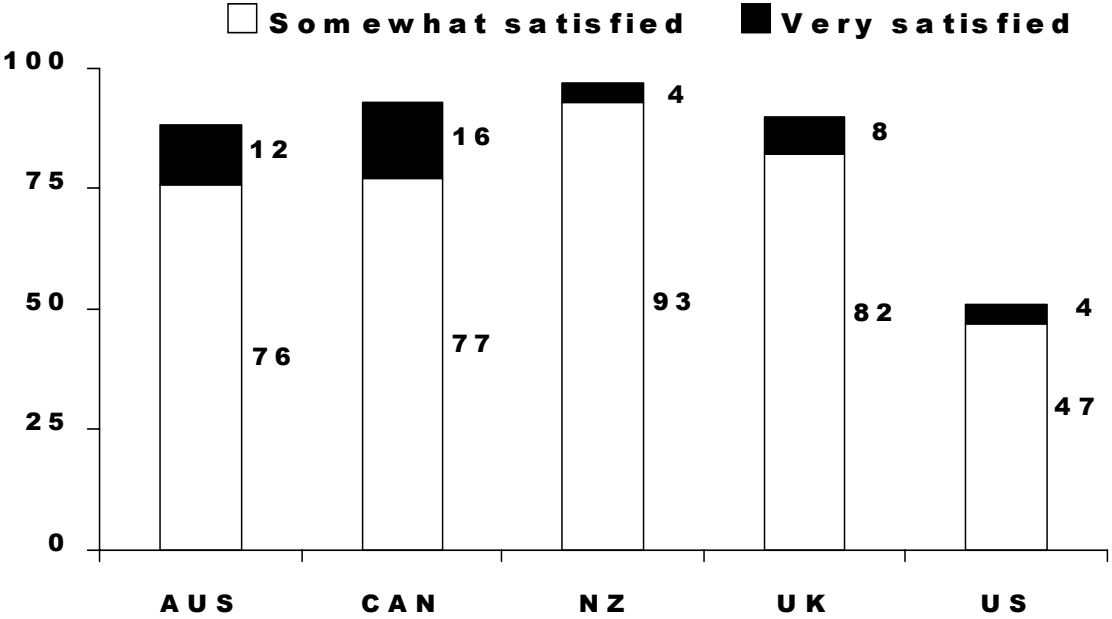
Source: OECD Health Data, 2003.

**Exhibit 6. Hospital Expenditures per Day in 2001,  
Adjusted for Differences in the Cost of Living**



Source: OECD Health Data, 2003.

**Exhibit 7. Hospital Executives' Level of Satisfaction with the Health Care System**



Source: R. J. Blendon, C. Schoen, C. M. DesRoches, R. Osborn, K. Zapert, and E. Raleigh, "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey," *Health Affairs* 23 (May/June 2004): 119-35.

**Exhibit 8. Hospital Leaders Evaluations of  
Quality and Safety Programs**

<b>Percent saying:</b>	<b>AUS</b>	<b>CAN</b>	<b>NZ</b>	<b>UK</b>	<b>US</b>
<b>Hospital has written policy to inform patients of preventable medical errors made in their care</b>	<b>59%</b>	<b>47%</b>	<b>50%</b>	<b>74%</b>	<b>88%</b>
<b>Hospital's program for finding and addressing medical errors is:</b>					
<b>Very effective</b>	<b>22</b>	<b>13</b>	<b>4</b>	<b>24</b>	<b>24</b>
<b>Somewhat effective</b>	<b>58</b>	<b>66</b>	<b>71</b>	<b>67</b>	<b>70</b>
<b>Physician support for reporting and addressing medical errors is:</b>					
<b>Very supportive</b>	<b>17</b>	<b>21</b>	<b>7</b>	<b>35</b>	<b>30</b>
<b>Somewhat supportive</b>	<b>59</b>	<b>59</b>	<b>57</b>	<b>54</b>	<b>56</b>
<b>Government policies and regulations designed to improve quality of care are:</b>					
<b>Very effective</b>	<b>5</b>	<b>5</b>	<b>4</b>	<b>4</b>	<b>2</b>
<b>Somewhat effective</b>	<b>63</b>	<b>41</b>	<b>57</b>	<b>71</b>	<b>38</b>

Source: R. J. Blendon, C. Schoen, C. M. DesRoches, R. Osborn, K. Zapert, and E. Raleigh, "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey," *Health Affairs* 23 (May/June 2004): 119–35.

**Exhibit 9. Hospital Leaders Evaluations' of the Nursing Crisis**

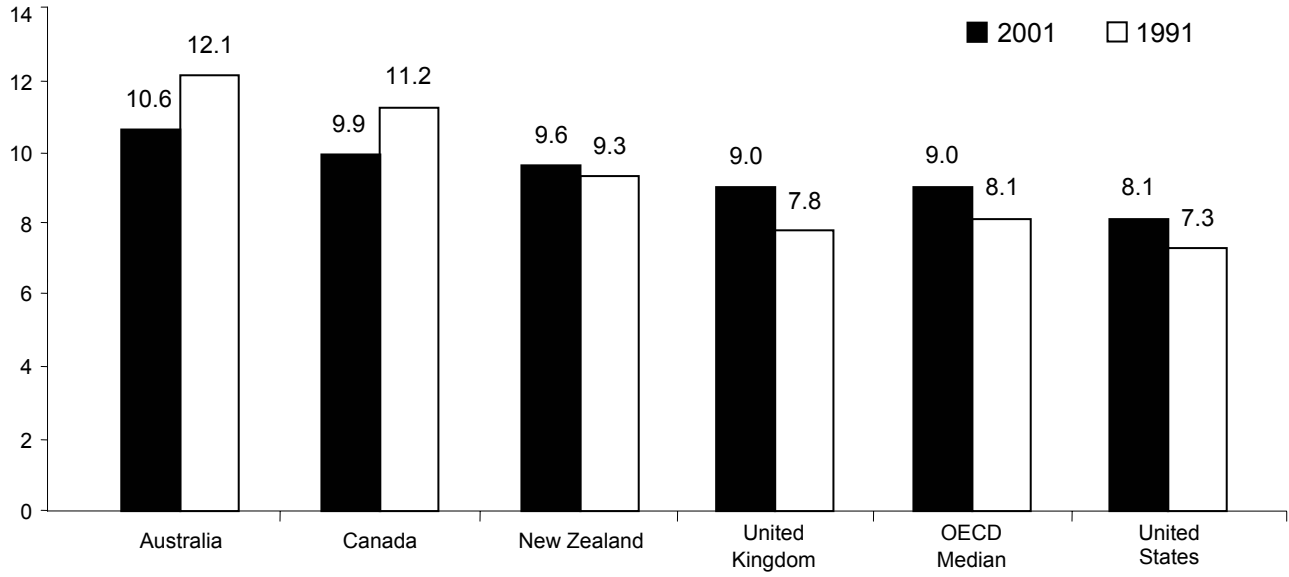
<b>Percent saying:</b>	<b>AUS</b>	<b>CAN</b>	<b>NZ</b>	<b>UK</b>	<b>US</b>
<b>Serious nurse staffing shortages</b>	<b>23%</b>	<b>30%</b>	<b>11%</b>	<b>22%</b>	<b>31%</b>
<b>Nurse staffing levels compared to two years ago:</b>					
<b>Situation is better</b>	<b>41</b>	<b>36</b>	<b>36</b>	<b>48</b>	<b>40</b>
<b>Situation is worse</b>	<b>28</b>	<b>24</b>	<b>25</b>	<b>15</b>	<b>25</b>
<b>Use strategies to recruit and retain nurses:</b>					
<b>Recruit from other countries</b>	<b>57</b>	<b>30</b>	<b>86</b>	<b>88</b>	<b>35</b>
<b>Flexible schedule/Job sharing</b>	<b>99</b>	<b>84</b>	<b>96</b>	<b>100</b>	<b>88</b>
<b>Redesign nurse jobs</b>	<b>73</b>	<b>82</b>	<b>86</b>	<b>93</b>	<b>78</b>
<b>Tuition reimbursement</b>	<b>75</b>	<b>51</b>	<b>54</b>	<b>NA</b>	<b>97</b>
<b>Sign-up bonuses</b>	<b>16</b>	<b>24</b>	<b>4</b>	<b>8</b>	<b>60</b>

Source: R. J. Blendon, C. Schoen, C. M. DesRoches, R. Osborn, K. Zapert, and E. Raleigh, "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey," *Health Affairs* 23 (May/June 2004): 119-35.



**Exhibit 10. Number of Practicing Nurses  
per 1,000 Population in 2001**

Nurses per 1,000 Population



Source: OECD Health Data, 2003.

