S. HRG. 111–347

# ACHIEVING HEALTH REFORM'S ULTIMATE GOAL: HOW SUCCESSFUL HEALTH SYSTEMS KEEP COSTS LOW AND QUALITY HIGH

## HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING
## UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

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# ACHIEVING HEALTH REFORM'S ULTIMATE GOAL: HOW SUCCESSFUL HEALTH SYSTEMS KEEP COSTS LOW AND QUALITY HIGH

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**WEDNESDAY, SEPTEMBER 30, 2009**

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.*

The Committee met, pursuant to notice, at 11 a.m. in Room SD–106, Dirksen Senate Office Building, Hon. Herb Kohl, Chairman of the Committee, presiding.

Present: Senators Kohl [presiding], Franken, Corker, and LeMieux.

## OPENING STATEMENT OF SENATOR HERB KOHL, RANKING MEMBER

The Chairman. At this time, we'd would like to call this hearing to order and commence.

We thank you all for being here today. Obviously, as we all know, there's a lot happening on health reform. The debate is shifting and progressing every day, and we've been at this for a long time, as you know.

Today, our committee will discuss one of health reform's most important goals, which is to get healthcare costs under control. The United States spends $7300 per person per year on healthcare, while the other 29 most developed countries in the world spend an average of just $2900. That's $7300 here in the United States versus $2900 per year elsewhere in the world. That means that we're spending nearly two and a half times what these other countries spend. It's not acceptable that we have so much more of our money tied up in healthcare, when we are not delivering demonstrably better healthcare than many of these countries.

Studies show that the United States ranks below average on major health indicators, including infant mortality and life expectancy, when compared to the rest of the world, and we'll be hearing more about that today.

Several of our witnesses will shed light on the ways in which other nations deliver high quality care at a cost much lower than we do here in the United States. We must be willing to learn from the many examples of successful healthcare systems around the world that are doing it as well or better than we are. But, it's also vital that we understand why our healthcare costs are higher. Our panel of witnesses will outline some of the reasons we pay more for

physician services, prescription drugs, medical equipment, and hospital services.

We also expect to learn about why our administrative costs are so much higher across the board. In 2004, the United States paid more than seven times the average of other developed countries on administrative costs. Very importantly, we'll also hear today about the need to reconfigure our healthcare system in a way so that it prioritizes the quality of care provided instead of the amount of care provided; in other words, value of care over volume of care. I support the provisions included in the Senate Finance Committee health reform bill that would transform the Medicare system to pay for value over volume, and I am hopeful that they will remain in the final health reform bill.

But, more must be done in order to get healthcare costs under control. With so many industries and special interests tied up in our healthcare system, reining in healthcare costs is not an easy task.

I urge my colleagues to be open, and to stay open, to the lessons that we hope to learn today, and take them into account as we make tough decisions and carry healthcare reform through to the finish line. If we pass a piece of healthcare reform legislation without sufficiently addressing the issue of healthcare spending, then we will have failed.

So, we thank you all, our witnesses particularly, for being here today.

At this time, it's an honor and a pleasure to turn to my new partner on this committee, our ranking member, Senator Bob Corker.

Senator Corker.

**STATEMENT OF SENATOR BOB CORKER**

Senator CORKER. Mr. Chairman, first of all I want to thank you for the kindness you've extended through your staff to us as we've come on board. I certainly look forward to working with you and other committee members.

I think this hearing, by the way, is most appropriate. I think the timing of it is excellent and I certainly appreciate the testimony that each of the witnesses have put forth.

I, you know, constantly was throughout our State in townhall meetings during August, and the whole issue of the us being ranked the 37th in the world, as it relates to health, continued to come up. I brought it up, myself, of course. But, I think, also, when you look at the comparisons, there are a lot of things that just aren't apples to apples. I'm sure that this testimony will certainly lead to that conclusion.

The fact is that if you happen to have a cancer episode, you want to be here in the United States of America. You have a heart issue, you want to be in the United States of America. If you want something electively done quickly, you want to be in the United States of America.

So, much of the comparison obviously is not accurate; on the other hand, I think much of your testimony has—will point out that there certainly are huge areas of improvement that need to occur in this country. I thank you each for those contributions.

The whole issue of our country being the third largest in the world, and having the most diverse population compared to other countries that we are compared to, certainly creates much of the distortion, if you will, as it relates to our health. But, again, I think much of what you have brought forth in your testimony, and will again orally today, will be helpful to us. I think it's appropriate that, when we hear numbers like 37th in the world as it relates to health, as we hear things as it relates to how much we pay, which is exorbitant—and I think all of us want to focus on that—that we deal with facts, and not myths. That's why I look forward so much to your testimony today.

So, Mr. Chairman, thank you for calling this hearing, and I look forward to hearing from the witnesses.

The CHAIRMAN. Thank you very much, Senator Corker.

Senator Franken.

**STATEMENT OF SENATOR AL FRANKEN**

Senator FRANKEN. Thank you, Mr. Chairman and Senator Corker, welcome——

Senator CORKER. Thank you.

Senator FRANKEN [continuing]. In your new role as ranking member.

Senator LeMieux, this is, I think, the first hearing I've been in when I've had someone junior to me— [Laughter.]

Senator FRANKEN [continuing]. So, I'd like to point that out, if you don't mind. But, welcome to the committee.

It's an honor to be here today, and I'm glad you're holding this hearing, Mr. Chairman, on such a critical and timely topic.

Since I've been in Washington, I've been disheartened about how little discussion there's been about containing healthcare costs. When I travel around Minnesota, people ask me over and over again, "What is Congress doing to make healthcare more affordable?" They know that, unless we get to the source of what's driving up healthcare costs, health reform will be incomplete.

I look forward to hearing, today, about models from other countries, and from within our own country, that can show us the way to bring down healthcare costs for everyone.

One of the most logical ways to get costs under control is to transform how we pay for and incentivize healthcare. Right now we have perverse incentives in Medicare, which actually pay doctors more if they just provide more procedures. There's no accountability for the quality of services or for getting and keeping patients healthy. In fact, there's incentive, in some ways, to not keep them healthy. But, the Finance Committee is making progress, and I commend Chairman Baucus for including an amendment to incentivize value in Medicare. The provision is called the "Value Index," and it's designed to move Medicare toward rewarding providers who provide high quality care at lower costs. I believe this is the only way to make the rest of the country more like the Mayo Clinic, in my State, improving healthcare delivery and bending the cost curve.

Even though I'm a proud Senator from Minnesota, I know that no other system is identical to Mayo, but Mayo is not alone in Minnesota. We have other great examples of high quality integrated

systems in our State, like HealthPartners, Allina, and Fairview. We know, from systems like Geisinger and Cleveland Clinic, and Kaiser, that this high-value healthcare is possible in other parts of the country.

These coordinated health systems distinguish themselves by focusing on patients, and not profits. They have physicians engaged in leadership, high levels of teamwork and collaboration, and more sharing of electronic medical records and information.

Perhaps more importantly, systems like Mayo have much greater use of what's called the "science of healthcare delivery." This means that their leaders are systematically looking at how patients flow through the organization in order to reduce waste and reduce errors. I look forward to hearing from the witnesses about policies that will foster this type of patient-centered care.

Administrative simplification is another area for cost savings that seem like just a no-brainer to me. In 2004, the U.S. paid an average of $465 per person for these expenses, seven times more than other developed nations, as the Chairman noted. It's unbelievable to me that every insurance company has different forms and processes that providers have to navigate in order to get paid. If you or your doctor, or your doctor's administrative assistant, fills out something wrong, the insurance companies simply, sometimes, deny payment. Maybe that's why they do it.

In Minnesota, the providers and nonprofit insurance companies have gotten together and decided that this madness has got to end. They developed a common payment and billing procedure that everyone is now starting to use. This will save millions of dollars in Minnesota. If we require all insurance companies to use a common payment system, we will save billions of dollars in administrative costs and prevent lots of headaches for doctors, other providers, and for patients.

Since we're here in the Aging Committee, I also want to mention that AARP in Minnesota has been holding regular tele-townhalls to get accurate—accurate—information out about health reform. During these discussions, there is unanimous agreement that our health system needs to be reformed. But, there's also some confusion about how we save money in Medicare Advantage without cutting benefits.

I want to be very clear that the discussion we're having today is about increasing efficiency in Medicare, and healthcare overall, not about cutting benefits. The more we can clarify this for folks, I think, the better off we'll all be.

Another topic I hope that will be discussed today is the importance of prevention in lowering healthcare costs. The cost of obesity in this country is a $147 billion dollars per year, half of which is direct cost to the Federal Government. This is a public health issue, and one that the prevention is really part of a medical system in a country, and should be considered part of healthcare, and not just be considered part of the culture. Obesity can lead to diabetes, heart disease, and even cancer. There's no other country that is facing the chronic disease epidemic that we're facing as a result of obesity. Again, this is something that can be targeted through public health measures, and should be considered as part of our healthcare system, and not divorced from it.

The current proposals to eliminate copays for preventive services like mammograms and colonoscopies are crucial. But, healthcare reform must also support community health, like the Senator—Senator Harkin's Prevention and Public Health Investment Fund. I look forward to hearing from witnesses about how prevention fits into this discussion on cost containment.

In closing, I'd like to share the words of a young woman I met when I was back in Minnesota in August. She's a cancer survivor, worried that she won't be able to pay for the care that she needs. When I go back to Minnesota, I want to be able to look her in the eye and say, "We've done everything we can in Washington to make health reform work for you, from ending preexisting-condition exclusions to bring down the cost of healthcare for everyone." Her words explains—explain far more eloquently than I can why we have to pass health reform this year. She says, "Healthcare reform means people not having to choose between their life and their life savings. Healthcare reform means that no American loses their life because they can't afford screenings or treatment. Healthcare reform means cancer patients receiving care that is available, adequate, and affordable, and it means getting rid of the fears that we are faced with every day."

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Franken.

Now we would like to hear from the newest member of this committee, and our newest United States Senator from Florida, Mr. George LeMieux.

**STATEMENT OF SENATOR GEORGE LeMIEUX**

Senator LEMIEUX. Thank you, Mr. Chairman. Thank you.

It's great to be here this morning, and I look forward to working with you and the other colleagues here on this committee.

With more than 3 million seniors living in Florida, the issue of healthcare reform is tremendously important to our State. We like to think that all seniors will eventually live in Florida. So, it will be a more—— [Laughter.]

Senator LEMIEUX [continuing]. Important issue as time goes on.

This issue of addressing healthcare cost is crucial to a successful reform effort. If we do not address rising costs, we won't get at the core of the healthcare crisis. As my colleague just said, "No American should be turned away from treatment because they can't afford a procedure."

These hearings come, as you know, at a pivotal time, as we are currently debating healthcare reform legislation. I support affordability and access to quality healthcare. Right now the costs are too high, and too many people do not have health insurance.

I've heard from, and my office has heard from, a number of Floridians who are dealing with skyrocketing healthcare costs. Last week, I met with some cancer survivors from Florida, one of whom is—has a husband who's employed, so she still has insurance, but is scared, if he were to lose his job, what it would mean for her; the other, who has lost her job and now is on COBRA and struggling to be able to provide for the healthcare, and they are making life decisions about not having healthcare procedures done in order to be able to keep some life savings for their family if they are not

able to win the fight against cancer. Those are decisions that no Floridian, no American, should have to make.

But, I believe there are a number of measures that we can look at to control costs. I hope that the panelists will talk about them today. One of them is, every patient has the right to know what a procedure costs. Requiring transparency would allow families to make better decisions about which doctor they see, which healthcare provider they go to. We must ensure families can obtain information about price and quality of healthcare services. Informed decisions are better decisions.

No one knows what these procedures cost right now. We have divided the patient from the process. We need a consumer-driven healthcare system to increase quality and to drive down costs.

We also need to address fraud, waste, and abuse. We have a Medicare system, where escalating costs are driven, in part, to out-of-control waste, fraud, and abuse. Florida, really, is ground zero for these problems, especially southeast Florida. There are as much, it's estimated, as $60 billion wasted every year in the Medicare program because we don't have transparency, and we don't know what's going on with this money.

When I was the deputy attorney general in Florida, we were responsible for the Medicaid Fraud Control Unit. We were able to recover $100 million in one year in Medicaid fraud just in Florida alone, and Medicaid is not near the program that Medicare is.

So, we need to learn from the private sector and other industries, industries like the credit card industry. The credit card industry handles as much money as the healthcare industry does in this State—in this country, and yet, they have a 0.01-percent fraud rate, when it's estimated that in healthcare it might be 10, 20, or even 30 percent of all the dollars that we spend. Everyone, Democrat and Republican alike, can agree that we should not be wasting these dollars on fraud, waste, or abuse.

I look forward to hearing from the panelists on this comparison between our health system and those of other countries. I, too, saw this ranking of 37th. I look forward to that discussion today. I don't buy it. I know that we train the world's doctors. I know that we create the drugs that help save the lives of people around the world. I know that people who have means from around the world choose to come to our country to have healthcare.

So, don't get me wrong, I know we can do better, I know that we can learn, I know that there are other models, and we always should have an open mind about it.

So, I welcome the panelists here today. I'm the new kid on the block. I've got the temporary sign, here. But, I look forward to being—— [Laughter.]

Senator LEMIEUX [continuing]. Part of this committee. As I said, it's such an important issue for Florida.

So, thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator LeMieux.

Now we turn to our panel. Our first witness today will be Mark Pearson, who heads the Health Division at the Organisation for Economic Co-operation and Development, or OECD. In this role, he helps countries improve their health systems by providing internationally comparable data, state-of-the-art analysis, and policy

recommendations on a wide range of health issues. He is the leading healthcare expert at the OECD.

Next, we'll be hearing from Dr. Carolyn Bennett, who's served as the Canadian Minister of State for Public Health and is now a sitting member of the Canadian Parliament. Prior to her becoming involved in politics in 1997, Dr. Bennett was a Family Physician. She is currently the leading spokesperson for her party on healthcare.

Next, we'll be hearing from Dr. Cathy Schoen, Senior Vice President at the Commonwealth Fund for Research and Evaluation. She has authored numerous publications on health policy issues, national and international health system performance.

Next, we'll be hearing from Dr. Arnold Epstein, Chairman of the Department of Health Policy and Management at the Harvard University School of Public Health. Dr. Epstein's research focuses on quality of care and access to care. He recently chaired the OECD's International Working group on Quality Indicators.

Then we'll be hearing from Michael Tanner. Mr. Tanner is a Senior Fellow at the Cato Institute, where he has led the health division for 16 years. Mr. Tanner conducts research on a variety of domestic policies, including healthcare reform, social welfare policy, and social security.

We welcome you all here today. We'll start out, Mr. Pearson, with your testimony.

**STATEMENT OF MARK PEARSON, HEAD OF HEALTH DIVISION, ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, PARIS, FRANCE**

Mr. PEARSON. Thank you very much. Honorable Senators, ladies and gentlemen, it's a great honor for me to be allowed to talk with you today.

As you've heard, I head up the work on health at the Organisation for Economic Co-operation and Development. The OECD grew out of the Marshall Plan. Secretary of State Marshall's vision was about a flow of money to war-torn Europe to help us recover. The OECD today doesn't do that, of course. We're about the flow of information and of ideas. We don't presume to tell countries what to do; instead, we help our 30 member countries, the world's economically developed democracies, to learn from one another. This is as true in health, as it is in other areas of policy.

We've worked hard over the years to collect comparable information on healthcare policies and outcomes, and our work shows, as you all well know, that the United States spends more on healthcare, relative to national income, than any other country—about 1 dollar in every 6. France and Germany, for example, spend just under 1 euro in every 9 of their national income on health. Japan, just 1 yen in every 12. These countries, of course, have full insurance coverage for their citizens.

America's a rich country, and rich people are willing to spend a lot more on healthcare than poor people. Even after allowing for this, America still spends up to $750 billion more than we would expect.

There's no reason to think that America's sicker than other countries, and—other OECD countries have to cope with an older population.

So, where does all the money go? We know some things. America spends more on inpatient care than any other country, more on pharmaceuticals, and more on administration. But, the biggest difference relative to other countries is spending on outpatient care, particularly day surgery, where America's spending here is about two and a half times as much as Canada's, and over three times as much as that in France.

So, the key question then is, Why does America spend so much more than other countries? Of course, there's no simple answer, but there are many clues in the OECD's databases. The total amount spent on health depends, of course, obviously, on the price that you have to pay for those services and the amount that you buy. Starting with prices, our most comprehensive data show American prices for healthcare about 25 percent higher than other OECD countries, well over 50 percent higher than in Japan. These data, I have to admit, are not as reliable as we would like them to be. As we dig deeper, we find, for example, that pharmaceuticals here cost maybe 40 to 50 percent higher than elsewhere, despite generic drugs being cheaper.

Preliminary results of our latest work show that a range of hospital procedures cost nearly twice as much here than in 12 other countries. Of course, doctors in the United States are paid $25- to $40,000 more per year than in Canada, Germany, and the United Kingdom; about $60,000 per year more than in France.

Moving on to the quantity of healthcare services provided, the picture's mixed. There are not that many doctors in the United States. America's see their doctors less than in most OECD's countries. Acute hospital-care beds are few. Stays in hospital are short. However, once people are in the medical system, they receive far more diagnostic tests, that cost a lot of money, such as MRI and CT scans, than in any other country. There are many more caesareans, knee replacements, and tonsillectomies—there are four times as many, of these than the average—procedures that are driven by doctors' judgments.

The balance of evidence is that high American spending on health is mainly the result of high prices, with a greater number of procedures and interventions playing an important, but lesser, role. Other OECD countries are striving to bend the cost curve, to slow the seemingly inexorable growth in health spending. They regulate various healthcare prices, pharmaceuticals, doctors' fees, payments for hospital services, or sometimes they regulate the kind and quantity of healthcare services available. These policies have kept healthcare costs well below the level in the United States without compromising health outcomes.

If the United States were to take additional steps to control health spending, there is indeed much to be learned from international experience.

I look forward to questions from the honorable members. Thank you.

[The prepared statement of Mr. Pearson follows:]

**Written Statement to Senate Special Committee on Aging**

**Mark Pearson, Head, Health Division, OECD**

**30th September 2009**

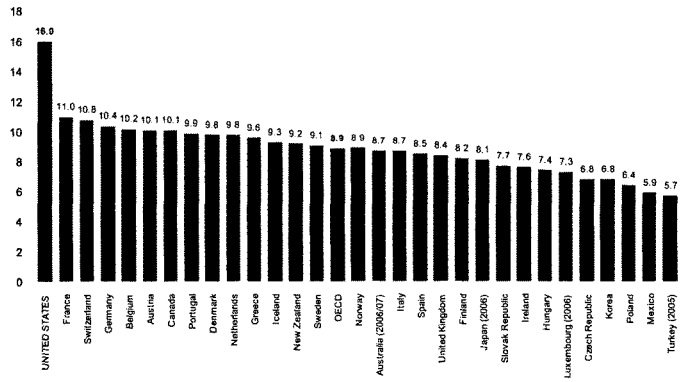
**Disparities in health expenditure across OECD countries:**
**Why does the United States spend so much more than other countries?**

## 1. Health expenditure in the United States is far higher than in other developed countries

***American citizens spend more of their national income on health than anywhere else but the United States has not yet achieved full insurance coverage of its population…***

The United States spent 16% of its national income (GDP) on health in 2007. This is by far the highest share in the OECD and more than seven percentage points higher than the average of 8.9% in OECD countries. Even France, Switzerland and Germany, the countries which, apart from the United States, spend the greatest proportion of national income on health, spent over 5 percentage points of GDP less: respectively 11.0%, 10.8% and 10.4% of their GDP. However, almost all OECD countries, with the exception of the US, and the middle-income countries, Mexico and Turkey, have full insurance coverage of their population.

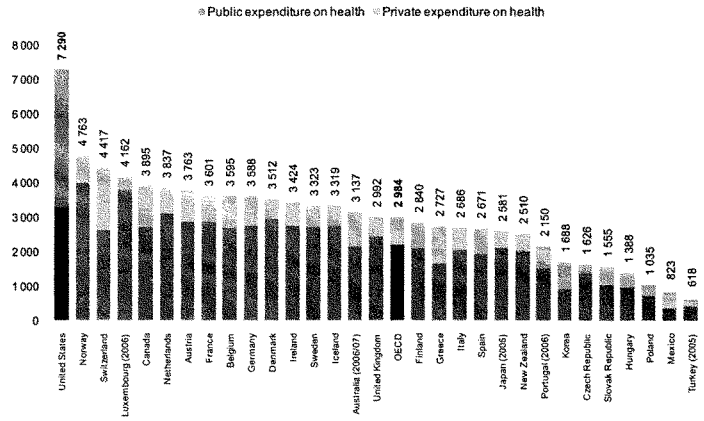
*Chart 1: Health expenditure as a share of GDP, OECD countries, 2007*




Source: OECD Health Data 2009.

Americans consumed $7,290 of health services per person in 2007, almost two-and-a-half times more than the OECD average of just under $3,000 (adjusted for the differences in prices levels in different countries). Norway and Switzerland spent around $4,500 per person. Americans spend more than twice as much as relatively rich European countries such as France, Germany and the United Kingdom.

*Chart 2: Health expenditure per capita US$, 2007*




Source: OECD Health Data 2009. Figures are adjusted to US$ using Purchasing Power Parities - see Annex 2.

***...even the government spends more on health than nearly anywhere else.***

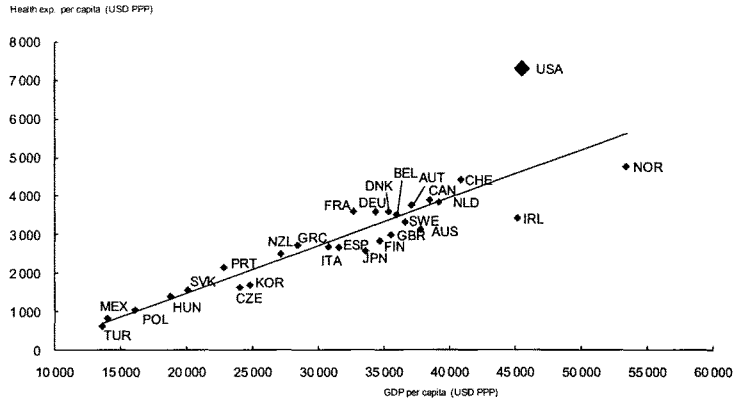
In most countries, health spending is largely financed out of taxes or social security contributions, with private insurance or 'out-of-pocket' payments playing a significant but secondary role. This is not the case in the United States which, other than Mexico, is the OECD country where the government plays the smallest role in financing health spending. However, such is the level of health spending in the United States that public (i.e. government) spending on health per capita in the United States is greater than in all other OECD countries, excepting only Norway and Luxembourg. For this amount of public expenditure in the United States, government provides insurance coverage only for elderly and disabled people (through Medicare) and some of the poor (through Medicaid and the State Children's Health Insurance Program, SCHIP), whereas in most other OECD countries this is enough for government to provide universal primary health insurance. Public spending on health in the United States has been growing more rapidly than private spending since 1990, largely due to expansions in coverage.

***Rich countries spend more than poor countries on health; even so, US spending is high.***

The richer a country is, the greater the amount of money it devotes to its health. Chart 3 shows that this relationship is very strong indeed. If per capita income is around $20,000, a country is 'expected' to spend

about $1,500 per person on health (and indeed this is the case for countries like Slovakia and Hungary), whereas if per capita income is $40,000, health spending of a bit more than $3,500 would be predicted. The relationship is simply an empirical observation: it does not imply that a country *should be* spending at or near the line, but it is a convenient way of thinking about national health spending levels. There are significant differences across countries: Canada spends a lot more than Australia, for example, though income levels are similar. But the United States is the biggest outlier, by a wide margin. A country with the income level of the United States would be expected to spend around $2,500 less per capita than it actually does – equivalent to $750bn per year.

*Chart 3: Health expenditure per capita and GDP per capita, OECD countries, 2007*




Source: OECD Health Data 2009

***This level of spending is nothing to do with aging and health status***

One factor which *cannot* explain why the US spends more than other countries is population aging. Many European countries and Japan have been aging much more rapidly than the United States. In Europe, 16.7% of the population is over 65 years old, and 21.5% in Japan compared with just 12.6% in the United States. Population aging can explain part of the *growth* in health expenditure over the past decade in the United States and elsewhere, it cannot explain why the United States spends more than other countries.

Similarly, Americans are not any more likely to be sick than Europeans or Japanese people, though the very high rates of overweight and obesity are already costly and will drive health spending higher in the coming decades (OECD 2009a). Americans have had much lower rates of smoking than most other OECD countries since 1980, and so this should be contributing to better health outcomes. Another reason which might explain high health spending in America might be that the quality of care is better than elsewhere. There is no simple way of saying whether this is true; the Box on quality of care below provides a very short summary of what we

know, which can be reduced to the statement that 'in some areas, US health care is very good; in others it is not.'

The next section describes in which areas the US spends more than other countries, before going on to look at whether this spending is due to medical services *costing* more in the United States, or whether there is simply *more* health care being delivered.

## 2. What areas of health spending are high (and low) in the United States?

Health expenditure can be broken down into different categories of spending: in-patient, out-patient, pharmaceuticals, etc. as well as those services allocated to the whole community, such as public health and administration of healthcare. These categories of spending do not match those often used in the United States, but allow for reliable international comparisons – see the Box 'How comparable is health expenditure data?'.

Chart 8 compares the level of spending in the US and elsewhere; Chart 9 shows trends in spending. In short, they show that:

- *In-patient* spending is higher than in other OECD countries, but not by as much as might be expected, given differences in GDP. This reflects in part a data problem – some spending which would be classified as in-patient care in other countries is classified in out-patient care in the United States. It has been growing somewhat less rapidly than other categories of spending.
- *Out-patient* care spending is also highest in the United States, being more than three-times greater than in France, Germany and Japan, and growing very rapidly indeed. The growth rate is high in other countries as well, but from a lower basis.
- *Administrative costs* are high.
- *Pharmaceutical* spending is higher in the US than in any other country, but it accounts for a smaller share of total health spending than in other countries.
- *Long-term care* spending is a little higher than in other countries, but proportionally accounts for less spending than elsewhere.

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**Box: How comparable are health expenditure data?**

Since the publication of the OECD manual *A System of Health Accounts* (OECD, 2000), the majority of countries now produce health spending data according to international definitions. The *System of Health Accounts* states that total health expenditure consists of current health spending and investment. Current health expenditure itself comprises personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (public health services and health administration). Curative, rehabilitative and long-term care can further be classified by mode of production (in-patient, day care in hospitals, out-patient care outside hospitals and home care.) The System of Health Accounts is currently being revised by OECD, Eurostat (the Statistical Office of the European Commission) and WHO. The draft of the revised manual will be completed by 2010.

The comparability of health expenditure data has improved as countries have modified the way they collect data to match the SHA definitions, particularly at the aggregate level and in areas such as the measurement of long-term care. However, some problems remain. For example, in-patient expenditure does not contain independent billing of physicians' fees for in-patient care in the United States. Also, in some cases, expenditure in hospitals is used as a proxy for in-patient care services, although in many countries hospitals provide out-patient, ancillary, and in some cases drug dispensing services.

**Box: How does the quality of care in the United States compare with other OECD countries?**

For all its spending, the US has lower life expectancy than most OECD countries (78.1; average is 79.1), and is below average on a wide range of other measures, including infant mortality, potential years of life lost, amenable mortality, and so on. It is true, however, that these 'aggregate' measures are not good measures of the effects of health *spending* on outcomes, as many other factors determine mortality.

There are many good things to say about the quality of the US health system. It delivers care in a timely manner – waiting lists are unknown, unlike in many OECD countries. There is a good deal of choice in the system, both in health care providers and, to some extent, the package of health insurance. The system delivers new products to consumers more quickly than in any other country. The United States is the major innovator, both in medical products and procedures. However, perhaps the best, but too-often neglected, way of assessing the performance of the system is to look in detail at the quality of care. Which areas of the healthcare system are providing value-for-money and which show opportunities for performance improvement? Quality of care, or the degree to which care is delivered in accordance with established standards and optimal outcomes, is one of the key dimensions of value.

The OECD's Health Care Quality Indicators project (HCQI) is developing a set of quality indicators at the healthcare systems level, and 23 indicators will be presented in the forthcoming edition of *Health at a Glance 2009*. These indicators cover key healthcare needs, all major healthcare services, and most major disease areas. The United States stands out as performing very well in the area of cancer care, achieving higher rates of screening and survival from different types of cancer than most other OECD countries (Charts 4 and 5). The United States does not do well in preventing costly hospital admissions for chronic conditions, such as asthma or complications from diabetes, which should normally be managed through proper primary care (Charts 6 and 7).

**Chart 4: Breast cancer, five-year relative survival rate, latest period**

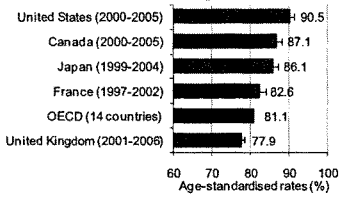



**Chart 5. Colorectal cancer, five-year relative survival rate, latest period**

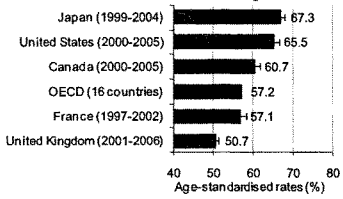



**Chart 6: Asthma admission rates, population aged 15+, latest year**

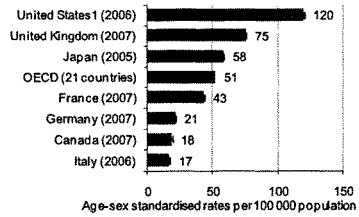
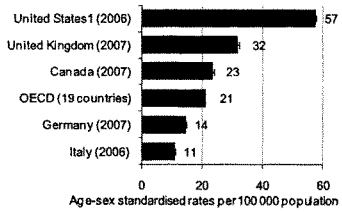



**Chart 7. Diabetes acute complications admission rates, population aged 15+, latest year**




*Note*: 95% confidence intervals are represented by H.
*Source*: OECD Health Care Quality Indicators Data 2009.

1. Does not fully exclude day cases

*Chart 8: Current health expenditure per capita by category of care, 2007*

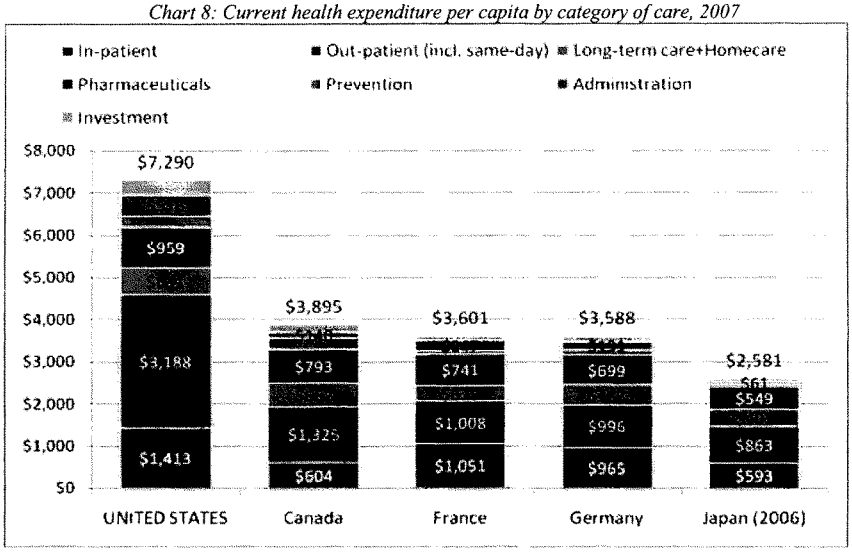
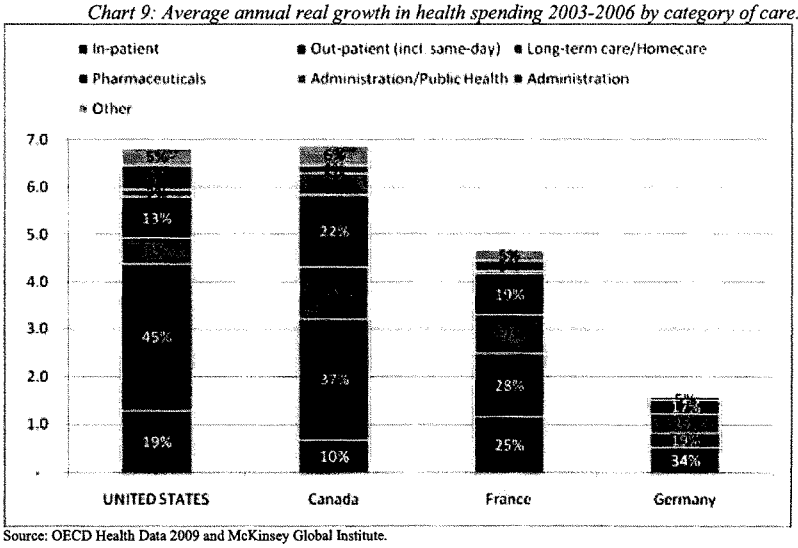



*Chart 9: Average annual real growth in health spending 2003-2006 by category of care.*




Source: OECD Health Data 2009 and McKinsey Global Institute.

***The cost of same-day surgery is high and growing rapidly…***

The stand-out difference in spending in the United States compared with other OECD countries is in elective interventions on a same day basis. These accounted for a quarter of the growth in US health spending between 2003 and 2006, compared with just 4% of the growth in Canadian spending. Such services are an important innovation in health care delivery, often being preferred, when possible, by patients to staying overnight in a hospital. Estimates of spending on same-day surgery performed by independent physicians for 2003 and 2006 suggest that this has been the fastest growing area of health care over this period (Mckinsey Global Institute, 2008).

***…as, to a lesser extent, is spending on pharmaceuticals.***

Pharmaceutical spending per capita is higher in the United States than in other OECD countries. Spending on prescription drugs has grown much more rapidly than total health spending, although the pace has slowed recently. In this, patterns in the United States are similar to those throughout the developed world.

***Administrative costs are high.***

Administration of the US health system is expensive: the 7% share of total spending going on administration is twice the average of OECD countries. This is on a par with a few other systems such as France, Germany and Belgium which also have multipayer systems (even if in some of them there is no or little competition across payers). In comparison, Canada and Japan devote around 2-4% of total health spending on administration.

The pace of growth in administrative spending in the US has slowed in recent years, but is high in part because of lack of investment in health ICTs. New OECD analysis shows that such investments will help – eventually – to reduce costs. Up to now, use of ICT in the US health sector has been little short of woeful in comparison with the best performing countries. Australia, the Netherlands, New Zealand, the UK and the Nordic countries have near-universal use of electronic health records (EHR) by GPs which, along with the potential benefits for quality of care, also reduces administrative costs.

## 3 Expenditure = Price times Quantity: which one explains high US health spending?

Logically, health expenditure must equal the amount of health services multiplied by the price of these services. This is true both in general and for each sub-category of expenditure (in-patient, pharmaceuticals, and so on). If the US spends more on same-day surgery than other countries, this must be either because there is more such surgery, or it is more expensive, or some combination of the two.

***Evidence suggests health* prices *are higher in the United States than elsewhere.***

The OECD collects information on the prices of health goods and services (OECD, 2007). In 2005 (the most recent data; new data for 2008 are currently being processed) health price levels in the United States were around 25% higher than the OECD average. Health prices in Japan, in contrast, were 25% below the average. In itself, after taking into account some other adjustment to reflect general price levels in an economy, this difference in health price levels would explain at least half of the differences in spending

between the United States and the rest of the developed world. However, as will be discussed below, there is good reason to think that prices in the United States are underestimated, and the real difference in prices is even larger.

***Pharmaceutical prices are 30-50% higher than in the rest of the OECD…***

The average price of 181 pharmaceutical drugs in the United States in 2005 was 30% higher than the average in other OECD. Other studies (e.g. Mckinsey Global Institute, 2008) suggest that this is an underestimate, and the true difference in price is as much as 50%. Most studies find that prices of *generic* drugs were cheaper in the United States (and indeed use of generics is higher in the US than in most countries), so all of this difference in prices between the US and elsewhere is due to very high prices of branded drugs.

***…and hospital services are particularly expensive.***

An OECD study (OECD, 2007) found that prices in US hospitals in 2005 were higher than in other OECD countries. But again, it seems that the real difference in costs was underestimated. A more detailed study is currently underway at the OECD, and preliminary results from this work shows US price levels of hospital services to be nearly twice as high as the average of 12 other countries (the old 2005 study suggested that prices were about 40% higher than in the same 12 countries).

***Physicians are paid significantly more than in other countries.***

The same may be true of the 'price' of physicians. Remuneration of US GPs exceeds those of doctors in other countries (being $25,000 to $40,000 more than in UK, Germany and Canada, and $60,000 more than in France, though the data is old, coming from 2003-5). The gap was even larger for specialists (Fujusawa and Lafortune, 2008). Income levels reflect both fees and activity – physicians are often remunerated on a fee-for-service basis, so the high rates of income of US doctors might reflect both higher fees and higher activity than in other countries. On balance, however, it seems likely that at least some part of the high rates of remuneration are due to high prices rather than to high volume of activity.

***'Prices' are not the <u>whole</u> story, however.***

There is convincing evidence that prices of health goods and services are high in the United States. But high prices are not a sufficient explanation of differences between the United States and the rest of the OECD. The United States has fewer 'inputs' in some areas of health care than in other countries, but more in others (further country details are found in Annex 1 to this note).

***There are fewer doctors and hospital beds than in other countries.***

Fewer people are admitted to hospitals and the average length of stay is lower than the OECD average. There are few hospital beds for acute care (Table 1). All these suggest that the hospital sector is not being overused, at least compared to other OECD countries. Furthermore, the United States has significantly fewer practising physicians in relation to the size of its population than in other countries, and the population is nearly 30% less likely to have a doctor consultation than on average in the OECD.

**Table 1: Where the United States health system does LESS than other countries**

| | *United States* | *Rank compared with OECD countries* | *OECD average* |
|---|---|---|---|
| Practising physicians | 2.4 per 1000 population | 23rd | 3.1 per 1000 population |
| Doctor consultations | 3.8 per capita | 26th | 6.8 per capita |
| Acute care hospital beds | 2.7 per 1000 population | 23rd | 3.8 per 1000 population |
| Hospital discharges | 126.3 per 1000 population | 22nd | 157.8 per1000 population |
| Average length of stay for acute care | 5.5 days | 22nd | 6.5 days |

Source: OECD Health Data 2009.

***There is heavy use of some surgical procedures in the United States...***

However, although there are fewer visits to doctors and fewer people staying in hospitals, once in the medical system there is evidence of higher rates of activity in the United States than elsewhere. Some surgical procedures are more widely used in the United States than elsewhere (Table 2) – caesarean sections are nearly 25% more common, knee replacements 50% more common and revascularisation procedures twice as common as on average.

**Table 2: Where the United States does MORE than other countries**

| | *United States* | *Rank compared with OECD countries* | *OECD average* |
|---|---|---|---|
| Revascularisation procedures | 521.3 per 100,000 population | 3rd | 266.7 per 100,000 population |
| Knee replacements | 183.1 per 100,000 population | 2nd | 117.9 per 1000,000 population |
| Caesarean sections | 31.1 per 100 live births | 4th | 25.7 per 100 live births |
| MRI units | 25.9 per million population | 2nd | 11.0 per million population |
| MRI exams | 91.2 per 1000 population | 1st | 41.3 per 1000 population |
| CT Scanners | 34.3 per million population | 5th | 22.8 per million population |
| CT exams | 227.8 per 1000 population | 1st | 110.7 per 1000 population |

Source: OECD Health Data 2009.

In 2006, the rate of ambulatory surgery procedures in the United States was more than three times greater than the average in OECD countries. For procedures such as tonsillectomy which involve physician judgment, the rate of day surgeries is four times greater than the OECD average (it is two-and-a-half times greater than in Canada and 33% greater than the second highest country, the Netherlands). The United States is also leading by a wide margin all other OECD countries in the rate of cataract surgery performed on a same-day basis in hospitals or in ambulatory centers. Over the past decade, the growing number of day surgeries in the United States was driven mainly by the growth in activity in ambulatory surgery centers. The rate of visits to ambulatory surgery centers tripled between 1996 and 2006, while the rate in hospital-based centers was flat (NCHS, 2009).

***...and of some of the more expensive diagnostic tests.***

Another component of outpatient care costs that has grown rapidly in the United States in recent years is the cost related to diagnostic tests, such as medical resonance imaging (MRI) scans and computed tomography (CT) scans. Billions of dollars are now spent each year on such tests in the United States. Comparable data on the number of MRI and CT exams are available for only 10 other OECD countries beside the United States. Based on these available data, the number of MRI and CT exams per capita are much greater in the United States than in any of these other countries, and are over twice as high as the OECD average. This is linked to a growing supply of this equipment in the United States, which has among the highest number of MRI units and CT scanners after Japan.

Some studies have attempted to assess the medical benefits of the substantial increase in MRI and CT exams in the United States but found no conclusive evidence (Baker et al., 2008). To the extent that there may be financial incentives for doctors to prescribe such exams, this increases the likelihood of over-prescription and overuse. Similarly with the surgical procedures mentioned above: the OECD has no evidence on whether these procedures are necessary or not. The Dartmouth Atlas of Health Care has shown that there are important *regional* variations in surgical procedures such as revascularisation and knee replacement within the United States, and these variations cannot be explained simply by differences in need. This provides indication on the possible overuse of certain interventions in different parts of the country (Dartmouth Atlas of Health care, 2005). In terms of explaining the differences between US health spending and spending in other OECD countries, the central fact remains that extra volume means extra cost.

## 4. Conclusion

The United States spends much more on health than any other OECD country on a per capita basis and as a share of GDP. This higher expenditure can only be partly explained by the high income level of US citizens. The extra $750bn that America spends on health more than expected is not due to greater 'need' due to aging or sickness.

The biggest difference in spending by category is in out-patient care. Within this, it is day surgery that has seen the most rapid growth in spending. But although out-patient spending is a particularly striking difference between the United States and other OECD countries, health spending per capita on in-patient care, administration, medical goods (including pharmaceuticals) and investment is also higher than in any other country, and spending per capita on long-term care and prevention policies is high.

Higher spending than in other countries is due either to higher prices for medical goods and services or to higher service use. Unfortunately, existing comparisons of health prices across countries are of poor quality. Nevertheless, all evidence suggests that prices of health goods and services are significantly higher in the United States than in most OECD countries, and that this is the main cause of high overall health spending. Health service use is high in some areas, particularly those which are funded on a fee-for-service basis, including some advanced diagnostic techniques and elective surgery. But it is notable that where there are payment structures that encourage cost-consciousness, the United States has a very efficient system: there are few physicians and hospital beds, and average length of stay in hospital is low. This is a sign that the structure of the health system determines expenditures.

Overall, health outcomes are below average in the United States, but this is due, at least in part, to factors outside the health system. The United States stands out as performing very well in the area of cancer care, achieving higher rates of screening and survival from different types of cancer than most other OECD countries. At the same time, many other countries, such as the United Kingdom and Canada, are doing much better than the United States in providing good primary care to their population, thereby reducing the need for costly hospital care for chronic conditions such as asthma or complications from diabetes which should normally be managed outside hospitals.

The US has an exceptionally complex system. It is a system which introduces new technology rapidly – at a price. It delivers (in some areas at least) high quality of care, together with greater innovation and choice than in most other OECD systems. But it is not a system set up to bend the cost curve, unlike many other OECD countries. This is one of the major reasons why costs are high: the US system leaves patients largely indifferent to the price eventually charged for a medical good or service. Those who have insurance know that their costs will be covered. Physicians know this, and furthermore have an incentive to offer services as they are, largely, paid on a fee-for-service. In addition, 'defensive medicine' due to the threat of litigation, gives a further reason why physicians might suggest an additional diagnostic test, even if the medical benefits are likely to be limited, and the costs of malpractice insurance pushes up the prices that doctors charge. Because of the high degree of choice, it is difficult to constrain costs because people can opt-out of the more regulated system.

The US has the highest rate of use of many new technologies such as CT scans and MRIs of any OECD country. New technology is likely to be more expensive than cheaper – almost uniquely, throughout all sectors of the economy – because no person or body is concerned with the overall cost level. Combined with other reasons, including the administrative costs inevitable in a multi-stakeholder system, far more complex than existing in any other OECD country, and the result is high prices, high volumes of some activities, and high expenditures.

All other OECD countries have more mechanisms built into their health systems to restrict expenditures than is the case in the United States, even though most if not all people in these other countries are covered by health insurance. This is done either by regulating quantities or prices or both, including the dissemination of new technologies, or by requiring a greater proportion of costs out of pocket (as is the case in the United States for long-term care spending, an area where, no doubt as a result, total spending is relatively low). Regulating the price of inputs – doctors' fees, hospital payments, pharmaceutical prices and so on – is one way of constraining prices. Controlling volume often requires measures that restrict choice; occasionally limit access to care which someone insured under a typical US health plan would be able to access, or expose people to the risk of catastrophically high out-of-pocket payments unless a safety net is in place. By paying such a price, the result is that other countries are able to afford universal health care access at a lower cost than in the United States.

## Bibliography

Dartmouth Atlas of Health Care (2005), *Studies of Surgical Variation, Cardiac Surgery Report*, www.dartmouthatlas.org/index.shtm.

Fujisawa, R. and Lafortune, G. (2008) 'The Remuneration of General Practitioners and Specialists in 14 OECD countries: What are the factors explaining variations across countries?' OECD Health Working Paper no. 41.

Mckinsey Global Institute (2008), *Accounting for the cost of US health care: A new look at why Americans spend more*, December 2008.

NCHS (2009), *Ambulatory Surgery in the United States, 2006*, National Health Statistics Reports, No. 11, January 28, 2009.

OECD (2000), A *System of Health Accounts.* OECD, Paris. See www.oecd.org/health/sha.

OECD (2007): *PPPs and Real Expenditures, 2005 Benchmark Year (2007 Edition)*, OECD, Paris.

OECD (2008), *Pharmaceutical Pricing Policies in a Global Market*, OECD, Paris.

OECD (2009), *OECD Health Data 2009 – Statistics and Indicators for 30 countries*, online and on CD-Rom, Paris. See www.oecd.org/health/healthdata.

OECD (2009a), *Health at a Glance 200 – OECD Indicators*, Paris. See www.oecd.org/health/healthataglance.

For more OECD work on Health issues, please visit www.oecd.org/health.

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# Annex: Additional Data

**Annex Table 1. Health care capacity and utilisation**
**Examples of United States below OECD average (2007 or latest year available)**

| | Practicing physicians<br>per 1 000 population | Doctor consultations<br>per capita | Hospital beds for acute care<br>per 1 000 population | Hospital discharges<br>per 1 000 population | ALOS for acute care<br>Days |
|---|---|---|---|---|---|
| Australia | 2.8 | 6.3 | 3.5 | 162.4 | 5.9 |
| Austria | 3.8 | 6.7 | 6.1 | 277.7 | 5.7 |
| Belgium | 4.0 | 7.6 | 4.3 | 173.7 | 7.2 |
| Canada | 2.2 | 5.8 | 2.7 | 84.3 | 7.3 |
| Czech Republic | 3.6 | 12.6 | 5.2 | 203.1 | 7.7 |
| Denmark | 3.2 | 7.5 | 2.9 | 169.8 | 3.5 |
| Finland | 3.0 | 4.2 | 3.7 | 190.1 | 4.6 |
| France | 3.4 | 6.3 | 3.6 | 273.8 | 5.3 |
| Germany | 3.5 | 7.5 | 5.7 | 226.9 | 7.8 |
| Greece | 5.4 | .. | 3.9 | 187.9 | 5.6 |
| Hungary | 2.8 | 10.8 | 4.1 | 189.2 | 6.0 |
| Iceland | 3.7 | 6.5 | .. | 156.2 | 5.5 |
| Ireland | 3.0 | .. | 2.7 | 138.0 | 5.9 |
| Italy | 3.7 | 7.0 | 3.1 | 138.9 | 6.7 |
| Japan | 2.1 | 13.6 | 8.2 | 105.5 | 19.0 |
| Korea | 1.7 | 11.8 | 7.1 | 132.2 | .. |
| Luxembourg | 2.9 | 6.1 | 4.4 | 166.0 | 7.3 |
| Mexico | 2.0 | 2.5 | 1.0 | 55.3 | 3.9 |
| Netherlands | 3.9 | 5.7 | 3.0 | 109.3 | 6.6 |
| New Zealand | 2.3 | 4.7 | .. | 134.8 | 5.9 |
| Norway | 3.9 | .. | 2.9 | 172.4 | 5.0 |
| Poland | 2.2 | 6.8 | 4.6 | 194.3 | 5.9 |
| Portugal | 3.5 | 4.1 | 2.8 | 108.0 | 6.8 |
| Slovak Republic | 3.1 | 11.2 | 4.9 | 190.9 | 7.0 |
| Spain | 3.7 | 8.1 | 2.5 | 106.6 | 6.6 |
| Sweden | 3.6 | 2.8 | 2.1 | 164.8 | 4.5 |
| Switzerland | 3.9 | 4.0 | 3.5 | 166.4 | 7.8 |
| Turkey | 1.5 | 5.6 | 2.7 | 104.9 | 4.4 |
| United Kingdom | 2.5 | 5.0 | 2.6 | 125.5 | 7.2 |
| **United States** | **2.4** | **3.8** | **2.7** | **126.3** | **5.5** |
| **OECD average** | **3.1** | **6.8** | **3.8** | **157.8** | **6.5** |

Source: *OECD Health Data 2009.*

**Annex Table 2. Health care capacity and utilisation**
**Examples of United States above OECD average (2007 or latest year available)**

| | Diagnostic procedures | | | | Surgical procedures | | |
|---|---|---|---|---|---|---|---|
| | MRI units | MRI exams | CT Scanners | CT exams | Revasculari-sation proc. (CABG+PTCA) | Knee replacement | Caesarean section |
| | per million population | per 1 000 population | per million population | per 1 000 population | per 100 000 population | per 100 000 population | per 100 live births |
| Australia | 5.1 [a] | 20.2 [d] | 56.0 | 88.6 [d] | 242.0 | 148.8 | 30.3 |
| Austria | 17.7 | .. | 29.8 | .. | .. | 187.0 | 24.4 |
| Belgium | 7.5 | 48.0 | 41.6 | 167.7 | 570.5 | 159.2 | 17.8 |
| Canada | 6.7 | 31.2 | 12.7 | 103.5 | 208.6 | 139.5 | 26.3 |
| Czech R | 4.4 | 24.5 | 12.9 | 75.1 | 308.5 | .. | 19.6 |
| Denmark | 10.2 | .. | 17.4 | .. | 260.9 | 105.8 | 21.4 |
| Finland | 15.3 | .. | 16.4 | .. | 194.3 | 171.1 | 16.0 |
| France | 5.7 [b] | 21.8 [d] | 10.3 [b] | 45.1 [d] | 224.2 | 113.2 | 20.8 |
| Germany | 8.2 [b] | .. | 16.3 [b] | .. | 682.1 | 194.0 | 28.5 |
| Greece | 13.2 | .. | 25.8 | .. | .. | .. | .. |
| Hungary | 2.8 | 27.9 | 7.3 | 58.8 | 191.7 | 41.9 | 30.8 |
| Iceland | 19.3 | 64.7 | 32.1 | 144.8 | 272.3 | 106.6 | 16.9 |
| Ireland | 8.5 | .. | 14.3 | .. | 127.5 | 44.2 | 24.6 |
| Italy | 18.6 | .. | 30.3 | .. | 455.9 | 89.6 | 39.7 |
| Japan | 40.1 | .. | 92.6 | .. | .. | .. | .. |
| Korea | 16.0 | .. | 37.1 | .. | .. | 78.9 | 32.0 |
| Lux. | 10.5 | 63.3 | 27.3 | 176.9 | 205.8 | 156.0 | 29.2 |
| Mexico | 1.5 | .. | 4.0 | .. | 5.0 | 3.2 | 39.9 |
| Neth. | 6.6 [c] | .. | 8.4 [c] | .. | 198.5 | 119.4 | 14.0 |
| NZ | 8.8 | .. | 12.3 | .. | 185.4 | 96.9 | 22.8 |
| Norway | .. | .. | .. | .. | 330.9 | .. | 15.9 |
| Poland | 2.7 | .. | 9.7 | .. | 282.4 | .. | 20.6 |
| Portugal | 8.9 | .. | 26.0 | .. | 143.4 | 46.4 | 31.2 |
| Slovak R | 5.7 | .. | 13.7 | .. | .. | .. | 23.5 |
| Spain | 9.3 [b] | 32.9 | 14.6 [b] | 70.2 | 282.2 | 101.8 | 26.0 |
| Sweden | .. | .. | .. | .. | 226.5 | 110.1 | .. |
| Switz | 14.4 | .. | 18.7 | .. | 144.1 | 178.2 | 30.0 |
| Turkey | 5.6 | .. | 8.1 | .. | .. | .. | 36.0 |
| UK | 8.2 | 28.8 | 7.6 | 59.1 | 136.2 | 136.8 | 25.8 |
| **US** | **25.9** | **91.2** | **34.3** | **227.8** | **521.3** | **183.1** | **31.1** |
| **average** | **11.0** | **41.3** | **22.8** | **110.7** | **266.7** | **117.9** | **25.7** |

*Source: OECD Health Data 2009.*

*Notes:*

a. Only MRI units eligible for reimbursement under Medicare.

b. Only include equipment in hospitals (and a small number of equipment outside hospitals in France).

c. Only include the number of hospitals reporting to have at least one item of equipment.

d. Only include exams for out-patients and private in-patients (excluding exams in public hospitals).

Annex Table 3: **Expenditure per capita on different health care aggregates in US$PPPs**

| 2007 | In-patient care | Out-patient[a] care | LTC/ Home-care | Medical[b] goods | Prevention and Public Health | Admin & Insurance | Investment | Total expenditure on health |
|---|---|---|---|---|---|---|---|---|
| Australia | 1092 | 1176 | 16[c] | 535 | 51 | 86 | 181 | 3137 |
| Austria | 1276 | 986 | 474 | 643 | 69 | 133 | 182 | 3763 |
| Belgium | 969 | 811 | 639 | 609 | 140 | 294 | 133 | 3595 |
| Canada | 604 | 1325 | 562 | 793 | 270 | 140 | 201 | 3895 |
| Czech R. | 486 | 501 | 64 | 408 | 36 | 53 | 79 | 1626 |
| Denmark | 1007 | 1103 | 718 | 445 | 49 | 41 | 150 | 3512 |
| Finland | 756 | 883 | 343 | 476 | 154 | 62 | 164 | 2840 |
| France | 1051 | 1008 | 379 | 741 | 70 | 247 | 105 | 3601 |
| Germany | 965 | 996 | 487 | 699 | 127 | 191 | 125 | 3588 |
| Hungary | 372 | 355 | 44 | 485 | 56 | 17 | 59 | 1388 |
| Iceland | 842 | 1186 | 654 | 517 | 54 | 65 | -[d] | 3319 |
| Japan (2006) | 593 | 863 | 407 | 549 | 60 | 61 | 49 | 2581 |
| Korea | 444 | 572 | 28 | 446 | 32 | 63 | 104 | 1688 |
| Lux (2006) | 1147 | 1234 | 706 | 438 | 44 | 381 | 70 | 4021 |
| New Zealand | 651 | 823 | 418 | 303 | 124 | 191 | -[d] | 2510 |
| Norway | 1244 | 1324 | 1184 | 584 | 90 | 38 | 300 | 4763 |
| Poland | 306 | 263 | 77 | 280 | 23 | 20 | 65 | 1035 |
| Portugal (2006) | 431 | 983 | 71 | 508 | 39 | 25 | 94 | 2150 |
| Slovak R | 332 | 453 | 8 | 556 | 73 | 57 | 76 | 1555 |
| Spain | 582 | 999 | 230 | 620 | 62 | 86 | 92 | 2671 |
| Sweden | 857 | 1319 | 267 | 545 | 115 | 52 | 169 | 3323 |
| Switzerland | 1268 | 1431 | 857 | 540 | 102 | 220 | -[d] | 4417 |
| **US** | **1413** | **3188** | **631** | **959** | **249** | **516** | **334** | **7290** |
| **OECD (22)** | **813** | **1034** | **420** | **551** | **91** | **132** | **137** | **3142**[e] |

[a] Out-patient care covers both hospital and non-hospital settings. Also includes same-day care and ancillary services.
[b] Covers pharmaceuticals (and other non-durables) and durable goods.
[c] Australia uses a narrower definition of LTC.
[d] No separate estimates of investment are available.
[e] It is not possible to include the breakdown of expenditures for 8 OECD countries, so the average of these 22 countries is different from that quoted in the text for all 30 OECD countries.

*Source: OECD Health Data 2009*

## Annex 2: A brief explanatory note on PPPs

International comparisons of expenditure on health use *economy-wide* (GDP) Purchasing Power Parities (PPPs) to compare spending across countries. The more expensive are general prices in a country, the less is the real value of what they spend, so the lower is the dollar value of their health spending, and this is what is shown in charts 1-3 and 8 and 9. Such comparisons can be interpreted as showing what else you could buy, if you did not spend the money on health. To calculate PPPs, information on the prices in different countries of a huge range of goods and services are collected, including in the area of health.

Chart A1 compares the price levels for health and GDP across a selected number of countries for 2005 (latest data available). If a bar goes to the left of the middle line, prices are cheaper than the OECD average, and more expensive if they go to the right. This chart shows that health price levels in United States are 25% higher than the OECD average. Across the economy as a whole, prices are cheaper in the United States than in the OECD. In contrast, economy-wide prices in Japan are high, but prices of health goods and services are particularly low. As noted in the text, there is reason to think that these estimates are not as reliable as they should be, and further work is underway to improve them. Using them for analysis therefore must come with a large public health warning. However, they do illustrate the importance of differences in prices in explaining different levels of health spending.

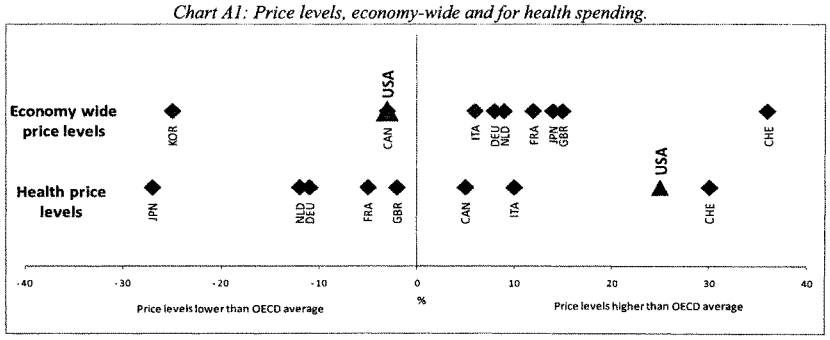
If, for whatever reason, the price of health services is either higher or lower (relative to other countries) than the level of economy-wide prices, this can 'explain' differences in the proportion of total income which is devoted to health. For example, although Japan only spends 8.1% of GDP on health, this buys a lot of health services because they are very cheap, relative to other goods and services. In contrast, the United States spends nearly twice as much as a percentage of GDP, but health prices are particularly high relative to other goods and services. If these prices differences are taken into account, much of the differences in health spending across countries are explained – see the Box below. For more details, see OECD (2007).

**Box: Using PPPs to explain expenditure differences across countries**

On average the US spent $7290 per person on healthcare in 2007, while France spent €3279 per person. The PPP work shows that 0.91 euros were equivalent to a dollar, so French spending was $3601 per person, as shown in chart 2.

However, French health prices were 76% of those in the United States in 2005. The exchange rate was 0.8 euros per dollar, so only 76% of 0.8 euros (=0.61 euros) were necessary to buy the same basket of health goods and services in France that $1 would buy in the United States. Therefore, if French patients had paid the same healthcare prices as in the US, each French resident would actually have spent €3279/0.61 = $5365.

*Chart A1: Price levels, economy-wide and for health spending.*



The CHAIRMAN. Thank you very much, Mr. Pearson.
Doctor Bennett.

**STATEMENT OF HON. CAROLYN BENNETT, OFFICIAL LIBERAL OPPOSITION CRITIC FOR HEALTH AND FORMER CANADIAN MINISTER OF STATE (PUBLIC HEALTH), OTTAWA, ONTARIO, CANADA**

Dr. BENNETT. I speak to you this morning from the perspective of a mother, a daughter, a doctor, the former Minister of Public Health, and an author of—about primary care in Canada.

Like other observers in our country, I believe the debate here in the United States has become less about debate about healthcare than about the role of government in your lives. But, for American families, the real question is a simple one, Should a man go bankrupt because his child gets leukemia? Should a woman hit by a drunk driver have to pay more for healthcare than those lucky enough to escape such an injury? Is it fair to make family genetically predisposed to cancer pay greater share of their health costs, to deny treatment to children with asthma or diabetes because their parents are poor?

As a family doctor in Canada, I almost never had to worry about what patients could or couldn't afford, or what level of insurance they had. You have asked me to focus today on the issue of costs and quality in comparing our systems. As Chairman Kohl has said, in 2007 the United States spent 16.2 percent of its GDP on healthcare; Canada spent 10.6 percent. That works out to $7,421 per American and $5,170 per Canadian. For that extra $2,200 per person per year, your health outcome should beat ours every time. But, they don't. Your infant mortality rate is 6.9 per 1,000 births, compared to 5.4 in Canada. Male life expectancy is 75.2 years here, compared to 78 years in Canada.

Please don't misunderstand me, our system is far from perfect. It still needs constant tinkering, and we're still struggling to realize the original goal of Canadian Medicare, which is to keep people well, not just patch them up once they get sick. As Senator Franken has said, we also are struggling to take the perverse incentives out of our system that reward quantity instead of quality.

In a survey of the ten OECD countries, your citizens are the least satisfied with the care they receive. Canadians, despite their criticisms we have of our own system, are apparently five times as likely to be satisfied with the care we receive than you are. Costs, as you've pointed out, are an integral part of the differences between the U.S. system and ours.

So, I have seven clear reasons why I think we pay less and feel better:

Insurance companies. As Congressman Weiner has said, 30 percent of your cost, almost a third, go to insurance companies. Your patients and taxpayers have to support massive organizations, the insurers, that set the premiums, design packages, asses risk, review claims, decide who to reimburse and for how much. But, they don't deliver healthcare. The administration, as Mr. Pearson has said, is much simpler in our country. Our single-payer system allows us to run the administration in our offices and our hospitals with much fewer staff. We don't have to deal with multiple payers

or chase bad debts. We don't have to charge higher fees to compensate for the unpaid-for procedures.

As was said, the pharmaceutical prices are very different in our country. Although drug costs are rising in Canada, as here, we're able to exercise much more control over the cost of brand-name drugs, as a result of our Patented Medicine Prices Review Board, and we also have a process for establishing the cost—its cost effectiveness of all new technologies.

In our country, almost all physicians receive medical liability protection from the not-for-profit Canadian Medical Protective Association. Its not-for-profit status, combined with its educational efforts to reduce the risk profile of its members, contributes to relatively low medical malpractice costs. This both reduces overall system costs and encourages physicians to provide the full spectrum of medical care.

Evidenced-based care is, again, what we are hoping to reward. But, from vaginal births after caesarean sections, to lumpectomy, to X-rays for sprained ankles, applying evidence to determine the appropriateness of tests and procedures translates into fewer unnecessary tests and procedures and less defensive medicine. We are committed to moving from the era of pure cost-containment approach of the early 1990's into a true evidenced-based cost-effective care in the future.

As was said before, prevention is extremely important, as are the social determinants of health. Diseases are cheaper to treat if they're caught early. Since all Canadians are insured, they're more likely to have pap smears, mammograms, and other early detection visits and tests than the U.S. patients who are not covered.

My last point is about the longstanding specialty in Canada family medicine. Family doctors in Canada are trained to help outpatients navigate their care. We interpret the difference between what patients think they want and what they actually need. It's a point of first contact, a trusted coach to explain the evidence and the choices. As Dr. Barbara Starfield has shown with her research here in the United States, the stronger the family medicine base in any healthcare system, the better the system is.

But, don't take my word for it. Harvard Dr. David Himmelstein wrote, recently in the New England Journal of Medicine, that, "A Canadian single-payer system would save your country $400 billion a year."

In conclusion, I want to leave you with the story of Barry Lamar Head, a Vietnam-decorated vet who married a Canadian, got sick, and had to remain in Canada because he could not get health insurance in the—in your country, at any price. Before he died, he made his Toronto friends promise that they would find a way to tell his story, the story of a hero who had served his country honorably, but could not afford to die there, and the excellent care that he received in the Canadian system. I am proud to leave you with a copy of his full story this morning, and also a document on myths versus reality on the Canadian healthcare system, that I hope you will read.

Thanks very, very much. I look forward to your questions.

[The prepared statement of Dr. Bennett follows:]

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

**Carolyn Bennett** MD

*Member of Parliament / députée – St. Paul's*

**REMARKS TO THE U.S. SPECIAL SENATE COMMITTEE ON AGING**

**Dr. Carolyn Bennett, Member of Parliament**
**Official Opposition Critic for Health**
**September 30, 2009**

I speak to you from the perspective of a mother, daughter, doctor, former Minister of Public Health, and author of a book about primary care in Canada.

Like other observers, I believe that the debate here in the US has become less about health care than about the role of government in your lives.

But for American families, the real question is a simple one: should a man go bankrupt because his child gets leukemia?

Should a woman hit by a drunk driver have to pay more for health care than those lucky enough to escape such injury?

Is it fair to make a family genetically predisposed to cancer pay a greater share of their health costs? ... To deny treatment to children with asthma or diabetes because their parents are poor?

As a family doctor in Canada, I almost never had to worry about what patients could or couldn't afford, or what level of insurance they had.

You have asked me to focus today on the issue of costs and quality in comparing our systems.

In 2007 the US spent 16.2% of its GDP on Health care.... Canada spent 10.6%.

That works out to $7,421 per American and $5,170 per Canadian.

For that extra $2,200 per person per year, your health outcomes should beat ours every time. But they don't.

Your infant mortality rate is 6.9 per 1,000 births compared to 5.4 in Canada. Male life expectancy is 75.2 years here, compared to 78 years in Canada.

Please don't misunderstand me: our system is far from perfect. It needs constant tinkering and we're still struggling to realize Canadian Medicare's original goal: to keep people well, not just patch them up once they get sick.

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And yet for all our system's faults, studies show that on average, Canadians are more likely than Americans to receive needed care quickly. Canadians get more physician visits per capita than Americans... more immunizations, more hospital admissions, and more surgical procedures.

It's not surprising then, that in a survey of 10 OECD countries; your citizens are the least satisfied with the care they receive. Canadians, despite the criticisms we have of our own system, are apparently five times as likely to be satisfied with the health care we receive than you are.

Costs are an integral part of the difference between us. Let me share 7 clear reasons for why we pay less and feel better:

1. INSURANCE COMPANIES: 30% of your costs – almost a third – go to insurance companies. Your patients and taxpayers have to support massive organizations. These insurers set premiums, design packages, assess risk, review claims and decide who to reimburse for how much. But they don't deliver health care.

2. ADMINISTRATION: Our single payer system is simpler, allowing us to run the administration of our offices and hospitals with much fewer staff – about 4%. We don't have to deal with multiple payers, or chase bad debts. We don't have to charge higher fees to compensate for unpaid for procedures

3. PHARMACEUTICAL PRICE CONTROLS: Although drug costs are rising in Canada as here, we're able to exercise more control over the cost of drugs as a result of our Patented Medicine Prices Review Board.

4. MALPRACTICE INSURANCE: Almost all Canadian physicians receive medical liability protection from the not-for-profit Canadian Medical Protective Association. Its not-for-profit status, combined with its educational efforts to reduce the risk profile of its members, contributes to relatively low medical malpractice costs. This both reduces overall system costs and encourages physicians to provide the full spectrum of medical care.

5. EVIDENCE-BASED CARE: From vaginal births after C-sections to, lumpectomy, to x-rays for sprained ankles, applying evidence to determine the appropriateness of tests and procedures translates into fewer unnecessary tests and procedures and less defensive medicine. We are committed to moving from the error of pure cost-containment approach of the early 90s into true evidence-based cost effective care.

6. PREVENTION: Diseases are cheaper to treat if they're caught early, and since all Canadians are insured, they're more likely to have pap smears, mammograms and other early detection visits and tests, than US patients who are not covered.

7. FAMILY MEDICINE: A long-standing speciality in Canada, family doctors are trained to help patients navigate their care; we interpret the difference between what patients think they `want`, and what they actually `need` . A point of first contact, a trusted coach to explain the evidence and the choices.

But don't take my word for it. Harvard doctor David Himmlestein wrote recently in the NEJM that a Canadian style-single payer system would save your country 400 billion dollars a year.

In conclusion, I want to leave you with the story of Barry Lamar Head, a Vietnam decorated vet, who married a Canadian, got sick and had to remain in Canada because he could not get health insurance in the US at any price. Before he died, he made his Toronto friends promise that they would find a way to tell his story, the story of a hero who had served his country well, but could not afford to die there and the excellent care he received in the Canadian system. I am proud to leave you with a copy of his full story this morning.

Thank you and I look forward to your questions.

The CHAIRMAN. Thank you very much, Dr. Bennett.
Dr. Schoen.

**STATEMENT OF CATHY SCHOEN, SENIOR VICE PRESIDENT FOR RESEARCH AND EVALUATION, THE COMMONWEALTH FUND, NEW YORK, NY**

Ms. SCHOEN. Thank you, Mr. Chairman and members of the committee, for the invitation to testify.

As the United States confronts the urgent need for Federal action to expand access and slow the increase in costs, we might well ask, How is it that other countries insure everyone, get outcomes that often rival or even exceed the United States, yet spend far less than we do?

We stand out, when we look at other countries, for our failure to cover everyone, our complex, inefficient insurance system, our fragmented healthcare system, with very weak primary care, lack of information that's an essential for markets to work, and incentives to increase volume, irrespective of quality.

I want to focus right in on the strategies we see other countries using. They all do it differently. They've adopted it to their own institutions and policies. But, there're some core themes and strategies where we stand out in comparison to them.

First, when we look at the payment systems in these other countries, it's clear, as we just heard from the OECD testimony, that the U.S. spends more. We're notable for paying higher prices, including very high prices for more specialized care and for incentives to do more, irrespective of value.

Unlike other countries with multiple payers—and there are several: Switzerland, Germany and the Netherlands—we lack a mechanism to coordinate those payers so they have a consistent set of price signals and they all move in the same direction. We lack a mechanism for group purchasing power, particularly in monopolized markets. Instead, U.S. private insurers often act as pricetakers to maintain networks, and they simply pass through higher prices, with a markup for marketing administrative costs and margins.

As a result, the U.S. tends to pay much higher prices for devices and specialized services, such as prescription drugs. A McKinsey study estimates that we pay, on average, about 50 percent more for brand-name drugs, and buy more expensive mix, which results in $90 billion in excess cost, compared to what other countries do.

Second, we have a very weak primary care system. Overall, we stand out for having an insurance system that does not promote continuity, and does not promote choice of primary care providers. Many countries encourage all their patients to identify a medical home, which is their main source of care, helps coordinate, stays with the patient for a lifetime, unless they move away. They've set up after-hour cooperatives; you don't have to go to the emergency room. You can talk to a doctor. Doctors are rewarded for talking to patients, including on the phone. Fundamentally, their insurance systems have a value-based benefit design which rewards effective, efficient care. They lower cost-sharing if they know a drug works very well, even if it's a high-priced drug. They want people to enforce chronic-care management.

Recent—other countries recently have adopted incentives particularly targeted at primary care, to strengthen it as all face rising rates of chronic disease. I've provided a range of examples in my testimony. These include direct payments for nonvisits, for talking to patients, for team-based care, for putting patients in a team with nurses.

Third, we have an information deficit. We lack an HIT system that cuts across and binds everyone together. Many other countries have even smaller practices than the United States—onsies and twosies—but they've said, "Let's integrate a flow of information," and they've done it with standardized information systems so that we see nearly all primary care practice having a system, and they're building that up so they can exchange information. Their national governments were supportive of making it possible for everyone to start to communicate with each other.

Fourth, we lack comparative information and transparency. As we just heard from Canada, but there are multiple other countries, there is assessment going on to provide physicians and hospitals and clinicians with independent sources of information on what works well for which patients, but there's also an effort to track performance. I believe Dr. Epstein will talk about some of this, but I can talk more later. In Germany, there's benchmarking, with multiple indicators of hospital performance, and feedback systems, where higher-performing hospitals talk with less-—lower-performing hospitals in a dialog to bring everyone up. There's transparency on public websites that is meant to encourage choice. But, also, people learn from each other when they can see someone else doing well.

As was mentioned, we have a very expensive insurance system with high administrative costs. We often look just at the part that's inside the insurance system. This is due to marketing, underwriting, churning, a variety of benefit designs. But, we've also imposed very high costs on our primary care doctors and our hospitals. You can see administrative staff in our practices that just don't exist in other countries. Instead, the people in the practice are delivering care.

To close, we have much to learn from shared strategies, and there are core strategies that really do span very different countries. They each do it in different way. Insurance for everyone provides a foundation for payment and system reforms. It's not just coverage, but it's also a foundation.

The way they buy care is as a group. They use group purchasing power, coordinated incentives focused on value. There is information system and system reforms that are really trying to guide markets. Markets don't work well if you don't know the price and you don't know what works well for which people. They're building that up. There's leadership to bring all of this together, including in multipayer systems, to bring the payers back together.

We have an opportunity for major change in the United States, and we can look at the variations, and have the benefit of saying, "This works relatively better, relatively worse," as we all seek to move forward.

Thank you.

[The prepared statement of Ms. Schoen follows:]


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

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**Invited Testimony**
**Senate Special Committee on Aging**

**September 30, 2009**

This testimony draws on Commonwealth Fund work authored by Karen Davis and Commonwealth Fund colleagues and benefits from their comments. The research assistance of Kristof Stremikis and Davis Squires and the editorial assistance of Chris Hollander of The Commonwealth Fund are gratefully acknowledged. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

## 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 U.S. from international experiences in reforming their health care systems to improve access, outcomes and value for their populations. As the United States 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, 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 healthcare delivery systems with a weak primary care foundation; lack of information; and for incentives to increase volume irrespective of quality or outcomes. Such concerns are "made in America" – virtually all other high income, advanced industrialized countries have adopted insurance policies that assure coverage for the entire population, access to care, and financial protection, with an emphasis on protecting those vulnerable due to poor health or low incomes. They do so at far lower costs with outcomes that are often comparable or better than those in the U.S.

The U.S. leads the world in health spending with costs projected to continue to rise far faster than incomes over the next decade if trends continue. Health care spending already consumes 17 percent of the nation's resources (gross domestic product) at $2.5 trillion or $7,290 per person – more than twice what other major high income, industrialized countries spend. Health spending as a percent of our Gross Domestic Product will likely reach 21 percent by 2020 if trends continue. Compared to other industrialized countries, we spend about twice as much per person and 50 percent to double the share of national resources (GDP). As a share of resources, we spend 50 percent to twice 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 growth relative to incomes and countries with lower spending such as the U.K. have increased outlays as a matter of deliberate public policy.

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. The key questions confronting U.S. national reforms are how to expand coverage to everyone and slow the growth in healthcare 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, U.S. will need to craft policies and adapt changes that fit our 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.

Five lessons from the international experience stand out:

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

In comparing the U.S. to other countries, in addition to insurance gaps, we are notable for paying higher prices, 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 to achieve coherent price signals or 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 US tends to pay higher prices for specialized services, including prescription drugs – particularly brand name drugs without generic options. A recent McKinsey study found the U.S. pays 50 percent more 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 – amounting to some $98 billion excess spending per year.

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

Overall, the U.S. stands out for a weak primary care foundation with poor care coordination. Most strikingly, other countries have insurance systems that promote

continuity and provide 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 responsible for coordinating specialist care when needed. After-hours cooperatives take over for primary care physicians at nights and weekends.

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. The US relies on market incentives to shape its health care system, yet other countries are more advanced in providing financial incentives to primary care physicians targeted on quality of care. Incentives and targeted support for primary care in other countries include extra payments to add nurses to care teams, payment for email 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 physician and specialists' income, especially compared to the widening gaps in the United States. 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, teams and serving as a "medical home" and fees for visits or incentives for quality.

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

Other countries have invested to spread 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 use of electronic medical records – compared with over nine in ten primary care physicians in the Netherlands, New Zealand, and the U.K. Primary care physicians in other countries also increasingly have an array of functionality, as countries build on capacity. When assessed against 14 different functions of advanced information capacity, one in five US primary care physicians reported having at least 7 out of the 14 functions compared to 60 percent to a high of ninety percent of physicians in the Netherlands, Australia, the U.K and New Zealand . The wide differences reflect national efforts to standardize and promote use, often with financial incentives.

- **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. 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 patient experiences. In both countries, this information is posted on public-websites as well as fed-back to clinicians (Figure 28). The U.K. publishes extensive information on hospital quality and surgical results by hospital and surgeon.

- **Insurance-Related Administrative Costs**

As currently structured, the U.S. insurance system also 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. 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 per year in excess costs.

**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 promote primary care, prevention and effective care of chronic disease,
- System reforms to 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 multi-payer 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. It also can serve as a base for a more rational payment system and incentives that reward value not volume. Coherent prices and payment policies that support effective and efficient care are critical for markets to work, as is 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 as countries seek to meet the health needs of current and future generations.

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 multiple examples of international strategies as well as care systems in the U.S. that achieve high quality/lower cost. We can learn from diverse international experiences as nations innovate to meet current and future needs for accessible, high quality, and efficient care. By enacting national reforms that take strategic steps to put the United States 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.

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

**Cathy Schoen**
**The Commonwealth Fund**

Thank you, Mr. Chairman and members of the Committee, for the invitation to testify regarding insights for the U.S. from international experiences in reforming their health care systems to improve access, outcomes and value for their populations. As the United States 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, 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 healthcare delivery systems with a weak primary care foundation; lack of information; and for incentives to increase volume irrespective of quality 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 that 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 to address the challenge of simultaneously achieving better access, higher quality, and greater efficiency.

## The U.S. Is the Only Major Industrialized Country Without Universal Coverage and Spends Far More Without 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 – their insurance leaves them exposed to high medical care costs compared to their incomes if sick.[4] An estimated 42 percent of all adults under-65 were either uninsured or underinsured in 2007, before the start of the recession. Insurance is

becoming ever-less affordable as premiums have doubled while incomes have stagnated: premiums are up by 108 percent since 2000 compared to a 32 percent increase in worker's wages and 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 business, federal and state/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" – virtually all other high income, advanced industrialized countries have adopted insurance policies that assure coverage for the entire population, access to care, and financial protection, with an emphasis on protecting those vulnerable due to poor health or low incomes. They do so at far lower costs with outcomes that are often comparable or better than those in the U.S.

The U.S. leads the world in health spending with costs projected to continue to rise far faster than incomes over the next decade if trends continue. Health care spending already consumes 17 percent of the nation's resources (gross domestic product) at $2.5 trillion or $7,290 per person. Health spending as a percent of our Gross Domestic Product will likely reach 21 percent by 2020 if trends continue.[6] Compared to other industrialized countries, we spend about twice as much per person and 50 percent to double the share of national resources (GDP) (Figure 3). As a share of resources, we spend 50 percent to twice as much as other countries and the gap has been widening since 1980 – particularly in the past five years.[7] Relatively higher-cost countries such as Germany and Canada have moderated their growth relative to incomes and countries with lower spending such as the U.K. have increased outlays as a matter of deliberate public policy.

With such a high investment, we should expect to lead on health outcome and care experiences. Yet we fall short of reaching achievable benchmarks for access, quality, or 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 onset of disease.[11] Although the U.S. death rates declined by 4 percent over five years (1997–1998 to 2002–2003), 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 healthcare – 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 low by international standards.[13] U.S. adults are also more likely to report medical errors, duplicative tests, and care coordination gaps and to lack rapid access to primary care or care after-hours. The contrasts indicate the U.S. could improve health and 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 twenty 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 or lower than in other countries. At the same time, more of U.S. physicians are specialists and subspecialists. [16] Research both within the US and across countries has shown that health care spending is higher and health outcomes worse when there is a lower ratio of primary care to specialist physicians and weak, less accessible primary care foundation.[17]

The resulting fragmented, highly specialized U.S. 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 increased spending without high 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 our failure to insure everyone, with benefits that assure access and financial protection. Those with insurance increasingly face high cost-sharing or limits that leave 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 costs – a rate far higher than in other countries (Figure 5). And sicker patients in the U.S. are far more likely to report high out

of pocket costs – whether insured or uninsured (Figure 6).[18] Forty-two percent of chronically ill U.S. adults who were insured all years went without needed care because of cost. Among all U.S. adults, 30 percent of insured and 34 percent of the uninsured spent more than $1,000 for the year in 2007 – much higher than any other country. [19]

In addition to the failure to guarantee financial access to care, the organization of care in the US also fails to ensure accessible and coordinated care. The U.S. stands out for patients who report either having no regular doctor or having been with their physician for a short period of time.[20] This in part reflects 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. U.S. job-linked coverage plus managed care plans with restricted networks exacerbate poor continuity of care, as patients may need to change physicians when they change jobs or their employers change coverage.

**Keys to Reform: Lessons from the International Experience**

The key questions confronting U.S. national reforms are 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, U.S. will need to craft policies and adapt changes that fit our 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 comparing the U.S. to other countries, in addition to insurance gaps, we are notable for paying higher prices, 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 to achieve coherent price signals or 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 U.S. higher prices plus a more expensive mix of prescription medications have contributed to rapid increases and higher U.S. spending per person than in other countries over the past decade (Figure 7). Although the U.S. started out in 1995 near other country spending levels on prescription drugs per capita, by 2007 it was far higher than the next highest country.

Advances in medical treatments and technology, including medications, confront all countries with upward pressures on costs. Other countries have responded by using group purchasing power and reference prices 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 – amounting to some $98 billion per year.[22] Other country 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 to pay more for surgical devices such as hip and knee prostheses.[25]

Increasingly, other countries are assessing the comparative information on clinical effectiveness and costs to inform insurance benefit designs to provide incentives for markets to work while assuring 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 multi-payers, such as Germany, the Netherlands, and Switzerland have also established multi-payer mechanisms for paying for care that allow more coherent policies changes over time. These policies also make it possible to ask what the

price is or the total cost of care 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 a weak primary care foundation with poor care coordination.[29] Studies indicate that this undermines timely access, preventive care, and control of chronic conditions and contributes to avoidable use of emergency rooms or hospital admissions/readmissions from preventable complications. The contrasts reflect 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 and provide 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 responsible for coordinating specialist care when needed. When asked whether they would value having a central source of care that knows them and helps coordinate care, U.S. adults' responses are similar to views 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 same or next day access to their physicians when sick and more likely to seek care in emergency rooms (Figure 11). Only one fourth of U.S. and Canadian chronically ill adults 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 in

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 say 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 US physicians say that 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 poorly coordinated. 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 not available at the time of their appointments.[32] In a separate survey, nearly half (47%) of U.S. adults reported one of five 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 aim 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 those 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 to ensure access and provide incentives for essential effective care.

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 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 and enable new payments for primary care practices with accountability, 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 financial incentives to primary care physicians 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 potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or quality improvement activities (Figure 17). In contrast, nearly all primary care physicians in the UK and over 70 percent in Australia and New Zealand report 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 UK 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 email consults, and enhanced visit payments for after-hours care. Recent Dutch national reforms blend capitation, fees for consultations, and encourage payments for performance.

The Maastricht Transmural Diabetes Organization in the Netherlands also started a program that offers financial incentives to both GPs and patients to participate 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 reforms, Germany launched disease management programs and clinical guidelines for chronic care, with financial incentives from insurance funds to develop and enroll patients and be held accountable for 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] Germany is also experimenting with an all-inclusive global fee for payment of care of cancer patients in Cologne.

In addition to a blend of capitation and consultation fees (including fees for email consults), Denmark and the Netherlands have initiated after-hours cooperatives that take over for primary care physicians at nights and weekends. These cooperatives rely on community physicians and nurses to provide off-hours service. 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 the spread between primary care physician and specialists' income, especially compared to the widening gaps in the United States. Denmark may be the extreme in seeking roughly similar net income levels. Danish specialists are salaried and employed by hospitals; primary care physicians own their own practices.

Countries, with 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 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, teams and serving as a "medical home" and 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 teams, 24 hour access, and spending time with patients or coordinating 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**

U.S. physicians are highly trained, and U.S. hospitals are well-equipped compared with hospitals in 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 rare. To bridge the divide and support clinicians, other countries have invested to spread 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 use of electronic medical records – compared with over nine in ten primary care physicians in the Netherlands, New Zealand, and the U.K. Primary care physicians in other countries also increasingly have an array of functionality, as countries build on 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; Rx alerts; prompt tests results; easy to list diagnosis, medications, patients due for care), one in five US primary care physicians reported having at least 7 out of the 14 functions compared to 60 percent to a high of ninety 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 ten countries ranks Denmark at the top, and concludes that countries with a single unifying organization setting standards and 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, with a health information exchange 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, accessible to patients, and authorized physicians and home health nurses. It captures 87% of all prescription orders; 88% of hospital discharge letters; 98% of lab orders; and 60% 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 services when services have to be provided elsewhere.[43]

All Danish primary care physicians (except a few near retirement) are required to have an electronic medical record 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, and electronic systems for prescriptions and refills 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-websites as well as 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 that includes the entire population are systemic policies that seek to make markets work in the public interest.

**Insurance-Related Administrative Costs**

The complex and fragmented U.S. insurance system makes it difficult to orchestrate such payer cohesion. As currently structured, the U.S. insurance system also 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 or 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 United States.[45]

Studies of U.S. administrative costs related to insurance for providers indicate that insurance complexity is also taking a toll on time and resources and driving up costs for medical practices. 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 3 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 insurance-related overhead in half, there would be $15 to $20 billion in savings per year for physicians and $25 to $40 billion in savings per year for hospitals.[47] The recent McKinsey study estimates such complexity – including multiple reporting requirements - accounts for some $90 billion per year in excess costs.[48]

Other countries with competing insurers – Germany, the Netherlands and Switzerland - have enacted market reforms, including more standardized benefit designs and 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 assure 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" with 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 – making it easy to track cost-sharing and facilitating payment to providers.

**Conclusion**

We have the world's costliest health system yet fail to provide everyone with access to care—and fall far short of what should be possible with the U.S. 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 that yield equivalent or better outcomes, better experiences for lower costs.[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 promote primary care, prevention and effective care of chronic disease,
- System reforms to 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 multi-payer 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 their call to action and vision of concrete policies that could move the United States in a new, more positive direction.[50,51]

Insurance reform is fundamental for access and financial protection. It also can serve as a base for a more rational payment system and incentives that reward value not volume. Coherent prices and payment policies that support effective and efficient care are critical for markets to work, as is 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 as countries seek to meet the health needs of current and future generations.

Moving forward in other countries required bold action – many of the initial foundation reforms were difficult to achieve politically. But their national governments and policy leaders responded to the needs of the population 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 United States to take bold steps to address the rising costs of healthcare and to assure everyone access to care with financial security. We can't afford to continue with rising costs undermining federal as well as family and business budgets and putting 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 have the benefit of multiple examples of international strategies as well as care systems in the U.S. that achieve high quality/lower cost. We can learn from diverse international experiences as nations innovate to meet current and future needs for accessible, high quality, and efficient care.

By enacting national reforms that take strategic steps to put the United States 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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[1] C. DeNavas-Walt, B.D. Proctor, and J.C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, (Washington: U.S. Census Bureau, September 2009).

[2] K. Davis, K. Stremikis, C. Schoen, S. R. Collins, M. M. Doty, S. D. Rustgi, and J. L. Nicholson, *Front and Center: Ensuring that Health Reform Puts People First*, (New York: The Commonwealth Fund, June 2009).

[3] The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, (New York: The Commonwealth Fund, February 2009).

[4] C. Schoen, S.R. Collins, J.L. Kriss, and M.M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008:w298–w309.

[5] S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, August 2008).

[6] The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System, Ibid.*

[7] Data from OECD 2009.

[8] Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008).

[9] P.S. Hussey, G.F. Anderson, R. Osborn et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs*, May/June 2004, 23(3):89-99; C. Schoen, R. Osborn, P.T. Huynh, M. Doty, J. Peugh, and K. Zapert, "On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive (Nov. 2, 2006):w555-w571; C. Schoen, R. Osborn, M. Doty, et al. "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive (Oct. 31, 2007):w717-w734; C. Schoen, R. Osborn, S. K. H. How, M. Doty, J. Peugh, "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs* Web Exclusive (Nov. 13, 2008):w1-w16.

[10] E. Nolte and C. M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs,* Jan/Feb 2008, 27(1):58–71; E. Nolte, C. Bain, and M. McKee, "Diabetes as a Tracer Condition in International Benchmarking of Health Systems," *Diabetes Care*, May 2006, 29(5):1007-11.

[11] E. Nolte and C. M. McKee, "Measuring the Health of Nations," *Ibid.*

[12] J.C. Cantor, C. Schoen, D. Belloff, S.K.H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance*, (New York: The Commonwealth Fund, June 2007); D. McCarthy, S.K.H. How, C. Schoen, J.C. Cantor, and D. Belloff, *Aiming Higher: Results from the 2009 State Scorecard on Health System Performance*, (New York: The Commonwealth Fund, forthcoming 2009).

[13] Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008).

[14] C. Schoen, R. Osborn, S.K.H. How, M.M. Doty, and J. Peugh, "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs* Web Exclusive, Nov. 13, 2008, w1-w16.

[15] G. F. Anderson and B. K. Frogner, Health Spending in OECD Countries: Obtaining Value per Dollar, *Health Affairs,* November/December 2008 27(6):1718–27

[16] G. Anderson and P. Markovich, *Multinational Comparisons of Health Systems Data, 2008* (New York, NY: The Commonwealth Fund, Nov. 2008).

[17] J. S. Skinner, D. O. Staiger, and E. S. Fisher, "Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction," *Health Affairs* Web Exclusive, Feb. 7, 2006, w34–w47.; B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly,* 2005 83(3):457–502.

[18] C. Schoen et al., "In Chronic Condition," *Ibid.*

[19] C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007, 26(6):w717–w734.

[20] C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007, 26(6):w717–w734.

[21] P.M. Danzon and M.F. Furukawa, "International Prices And Availability Of Pharmaceuticals In 2005," *Health Affairs*, Jan./Feb. 2008, 27(1): 221-233.

[22] G. F. Anderson et al., "Doughnut Holes and Price Controls," *Health Affairs* Web Exclusive (July 21, 2004):w396–w404; Gerard Anderson et al., "It's the Prices, Stupid: Why the United States is So Different from Other Countries," *Health Affairs*, May/June 2003, 22(3):89-105.

[23] 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).

[24] Corrina Sorenson, Caroline Mudsisill, Elias Mossialos and Sherry Glied, et al. *Pharmaceutical Pricing and Coverage in Seven European Nations: Policy Levers and Mechanisms*, Working Paper November 12-14, 2008 prepared for the 2008 Commonwealth Fund International Symposium on Health Care Policy.

[25] Leif Wellington Haase, The Century Foundation, presentation at *Outpatient Outlook 2007:The Future of Healthcare* on "Health Care Reform and Outpatient Care," March 13, 2007. In 2004, U.S. payments for hip and knee implants were 50 percent to 200 percent higher than in Germany, France, Italy, and the U.K. Data based on Millennium Research, Bernstein Research, and MGI analysis.

[26] For brief description of Germany see T. Cheng and U. Reinhardt, "Shepherding major Health Systems Reforms: A Conversation with German Health Minister Ulla Schmidt," *Health Affairs*, April 8, 2008.

[27] S. Thomson 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); C. Sorenson, *The Use of Comparative Effectiveness Research for Evidence-Based Policy and Value for Money: A Six-Country Comparison of Drug Coverage and Pricing Decisions*, (New York: The Commonwealth Fund, forthcoming 2009).

[28] U. E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, January/February 2006; 25(1): 57-69.

[29] B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly* 2005; 83(3): 457-502..

[30] C. Schoen et al., "Toward Higher-Performance Health Systems," *Ibid.*; C. Schoen et al., "In Chronic Condition," *Ibid.*

[31] R. Grol et al. "After-hours Care in the U.K., the Netherlands and Denmark: New Models," *Health Affairs*, Nov/Dec. 2006, 25(6): 1733-1737.

[32] C. Schoen et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive, Nov. 3, 2005, w509-525.

[33] S.K.H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, Aug. 2008).

[34] S. Thomson and E. Mossialos, *Primary Care and Prescription Drugs*, Ibid.; C. Schoen et al., "Focus on Health System Foundations: Primary Care Physician Experiences and Perspectives in Eleven Countries, 2009," *Health Affairs*, forthcoming 2009.

[35] T. Doran, C. Fullwood, H. Gravelle, D. Reeves, E. Kontopantelis, U. Hiroeh, and M. Roland, "Pay-for-Performance Programs in Family Practices in the United Kingdom," *New Engl J Med,* 2006 355(4):375-384

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

[37] Michael Hallek, "Typical problems and recent reform strategies in German health care - with emphasis on the treatment of cancer," Presentation to the Commonwealth Fund International Symposium, November 2, 2006.

[38] R. Grol et al. "After-hours Care in the U.K., the Netherlands and Denmark," *Ibid.*

[39] C. Schoen et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive, Nov. 3, 2005, 24 :w509-525; C. Schoen, R. Osborn, P.T. Huynh, M. Doty, J. Peugh, and K. Zapert, "On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive, Nov. 2, 2006, w555-w571.

[40] T. Bodenheimer, K. Grumbach, and R.A. Bereson, "A Lifeline for Primary Care," *N Engl J Med*, June 2009, 360:2693.

[41] C. Schoen et al., *2003 Commonwealth Fund International Health Policy Survey of Hospital Executives*, (New York: The Commonwealth Fund, September 2004); R.J. Blendon, C. Schoen, C.

DesRoches, R. Osborn, and K. Zapert, "Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries," *Health Affairs*, May/June 2003, 22(3):106-21.

[42] D. Protti, "A Comparison of Information Technology in General Practice in Ten Countries," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.

[43] B. Starfield, "Why More Primary Care: Better Outcomes, Lower Costs, Greater Equity," Presentation to the Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006.

[44] 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.

[45] R.E. Leu, F.F.H. Rutten, W. Brouwer et al., *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, (New York: The Commonwealth Fund, January 2009).

[46] L. Casalino et al. "What Does it Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs*, July/Aug. 2009, 28(4):w533-w543; J. Sakowski, et al. "Peering into the Black Box: Billing and Insurance Activities in a Medical Group," *Health Affairs*, July/Aug. 2009, 28(4):w544-w554; and J. Kahn et al. "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians and Hospitals," *Health Affairs*, Nov./Dec. 2005, 24(6):1629-1639.

[47] Authors' estimate based on 2009 total hospital spending and physician practice estimates. C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork In the Road: Alternative Paths to a High Performance U.S. Health System*, (New York: The Commonwealth Fund, June 2009).

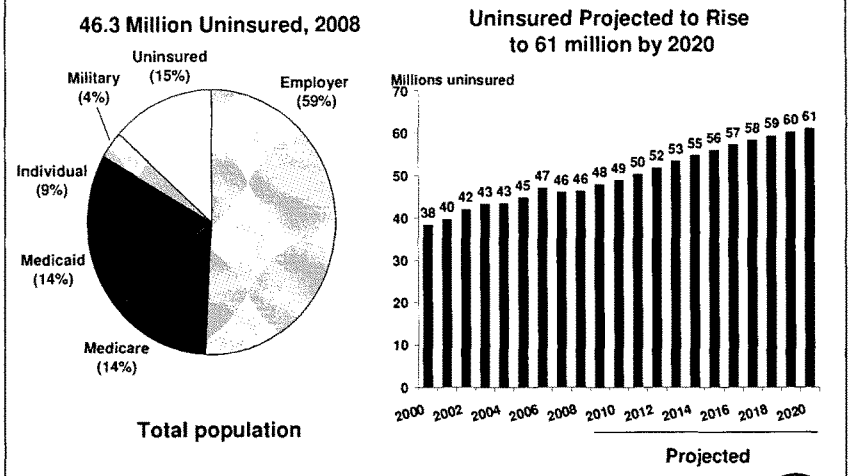
[48] McKinsey Global Institute, *Accounting for the Costs of U.S. Health Care*, Ibid.

[49] Karen Davis et al., *Room for Improvement: Patients Report on the Quality of Their Health Care.* (New York: The Commonwealth Fund, April 2002); K. Davis et al., *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care,* (New York: The Commonwealth Fund, May 2007).

[50] Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President,* (New York: The Commonwealth Fund, Nov. 2007).

[51] The Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System, Ibid.*

## Figure 1. Health Insurance Coverage and Uninsured Trends




Data: Analysis of the U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplement 2001–2009; projections to 2020 based on estimates by The Lewin Group.
Source: K. Davis, *Changing Course: Trends in Health Insurance Coverage, 2000–2008*, Hearing on "Income, Poverty, and Health Insurance Coverage: Assessing Key Consensus Indicators of Family Well-Being in 2008," Joint Economic Committee, U.S. House of Representatives, September 10, 2009.

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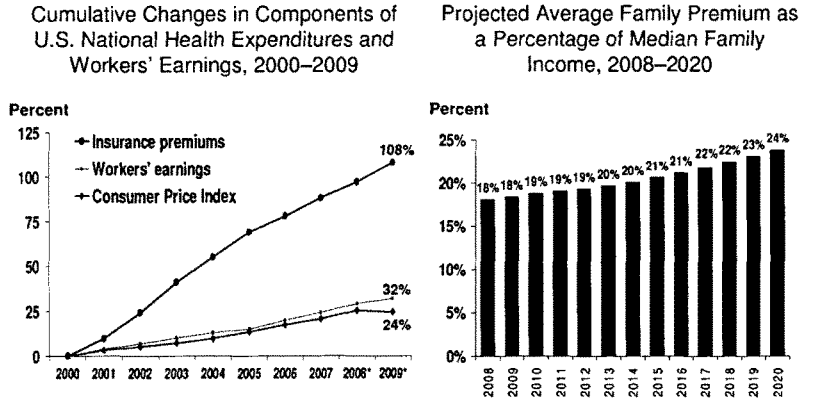
## Figure 2. Premiums Rising Faster Than Inflation and Wages




* 2008 and 2009 NHE projections.
Data: Calculations based on M. Hartman et al., "National Health Spending in 2007," *Health Affairs*, Jan./Feb. 2009 and A. Sisko et al., "Health Spending Projections through 2018," *Health Affairs*, March/April 2009. Premiums, CPI and Workers' earnings from Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 2000–2009.*

Source: K. Davis, *Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums*, (New York: The Commonwealth Fund, August 2009).

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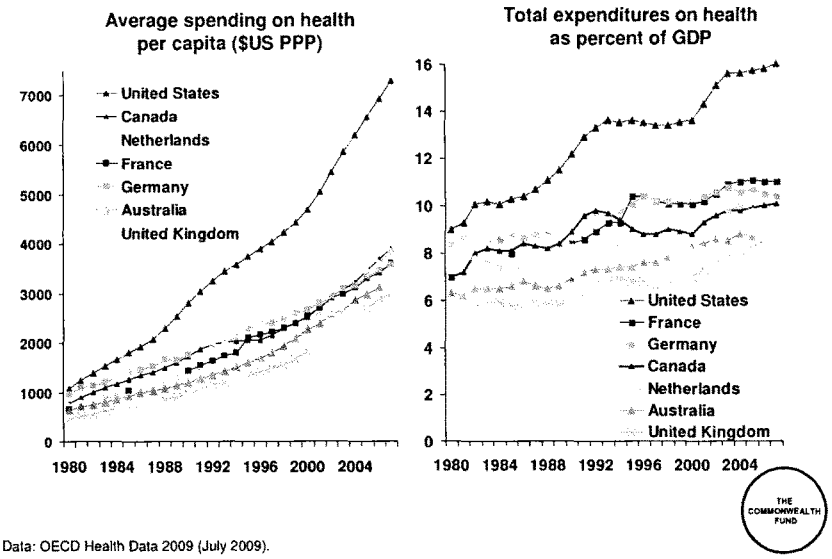
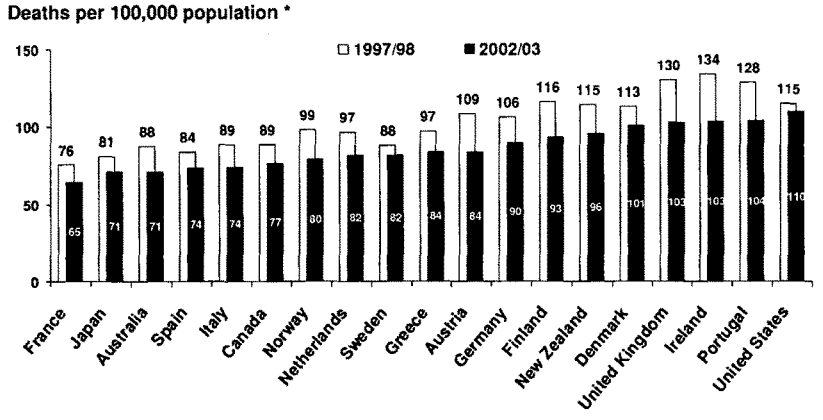
## Figure 3. International Comparison of Spending on Health, 1980–2007




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.
Data: E. Nolte and C. M. McKee, "Measuring the Health of Nations," Health Affairs, Jan/Feb 2008).

Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).

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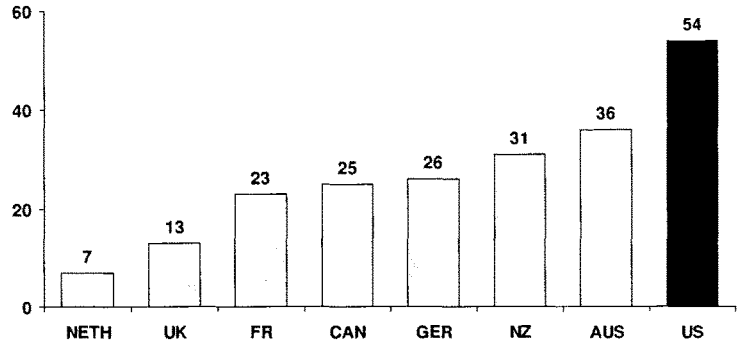
## Figure 5. Cost-Related Access Problems Among the Chronically Ill, in Eight Countries, 2008

**Base: Adults with any chronic condition**

**Percent reported access problem due to cost in past two years***

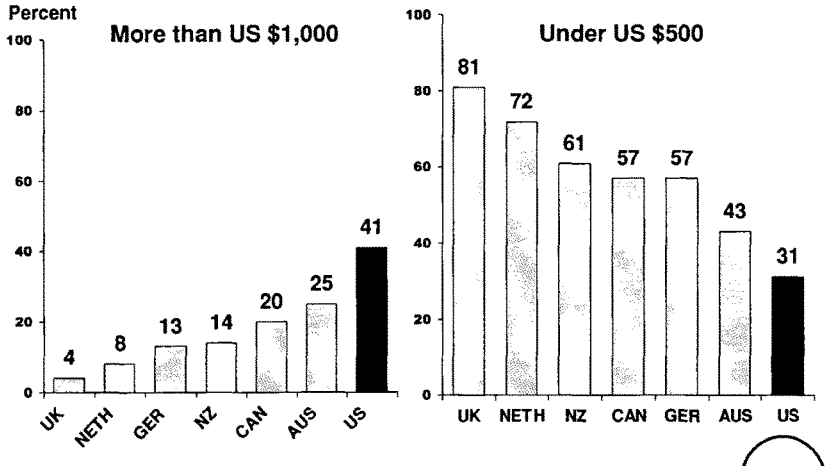



* Due to cost, respondent did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.
Data: The Commonwealth Fund International Health Policy Survey of Sicker Adults (2008).
Source: C. Schoen et al., "In Chronic Condition: Experiences 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**

**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.

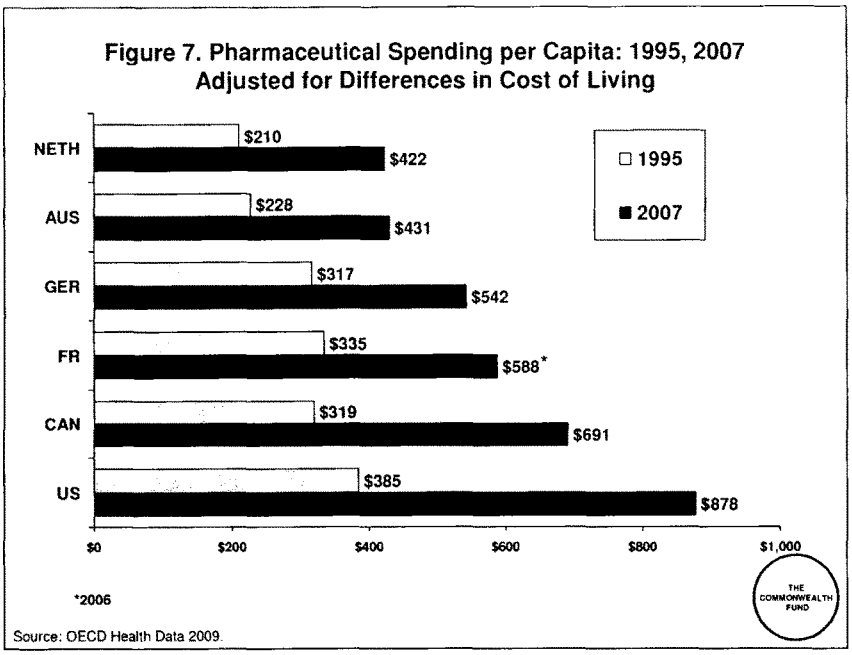


Figure 7. Pharmaceutical Spending per Capita: 1995, 2007
Adjusted for Differences in Cost of Living
NETH
$210
$422
AUS
$228
$431
GER
$317
$542
FR
$335
$588*
CAN
$319
$691
US
$385
$878
□ 1995
■ 2007
$0
$200
$400
$600
$800
$1,000
*2006
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Source: OECD Health Data 2009.

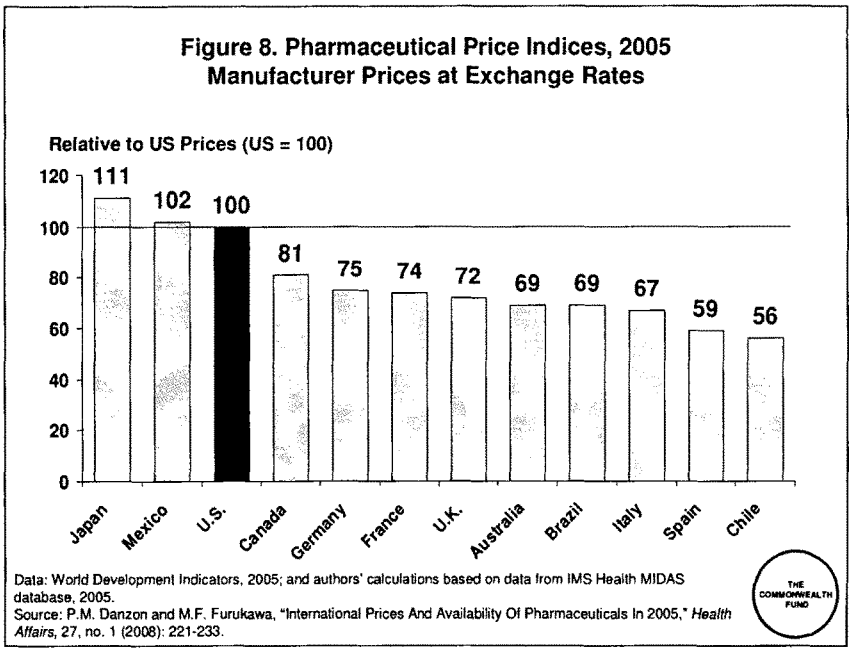
Figure 8. Pharmaceutical Price Indices, 2005
Manufacturer Prices at Exchange Rates
Relative to US Prices (US = 100)
120
100
80
60
40
20
0
111
102
100
81
75
74
72
69
69
67
59
56
Japan
Mexico
U.S.
Canada
Germany
France
U.K.
Australia
Brazil
Italy
Spain
Chile
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Data: 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 | *Deductible*: DKK520 ($93) per 12-month period.<br>*Co-insurance*: 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. | *Chronically ill people*: DKK 3,805 ($678). |
| England | *Co-payment*: £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. | *Annual pre-payment certificate*: £102.50 ($147). |
| France | *Co-insurance*: 0% for highly effective drugs; 35%, 65% and 100% for drugs of limited therapeutic value.<br>*Non-reimbursable co-payment*: €0.50 ($0.8) per prescription. | *Co-insurance*: People receiving invalidity and work injury benefits, people with one of 30 chronic or serious conditions (for that condition only), low income people.<br>*Non-reimbursable co-payments*: Children <18 and low income people. | *Non-reimbursable co-payments*: €50 ($66) per person per year for all health care, not just prescription drugs. |
| Germany | *Co-insurance with minimum and maximum co-payment*: 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). | *For all cost sharing*: 2% of household income (1% for chronically-ill people). Household income is calculated as lower for dependants. |
| Netherlands | None | N/A | N/A |
| Sweden | *Deductible*: SEK900 ($105) in a 12-month period.<br>*Co-insurance*: 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. | *12-month cap*: 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).

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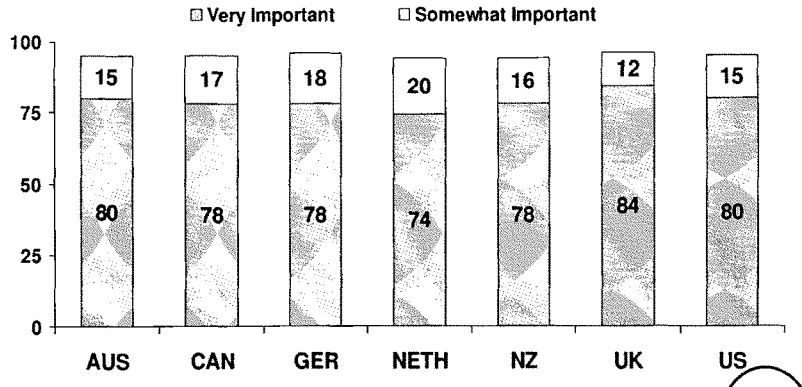
## Figure 10. Strong Public Support for Having A "Medical Home": Accessible, Personal, Coordinated Care

***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.

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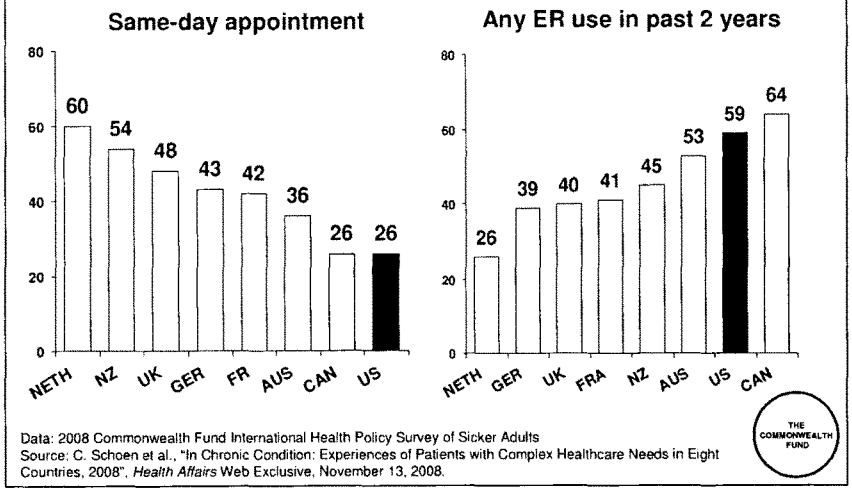
## Figure 11. Access to Doctor When Sick or Needed Care, 2008

Base: Adults with any chronic condition

Percent

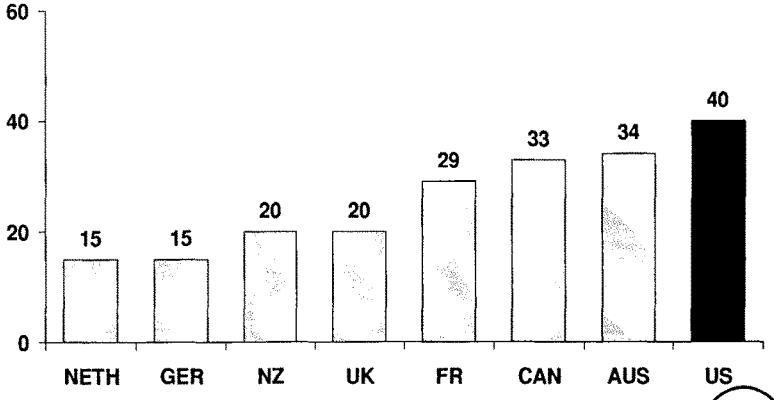



Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.

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

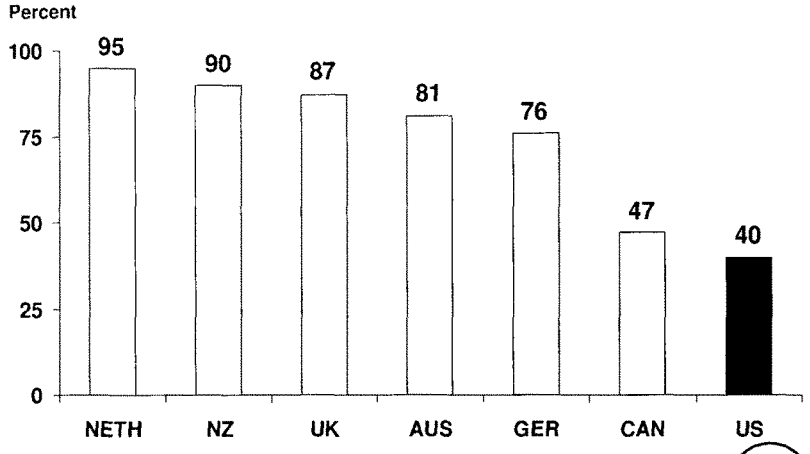
**Base: Adults with any chronic condition who needed after-hours care**

**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.

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## 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.

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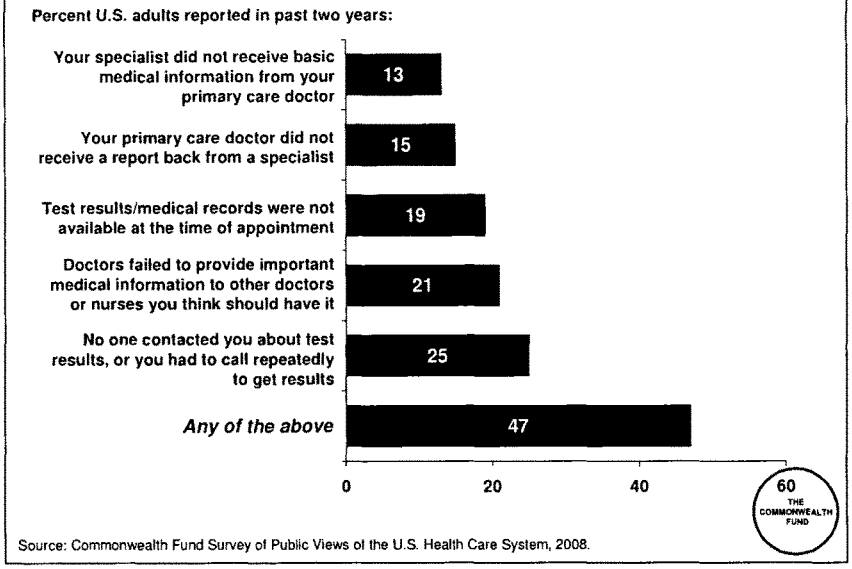
## Figure 15. Poor Coordination: Nearly Half of U.S. Adults Report Failures to Coordinate Care



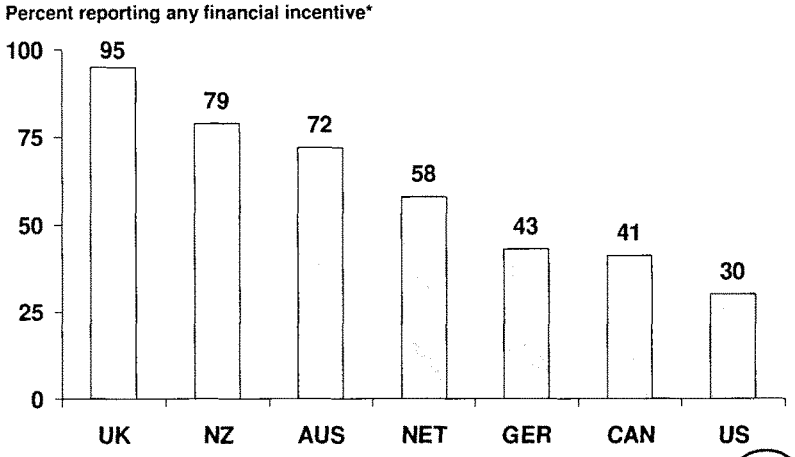

Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

## 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 | *Co-insurance*: 30% with gate keeping or 50% *Non-reimbursable co-payment*: €1 ($1.3) per visit | *Co-insurance*: 30% with gate keeping or 50% *Non-reimbursable co-payment*: €1 ($1.3) per visit | *Co-insurance*: 20%. *Non-reimbursable co-payment*: €16 ($21) per day up to 31 days per year. | *Co-insurance*: 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. *Non-reimbursable co-payments*: Children <18 and low income people. | *Non-reimbursable co-payments*: €50 ($66) for all health care including prescription drugs. |
| Germany | *Co-payment*: €10 ($13) for the first visit per quarter and subsequent visits without referral. | *Co-payment*: €10 ($13) for the first visit per quarter and subsequent visits without referral. | *Co-payment*: €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. | *Deductible*: €150 ($199) per year. | | Children <18, GP services, mother and child care, preventive care dental care for <22. | None. |
| Sweden | *Co-payment*: SEK100-150 ($12-18) per GP visit. | *Co-payment*: SEK200-300 ($24-36) per specialist or emergency department visit. | *Co-payment*: 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




* 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

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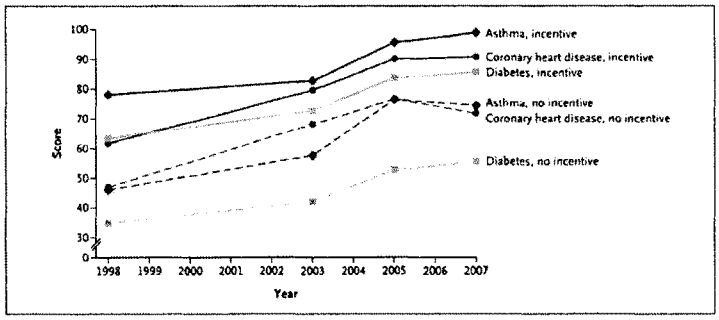
## Figure 18. Effects of Pay-for-Performance on the Quality of Primary Care in England




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.

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## 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.

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## 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.

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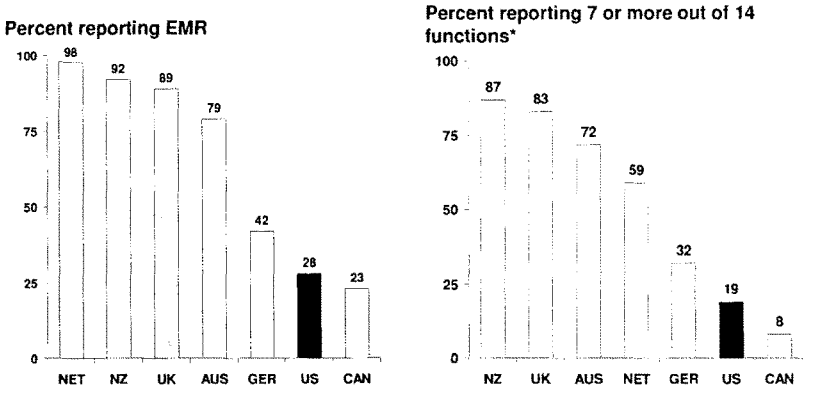
## Figure 21. Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Advanced IT Capacity, 2006




*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Data: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Source: Schoen et al., "On the Front Lines of Care," *Health Affairs* Web Exclusive, Nov. 2, 2006.

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

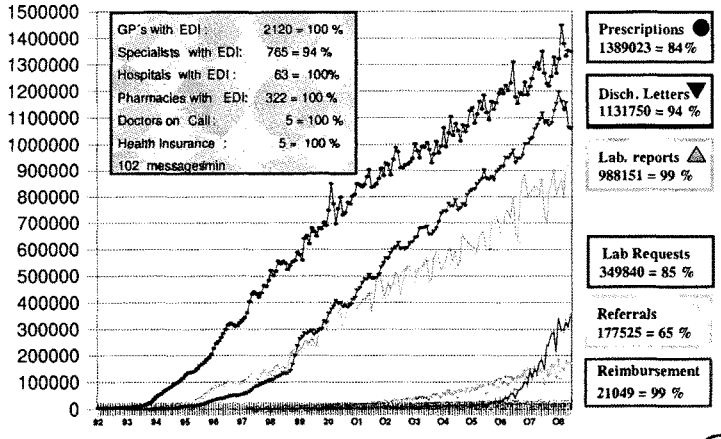


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Figure 23. Why Invest in E-Health? Registries?
Denmark Physicians and Patients Example

- 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:

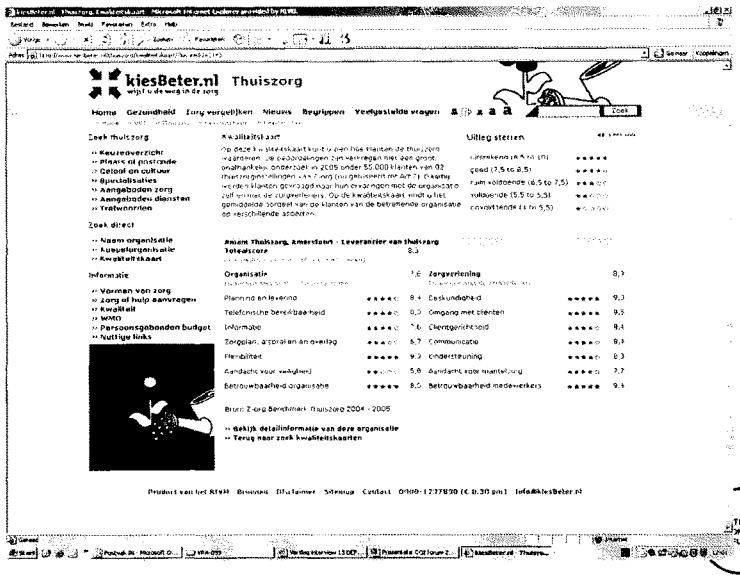
- 2,000 German Hospitals (> 98%)
- 5,000 medical departments
- 3 Million cases in 2005
- 20% of all hospital cases in Germany
- 300 Quality indicators in 26 areas of care
- 800 experts involved (national and regional)

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

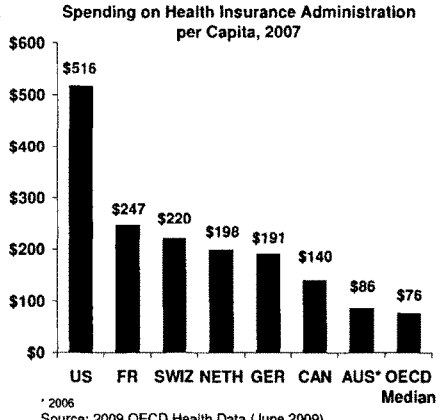
Source: C. Veit, "The Structured Dialog: National Quality Benchmarking in Germany," Presentation at AcademyHealth Annual Research Meeting, June 2006.

## 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**

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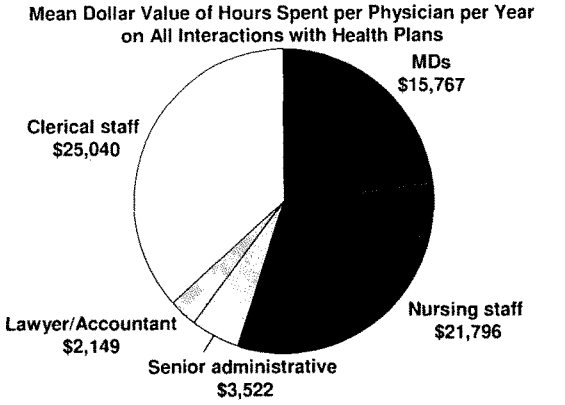
* McKinsey Global Institute, *Accounting for the Costs of U.S. Health Care: A New Look at Why Americans Spend More*, (New York: McKinsey Global Institute, Nov. 2008).

## Figure 27. Complexity Drains Resources: Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at $31 Billion[1]




**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.

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## 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 ostéoarthrite | 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."

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The CHAIRMAN. Thank you very much, Dr. Schoen.
Dr. Epstein.

**STATEMENT OF ARNOLD EPSTEIN, CHAIR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MA**

Dr. EPSTEIN. Good morning, Mr. Chairman, distinguished committee members. I speak to you this morning as someone who has studied quality of care and related issues for well more than two decades, as someone who's a primary care practitioner today with an ongoing clinical practice, as someone who has chaired the OECD panel comparing international quality indicators, and as someone who, in a former administration, worked in the Executive Branch with policy responsibility for quality of care.

At the end of the day, I want to make three simple points. First, that we have, in the last few years, developed increased ability to measure quality of care; and, while not comprehensive or perfect, we can now start to talk about how to gauge quality of care across different regions within our country, and across countries.

Second, the overwhelming amount of the evidence—and I'll present a good deal of it very specifically to you—suggests that, in some cases, the U.S. has the best quality in the world; in some case, we're at the bottom of the heap; and often, we're right in the middle.

Third, juxtaposing with the data you've already heard about on costs, is that these figures raise important concerns about value.

Let me start by just trying to puncture two important myths:

The first myth is one that probably everyone in this room shares. If I was to ask all of you, "Is your doctor average or better than average?" almost all of you would say your doctor is average or better than average. Even though statistically, that's just not plausible.

The other myth we share is the often-repeated refrain that care in the United States is the best in the world. I'm going to show you some data which suggests that that may not be the case.

Starting in 2001, I chaired a group for a few years, that was dedicated to comparing quality of care internationally. The OECD has continued that work, covering representatives of approximately 30 countries across the world to compare measures of quality of care. The measures are not comprehensive, but they are broad and cover important aspects of care and prevalent clinical conditions. As I've said, the bulk of those data show very variable quality of care. The measures are scientifically valid and have been based on data that are comparable across countries or as much so as possible.

Let me start—and I hope you have a set of displays from me—exhibit number 1 really identifies—and I won't, in interest of time, call them out one by one—23 different measures that cover care for chronic conditions, acute exacerbations, mental health disorders, cancer care, and communicable disorders. What you should take away is that there are a broad range of quality measures that we can now examine.

On exhibit number 2, I've listed asthma admission rates across different countries in the world. Asthma is a chronic condition with

a lot of morbidity. We now have treatments that can effectively treat the inflammation, and bronchial spasm that accompanies asthma. So, among quality experts, the belief is that, high rates of hospitalization for asthma are a sign of inadequate access to care and inadequate quality of care. The United States is, deplorably, number 1 in the world, with the highest rates of hospital admission for asthma.

Exhibit number 3 displays diabetic lower-extremity amputation rates. Glycemic control is associated with vascular side effects from diabetes. WHO reports suggest that up to 80 percent of diabetic lower-extremity amputations can be prevented. If you look at the rates across countries, again the United States is No. 1 in the world.

Exhibit number 4, shows in-hospital case fatality rates after acute myocardial infarction. We know that aspirin therapy, beta-blocker therapy, thrombolysis, and coronary revascularization can all be very helpful therapies for someone with an acute myocardial infarction. So, there's a lot we can do to bring down mortality rates. The United States rate, in the middle of the pack, is 5.1 percent, far higher than Iceland's 2.4 percent, far better than Korea's 8.1 percent, 13th out of 20.

If you go to Exhibits number 5 and number 6, these are for breast cancer, the most common malignancy for females in our country. One out of nine women in our country has breast cancer. It is certainly a plague. Exhibit 5, shows mammography rates. There is hard evidence that mammography allows us to diagnose breast cancer earlier before it's spread, when it's more treatable, when we will have better outcomes. The United States rate is 72 percent, far less than the Netherland's, at 89, although we're better than many other countries.

Exhibit number 6, shows breast cancer 5-year relative survival rates, and the United States is far and away the best, an instance where in—we're really leading the pack and doing well, and we think other countries can learn from us.

Finally, to conclude, exhibit 7 and 8 are two vaccination rates; the first, for Hepatitis B, a vaccination that we think is very important 95-percent efficacy, highly cost effective. Our rate is 92 percent, trailing a whole host of other countries.

On the last page, exhibit number 8, shows data on influenza vaccination timely vaccination can overt tremendous morbidity and mortality for the elderly. It can also reduce work loss among the working population. Our rate, again, 65 percent, is far less than optimal.

I've put those exhibits, and labored through those, so you can get a sense of the hard data, and the variability of it. But, I think the takeaways here are very clear: We can, now measure quality of care—not perfectly, but better than even before; there is a lot of variability in quality, internationally, and there is strong evidence that we're just not, far and away, consistently the best in the world, taken together these data raise very important questions about how we spend our money and the value we obtain for it.

In the interest of time, I'll stop there. If there are further questions, I will be happy to field them.

Thank you for the opportunity to address the committee.

[The prepared statement of Dr. Epstein follows:]

Statement for the Senate Special Committee on Aging on Differences in Quality of Health Care in Developed Countries

Submitted by

Arnold M Epstein M.D., M.A.
John H Foster Professor and Chair,
Department of Health Policy and Management,
Harvard School of Public Health

September 30, 2009

Mr Chairman and Distinguished Committee Members:

It is an honor to be part of this morning's hearing which explores differences in cost of health care and quality of health care in developed countries. I have spent many years studying quality of care. I also chaired a group of experts for two years from approximately 20 countries seeking to compare quality of care internationally. The group worked under the auspices of the Organization for Economic Co-operation and Development (OECD). Based on that experience and on the data subsequently collected through the OECD, I want to make three points this morning:

- First, while not comprehensive, we have developed an increasing number of indicators that can be used to measure differences in quality of care across developed countries.

- Second, no country is consistently very high or very low in quality performance across the full range of measures. The United States performs well on some, but poorly on others.

- Third, the variable performance on indicators of quality of care stands in contrast to cost of care where the United States is the most costly by far.

**The Context for Measuring Quality of Care**

In the United States, reports by the Institute of Medicine and others have prompted awareness that quality of care is often less than optimal. For example the RAND report by Beth McGlynn and colleagues showed that for a broad range of medical services patients get indicated care only 55% of the time. Iatrogenic injury is also a major concern. According to the Institute of Medicine, patient injury during the process of getting health care is the eighth leading cause of death. Iatrogenic injury leads to more deaths than AIDS, breast cancer or motor vehicle accidents. Finally there are dramatic differences in health care across different demographic groups. Racial minorities and patients of lower economic status are less likely to receive important preventive services, they are less likely to see the doctor when ill and even once they get to the doctor they are less likely to get important treatments that can alleviate suffering or prolong life expectancy.

Despite these concerns about quality of care, United States policy makers and clinicians often repeat the refrain that "Quality of Care in the United States is the best of any country in the world." However, there is no evidence to support this belief. In fact, until recently we have lacked the wherewithal to compare quality of care internationally.

**The OECD Health Care Quality Indicator (HCQI) Project**

The OECD's Health Care Quality Indicator (HCQI) Project began in 2001 and is on going. It now includes a consortium of more than 30 countries. The consortium has taken substantial effort to identify a series of quality indicators that fit three general criteria.

- The first is importance. The quality indicators have a potentially important impact on health in terms of avoiding morbidity or mortality. Policy makers and consumers are generally concerned about the area. There is literature demonstrating that the health care system can meaningfully influence or address the indicator.

- Second is scientific soundness. The quality indicators must have face validity and make sense logically and clinically. If the indicator is a measure of the process of care, there must be evidence that the medical services in question lead to improved outcomes. If the indicator is a measure of the outcomes of care there must be evidence that the improved outcomes are the result of better health care services

- Third, the data to compare the quality indicator must be available from different countries in a comparable format. The limited adoption of information technology means that the detailed clinical information required for many quality indicators is often unavailable. Most often we have been forced to use administrative data for quality measurement, which is helpful, but more limited than ideal.

The current set of quality indicators includes both measures of the process of care and the outcomes of care. Twenty three indicators are featured in the forthcoming OECD publication, "Health at a Glance." The table below lists the indicators that cover important healthcare needs, major health care services and many common disease areas.

**Exhibit 1: Areas Covered by the Current Set of OECD Indicators**

| | **Process Measures** | **Outcome Measures** |
|---|---|---|
| **Care for chronic conditions** | | Avoidable asthma admission rate<br>Avoidable chronic obstructive pulmonary disease (COPD) admission rate<br>Avoidable diabetes acute complications admission rate<br>Avoidable diabetes lower extremity amputation rate<br>Avoidable congestive heart failure (CHF) admission rate<br>Avoidable hypertension admission rate |
| **Care for acute exacerbations of chronic conditions** | | Acute Myocardial Infarction (AMI) 30 day case-fatality rate<br>Stroke 30 day case-fatality rate |
| **Care for mental disorders** | | Unplanned schizophrenia re-admission rate<br>Unplanned bipolar disorder re-admission rate |
| **Cancer care** | Cervical cancer screening rate<br>Breast cancer screening rate | Cervical cancer survival rate<br>Cervical cancer mortality rate<br>Breast cancer survival rate<br>Breast cancer mortality rate |

| | | |
|---|---|---|
| | | Colorectal cancer survival rate<br>Colorectal cancer mortality rate |
| **Care for communicable diseases** | Rate of childhood vaccination for pertussis<br>Rate of childhood vaccination for measles<br>Rate of childhood vaccination for hepatitis B<br>Rate of influenza vaccination for elderly people | Incidence of hepatitis B |

Source: OECD Health Care Quality Indicators Data 2009.

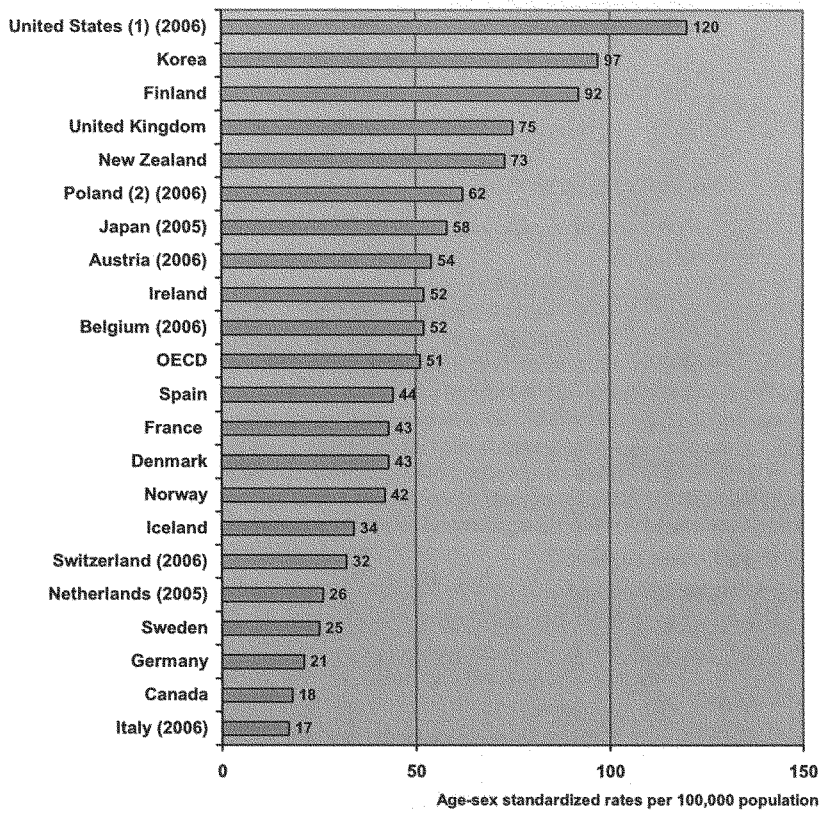
While existing quality measures do not cover all aspects of quality including satisfaction with care, other interpersonal aspects of care, and patient safety, the existing indicators allow us to gauge quality of care and draw inferences about system performance in a number of key clinical areas. Here I have to give the standard caveats about the OECD indicators. Not all countries participating in the project were able to provide data for all of the indicators. And in many instances the data provided by different countries differed slightly in terms of age breakdowns, definitions, or the source. While the comparisons are not perfect they are still generally useful for gauging the differences in quality performance in the different health systems. Below I review data for a selection of representative quality indicators from the forthcoming OECD report.

## I. Care for Chronic Conditions

### Asthma Hospital Admission

Asthma is a disease characterized by hyper-reactivity of the airways and chronic inflammation. Treatment for asthma with bronchodilators and medications to reduce airway inflammations is effective in reducing symptoms, increasing patients' functional capacity and reducing the incidence of exacerbations that warrant hospitalization. High hospital admission rates may therefore be an indication of poor quality of care, and asthma admission rates are included as a quality indicator in the United States Healthcare Quality Report. Below are admission rates for asthma in 21 countries. The United States rate is 20 percent higher than any other country.

**Exhibit 2: Asthma admission rates, population aged 15 and over, 2007**



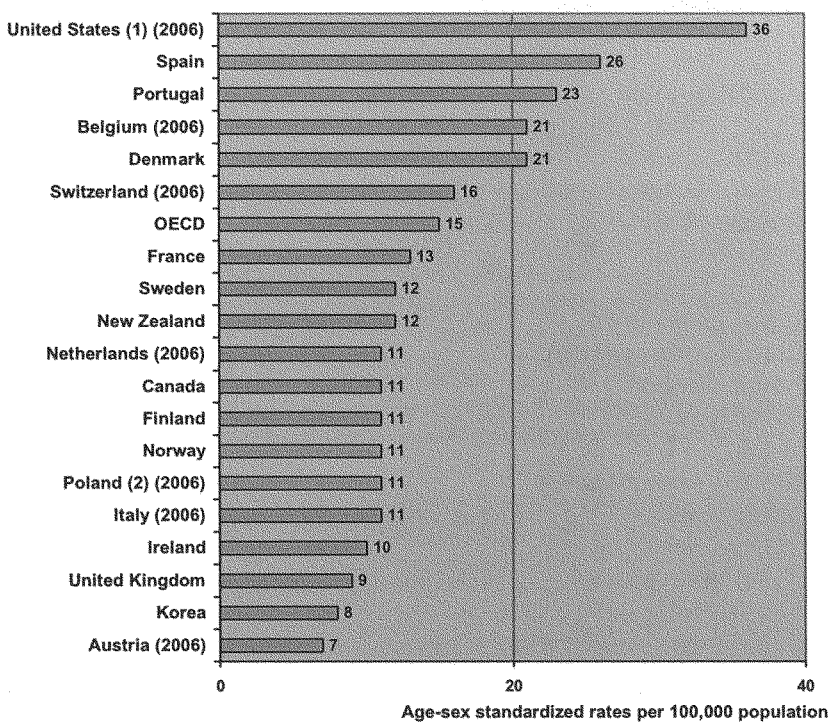

(1) Does not fully exclude day cases.
(2) Includes transfers from other hospital units, which marginally elevates rates.
Source: OECD Health Care Quality Indicators Data 2009.
Rates age-sex standardized to 2005 OECD population.

## Diabetic Lower Extremity Amputations

Diabetes is a major public health challenge, although better glycemic control can reduce organ damage and vascular complications. Lower extremity amputation is considered an indicator of the quality of care for diabetes. Proper foot care can reduce the risk of lower extremity amputation and approximately 80% of amputations can be prevented according

to WHO estimates. The chart below again shows the United States with the highest rates among 19 countries.

**Exhibit 3: Diabetes lower extremity amputation rates, population aged 15 and over, 2007**




(1) Does not fully exclude day cases.
(2) Includes transfers from other hospital units, which marginally elevates rates.
Source: OECD Health Care Quality Indicators Data 2009.
Rates age-sex standardized to 2005 OECD population.

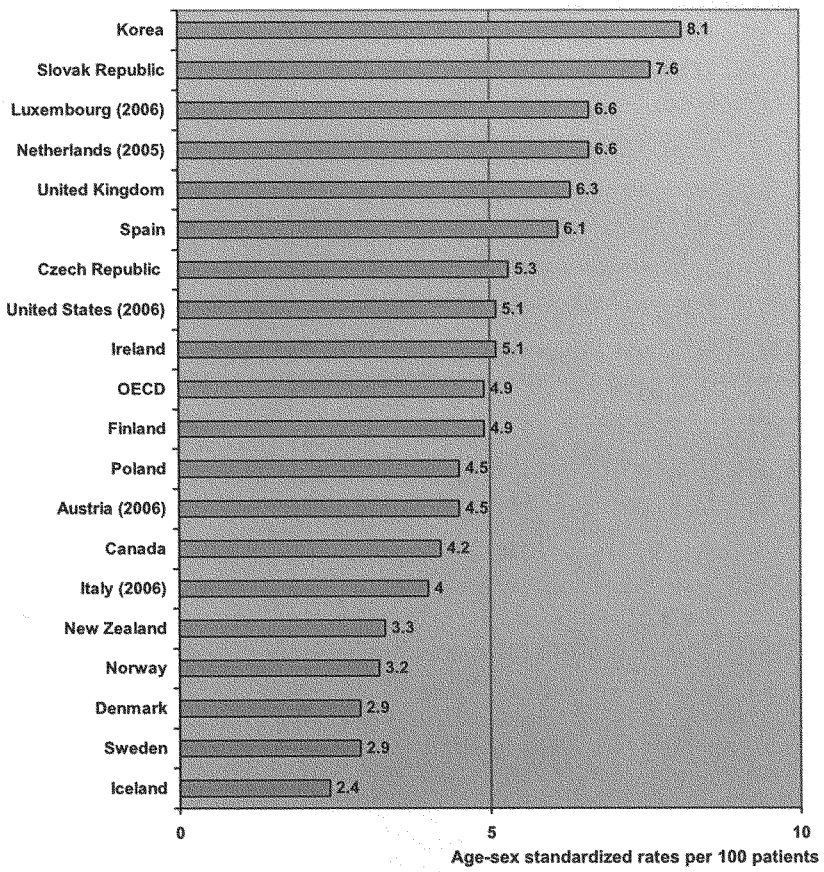
## II. Care for Acute Exacerbation of Chronic Conditions

### Mortality After Acute Myocardial Infarction (AMI)

Mortality rates after acute myocardial infarction (AMI) have declined substantially in the last 30 years. Much of this success is due to better treatment in the acute phase. Evidence

links processes of care such as early treatment with aspirin, beta blockers, thrombolysis and procedures to restore coronary artery blood flow with improved rates of survival after AMI. Thus the 30 day case fatality rate is considered a good marker for the quality of acute care.

**Exhibit 4: In-hospital case-fatality rates within 30 days after admission for AMI, 2007**




Source: OECD Health Care Quality Indicators Data 2009.
Rates age-sex standardized to 2005 OECD population (45+).

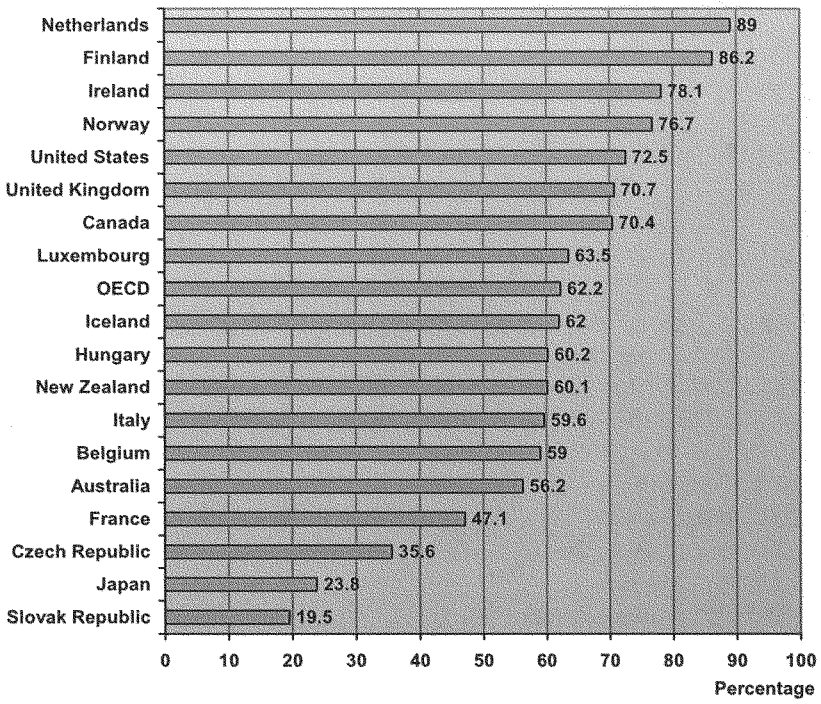
The United States case fatality rate of 5.1% is just above the OECD average and is 9th among the 19 countries that submitted data.

## III. Cancer Care

### Mammography Screening and Breast Cancer Survival

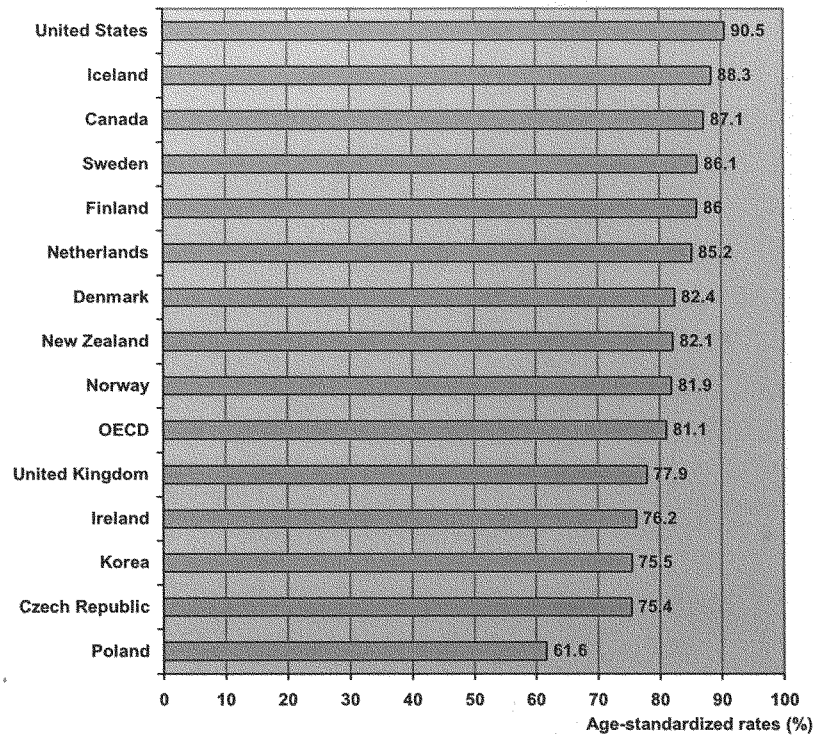
Breast cancer is the most common malignancy among women. More than 10% of women develop the disease and one in thirty women dies from it. Increased public awareness, promotion of self examination and screening mammography have all contributed to earlier diagnosis and initiation of therapy when the disease is more treatable. Improvements in care such as increased use of adjuvant chemotherapy have also contributed to increased survival. The table below suggests that the United States does well compared to most other countries The US has the fifth highest rate of mammography screening and the highest five year survival rate among women diagnosed with the disease.

**Exhibit 5: Mammography screening, percentage of women age 50-69 screened, 2006**




Source: OECD Health Care Quality Indicators Data 2009.
Survival rates are age-standardized to the International Cancer Survival Standards population. OECD Health Data 2009 (cancer screening; mortality data extracted from the WHO Mortality Database and age standardized to 1980 OECD population).

**Exhibit 6: Breast cancer five-year relative survival rate, 2002-2007**




Source: OECD Health Care Quality Indicators Data 2009.
Survival rates are age-standardized to the International Cancer Survival Standards population. OECD Health Data 2009 (cancer screening; mortality data extracted from the WHO Mortality Database and age standardized to 1980 OECD population).

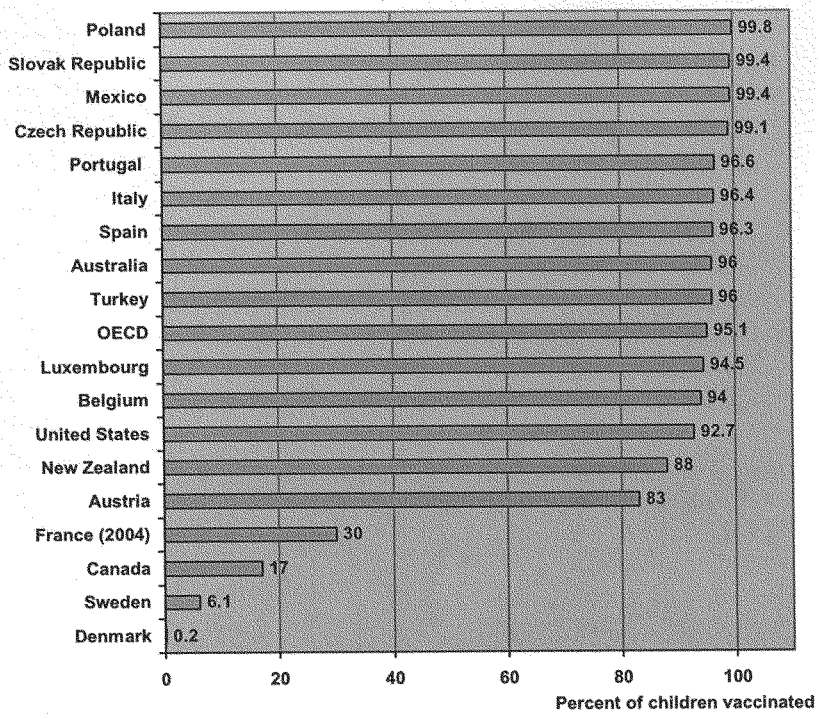
## IV. Care for Communicable Diseases

### Hepatitis B Vaccination

Child hood vaccination continues to be one of the most cost-effective health policy interventions. Vaccine for hepatitis B has been available for more than 20 years. It is estimated to be 95% effective in protecting against infection. The chart below shows the

vaccination rate for hepatitis B among children, aged 2. While the United States has vaccinated more than 90% of the eligible cohort, it still lags behind a number of other countries.

**Exhibit 7: Vaccination rates for hepatitis B, children aged 2, 2007**



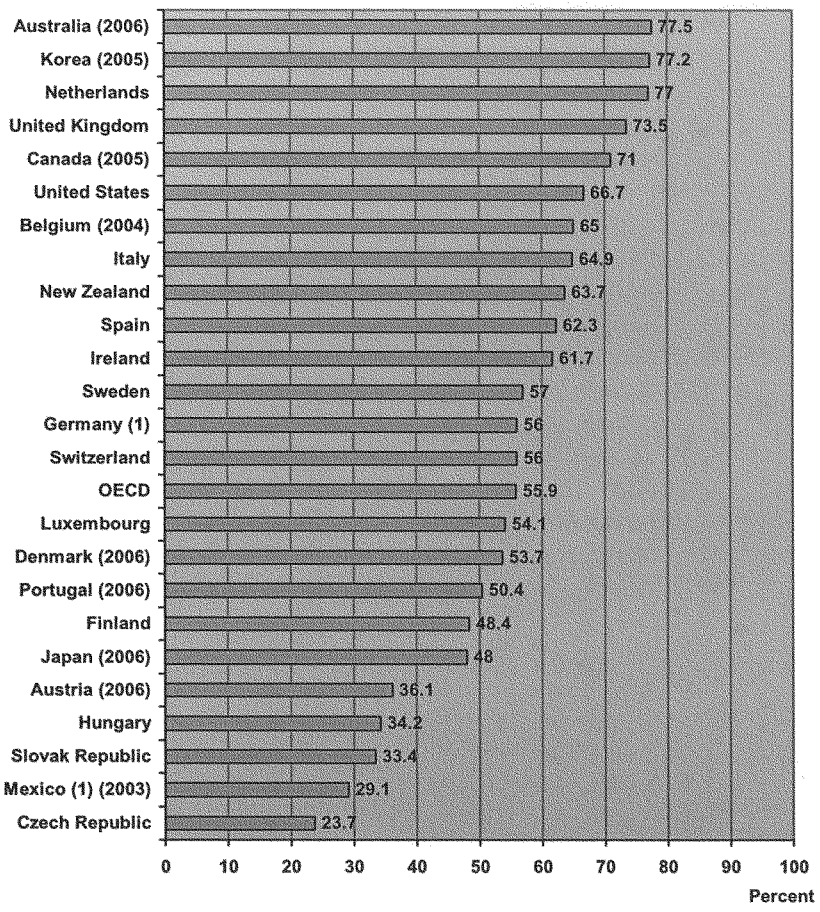

Note: OECD average only includes countries with required or routine immunization.
Source: OECD Health Care Quality Indicators Data 2009.

## Influenza Vaccination

Even when we are not facing an outbreak of H1N1, influenza is a very common and important infectious disease. Usually the disease causes a higher incidence of complications and mortality among the elderly and those with chronic medical conditions. Nevertheless influenza takes a large toll on the employed population as well

and accounts for substantial absence from work and lost productivity. The United States rate of vaccination, 66% was sixth of twenty three countries.

**Exhibit 8: Influenza vaccination coverage, population aged 65 and older, 2007**




1. Population aged 60 and over.
Source: OECD Health Care Quality Indicators Data 2009.

**Conclusion**

The OECD health care quality indicators project is still evolving, but now includes a number of quality indicators for important medical services and clinical conditions. Quality performance in the United States seems comparable to that of many other developed countries but does not clearly justify the claim that the quality of care here is the best in the world. We have, however, the most expensive care in the world, raising clear and important questions about the value we are receiving for our money.

The CHAIRMAN. Thank you very much, Dr. Epstein.
Mr. Tanner.

**STATEMENT OF MICHAEL TANNER, SENIOR FELLOW, CATO INSTITUTE, WASHINGTON, DC**

Mr. TANNER. Thank you, Mr. Chairman, Senator Corker, members of the committee.

I've been studying healthcare for over 20 years, including 16 years with the Cato Institute, author of a number of books on the issue, and a number of studies, including those looking at healthcare in other countries.

I'd like to say, to start, that, in examining how other countries handle the tradeoff between controlling costs and preserving quality, it is very important to remember that each country's system is a product of its unique conditions, history, politics, and national character. These systems range from the managed-competition approach of the Netherlands and Switzerland to the more rigid single-payer systems of Great Britain, Canada, Norway, and others, with great many variations in between.

Some of these countries have a true single-payer system, prohibiting private insurance and even restricting the ability of patients to spend their own money on healthcare. Others are multipayer systems, with private, competing insurers in varying degrees of government subsidy and regulation. Some countries base their systems around employment, while others have completely divorced work and insurance. Some require consumers to share a significant part of healthcare costs through high deductibles or high copayments, others subsidize virtually first-dollar coverage. Some allow unfettered choice of physicians, others allow a choice of primary care physicians, but require referrals for specialists. Still others restrict even the choice of primary care physician.

Even so, I believe it's possible to draw some important lessons and some important comparisons. First, when it comes to healthcare quality, on various measures the United States actually fares quite well, despite many of the criticisms we've heard. Measures such as life expectancy and infant mortality are actually very poor measures of a country's healthcare system and the quality thereof. Much better is to look at outcomes for specific diseases and whether your—what your survival rates are if you actually get sick. Here, the United States fares very well.

Recently, the British medical journal, The Lancet, looked at 5-year survival rates for cancer, to cite just one example. For both men and women, the United States was not only No. 1, in terms of survival rates, but it was far superior to most of the other countries that we are compared with.

Second, while the United States clearly spends far more than other countries when it comes to healthcare, healthcare—the rising healthcare spending is not a uniquely American phenomenon. Both as a percentage of GDP and per capita, healthcare costs are rising in many other countries. To cite just one example, in 2004, the year in which I was conducting a survey, healthcare spending in OECD countries rose at about 5.55 percent, and the U.S. was about 6.21 percent. We're higher, but theirs is still rising significantly, putting

significant strains on their budgets, leading to increased debt and tax increases or benefit cuts.

Third, universal health insurance does not necessarily mean universal access to care. In practice, many countries promise universal coverage, but ration care or have extremely long waits for treatment. Some countries with ostensibly universal systems actually fall far short of true universal coverage. Even the best tend to leave a small remnant, 1 or 2 percent, of the population as uninsured.

Fourth, those countries that have single-payer systems, or systems heavily weighted toward government control, are the most likely to face waiting lists, rationing, and restrictions on the choice of physician or other barriers to care, while those countries with national healthcare systems that work better, such as France, the Netherlands, and Switzerland, are successful to the degree that they incorporate market mechanisms such as competition, cost consciousness, cost sharing, market prices, and consumer choice.

Finally, while no country with universal coverage is contemplating abandoning a universal system, the broad and growing trend across countries with national healthcare systems is to move away from centralized government control and to introduce more market-oriented features. As Richard Saltman and Josep Figueras of the World Health Organization put it, to quote, "The presumption of public primacy is being reassessed."

Alan Jacobs, of Harvard—I'm sure, a colleague of yours—has—points out that, "While there are significant differences in goals, content, and strategies, there is a general convergence toward market practices among European nations when it comes to healthcare." Thus, even as we are talking about moving in a more European direction, toward more government control of our healthcare in this country, many European systems are debating how to add more U.S.-like market-oriented features into theirs.

Mr. Chairman, members of the committee, I believe that there is a great deal we can learn from the successes of other countries in controlling costs and improving quality, but probably even more that we can learn from their failures. We should bear those in mind, as well.

Thank you. I look forward to the committee's questions.

[The prepared statement of Mr. Tanner follows:]

Testimony of

**Michael Tanner**

Senior Fellow

Cato Institute

before the

**Senate Special Committee on Aging**

September 30, 2009

Mr. Chairman, Sen. Corker, Distinguished Members of the Committee:

My name is Michael Tanner. For the past 16 years I have been in charge of health care research for the Cato Institute in Washington, DC. Before that I served as legislative director for the Georgia Public Policy Foundation and as legislative director for health & welfare with the American Legislative Exchange Council. In all, I have spent more than 20 years studying the American health care system and am the author of five books on health care reform, most recently *Healthy Competition: What's Holding Back American Health Care and How to Free It.*

As part of my research, I have investigated health care systems in other countries, with particular attention to cost within those systems and the quality of care provided. The results of that research is detailed in my Cato Institute study "The Grass Isn't Always Greener: A Look at National Health care Systems Around the World," which I have attached to this testimony. The study looks at a number of specific countries, but it is possible to draw some broader general conclusions.

First, looking at the United States, there is no doubt that the United States spends far more on health care than any other country, whether measured as a percentage of GDP or by expenditure per capita. The United States now spends close to 16 percent of GDP on health care, nearly 6.1 percent more than the average for other industrialized countries.[1] Overall health care costs are rising

[1] "OECD Health Data 2007: Statistics and Indicators for 30 Countries." Organization for Economic Cooperation and Development, July 2007.

faster than GDP growth and now total more than $1.8 trillion, more than Americans spend on housing, food, national defense, or automobiles.[2]

Health care spending is not necessarily bad. To a large degree, America spends money on health care because it is a wealthy nation and chooses to do so. Economists consider health care a "normal good," meaning that spending is positively correlated with income. As incomes rise, people want more of that good. Because we are a wealthy nation, we can and do demand more health care.[3]

But because of the way health care costs are distributed, they have become an increasing burden on consumers and businesses alike. On average, health insurance now costs $4,479 for an individual and $12,106 for a family. Health insurance premiums rose by a little more than 6 percent in 2007, faster on average than wages.[4]

Moreover, government health care programs, particularly Medicare and Medicaid, are piling up enormous burdens of debt for future generations. Medicare's unfunded liabilities now top $50 trillion.[5] Unchecked, Medicaid spending will increase fourfold as a percentage of federal outlays over the next century.[6]

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[2] C. Borger, et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs Web Exclusive* W61: February 22, 2006.
[3] Uwe Reinhardt of Princeton University, for example, estimates that nearly half of the difference in spending between the U.S. and other industrial nations is due to America's higher GDP. Uwe Reinhardt, Peter Hussey, and Gerald Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs* 23 (May/June 2004): 11-12.
[4] "Employer Health Benefits Annual Survey," Kaiser Family Foundation, September 11, 2007.
[5] *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal supplemental Medical Insurance Trust Funds* (Washington: Government Printing Office, 2007).
[6] Jagadeesh Gokhale, "Medicaid's Soaring Costs: Time to Step on The Breaks," Cato Institute Policy Analysis no. 597, July 19, 2007.

But, while the US does not do a very good job of controlling costs, we actually do fair well on many measures of quality. I am aware, of course, that not every survey recognizes this. For instance, there is the famous World Health Organization study that ranks the U.S. health care system as 37th in the world in terms of health quality.

However, this study bases its conclusions on such highly subjective measures as "fairness" and criteria that are not strictly related to a country's health care system, such as "tobacco control." For example, the WHO report penalizes the United States for not having a sufficiently progressive tax system, not providing all citizens with health insurance, and a general paucity of social welfare programs. Indeed, much of the U.S.' poor performance is due to receiving a ranking of 54th in the category of "fairness." The U.S. is actually penalized for adopting Health Savings Accounts and because patients pay too large an amount out-of-pocket, according to the WHO.[7] Such judgments clearly reflect a particular political point of view, rather than a neutral measure of health care quality. On the other hand, the WHO report ranks the U.S. number one in the world in responsiveness to patients' needs in choice of provider, dignity, autonomy, timely care, and confidentiality.[8]

There are even difficulties in using more neutral categories of comparison. Nearly all such cross-country rankings use life expectancy as a measure. In reality though, life expectancy is a poor measure of a health care system. Life

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[7] Edward Kelley and Jeremy Hurst, "Health Care Quality Indicators Project: Initial Indicators Report," OECD Health Working Papers no. 22, March 2006.
[8] Edward Kelley and Jeremy Hurst, "Health Care Quality Indicators Project: Initial Indicators Report," OECD Health working Papers no. 22, March 2006.

expectancies are affected by exogenous factors such as violent crime, poverty, obesity, tobacco and drug use, and other issues unrelated to health care. As the OECD explains, "It is difficult to estimate the relative contribution of the numerous non-medical and medical factors that might affect variations in life expectancy across countries and over time."[9] Consider the nearly three-year disparity in life expectancy between Utah (78.7 years) and Nevada (75.9 years), despite the fact that the two states have essentially the same health care systems.[10] In fact, a study by Robert Ohsfeldt, John Schneider for the American Enterprise Institute found that those exogenous factors are so distorting that if you correct for homicides and accidents, the U.S. rises to the top of the list for life expectancy.[11]

Similarly, infant mortality, a common measure in cross-country comparisons, is highly problematic. In the United States, very low birth-weight infants have a much greater chance of being brought to term with the latest medical technologies. Some of those low birth-weight babies die soon after birth, which boosts our infant mortality rate, but in many other Western countries, those high-risk, low birth-weight infants are not included when infant mortality is calculated.[12] In addition, many countries use abortion to eliminate problem pregnancies. For example, Michael Moore cites low infant mortality rates in

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[9] "Health at a Glance: OECD Indicators, 2005," Paris, OECD Publishing, 2005.
[10] U.S. Census Bureau, 2000 Census.
[11] Robert L. Ohsfeldt, John E. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington AEI Press, 2006).
[12] In Austria and Germany, fetal weight must be at least 500 grams (1 pound) to count as a live birth; in other parts of Europe, such as Switzerland, the fetus must be at least 30 centimeters (12 inches) long. In Belgium and France, births at less than 26 weeks of pregnancy are registered as lifeless. And some countries don't reliably register babies who die within the first 24 hours of birth. For a full discussion of the issue, see Miranda Mugford, "A Comparison of Reported Differences in Definitions of Vital Events and Statistics," *World Health Statistics Quarterly* 36 (1983), cited in Nicholas Eberstadt, *The Tyranny of Numbers: Measurements & Misrule* (Washington: American Enterprise Institute press, 1995), p. 50. Some, but not all, countries are beginning to standardize figures and future data may be more reliable.

Cuba, yet that country has one of the world's highest abortion rates, meaning that many babies with health problems that could lead to early deaths are never brought to term.[13]

On the other hand, when you compare the outcome for specific diseases, the United States clearly outperforms the rest of the world. Whether the disease is cancer, pneumonia, heart disease, or AIDS, the chances of a patient surviving are far higher in the U.S. than in other countries. For example, according to a study published in the British medical journal *The Lancet*, the U.S. is at the top of the charts when it comes to surviving cancer. Among men, roughly 62.9 percent of those diagnosed with cancer will survive for at least five years. The news is even better for women, the five year survival rate is 66.3 percent, two thirds. The next best countries are Iceland for men (61.8 percent) and Sweden (60.3 percent for women). Most countries with national health care fare far worse. For example, in Italy, 59.7 percent of men and 49.8 of women survive five years. In Spain, just 59 percent of men and 49.5 percent of women do. And in Great Britain a dismal 44.8 percent of men and only a slightly better 52.7 percent of women live for five years after diagnosis.[14]

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[13] Anthony DePalma, "SiCKO, Castro, and the 120 Year Club," *New York Times*, May 27, 2007.

[14] Arduino Verdecchia et al., "Recent Cancer Survival in Europe: a 2000-02 period analysis of EUROCARE-4 data," *The Lancet* Oncology, Available online August 21, 2007, http://www.thelancet.com/journals/lanonc/article/PIIS1470204507702450/abstract; Nicole Martin, "UK Cancer Survival Rate Lowest in Europe, *Daily Telegraph*, August 24, 2007. Of course it can be argued that these figures are skewed by aggressive US testing and diagnostic procedures. In the U.S., we catch many cancers that would go undetected in other countries. These cancers are small or slow growing and would not kill the person suffering from it. That it is diagnosed in the US, but not other countries, makes our survival rate look higher. Jonathan Cohn, "What Jacques Chirac Could Teach Us about Health Care," *New Republic*, April 10, 2007. That is a theory worth considering and it is likely that increased screening has an impact on the figures for slow growing cancers such as prostate cancer (the source of much controversy since Rudy Giuliani raised the issue in his campaign). "Rudy Wrong on Cancer Survival Chances," *Washington Post*, October 31, 2007; David Gratzer, "Rudy Is Right in Data Duel about Cancer," *Investors Business Daily*, November 6, 2007.

It is notable that when former Italian Prime Minister Silvio Berlusconi needed heart surgery last year, he didn't go to France, Canada, Cuba, or even an Italian hospital—he went to the Cleveland Clinic in Ohio.[15] Likewise, Canadian MP Belinda Stronach had surgery for her breast cancer at a California hospital.[16] Berlusconi and Stronach were following in the footsteps of tens of thousands of patients from around the world who come to the United States for treatment every year. One U.S. hospital alone, the Mayo Clinic, treats roughly 7,200 foreigners every year.[17] Johns Hopkins University Medical Center treats more than 6,000; the Cleveland Clinic more than 5,000. One out of every three

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As, Robert Ohsfeldt and John Schneider concede in their book, *The Business of Health* "[Many] cancer survival rate estimates…do not adjust for cancer stage at diagnosis. This could result in survivor time bias – those with cancers detected at an earlier stage would exhibit longer post diagnosis survival times, even for cancers that are essentially untreatable." Robert Ohsfeldt and John Schneider, *The Business of Health* (Washington: American Enterprise Institute, 2007), pp. 23-24. However, survivor time bias is not as big an issue for cancers that have faster metastasizing times or strike younger patients.

As Ohsfeldt and Schneider go on to note,

> Survivor time bias, however, should not be a significant concern for cancers that respond well to treatment if detected early. For such cancers, early detection makes a substantive contribution to survival time – the longer survival time associated with early detection thus is not a spurious effect of early detection. An example is thyroid cancer. In the United States, virtually all females with thyroid cancer survive for at least five years. The lower survival rates for thyroid cancer in European countries suggest some underperformance in either early detection or post diagnosis management in these countries. In contrast, the differences in survivor rates are less pronounced for cancers that are more difficult to treat, such as lung cancers.

Thus, it is significant that the U.S. advantage holds for other cancers, too, including breast cancer, colon cancer, and thyroid cancer among others. Moreover, there are many benefits to early detection and treatment beyond survival rates. Even for prostate cancer, early treatment can have a significant effect on the quality of life. And it could be that the U.S. simply has more cases of prostate cancer than other countries (diet could play a significant role, for example. Kyung Song, "Study Links Diet to Prostate Cancer," *Seattle Times*, October 11, 2007).

Finally, it should at least be mentioned that one of the most common arguments for socialized medicine is that it would increase screening and preventive care. Indeed, John Edwards actually wants to make testing mandatory for all Americans. "Edwards Backs Mandatory Preventive Care," Associated Press, September 2, 2007.

[15] "World Briefing: Berlusconi has Heart Surgery in US," *New York Times*, December 19, 2006.

[16] "Stronach Went to US for Cancer Treatments: Report," CTV, September 14, 2007; available at http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070914/belinda_Stronach_070914/20070914

[17] Steve Findlay, "U.S. Hospitals Attracting Patients from abroad," *USA Today*, July 22, 1997.

Canadian physicians has sent a patient to the U.S. for treatment each year,[18] and those patients along with the Canadian government spend more than $1 billion annually on health care in this country.[19]

Moreover, the United States drives much of the innovation and research on health care worldwide. Eighteen of the last 25 winners of the Nobel Prize in Medicine are either U.S. citizens or work here.[20] U.S. companies have developed half of all new major medicines introduced worldwide over the past 20 years.[21] In fact, Americans played a key role in 80 percent of the most important medical advances of the past 30 years.[22] And, dvanced medical technology is far more available in the United States than in nearly any other country.[23]

The same is true for prescription drugs. For example, 44 percent of Americans who could benefit from taking statins, a lipid lowering medication that reduces cholesterol and protects against heart disease, take the drug. That number seems low until compared with the 26 percent of Germans, 23 percent of Britons, and 17 percent of Italians who could both benefit from the drug and receive it.[24] Similarly, 60 percent of Americans taking antipsychotic medication for the treatment of schizophrenia or other mental illnesses are taking the most

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[18] The two principal reasons for sending a patient abroad were the lack of availability of services in Canada (40 percent) and the length of the wait for certain treatments (19 percent),"Robert J. Blendon et al., "Physician's Perspectives on Caring for Patients in the United States, Canada, and West Germany." *New England Journal of Medicine*, 328, (April 8, 1993).

[19] John Goodman, "Moore's SiCKO Could Put Lives at Risk," *The Michael Moore Chronicles*, National Center for Policy Analysis, 2007.

[20] "Nobel Prize in Physiology or Medicine Winners 2007–1901," The Nobel Prize Internet Archive, http://almaz.com/nobel/medicine/medicine.html.

[21] Pharmaceutical Manufacturers Association, "Facts about the U.S. Pharmaceutical Industry," 2002.

[22] *Economic Report of the President* (Washington: Government Printing Office, 2004), p. 192.

[23] Gerard Anderson et al., "It's the Prices Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): 99.

[24] Oliver Schoffski, "Diffusion of Medicines in Europe," paper prepared for the European Federation of Pharmaceutical Industries and Associations," 2002, cited in Daniel Kessler, "The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature," June 2004.

recent generation of drugs, which have fewer side-effects. But just 20 percent of Spanish patients and 10 percent of Germans receive the most recent drugs.[25]

This is not to diminish the very serious problems facing the US health care system or the need for health care reform. problems with the U.S. system. Too many Americans lack health insurance and/or are unable to afford the best care. More must be done to lower health care costs and increase access to care. Both patients and providers need better and more useful information. The system is riddled with waste, and quality of care is uneven. Government health care programs like Medicare and Medicaid threaten future generations with an enormous burden of debt and taxes.

In reforming our health care system, it may indeed be possible to learn from the experiences of other countries, to see how they are able control costs so much better than us, and to examine what impact those cost controls have on the quality of care.

Of course, there is no single model for national health care systems in other countries. Indeed, the differences from country to country are so great that it is almost misleading to refer simply to "national health care" or "universal coverage" as if there were a collective model for how other countries deal with health care and health insurance. Each country's system is the product of its unique conditions, history, politics, and national character. Those systems range from the managed competition approach of the Netherlands and Switzerland to

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[25] Oliver Schoffski, "Diffusion of Medicines in Europe," paper prepared for the European Federation of Pharmaceutical Industries and Associations," 2002, cited in Daniel Kessler, "The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature," June 2004.

the more rigid single-payer systems of Great Britain, Canada and Norway, with many variations in between.

Some countries have a true single-payer system, prohibiting private insurance and even restricting the ability of patients to spend their own money on health care. Others are multi-payer systems, with private competing insurers and varying degrees of government subsidy and regulation. Some countries base their systems around employment, while others have completely divorced work and insurance. Some require consumers to share a significant part of health care costs through either high deductibles or high co-payments. Others subsidize virtual first-dollar coverage. Some allow unfettered choice of physicians. Others allow a choice of primary care physicians but require referrals for specialists. Still others restrict even the choice of primary care doctors.

It is also important to realize that no country's system is directly importable to the U.S. Americans are unlikely to accept the rationing or restrictions on care and technology that many countries use to control costs. Nor are U.S. physicians likely to accept a cut in income to the levels seen in countries like France or Germany. The politics, economics, and national cultures of other countries often vary significantly from that of the U.S. Their citizens are far more likely to have faith in government actions and to be suspicious of free markets. And polling suggests that citizens of many countries put social solidarity and equality ahead of quality and choice when it comes to health policy.[26] American attitudes are quite different. As pollster Bill McInturff notes, "Never, in my years

[26] Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006); Helen Disney, et al., *Impatient for Change: European Attitudes to Healthcare* Reform (London: Stockholm Network, 2004),

of work, have I found someone who said, 'I will reduce the quality of the health care I get, so that all Americans can get something.'"[27]

Even so, it is possible to draw some important lessons from the experience of other countries:

- Universal health insurance does not mean universal access to health care. In practice, many countries promise universal coverage, but ration care or have extremely long waiting lists for treatment. Nor does a national health care system necessarily mean universal coverage. Some countries with ostensibly universal systems actually fall far short of universal coverage, and most leave at least a small remnant (1-2 percent of the population) uncovered. While this is certainly wider coverage than the United States provides, it shows the difficulty of achieving either truly universal coverage or universal access to care.

- Rising health care spending is not a uniquely American phenomenon. While other countries spend considerably less than the U.S. on health care both as a percentage of GDP and per capita, it is often because they begin with a lower base of expenditures. But their costs are still rising, leading to budget deficits, tax increases, and/or benefit cuts. In 2004, the last year for which data is available, the average annual increase for per capita

[27] Robin Toner, "Unveiling Health Care 2.0, Again," *New York Times*, September 16, 2007.

health spending in the countries discussed in this study was 5.55 percent, only slightly lower than the United States' 6.21 percent.[28] As the *Wall Street Journal* notes, "Europeans...face steeper medical bills in the future in their cash-strapped governments."[29] In short, there is no free lunch.

- Those countries that have single-payer systems or systems heavily weighted toward government control are the most likely to face waiting lists, rationing, restrictions on the choice of physician, and other barriers to care. Those countries with national health care systems that work better, such as France, the Netherlands, and Switzerland, are successful to the degree that they incorporate market mechanisms such as competition, cost-consciousness, market prices, and consumer choice, and eschew centralized government control.

- While no country with universal coverage is contemplating abandoning a universal system, the broad and growing trend in countries with national health care systems is to move away from centralized government control and to introduce *more* market oriented features. As Richard Saltman and Josep Figueras of the World Health Organization put it, "The presumption of public

[28] OECD Health Data 2007: Statistics and Indicators for 30 countries, OECD, Oct. 2007
[29] Quoted in Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006), p. 109.

> primacy is being reassessed."[30] Alan Jacobs of Harvard points out that while there are significant differences in goals, content, and strategies, there is a general convergence toward market practices in health care among European nations.[31] Thus, even as the U.S. debates adopting a government-run system, countries with those systems are debating how to make their systems look more like the U.S.

Looking at other countries and their experiences, then, can provide guidance to Americans as we debate how to reform our health care system. National health care is not a monolithic idea, nor is it always as disastrous as its U.S. critics would sometimes portray. *Some* national health care systems do *some* things well.

Yet, neither are those systems without serious problems. In most cases, national health care systems have successfully expanded insurance coverage to the vast majority, if not quite all, of the population. But they have not solved the universal and seemingly irresistible problem of rising health care costs. In many cases, attempts to control costs through governmental fiat have led to problems with access to care, either delays in receiving care or outright rationing.

In wrestling with this dilemma, many countries are loosening government controls and injecting market mechanisms, particularly cost-sharing by patients,

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[30] Richard Saltman and Josep Figueras, "Analyzing the Evidence on European Health Care Reforms," *Health Affairs*, March-April 1998.
[31] Cited in Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006), p. 91.

market pricing of goods and services, and increased competition among insurers and providers. As Pat Cox, former president of the European Parliament, put it in a report to the European Commission, "we should start to explore the power of the market as a way of achieving much better value for money."[32]

Moreover, the growth of the government share of health care spending, which had increased steadily from the end of World War II until the mid-1980s, has stopped, and in many countries the private share has begun to increase, in some cases substantially. There is even evidence of a growing shift from public to private provision of health care.[33] If the trend in the U.S. over the last several years has been toward more of a European-style system, the trend in Europe is toward a system that looks more like the U.S.

Therefore, if there is a lesson which U.S. policymakers can take from national health care systems around the world, it is not to follow the road to government-run national health care, but to increase consumer incentives and control. The U.S. can increase coverage and access to care, improve quality, and control costs without importing the problems of national health care. In doing so, we should learn from the successes—*and the failures*—of systems in other countries.

Thank you and I would be happy to answer any questions.

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[32] "'Cox Report' on Financing Sustainable Healthcare in Europe Presented to European Commission today," Press Release, February 13, 2006.

[33] Hans Maarse, "The Privatization of Health Care in Europe: An Eight Country Analysis," *Journal of Health Politics, Policy, and Law* 31 (2006): 981-1014.

The CHAIRMAN. Thank you very much, Mr. Tanner.

We'll now begin our questioning with 5-minute rounds.

My first question is to the whole panel. Where OECD countries have chosen to use private insurance companies to administer healthcare benefits, the insurance companies, unlike most of the United States insurance companies, are nonprofit. Does this distinction have an effect on the cost of healthcare or barriers to access to healthcare for the United States?

Mr. Pearson.

Mr. PEARSON. I would expect that it would have some effect. I don't think it's the most important feature in health systems, about whether we're talking about profits or nonprofits. I think what really matters are the incentives and the fees that are paid for the services by the insurance companies. So——

Thank you.

The CHAIRMAN. What do you think, Dr. Bennett?

Dr. BENNETT. We used to have an insurance that was run by the physicians, before we had——

The CHAIRMAN. Your mic.

Dr. BENNETT [continuing]. Medicare that—it was a—sorry—it was a—the physicians themselves came together to develop a system such that they wouldn't have to worry about whether people could pay or not. I think profit gets in the way, where we're what many Americans have described to me as denial-based care, that—where the sick people are cutoff if there is a desire for profit in the insurance, so that you watch, if—the majority of people don't need healthcare—80 percent—20 percent are the high users. If you can get rid of those people, because of preexisting conditions or because they've gotten sick and now changed jobs, you are going to take—that is an incentive, if you are responsible to a board of directors that wants you to have profit.

I must say that—to Mr. LeMieux, that my parents used to love going to Florida, every year for 40 years, but when my mother got cancer and my father had arrhythmia, they could never—they could not any longer find insurance that would cover them at all, so they stopped coming to Florida. That's bad for you.

The CHAIRMAN. Dr. Schoen.

Ms. SCHOEN. I think, when you look closely at other countries that do rely on private insurers—in fact, the Netherlands and the Swiss systems use those carriers—you find several things that dramatically lower overhead costs. One, the benefits are very standardized; you can really compare plans. They go out of their way to avoid churning, so you can stay with a plan for as long as you want to stay. Marketing costs are extremely low, because there are public websites, where I can get on and compare. There's accountability for the type of insurance market behaviors that we've just heard about. Those are prohibited, any sort of risk rating or turning down, and they're doing risk adjustment. They're very aggressively trying to get the carriers focusing on quality and value.

When we asked the Swiss people how it is the Swiss private insurance run for 5 percent overhead, the Germans run for 5 percent, the Netherlands do, and ours average 15 percent, they said, "No one would tolerate more than 5 percent in Switzerland." I mean, "What are you talking about?" So, the margins are extremely low,

there's a large amount of public transparency that's going on, and the competition is around quality, so you can't really have a big margin, even if you're for-profit. So, these systems have sort of done nonprofit or for-profit, but the way they compete with each other forces that overhead down.

The CHAIRMAN. Thank you.

Dr. Epstein.

Dr. EPSTEIN. I will say something, if I'm permitted, about national data on this question we are all aware of potential concerns about for-profit medicine prior studies have examined use of high-cost procedures among elderly persons in the Medicare population who are in Medicare Advantage plans both on for-profit plans and not-for-profit plans. They show no evidence of skimping in the for-profit sector. But that is just evidence from our country.

The CHAIRMAN. Mr. Tanner?

Mr. TANNER. Yeah, likewise, looking at the evidence largely in our country, about 40 percent of insurers are actually nonprofits in this country, and there's no significant evidence that I've seen, in terms of difference in cost between the for-profits and nonprofits, or in the quality that they produce.

I would also just note that insurance company profits are not particularly high as a percentage of healthcare costs. If you look at the actual profit margin that insurers make, they range from about 3 percent in the—for HMOs, to about 5 and a half percent under fee-for-service plans, which is relatively modest by most corporate standards. So, they're—it's not insurance company profits that are really driving healthcare costs in this country.

The CHAIRMAN. All right.

Senator CORKER.

Senator CORKER. Well, thank you, Mr. Chairman.

Thank each of you for your testimony. I'm not going to pursue the OECD comparisons, because I don't think that really helps much, and—it's interesting to look at, but the characteristics of the—countries are so different, I'm not sure it's useful as far as helping us look inward and figure out what we need to do. I think Mr. Tanner's done a good job of sort of teasing some of that out.

What I do want to focus on, though, are some of those things that, within our own country, create issues. Again, I really do appreciate all of the testimony. I read all of it early this morning.

Dr. Bennett, one of the things that has troubled me greatly about our system is the fact that we pay more for pharmaceuticals and devices than other countries. Yet, it—it's not really our country so much that's the problem, it's the—sort of the parasitic relationship that Canada and France and other countries have toward us; meaning that you set prices, and, unfortunately, all the innovation, all the technology breakthroughs, just about, take place in our country, and we have to pay for it. So, you're living off of us. What you use typically is older, but—I just had a meeting—I've met with our former Trade Representative; I met, this morning, with PhRMA to, you know, if you will, put a stick in their eye over this. But, I will say that you benefit from us, and we pay for that. I resent that, and I want to figure out a way of solving that. I wonder if there's a way that—if you have any ideas in that regard.

Dr. BENNETT. Well, Senator, I think—with due respect. These are multinational corporations and that—when we don't treat our pharmaceuticals companies properly, they invest somewhere else, and they take their——

Senator CORKER. They invest here.

Dr. BENNETT [continuing]. Research dollars somewhere else.

Senator CORKER. That's right. That's right.

Dr. BENNETT. So, it is a global issue, and that whether it's Switzerland or whether it's the United States or whether it's Canada, we're all in this together. We want the breakthrough drugs, we want—and, frankly, in our country, our generics are way too expensive——

Senator CORKER. Ours are less.

Dr. BENNETT [continuing]. Yours are less. So, you know, I think it's a matter of us learning from one another as to how this works. But, we want the research, we want—we need drug companies to be making more. I mean, in my country, quite often they say, "We're now spending more on drugs than we are on doctors." You're going, "Well, maybe that's a good thing," that—you know, that my father is now on a drug that previously would have required a pacemaker. So, it is a shared——

Senator CORKER. I think——

Dr. BENNETT [continuing]. But, I think that we are, I think, very in favor of our price controls. In some of our things, like even bulk buying, you know, on pandemic preparedness, we have got a good price because we've decided to buy, as a country, enough vaccine for the whole country. Therefore, we are self-sufficient as we come forward looking at the pandemic.

Senator CORKER. I think my goal would be, over time, to—for us not to pay more than you, because you set prices and cause us to pay more, when we're doing all the innovation. So, I hope that we can figure out, on a world basis—have you—and I want to move on to another question.

Dr. BENNETT. Well, I just want to say, please don't think that you can import cheap drugs from Canada. It'd last us about 36 days.

Senator CORKER. No, no, no. That's a——

Dr. BENNETT. OK.

Senator CORKER [continuing]. That's a silly way of dealing with it, but a way to at least get it started, because, in essence, the Canadian government and its citizens are taking advantage of our citizens by virtue of setting prices that are lower than competitive prices.

Dr. BENNETT. No, I think it's the drug companies, sir.

Senator CORKER. Well——

Dr. BENNETT [continuing]. They're multinational. It's nothing about the——

Senator CORKER. Yeah.

Dr. BENNETT [continuing]. United States of America.

Senator CORKER. Yeah. All right. Well, thank you for that. I think that's something we all need to work together on and even it out across the world, so that our citizens are paying less.

Dr. Schoen, I appreciated the contributions you made about the frailties in our system. I agree with most of those, as far as the in-

centives go. I noticed that one of the things you alluded to was capitation or some hybrid thereof, where we have capitation plus, maybe, incentives.

I came into a situation after a capitation program had been put in place in Tennessee. It was called, TennCare. I came in about a year later. What I saw in that—and that was interesting to me, by the way; you pay so much per member, per month, to keep people healthy—what I saw happening, though, was something very different. By the way, a lot of these providers were nonprofits, I might add. But, in essence, what they were doing is denying care. I mean, in essence, what you had was the private sector, through capitation—you might get paid a $110 per member, per month, or whatever the number was—$6 of that was supposed to go to prevention. Never happened. In essence, what happened was, there was a denying of care that took place so that there was a profit margin. So, I agree that we pay for activities here, and that's problematic, cause there's a lot of self-referral, and we inflate costs. On the other hand, I don't know yet what the solution is, and I'm wondering if you might shed some light on that.

Dr. SCHOEN. I think, when you look at what other countries have been doing, one of the things that's interesting is how much variation there is on payment methods, both from what they did two years ago and what they're doing now. The U.S. is, in fact, the only one that does full capitation, like you've just described, where the whole risk is underneath one risk-bearing entity.

What other countries have started to do is what many of our very innovative care systems are doing is saying, "If you have a heart attack, let's give you a global fee that covers all of your treatment, including—we're going to be at risk that we did it right the first time so you don't have a readmission." Geisinger is doing that, with a proven care—around very specific episodes of care, and the bundled care for that, with a high-quality promise. We see Germany experimenting with that, moving from more tightly budgeted hospitals to something like our DRGs, and expanding.

What other countries are doing with primary care is paying doctors in a mixed way. They're paying them an average amount per month to help them support teams, support nurses, support after-hours-care systems, so when you call up, someone answers or comes to see you, has time to talk to you; you don't have to have a visit; but, they're also paying a fee for service to make sure you respond to patients. They're paying more for after-hours care. So, it's a blended capitation fee-for-service that's trying very much to push a very responsive—patient responsive system.

Increasingly, in countries like the Netherlands, they're saying, "How can those primary care doctors in the community also work with the hospital, have transition-care nurses, that, as I leave the hospital, someone's there to take care of me, and someone know what's happening?" So, there's a very interesting mix of how do we get a more integrated care system, when it's fragmented, and using the payment systems to move with the quest to value.

Every single one of these initiatives has an accountability feature, where an outcome is being measured to make sure that there is not a shirking. But, what you see is a very responsive system. Visits rates are higher in a lot of these other countries. What's

starting to be wonderful is, in the Netherlands, you don't have to go to the doctor's office, you can get a visit by an e-mail. The physician can fill a prescription for you, if that's a better way of getting it. You can contact through multiple sites. We're seeing this in the U.S., some experiments. The difference is, the other countries take it nationwide.

The CHAIRMAN. Thank you.

Senator CORKER. My time is up, I apologize.

The CHAIRMAN. Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

So many things I want to ask about. Mr. Tanner, how many people have gone bankrupt in the last 10 years in Switzerland because of a medical crisis?

Mr. TANNER. I don't have a number, but I would assume it's relatively few.

Senator FRANKEN. I believe it's zero.

Mr. TANNER. That's quite possible.

Senator FRANKEN. How many in Germany?

Mr. TANNER. I assume you're going to say zero, as well. I don't have bankruptcy numbers on any of the European countries.

Senator FRANKEN. You don't.

Mr. TANNER. No.

Senator FRANKEN. You've been studying this for 20 years.

Mr. TANNER. But, I have not looked at the bankruptcy numbers in those countries.

Senator FRANKEN. OK. Thank you, sir.

Mr. TANNER. I will say——

Senator FRANKEN. No.

Mr. Pearson, your testimony mentions high administration costs as a primary reason that our healthcare spending is so high. What's included in these administrative costs?

Mr. PEARSON. Yeah, there's international standards that we agree what is included and what isn't included. So, the OECD definition is actually more narrow than the one that you usually use in the United States. It concentrates very much on the payment systems and the reimbursement systems and misses out some of the things that you would use in your national definition, which is why, when we do the international comparisons, you see a smaller number in the—when we look at the OECD, what the United States spending on administration than you're used to seeing. So, on our figures it's about, if I remember rightly, 7 percent of your total health spending. I think you're used to seeing a much larger number. But, relatively, it is still by far and away the highest in the OECD, together with some of the multipayer—multipayer systems are also similarly expensive.

Senator FRANKEN. Ms. Schoen, we were talking, before, about nonprofits—insurance. Minnesota is covered all—it's all nonprofit. We—for every dollar, in Minnesota, that goes to health insurance, 91 cents comes back in healthcare. There's a thing called "medical-loss ratio," that—our medical-loss ratio is 91. For private individual plans in this country, it's 60.

VOICE. 70.

Senator FRANKEN. Can we pay for healthcare if we bring up that number from 60 to 90?

Ms. SCHOEN. If you—I've included a chart in my testimony, figure 26, the McKinsey study, that compared our excessive costs. We're looking at those kinds of medical-loss ratios, as well as transaction costs. They estimate that the excess is in the neighborhood of $90 billion per year. It's a lot of money. Those high medical-loss ratios that you mentioned, particularly in the small group and individual market, you're actually even on the low side. When Maine opened up its books, it found one that's only paying 40 cents out in claims.

Senator FRANKEN. OK.

Ms. SCHOEN. The highest, particularly in the individual and small group market. Other—every other country—and we can see it in our large group—when you bring group risk back together, the running of the health plan, the overhead comes way down, and when you simplify. It's critical we do both.

Senator FRANKEN. Let me continue, cause I don't have that much time. Some estimates—continue with you, Ms. Schoen—show that we can save billions by streamlining the claims process so clinicians waste less time on paperwork and redundancies. Do you think there'd be a benefit in this country having a unified system for billing and payments in healthcare?

Ms. SCHOEN. Absolutely.

Senator FRANKEN. If we were to create a streamlined system for all payers, would the Medicare administration structure for billing and payment be a good option to buildupon? Just to be clear, I'm talking about Medicare's administrative system, not Medicare's payment schedule.

Ms. SCHOEN. Well, it's—as I think you know, Medicare uses private carriers to pay claims. So, I think any effort that would say, "Let's have our claims form use common codes, let's start to make it electronic"—I often hold up my insurance card and say "It's plastic, but we Xerox it; in Germany, they swipe it." It's electronic. It just—we know what you're going to pay. If we could move toward that, we remove layers in the physician's office, in the hospital office, as well as the insurance companies.

All I've talked about so far is the overhead in insurance. So, yes, I think we don't even—we can't even foresee how many layers are there that don't need to be there.

Senator FRANKEN. Right.

Dr. Tanner, are you aware of—I—in your written testimony, you talked about 7,000 patients coming from abroad to Mayo. Are you aware that there are 750,000 Americans who traveled abroad for medical care in 2007?

Mr. TANNER. Yes, I am.

Senator FRANKEN. That they went to places like Mexico and India because they found less expensive healthcare in those countries?

Mr. TANNER. Yeah, the primary destinations are India and Thailand, but——

Senator FRANKEN. Do you find anything wrong with that——

Mr. TANNER. No, they are not getting——

Senator FRANKEN [continuing]. Picture?

Mr. TANNER [continuing]. The quality of care that Indians and Thais get in their country. They are getting a specialized care

that's available for tourists who pay with U.S. dollars in those countries. It is not the quality——

Senator FRANKEN. Why are they leaving the——

Mr. TANNER.—the overall quality of care.

Senator FRANKEN. "Why are they leaving the United States?" is the question, but I've run out of time.

Thank you.

The CHAIRMAN. Thank you so much.

Senator LeMieux.

Senator LEMIEUX. Thank you, again, for all the folks on the panel. It's been very educational this morning.

I want to ask two sort of open-ended questions, and hopefully there will be enough time for everyone to respond.

My first question is, is, What do other countries do to try to prevent fraud, waste, and abuse? What procedures do they have in place? We obviously have a huge problem with that in our Medicare system and our Medicaid system in this country. So, I would love to hear what other countries are doing to address those issues.

I'll start with Mr. Pearson.

Mr. PEARSON. I'm afraid I'm going to plead ignorance here. I actually have no knowledge of this area of policy.

Senator LEMIEUX. Dr. Bennett.

Dr. BENNETT. We now have a——

Senator LEMIEUX. Microphone, please.

Dr. BENNETT [continuing]. Now have a photo ID card that actually has begun to eliminate the fraud that was happening. I am sorry to say that some of the fraud was not in—that the health clinics very close to the American border, there were a lot of Americans who had Ontario health cards and were coming up to St. Catherine's to actually get their—the license plates in those parking lots was filled with Americans. So, we ended up having to change our health card in Ontario to one with a photo on it, and we've begun to get there.

But, I think that having primary care, having a family doctor who actually can coach somebody through the system, I think actually—and——

Senator LEMIEUX. What about—if I can interrupt——

Dr. BENNETT. Yeah.

Senator LEMIEUX [continuing]. Because I don't have much time—how about provider fraud? Do you require a background check for your healthcare providers or do extensive checks? We don't do that in this country. I was wondering what you might do in Canada.

Dr. BENNETT. Well, in our College of Physicians and Surgeons in—each of the provinces and territory does do a background check for the physicians before they even try and move provinces or come in. They're very serious, in terms of prosecuting any sort of billing fraud. It is very seriously dealt with.

Senator LEMIEUX. OK.

Ms. Schoen.

Ms. SCHOEN. I can't speak in depth about it, but, when you look abroad, what you often find is systems that—- where the specialists are paid on salary. They work with a hospital, that there's a lot less of a fee-for-service incentive to just bill for things that you didn't do. There's less ownership of labs. The labs are more free-

standing. They're in a nonprofit facility, so there's less that I could take something by prescribing you extra.

So, some of the oddities of the way we have—in ownership arrangements, just do not exist in the same way. The physicians' offices look quite different. Again, if you pay primary care doctors, and have a very strong primary care system, where they're accountable for patients with registries, some of the fee-for-service "just doing more" goes away and there's a much higher emphasis on prevention and keeping people healthy.

Senator LEMIEUX. Dr. Epstein?

Dr. EPSTEIN. Senator, it's a great question, but I can't enlighten us further.

Senator LEMIEUX. OK.

VOICE. Yeah, I also can't go into great depth, but I will suggest that the level of fraud in various countries often has as much to do with sort of national character and history as it does with the actual system.

Even in those systems that have sort of rigid payment systems so the doctors are sort of secondary corruption that goes on—Greece, for example—there's often doctors who refuse to treat patients during the day while they're on salary, and they take what's called "informal payments" to treat patients at night, off the books. A large portion of that goes on, as well.

Senator LEMIEUX. Thank you very much. The last question I have—and I think it's a question that you'll like answering, which is, you know, we're trying to do a lot of things with healthcare in this country, but what would be the first thing that you would do? What's the lowest hanging piece of fruit to reduce cost and increase the quality of care?

Mr. Pearson.

Mr. PEARSON. You're right, I love that question. Moving away from fee-for-service payments to episodic payments.

Senator LEMIEUX. Dr. Bennett.

Dr. BENNETT. Well, I think having everybody covered, and then have a coordinator for the system. But, I did want to talk about the fee-for-service versus—the vets used to get paid for the downer cow and going out and looking after them one at a time. Now vets are being paid for herd health. They get paid if they are able to keep the herd healthy. I think that if we could look to a system where doctors were awarded for keeping people well, that—in terms of what Senator Franken had said, in terms of the—that they get rid of the perverse incentives for churning patients through more and more tests and actually reward them for keeping people well—do they have their immunizations? Did they get their mammogram? It is a system that is about health outcomes, not volume piecework.

Senator LEMIEUX. Thank you.

Ms. Schoen.

Ms. SCHOEN. You've asked for one, but I have to give you two.

Senator LEMIEUX. OK.

Ms. SCHOEN. I think, unless we bring our insurance system back together, we can't pay in a way that's rational, and then we need to be starting to pay with a focus on value. We have pricing system that's unbelievable, when you look at it right now. You can't ask

what the price is. It's behind a veil of secrecy. So, we really need to do the insurance side, bring everyone in, and start to focus on paying differently and using our group purchasing power.

Senator LEMIEUX. Dr. Epstein.

Dr. EPSTEIN. I'm going to say something which is similar to Ms. Schoen. The usual shibboleths are primary prevention, the medical home, public reporting, paying for results, comparative effectiveness, information technology. I think they're all going to be helpful, but none will provide dramatic relief. If we're going to really make progress, we're going to have to move towards more highly integrated care. In the best of all worlds, we'd have certain parts of the population for whom they would find it compatible in fully capitated systems, and in other instances, we would use intermediate approaches such as bundling and accountable-care organizations and the like. But, I think we have to move in that direction.

Senator LEMIEUX. Mr. Tanner.

Mr. TANNER. I think what we need to do is have more competition within the healthcare industry, and more consumer involvement within the healthcare industry. The lowest hanging fruit would simply be to allow people to buy insurance across State lines. People should not be a captive of the insurance cartels within their State, nor should they be captive of the regulatory regimes within their State.

In the longer term, we need to move away from an employer-based healthcare system to one where individual consumers have healthcare, so that you don't lose your insurance when you lose your job and so that you can get insurance in a long, lifetime contract, where you can buy it when you're young and healthy, and keep it the long term, which means you need to change the tax incentives in the current tax code.

Senator LEMIEUX. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. We have a—time for just one more round, two minutes a Senator. I'd like to give one minute to Dr. Bennett and one minute to Mr. Pearson.

Dr. Bennett, we hear, and we've heard today, about lines and rationing and people apparently not very happy with their healthcare in Canada. You said people in Canada are as much as five times more pleased with their healthcare as we are. I'll give you one minute to answer that.

Then, Mr. Pearson, regulation. I think you indicated that countries that are doing a good job in controlling costs have a good deal of government regulation, perhaps to an extent that we do not have here. One minute.

Dr. Bennett would you speak first?

Dr. BENNETT. I think that we are doing better on the wait-times end, but, you know, as I was coming yesterday, one of my former colleagues said to me—his father's a very wealthy man, but had a heart attack and, within one hour, was on the table getting a stent operated on in extraordinary way that—in terms of a truly integrated system.

So, in our system, if you're sick, you do very well. The "worried well," we have, sometimes, more trouble with. But, there's no one

in our country who is dying because they don't have health insurance. I think the Harvard study, from two weeks ago, that had 45,000 people a year dying in the United States of America because they don't have healthcare, is, again, where we need to focus.

The CHAIRMAN. Thank you.

Mr. PEARSON.

Mr. PEARSON. Yes, thank you. I will focus on, if you like, the multipayer systems, the systems most similar to the United States. It's not much point in me talking about the regulation in national health service systems. You're never going to be having one of those.

Within those multipayer systems, they could use a lot more regulation than happens in the United States. There's ex-post-risk adjustment to make sure that the competing providers compete on the grounds of price and quality. They don't try and get a better mix of people.

So, in other words, what I think the regulations are doing is that they're trying to channel the competition in a way that's more productive for society. They're trying to channel the competition into, Can we make sure that we get prices down? So, they also regulate on making sure that the information is made available to insurees. They regulate, maybe, on where—what sort of pharmaceutical prices can be charged. So, again, there's no, kind of, cost-gouging going on within the system.

So, what they're trying to do is to make sure—they are regulating, but they're regulating to try and make sure the competition works, rather than people just trying to find a way around competition in order to maximize their profits.

The CHAIRMAN. Thank you.

Senator CORKER.

Senator CORKER. Thank you, Mr. Chairman, and again, all of you, for your testimony.

Dr. Epstein, I—my guess is—you talked, in your testimony, about racial minorities having difficulties getting the care they need. I assume that's a pretty major indictment of the Medicaid system itself. I saw you and Dr. Tanner sort of agreeing with each other on many of the competition, the notions that the nickels and the competition that ought to occur.

I'd like for you, in the short time I have, to address two things. You mentioned the integrated system that we need to have. I think most of us agree with that. One of the things I don't like at all about the debate we're having right now is, you know, it's like a 100 folks sitting around the table, changing that, where, in essence, it's tough sledding. We need to figure out a—I agree that that needs to happen. It's tough work. It's hard to do it in a piece of legislation. But, working through Medicare and—not Medicaid so much—but, doing pilots and seeing what works and spreading it out probably is the best way to do it. Over an entire Presidential term, we could probably do a lot of damage.

But, I'm wondering if you might—in a good way—and what we're doing now, probably the other way—but, could you address that, and also the fact that, in your testimony, you mentioned that, under our system today, people really don't have any skin in the game, they don't really have any money out, and so, therefore, its—

the cost to them, they're not aware—it seems like, to me, that would be the same in the single-payer system, too. I wonder if you might educate us there a little bit.

Dr. EPSTEIN. I think you're asking a couple of different questions, and I'll try and do my best to address them both.

I didn't address the latter, which is the issues that Mr. Tanner talked about, which is particular individual incentives and how they play out and where that goes.

In terms of integration, it is my sense—and I say this, not only as someone who's studied health policy, but as a primary care provider—that integration is really key for providing better care. We see that in the appalling number of readmissions we have, because we don't get transitions to ambulatory care right or have proper incentives to keep patients out of the hospital. I think we need to align those incentives over time.

We also need to do it in a way that is attractive, to patients who don't want to be constrained fully. So, I really want to pick up on the——

Senator CORKER. So, how do we make that happen in—you know, with the legislative process we have that—so much of what we do in the public sector affects the private sector—how do we actually do that? You know, we have great universities and Mayo Clinics and Vanderbilt and places like that, that talk about this all the time, but they can't make it happen. How do we do that?

Dr. EPSTEIN. Sure. Delivery-system change is going to be even harder and more difficult to accomplish than changing coverage. Delivery system is very difficult to change. I believe the current bills have funding and provisions for a series of what I would hope will be more rapid-fire-than-before demonstrations, which will lead to incremental knowledge and guide us as we think about strategies, like bundling, and creating organizations that are accountable for a broader range of services. We need to empower and incent hospitals, not only to do their job with inpatient care, but to do their job in transitioning patients to ambulatory care, they need to work with other providers to ensure that patients don't just cycle back and forth to the ambulatory-care and hospital setting. The exact details of that have got to be worked out.

But, what you can do at the Federal level is invest money in it and give notice that you see the future being, not the perpetuation of entropic fee-for-service going on and on, but, in fact, changing the payment system and incentives so that we move towards more integrated care.

Senator CORKER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Corker.

Senator FRANKEN.

Senator FRANKEN. Yeah. Haven't we had—haven't we seen what works? Mr. Epstein—Dr. Epstein, haven't we seen what works? Doesn't Mayo work? Doesn't Cleveland Clinic work? Doesn't Geisinger work? Haven't we seen that?

Dr. EPSTEIN. I don't know that we have the model that we can bring to scale and transport comfortably across America and say, "We've got it.

Senator FRANKEN. Yeah, but—but, I mean, do we need more pilot programs, or do we need to do what we're doing in this legislation, to try to encourage a quality and value versus fee for service, say?

Dr. EPSTEIN. I think, if I read the legislation correctly, that there is money in there for starting pilot programs, demonstrations, and evaluations of a host of different ideas that will be brought to scale. You know, the history of medical innovation is that you get a few zealots who can produce a model that seems effective either in providing better quality or lower cost, but it is hard to tease out the unique contextual factors that have allowed them to succeed. When you try and recapitulate the model elsewhere, it often doesn't work. But that's what needs to happen here.

Senator FRANKEN. But, aren't there things in common in these places that seem to deliver quality healthcare for a lower cost? Aren't there things in common? For example, let's talk about your primary care physician. What's the ratio of primary care physicians/specialists in this country?

Dr. EPSTEIN. Right now?

Senator FRANKEN. Yeah.

Dr. EPSTEIN. About 0.35, depending on what you call a primary care doctor. About 35 percent.

Senator FRANKEN. What would it be in Europe?

Dr. EPSTEIN. It's variable quite a bit in Europe. The prevailing wisdom is that is close to 0.5. In fact, if you look across multiple different countries, it's really quite variable.

Senator FRANKEN. So, we need more primary care physicians, wouldn't you say?

Dr. EPSTEIN. I think that. It's becoming vogue to believe that we do. But we've got a payment system that doesn't favor that, as you well know.

Senator FRANKEN. Right. Part of the health bill is for workforces to try to steer people into that, incentivize them to go into it, is it not?

Dr. EPSTEIN. It's less in the health bills and more in the popular dogma. What's in the health bills is the notion of a medical home, which we hope will move us towards greater emphasis on primary care—I think we could do much more.

Senator FRANKEN. OK. My time's run out. I have so many more questions, but, thank you, to all our witnesses.

Thank you.

The CHAIRMAN. Thank you so much, Senator Franken.

Senator LEMIEUX.

Senator LEMIEUX. I want to talk about the medical malpractice issue. There was a—Dr. Bennett, in your comments of the ways that—seven clear reasons why you pay less and feel better in Canada, No. 4 was malpractice insurance, and you mentioned that in your remarks.

We have a situation, in this country, where our doctors are paying exorbitant amounts for medical malpractice insurance. My wife, Meike, and I are expecting our fourth child. We live in Tallahassee, FL, which is not a big town. I went to do the sonogram with her, with the OB–GYN, and he told me that he's paying $120,000 a year in Tallahassee, FL, for medical malpractice insurance. There's ten OB–GYNs in a practice together, so a million-two for medical

malpractice. I wanted to get a sense of what you're doing in your country, that you outline, and then maybe hear from other folks on the panel of what we need to do to reform this problem so that we can drive costs down.

Dr. BENNETT. I, at the time, delivered about 150 babies a year, as a family physician, and my malpractice insurance was about $10,000. It was reimbursed by the province. It—so, I paid nothing. So, it is—what the Canadian Medical Protective Association has done is the two phases. One is to keep the premiums down—and it's an association and a board of physicians who manage it; but also do huge education on risk. Anybody who slightly got into trouble gets sort of taken to school and told how to reduce their risk in those. Also, our court system, that the jury system may decide whether somebody is guilty or not, but it is only the judge that makes the award. So, our tort system is very different, and so, the payouts are lower.

But, I think that, again, nobody wants misadventure, and I think that we are—you know, we need to reduce the problems in our system. Yet, 100,000 people a year die because of medical misadventure in this country; 10,000 in ours. We've got to get that down.

I think that, if I was allowed one more thing to say, the IT system, that—because of what Don Berwick says, in terms of our—our system is forgetful. We forget about allergies, we forget about many things that a really good IT system, like you put in place for your Veterans Administration, that turned the worst healthcare system to the best in less than 10 years—that we've got to have people—make it easier that they don't make a mistake, in the first place. If you've got a system that—- where you can push a button and get somebody's record, and can remember the patient, and—truly patient-centered care.

The CHAIRMAN. Thank you, Senator LeMieux.

Thank you so much for being here today. You've shed a lot of light on a very important topic in the United States today, as you know. So, we appreciate your being here.

I—that's it, we're done.

[Whereupon, at 12:33 p.m., the hearing was adjourned.]

# APPENDIX

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY, JR.

I would like to thank Chairman Kohl for scheduling this important hearing and welcome our new ranking member, Senator Corker to his new position. This hearing will examine how certain systems have kept the costs of health care low while keeping quality high. Right now we are in the midst of deciding how best to reform the health care system in this country and one of the most important questions we confront is how we can lower costs while increasing quality. To some this idea may seem contradictory, but it does not have to be.

There are a number of models that we can examine when considering health care reform, and I would like to share a successful example from Pennsylvania. The Geisinger Health System stands out because of its commitment to quality and innovative care. Though the context for Geisinger's success is unique, surely the measures this hospital has taken to reduce patients' costs while increasing the quality of their care can be an example for the rest of the country. Geisinger is a comprehensive, integrated and physician driven health care network of 45 community sites across Pennsylvania with physicians who practice in more than 75 specialties and sub-specialties.

The focus of this network is quality patient care. Geisinger uses a system of quality metrics called Quality Measure Scores. Patients and consumers have access to these metrics on Geisinger's website. We know that the measure of the quality of one patient's care is unique to that patient, so Geisinger also allows its patients to score the hospital and allows potential patients to compare these scores to other institutions across the state and the nation.

Geisinger also measures the level of patient satisfaction through an independent researcher, and they make the outcome and performance data of every procedure and course of treatment available online, once again so that patients can know and evaluate their options. Through an innovative program called ProvenCare, Geisinger was able to compile the data within the electronic medical records of consenting patients to compare what combinations of treatment work best for future patients with similar conditions. Through their research with the ProvenCare program, the average total length of stay at Geisinger fell 0.5 days and the thirty-day readmission rate for the hospital fell 44 percent.

Ultimately, the success of this hospital can be summarized by two points. First, patients who are more informed about their care options are better able to participate in their own care. Second, doctors with a better knowledge of what combination of procedures has worked in the past are better able to streamline the treatment options they provide to their patients. As the Geisinger system has demonstrated, patients pay less because they're not receiving extraneous treatments, they stay in the hospital for less time and they return to the hospital less often. We can learn from this hospital, and I think that as we advance in the health care reform process we must consider examining what is working in Pennsylvania so that we can make the best possible policy decisions.

Again, Mr. Chairman, I thank you for organizing this important hearing. I look forward to working with you and the rest of our colleagues on these important issues as we continue to debate health care reform.

PREMIER

Statement for the Record

Submitted by

The Premier healthcare alliance

Senate Special Committee on Aging

## Achieving Health Reform's Ultimate Goal: How Successful Health Systems Keep Costs Low and Quality High

October 8, 2009

Chairman Kohl, Ranking Member Corker and members of the Senate Special Committee on Aging, the Premier healthcare alliance is pleased to submit the following statement for the record for the hearing entitled "*Achieving Health Reform's Ultimate Goal: How Successful Health Systems Keep Costs Low and Quality High.*" The Premier healthcare alliance is a hospital quality and cost improvement alliance of 2100 non-profit hospitals and health systems. The Premier healthcare alliance operates the nation's most comprehensive repository of hospital clinical, outcomes and financial information as well as one of the nation's leading group purchasing organizations. The hospitals united in the Premier healthcare alliance share the goal of providing safe, affordable, quality care through the sharing of knowledge, experience and tools. A world leader in helping deliver measurable improvements in care, Premier works with the Centers for Medicare & Medicaid Services (CMS) and the United Kingdom's National Health Service North West to improve hospital performance.

We applaud the committee for holding this important hearing and we support your efforts to reform the healthcare system and to enact meaningful reforms to improve the quality of healthcare and reduce costs. In fact, many of the initiatives spearheaded by our alliance hospitals are already showing impressive results to improve the quality of care received by patients and are reducing costs. Below is a brief summary of these projects.

**Hospital Quality Incentive Demonstration ("HQID")**
This pioneering pay-for-performance ("P4P") project, being conducted by Premier in partnership with CMS, is the first national project of its kind, designed to determine if economic incentives to hospitals are effective at improving the quality of inpatient care. Hospitals participating in HQID include small/large, urban/rural, and teaching/non-teaching facilities that volunteered to report their quality data for five high-volume

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inpatient conditions using national measures of quality care. Through the project, Premier collects a set of more than 30 evidence-based clinical quality measures from over 230 hospitals across the country, developed by government and private organizations, from participating hospitals.

- The more than 1.5 million patients treated in the project are living longer and receiving recommended treatments more frequently, according to project results over a four-year period.
- CMS has awarded more than $36.5 million to top performing hospitals.
- According to a Premier analysis of the HQID project, if all hospitals nationally were to achieve the cost and mortality improvements found among the HQID participants in the first three years of the project, they could save an estimated 70,000 lives per year and reduce hospital costs by more than $4.5 billion annually.
- Hospitals participating in the HQID project raised their overall quality by an average of 17.2 percent over four years based on their delivery of more than 30 nationally standardized and widely accepted care measures to patients in the five clinical areas.
- These improvements saved the lives of an estimated 4,700 heart attack patients in four years, according to a Premier analysis of mortality rates at hospitals participating in the project.
- The more than 1.5 million patients treated in five clinical areas at the 230 participating hospitals also received approximately 500,000 additional recommended evidence-based clinical quality measures, such as smoking cessation, discharge instructions and pneumococcal vaccination, during that same timeframe.

**QUEST: High Performing Hospitals**

A collaborative of 157 hospitals treating approximately 2.3 million patients annually, QUEST is designed to help springboard hospitals to a new level of performance. QUEST is the largest, most comprehensive hospital collaborative in the nation committed to benchmarking, implementing, measuring and scaling innovative solutions to the complex task of caring for patients. QUEST represents a promise for measurable improvements in quality, safety and cost of care for patients and shared results to benefit all in healthcare.

- Using benchmarked data from Premier's Perspective® database, Premier and the Institute for Healthcare Improvement ("IHI") identified the main factors that lead to deaths, errors and excessive costs.
- Using this information, hospitals are able to share best practices and systematically initiate efforts proven to dramatically improve quality and patient outcomes.
- According to an analysis of QUEST, of the approximately 2.3 million patients treated annually by hospitals participating in the project, achieving designated top performance goals translates to 8,040 lives saved, $577 million in reduced costs and 22,364 additional patients receiving all appropriate evidence-based care measures each year.

**Comparative Effectiveness Research**

Premier supports the establishment of a federally sanctioned organization that is independent and its processes transparent in identifying priority areas of comparative clinical research and overseeing the conduct of this research. Such an organization will assist in providing a repository of scientific, evidence-based comparative information that will be widely available to all healthcare stakeholders.

- The QUEST Comparative Innovation Program tests the effectiveness of new healthcare products and technologies through QUEST. These solutions show evidence of effectiveness in decreasing hospital-associated conditions, including many healthcare-associated infections ("HAIs").

**Premier Perinatal Safety Initiative ("PSI")**

The Premier healthcare alliance launched a 21-month national collaborative designed to achieve consistent delivery of evidence-based care with the goal of eliminating preventable birth related injuries and deaths. The Premier Perinatal Safety Initiative is comprised of 16 of the country's leading hospitals of varying sizes and locations, representing 12 states, at which approximately 115,000 babies will be delivered over the course of the collaborative. Leveraging knowledge gained from similar initiatives, including a Premier/Institute for Healthcare Improvement collaboration, the participating hospitals aim to improve their culture of safety, increase teamwork and improve communications among team members.

- The initiative seeks to significantly lower the incidence of certain infrequent, though serious, injuries that could result in birth asphyxia or permanent neurologic disability.
- Through the use of "care bundles" (groups of evidence-based interventions that are more effective when implemented together rather than individually) participants work toward the elimination of perinatal injuries.
- These bundles, which follow national standards established by expert clinical organizations, such as the American College of Obstetricians and Gynecologists (ACOG) and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), are scored in an "all-or-none" fashion.
- For a bundle to be considered successfully implemented a patient must receive all elements in the bundle, unless a medical condition suggests otherwise.

**South Carolina Healthcare Quality Trust ("SC HQT")**
All 65 acute care hospitals in South Carolina have joined the South Carolina Healthcare Quality Trust (SC HQT), aimed at eliminating preventable HAIs statewide while safely reducing associated costs. Health Sciences South Carolina (HSSC), the South Carolina Hospital Association (SCHA) and the Premier healthcare alliance formed the SC HQT, a voluntary, first of its kind partnership. Through the SC HQT, the state's largest research universities—Clemson University, Medical University of South Carolina and the University of South Carolina—and its largest health systems—Greenville Hospital System, Palmetto Health and Spartanburg Regional Healthcare System—are working through HSSC, utilizing existing evidence-based best practices, as well as researching and developing new methods, to eliminate preventable infections.

- Through this collaborative SC will use its state's best researchers to determine the causes of specific infections. Solutions will be tested in the state's four largest health systems, which today treat about 30 percent of all patients, and all 65 of the state's acute care hospitals will share best practices, products and services that result in reduced infections.
- SC hospitals will use Premier's Performance Improvement Portal, a knowledge exchange community of more than 1,500 healthcare experts nationwide, to track improvement against state and national benchmarks to develop and share best practices and knowledge on strategies for combating HAIs.

**Premier Safety Institute**
The Premier Safety Institute™ was established in 1999 to fulfill Premier's vision and embrace its responsibility to promote a safer and greener healthcare delivery environment for patients, workers and their communities. The Premier Safety Institute coordinates safety-related activities among national safety organizations, Premier members, internal business units, contracted suppliers and communities. The Institute also brings together a vast array of safety products, services, information and technical resources in a timely and effective manner by:

- Ensuring a focus on safety in Premier contracting and purchasing;
- Identifying safe and environmentally preferable products, equipment and services;
- Providing patient safety education and training resources;
- Sharing safety tools and reference materials;
- Providing clinical and technical safety information;
- Offering reverse auctions for lower cost energy, including renewable energy;
- Maintaining a publicly accessible Safety Institute Web site, two electronic newsletters and related resources.

**Premier Patient Safety Organization (Premier PSO)**
The Premier PSO has been listed by the Agency for Healthcare Research and Quality (AHRQ). In this role, the Premier PSO will voluntarily collect, report and share data on patient safety in order to improve outcomes and reduce harm.

- The Premier PSO will help create system-wide improvements consistent with an overall culture of quality and safety.
- With our breadth of clinical data and trusted relationships with hospital members of our alliance, the Premier PSO will be in a unique position to track events, critically examine the causes of harm and freely share safety recommendations, protocols and best practices that benefit clinicians, hospitals and patients nationwide.

The Premier healthcare alliance appreciates the opportunity to submit this statement for the record and stands ready to work with the Senate Special Committee on Aging to enact meaningful healthcare reform that improves the quality of care for patients and reduces costs.