



# In the Literature

## **HEALTH AFFAIRS 2004 INTERNATIONAL ISSUE: GLOBAL VIEWS ON COSTS, ACCESS, AND QUALITY**

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Each year, The Commonwealth Fund supports an international issue of *Health Affairs*. This year's issue offers cross-national comparisons and lessons from other countries for improving the quality of care, ensuring access to care, and controlling costs. Eight articles by Fund grantees are summarized below.

[“U.S. Health Care Spending in an International Context,”](#) by Uwe E. Reinhardt, Ph.D., of the Woodrow Wilson School of Public and International Affairs at Princeton University and colleagues, uses the most recent data from the Organization for Economic Cooperation and Development (OECD) to explore why U.S. health care costs are so much greater than costs in other countries with much older populations.

The authors point to several reasons for higher U.S. health costs: the fragmented financing system entails higher administrative costs; health care providers have greater market power than health care purchasers, allowing prices to soar above levels of other countries where the government exercises collective bargaining power; and the U.S. provides a more specialized, intensive form of care.

While U.S. prices for drugs are high by international standards, U.S. officials accuse foreign governments of keeping drug prices artificially low, thus placing the burden of drug research and development on the United States.

The authors also consider whether the growth of health care spending as a component of the U.S. gross domestic product is economically or politically sustainable. They note that increasing health insurance premiums may prompt some firms to drop coverage for low-wage workers, adding to the ranks of the uninsured. Continued debate over health care will be less a purely macroeconomic discussion than an “exercise in the political economy of sharing.”

[“Disease Management Programs in Germany’s Statutory Health Insurance System,”](#) by Reinhard Busse, M.D., M.P.H., of the Berlin University of Technology, focuses on the introduction of such programs in 2002 into the country’s statutory health insurance pools, which cover about 88 percent of the population. An earlier reform had introduced consumer choice among the various “sick funds,” resulting in adverse selection and disadvantaging the chronically ill. Disease management was introduced to help improve quality and cost-effectiveness of treatment for chronic conditions, specifically by setting evidence-based guidelines for treatment and drug formularies and by better coordinating care.

The author notes that this approach may be of interest in the United States, where adverse selection has thus far hindered managed care efforts among the Medicare population.

[“How Does the Quality of Care Compare in Five Countries?”](#) by Peter S. Hussey of the Johns Hopkins Bloomberg School of Public Health and colleagues, reports on efforts of the Commonwealth Fund International Working Group on Quality Indicators to compare the quality of care among different countries. The group used 21 indicators—such as five-year cancer survival rates, breast cancer screening rates, asthma mortality rates, and others—to compare the quality of care in Australia, Canada, New Zealand, the United Kingdom, and the United States.

None of the countries consistently scored best or worst overall. For example, Australia scored highly on many of the indicators (cancer survival, breast cancer screening, asthma mortality) but had higher incidences of pertussis, or whooping cough, than other countries. In Canada, 30-day case fatality rates from acute myocardial infarction were higher than Australia and New Zealand in older age groups, but

kidney and liver transplant survival rates were better than in the other countries. Rates of cancer survival were not as high as other countries in the U.K., while suicide rates were notably lower than other countries. By contrast, suicide rates in New Zealand—particularly among young people—were much higher than elsewhere. Breast cancer five-year survival rates and cervical cancer screening rates were highest in the U.S., but asthma mortality rates were increasing while they were decreasing in the other four countries.

In “[Quality Incentives: The Case of U.K. General Practitioners](#),” Peter Smith, M.Sc., of the Centre for Health Economics and Nick York of the U.K. Department of Health describe an ambitious new quality measurement program launched in the U.K. last month. All general practices will now be scored on 146 measures of performance. About half of the measures consider clinical quality; others consider practice organization and patient experience. The accumulated scores will determine the amount of quality payment that practices receive, with about 18 percent of practice earnings at stake.

Evaluations will now seek to determine the impact of the measures, incorporate new clinical evidence, and refine the administration of the program.

“[Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey](#),” by Robert J. Blendon, Sc.D., of the Harvard School of Public Health and colleagues, reports on results of the Commonwealth Fund International Health Policy survey of hospital executives in Australia, Canada, New Zealand, the United Kingdom, and the United States. Hospitals account for 40 percent of spending on health care in industrialized nations and are at the center of efforts to improve quality and control costs. (Click here for [Fund data briefs](#) on each country.)

Half of U.S. hospital executives said they were very or somewhat dissatisfied with their country’s health care system, while only 12 percent or fewer hospital executives from the other countries reported this. In general, American hospital executives were most negative about the health care

system, even though they had more positive views about their hospitals’ financial status, quality of resources, and waiting times.

Written policies to inform patients about preventable medical errors were common in the U.S. and U.K. but in only about half of other countries. Majorities in every country rated the system for finding errors as at least somewhat effective, but no more than one-quarter in any country thought their system was very effective. The majority of hospital executives favor releasing quality-of-care data to the public, though U.S. and Australian executives expressed the most reluctance about doing so.

When hospital executives in the five countries were asked what their top priority would be for a one-time capital investment to improve quality of care for patients, they named information technology (IT) as the top choice (see figure).

“[Outcomes-Based Drug Coverage in British Columbia](#),” by Steven Morgan, Ph.D., of the University of British Columbia and colleagues, draws lessons from a decade’s worth of experience in pharmacy benefit management. Under British Columbia’s PharmaCare program, manufacturers are required to provide scientific evidence that a certain drug offers comparative benefits over therapeutic alternatives before it becomes eligible for public subsidies. There has been widespread opposition to the program, including legal challenges, negative media campaigns, and threats to cut off research funding. But independent studies have shown that it has effectively contained costs—estimated at \$12 million savings annually—while ensuring ongoing access to needed care.

The Fund also supported two other articles in this issue. “[Reform Strategies for the English NHS](#),” by Simon Stevens, M.B.A., the British prime minister’s health policy adviser, describes the role of incentives and local accountability in England’s health reform strategy. “[Trends in International Nurse Migration](#),” by Linda H. Aiken, Ph.D., R.N., of the University of Pennsylvania School of Nursing and colleagues, explains how the “pull” of nurses away from developing countries to jobs in wealthier nations affects global health.

### **If You Had New Funding to Invest in a One-Time Capital Improvement in Only One Area of Your Hospital, What Would It Be?**

<b>Percent saying:</b>	<b>AUS</b>	<b>CAN</b>	<b>NZ</b>	<b>UK</b>	<b>US</b>
<b>Electronic medical records/IT</b>	<b>35%</b>	<b>47%</b>	<b>46%</b>	<b>38%</b>	<b>62%</b>
<b>Emergency room/OR/Critical care facility</b>	<b>26</b>	<b>18</b>	<b>4</b>	<b>22</b>	<b>13</b>
<b>Basic hospital/patient facilities</b>	<b>17</b>	<b>14</b>	<b>21</b>	<b>22</b>	<b>3</b>
<b>Diagnostic equipment/medical technology</b>	<b>9</b>	<b>16</b>	<b>11</b>	<b>10</b>	<b>3</b>

Source: R. J. Blendon et al., “Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey,” *Health Affairs* 23 (May/June 2004): 119–35, based on Commonwealth/Harvard/Harris, Commonwealth Fund International Health Policy Survey (2003).