

**WE SPEND MORE GDP ON HEALTH
CARE THAN ANY OTHER NATION IN THE
WORLD, YET RANK #37,
HOW DO OTHER COUNTRIES DO
BETTER?**



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PRESENTATION OUTLINE

- I. International Rankings
- II. Why the US Fares Badly
 - I. Massachusetts & Hawaii Exceptions?
- III. Culture Matters
- IV. Comparative Systems
 - I. France
 - II. Germany
 - III. Netherlands
 - IV. Sweden
 - V. U. K.
 - VI. Canada
- V. Lessons from Taiwan
- VI. Bottom Line for the US?

WHO Ranking of World Health Systems*

- Compiled in 2000 (not uncontroversial)
- 5 performance indicators
 1. Overall level of Health (disability-adjusted life expectancy)
 2. Population health inequalities
 3. Health system responsiveness
 4. Distribution of responsiveness
 5. Distribution of financial burden

* World Health Report 2000, *Health Systems Performance*

WHO Rankings



Rank - Country

1 <u>France</u>	14 Greece	26 Saudi Arabia
2 Italy	15 Iceland	27 United Arab
3 San Marino	16 Luxembourg	Emirates
4 Andorra	17 <u>Netherlands</u>	28 Israel
5 Malta	18 <u>United</u>	29 Morocco
6 Singapore	19 Ireland	30 <u>Canada</u>
7 Spain	20 Switzerland	31 Finland
8 Oman	21 Belgium	32 Australia
9 Austria	22 Colombia	33 Chile
10 Japan	23 <u>Sweden</u>	34 Denmark
11 Norway	24 Cyprus	35 Dominica
12 Portugal	25 <u>Germany</u>	36 Costa Rica
13 Monaco		37 <u>United States</u>

Another Six Country Ranking of Healthcare Quality, Access, Efficiency, Equity and Mortality



Overall Ranking

Country Rankings	
	1.0-2.66
	2.67-4.33
	4.34-6.0

	AUSTRALIA	CANADA	GERMANY	NEW ZEALAND	UNITED KINGDOM	UNITED STATES
OVERALL RANKING (2007)	3.5	5	2	3.5	1	6
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centered Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, Healthy, and Productive Lives	1	3	2	4.5	4.5	6
Health Expenditures per Capita, 2004	\$2,876*	\$3,165	\$3,005*	\$2,083	\$2,546	\$6,102

* 2003 data

Source: **Calculated by Commonwealth Fund** based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.

Why Has the US Fared so Poorly in International Comparisons?

- **Biggest reason by far: 16+% of US population has had no health insurance***
 - **Uninsured health status = negative impact on indices of public health**
 - **Should improve markedly post-2014 with PCA**



*Hawaii & MA exceptions

Uninsureds = Negative Impact On Indices of Public Health

- For example, in 2006:*



- US ranked 39th for infant mortality
- 43rd for adult female mortality
- 42nd for adult male mortality, &
- 36th for life expectancy

– * WHO Statistical Information System, Sept. 2009



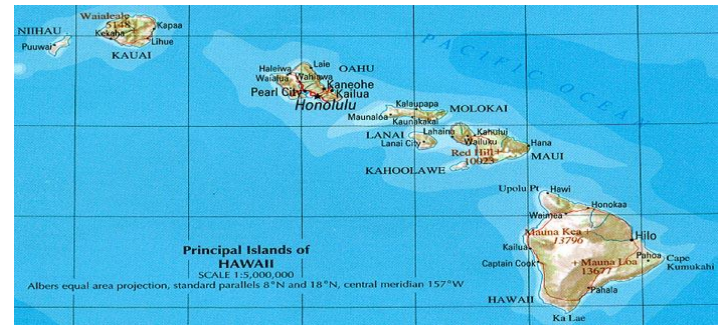
But see MASSACHUSETTS

“Universal” coverage = fundamental culture shift in ‘06

- Individual mandate
 - Employer & gov’t contributions
 - Enforced via tax penalties
- Insurance “connector” to facilitate purchase
- 97+% of residents now covered
 - 19% Medicaid
- Next phase = controlling costs



And HAWAI`I



Universal” coverage under Prepaid Healthcare Act since 1975 (three-plus *decades* of experience)

- Employer mandate (employee contributions)
 - Employee contributions capped @ 1.5% of salary
 - Part-time employees exempt
 - ERISA waiver = amendment cap
- 8% of population uninsured (15% Medicaid)
- Big issue: Can/should Prepaid Healthcare Act co-exist with PPACA?

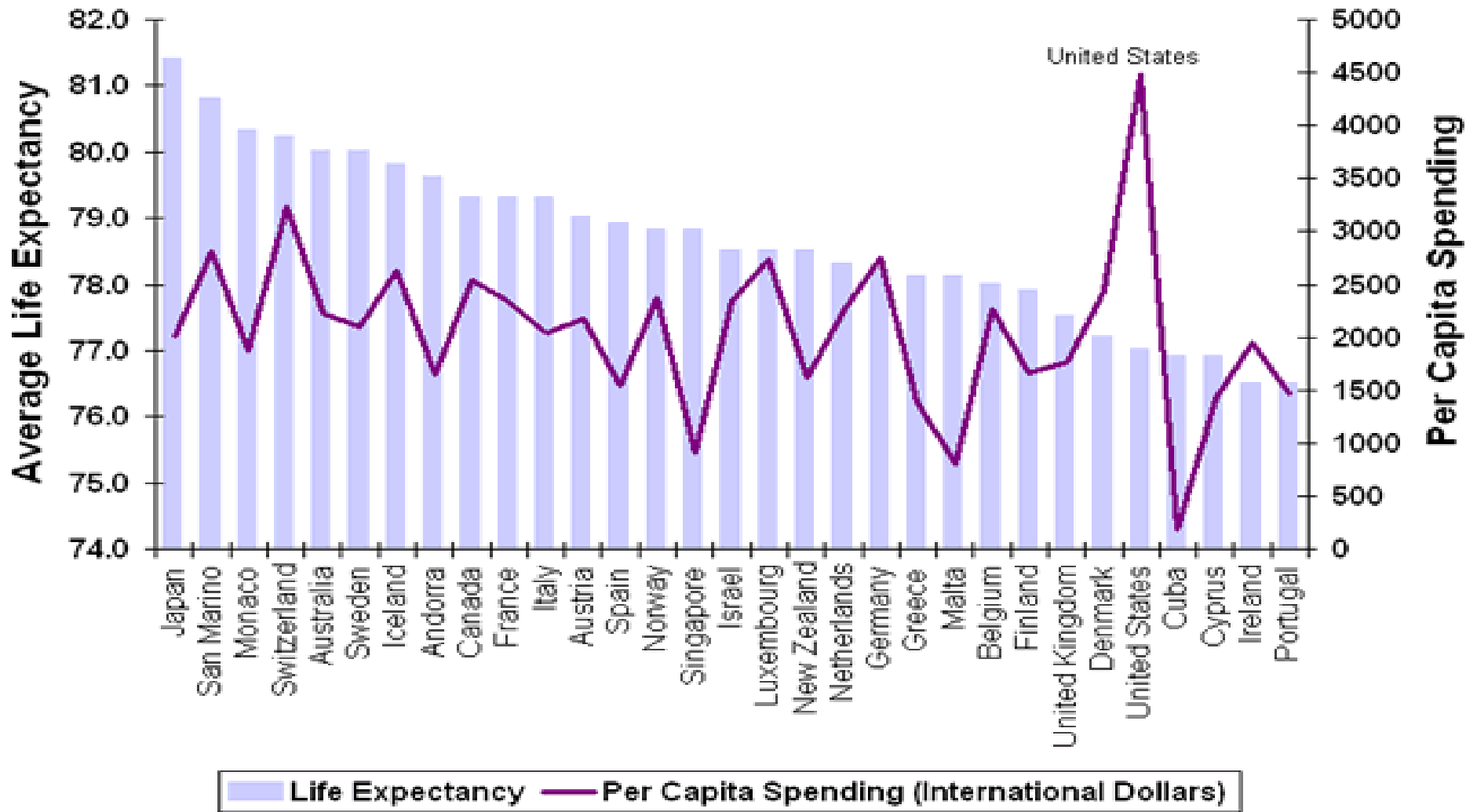
Why *Else* Does the US Fare so Poorly in International Comparisons?

- We do not go gently into that good night

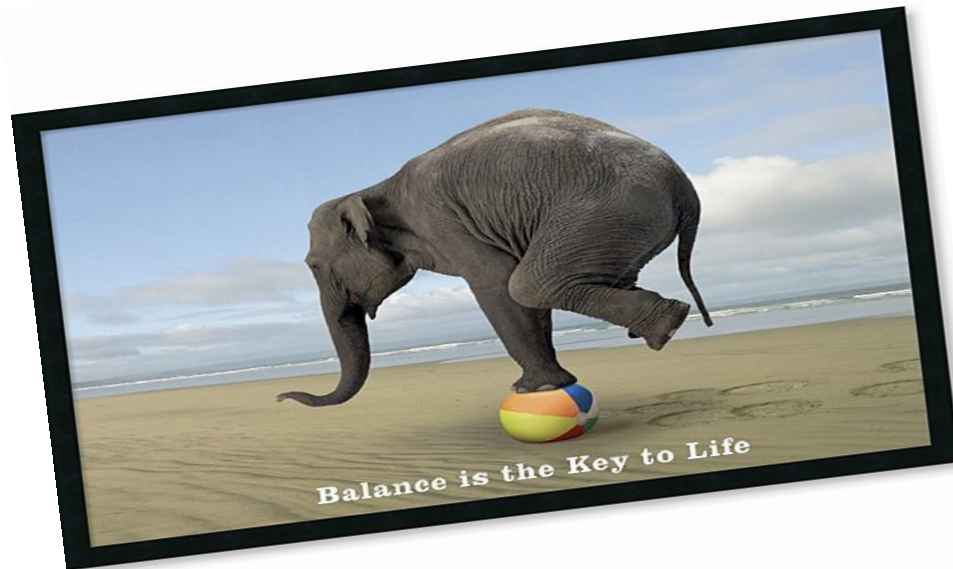


Cf. CABG & Kidney
Transplant Data

The Cost of a Long Life



Balance of Health Care Expenditures



- We tilt (regionally) more toward using expensive high tech care to avoid death
- Than toward investing in primary care to avoid preventable illness

And Why Else Does the US Fare so Poorly in International Comparisons?

- **“It’s the prices, Stupid”**
 - US doctors & nurses are among world’s highest paid professionals
 - US prices for medical equipment, procedures & pharmaceuticals also among world’s highest

And Why Else Does the US Fare so Poorly in International Comparisons?

- **Wider income disparities**



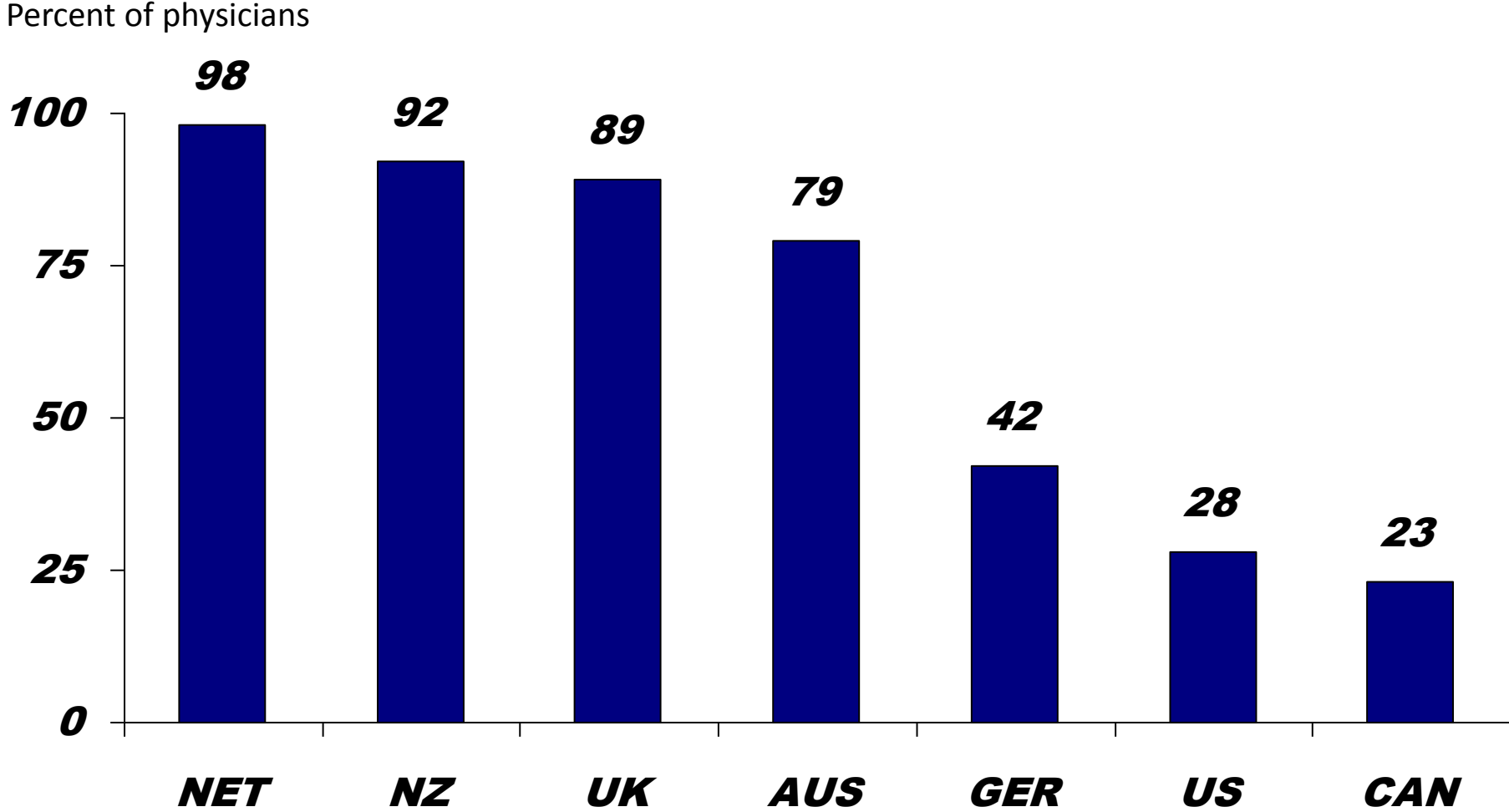
- **The richest 1 percent of Americans now take home almost 24 percent of income, up from “only” 9 percent in 1976.**

And Why Else Does the US Fare so Poorly in International Comparisons?

- **Historic lack of controls re inflationary medical care trends**
- **Do we have a ray of sunshine with PPACA?**

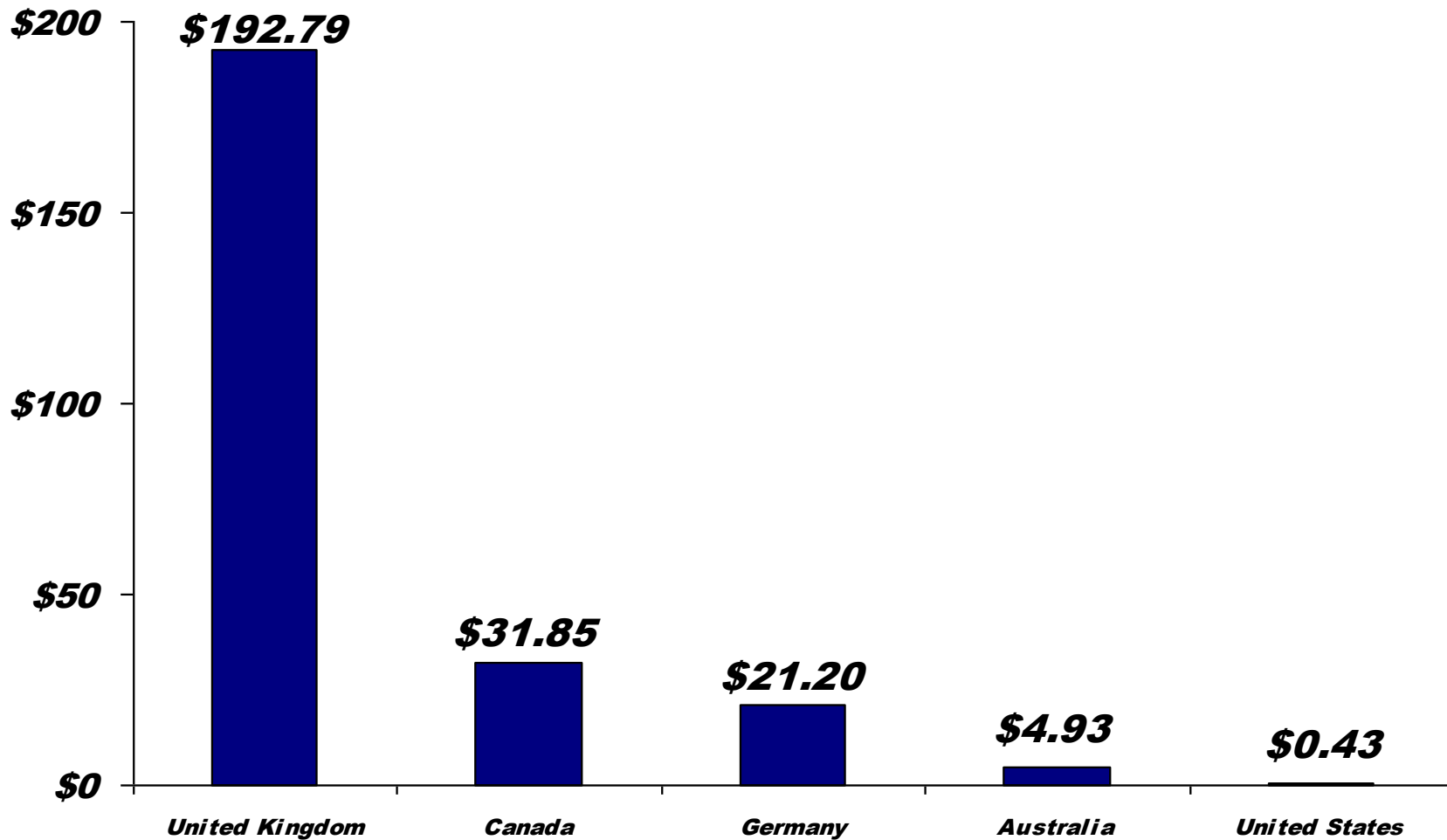


And the downside of fragmentation: Primary Care MDs' Electronic Patient Medical Records Use (2006)



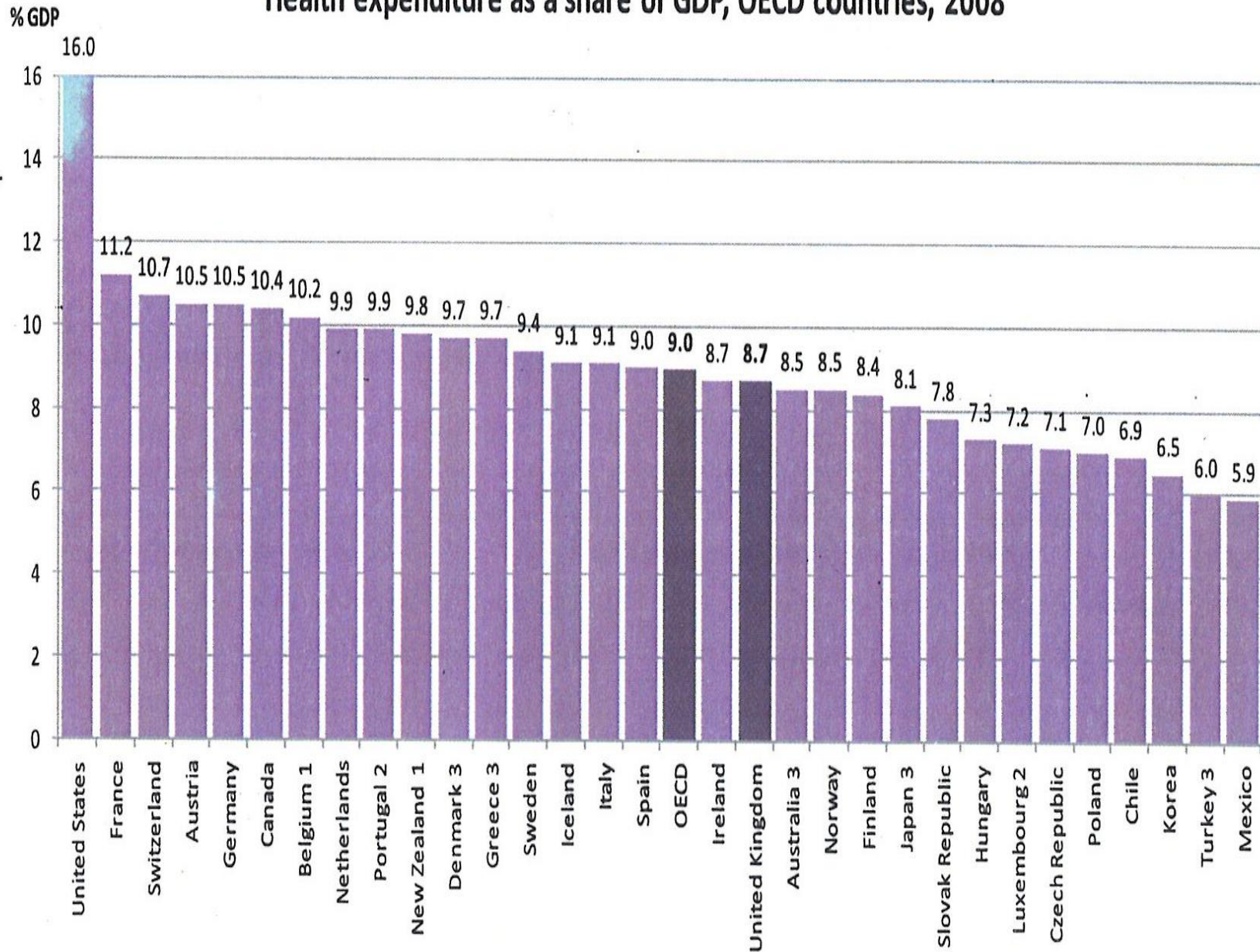
Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

Public Investment per Capita in Health Information Technology (HIT) 2005



Source: The Commonwealth Fund, calculated from Anderson, G.F., Frogner, B., Johns, R.A., and Reinhardt, U. "Health Care Spending and Use of Information Technology in OECD Countries," *Health Affairs*, 2006.

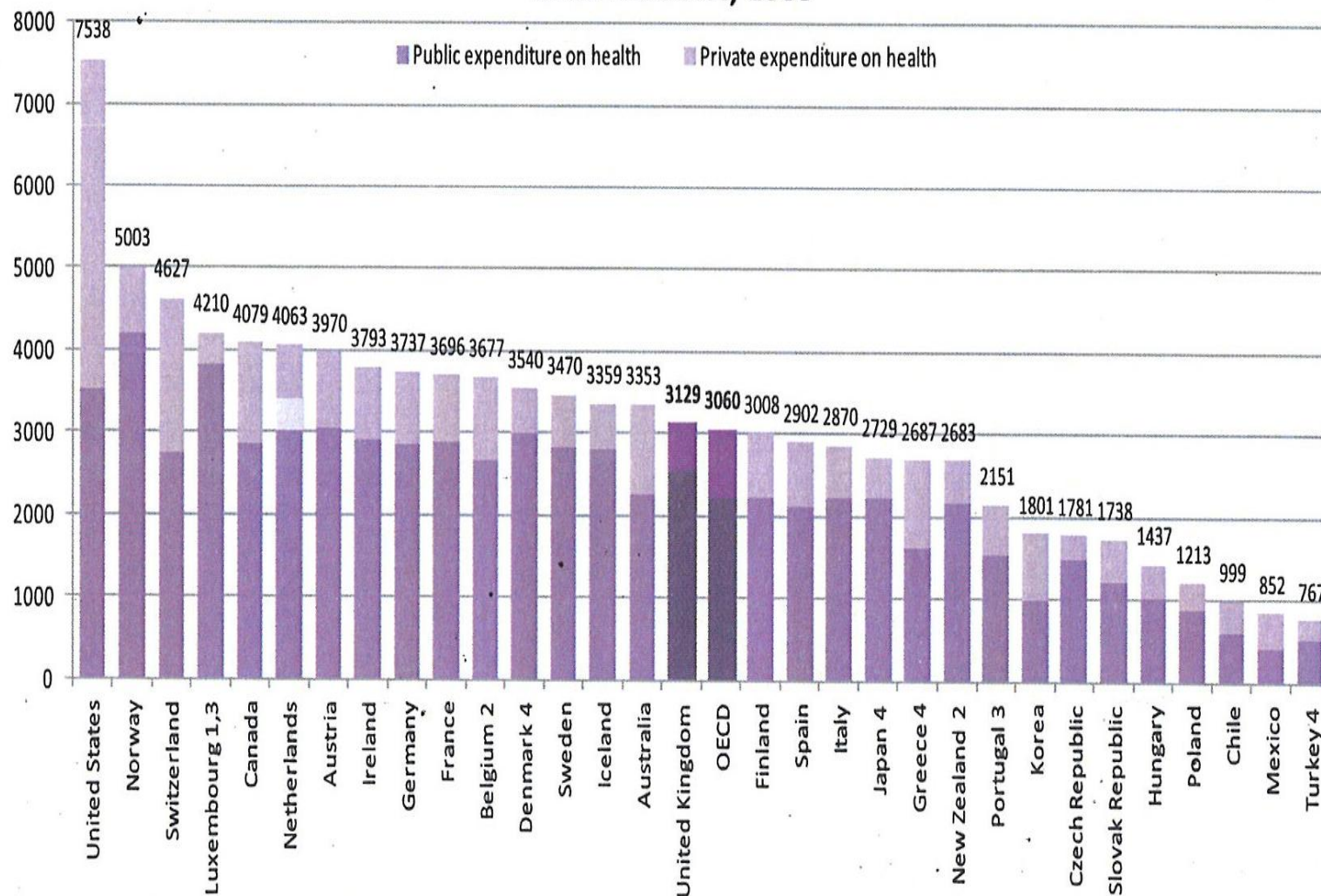
Health expenditure as a share of GDP, OECD countries, 2008



1. Current expenditure. 2. 2006. 3. 2007. Source: *OECD Health Data 2010*, June 2010.

Health expenditure per capita, public and private expenditure, OECD countries, 2008

USD PPP

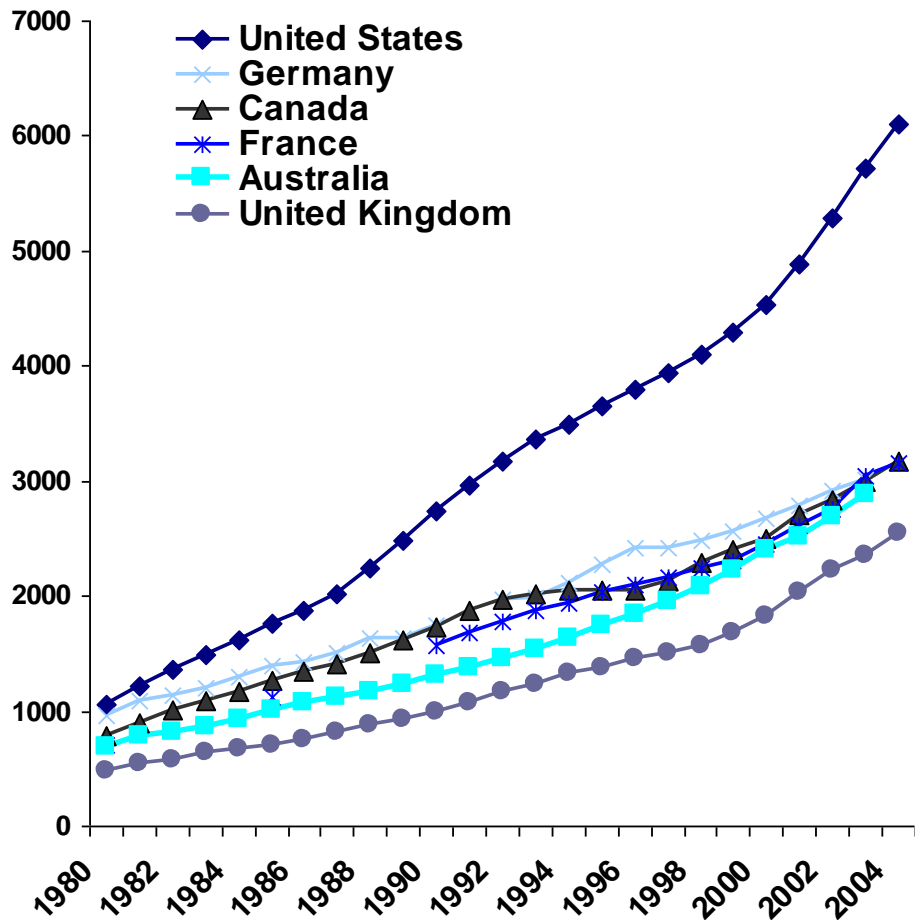


1. Refers to insured population rather than resident population. 2. Current expenditure. 3. 2006. 4. 2007. Source: *OECD Health Data 2010*, June 2010.

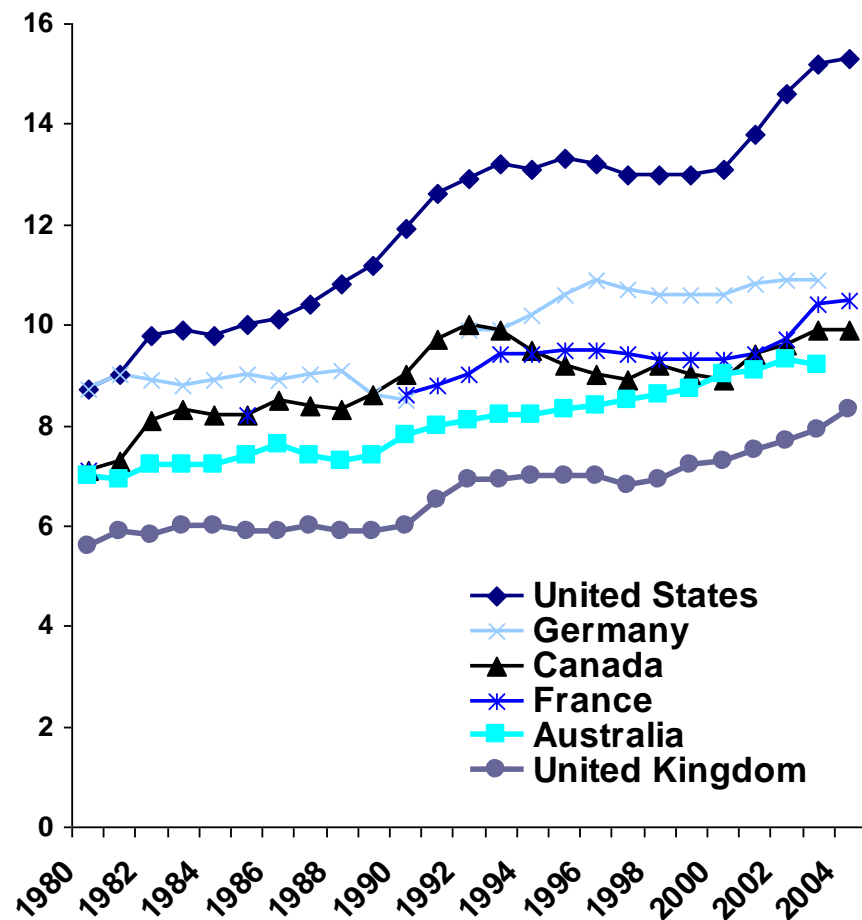
Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries.

International Comparison of Spending on Health, 1980–2004

Average spending on health per capita (\$US PPP)



Total expenditures on health as percent of GDP

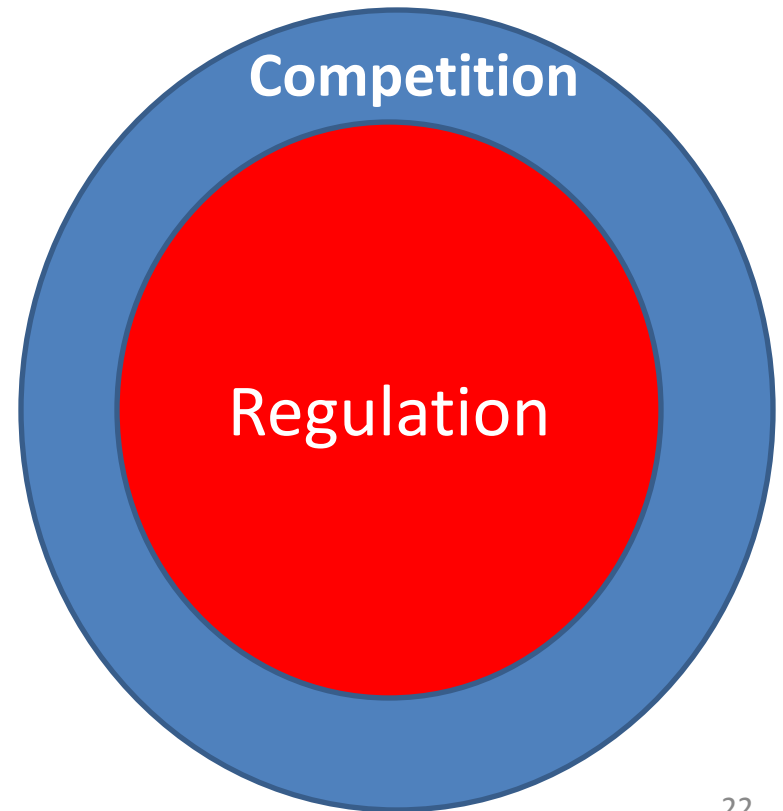
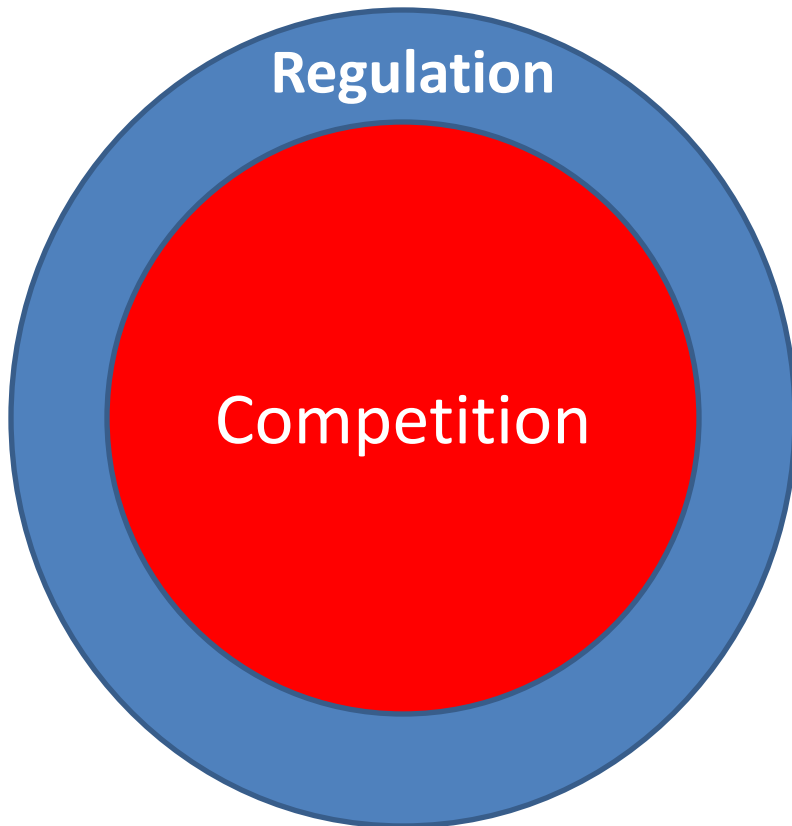


Data: OECD Health Data 2005 and 2006.

A Closer Comparative Look at How Some Other Countries Get More From Spending Less

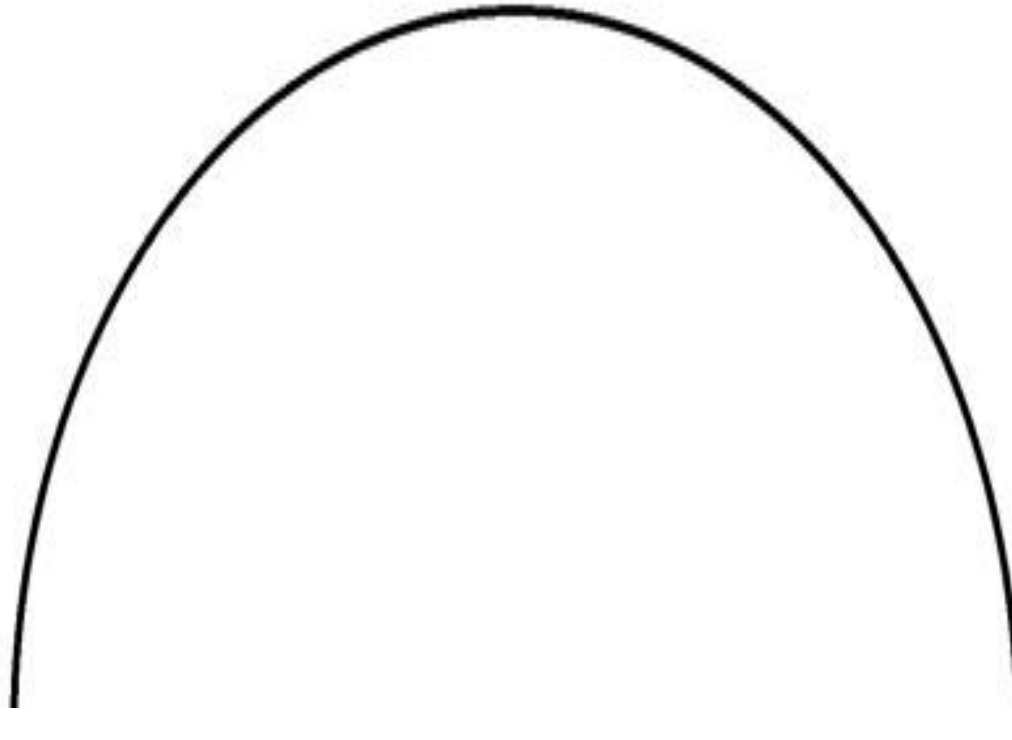
Two preliminary points:

1. Health sector structure matters



Canada

Private hospitals
Private MDs
Public funding



U.K.

Public Hospitals
Public MDs
Public Funding

U.S.

Private Hospitals
Private MDs
Private funding

Think in Terms of a
Spectrum

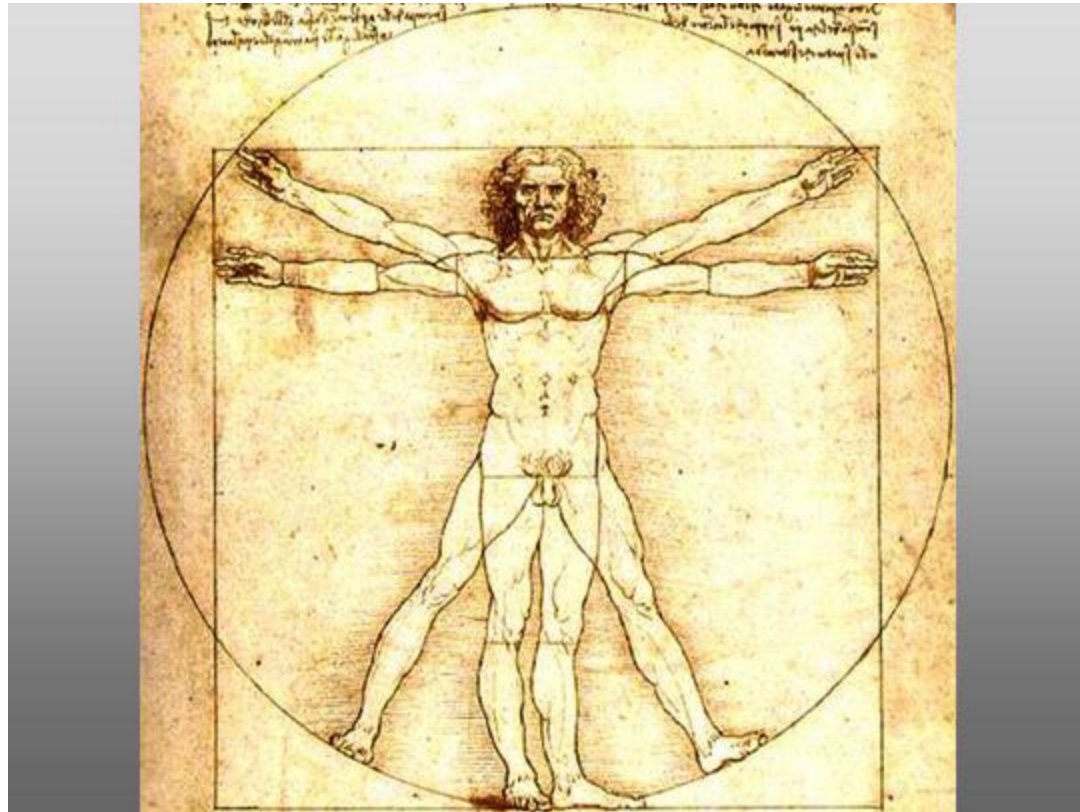
2. Culture Matters



Rudolf Klein

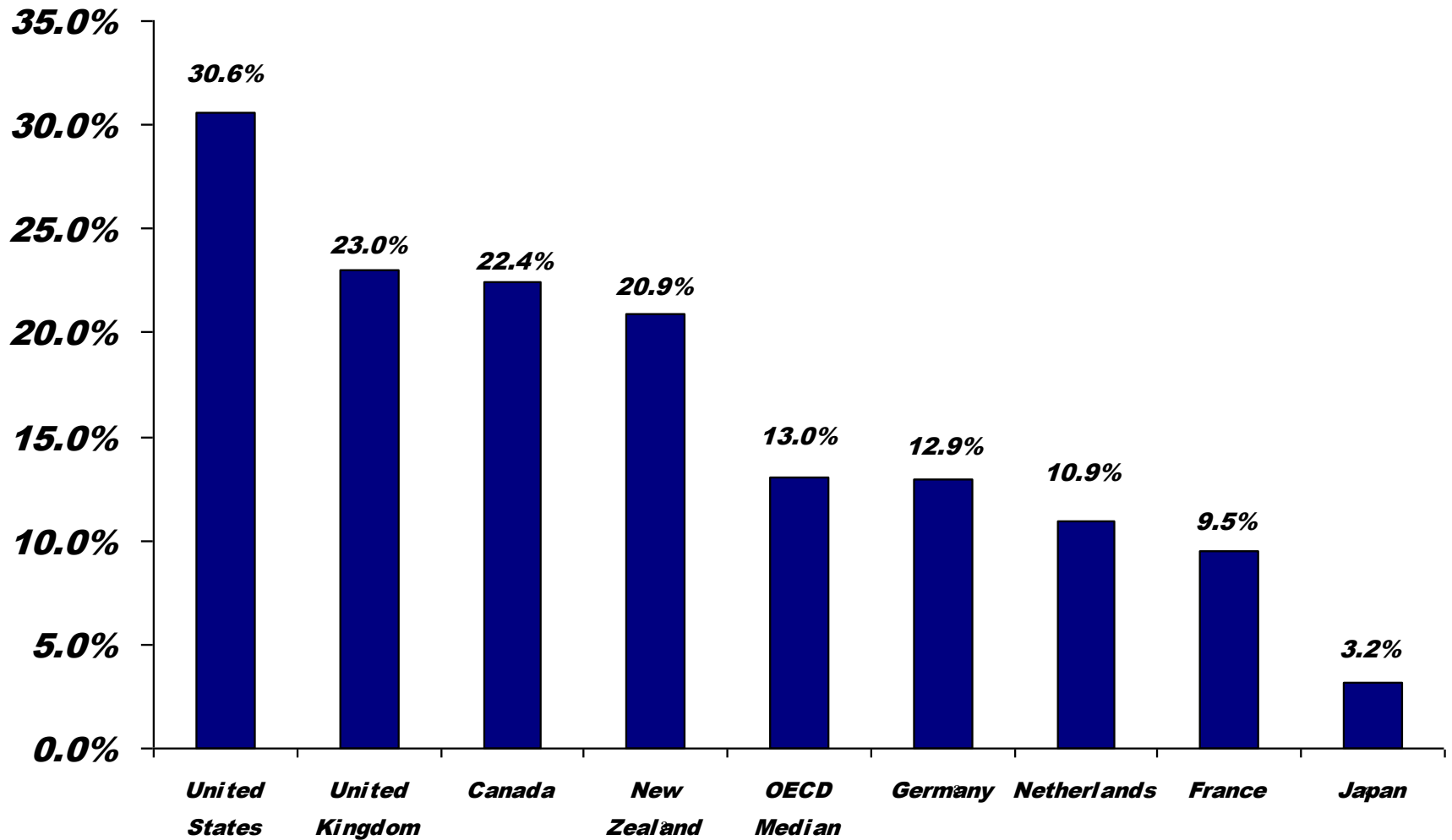
England is an original sin society

Culture Matters (cont.)



America is a perfectibility of man society

Example: Obesity (BMI>30) Prevalence (2004)



b

^a2003

^b2002

FRANCE (#1 WHO Ranking)



- **Universal coverage - incl. illegal aliens**
 - Hospital & ambulatory care + Rx drugs covered
 - Cost-sharing widely applied
 - 92% have complementary private health ins
- **Publicly-financed (payroll, income & “sin” taxes)**
- **Cost controls**
 - Gatekeepers
 - Certain co-payments *not* reimbursable by private ins
 - Increased generic prescribing & use of OTCs
- **Health sector = 11.2% GDP (2008)**



NETHERLANDS (WHO Rank #17)

- All residents required to buy health ins since '06
 - Standard benefit package, from private health insurers
 - Most buy add'l private health ins to top up services
 - Deductibles
- Financed by mix of premiums & income-related contributions
- Cost controls
 - Regulated competition among insurers
 - GP gatekeepers
 - Health technology assessment
 - Performance-related reimbursement
 - MDs paid by capitation, Hospitals by DTCs (\$ for “specific products”)
- **Health sector = 9.9% GDP (2008)**

UNITED KINGDOM (#18 WHO Ranking)

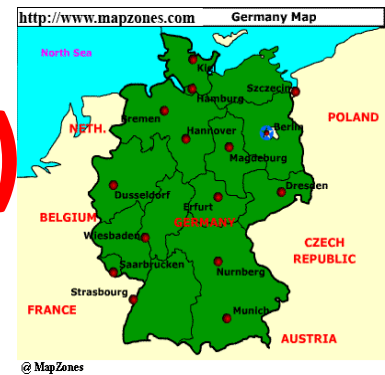


- Universal coverage for all “ordinarily resident” in UK
- Public funding for comprehensive care, “free at point of use”
 - Financing: gen’l taxation (76%), nat’l ins contr. (19%), & user charges (5%)
- Internal mkts introduced in 1991 - reforms imposed by newly-elected Conservative govt devolve \$\$ control down to GP level
 - Shift from process standards to outcome standards
- Relatively few cost-sharing arrangements (some drugs, dental)
- 12% of pop. has private ins to avoid elective surgery queues, etc.
- Cost control: capped overall & GP budgets, centralized adm system & systematic technology assessment via NICE
 - GP gatekeepers to specialist care
- **Health sector = 8.7% GDP (2008)**

SWEDEN (#23 WHO Ranking)



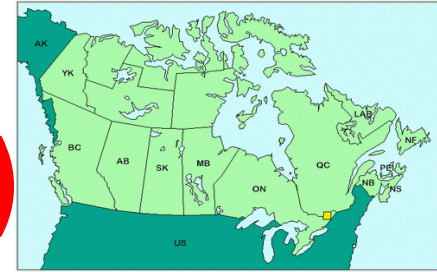
- Universal coverage of comprehensive services
 - 2.5% of population has private ins for faster access
- Publicly-financed care via central & local taxation
 - Value-based pricing of prescription drugs (cost-effectiveness)
- No formal primary care gate-keeping
- Primary services paid via capitation
- Hospitals paid via DRGs + global budgets
- **Health sector = 9.4% GDP (2008)**



GERMANY (#25 WHO Ranking)

- **Mandatory social health insurance**
 - Broad coverage of medical & rehab services
 - Modest cost-sharing (limited to 2% household income)
 - Mandatory separate long-term care insurance
- Coverage provided by >200 competing sickness funds, funded by compulsory employer/employee contributions
- Cost controls
 - Reference pricing for drugs
 - DRGs for hospital care
 - Disease management program
- **Health sector = 10.5% GDP (2008)**

CANADA (#30 WHO Ranking)



- Universal coverage (“residents”) since 1972
 - First dollar coverage for all medically necessary hospital & physician services - no prescription drug coverage
- Funded by taxation (federal & provincial)
 - 10 provincial & 3 territorial health ins schemes, linked thru compliance w federal stds (condition of federal funding)
- 66% of pop. has private ins for Rx drugs & dental (but not med. necessary care)
- MDs wishing to deliver private care must “opt out” of public system (3 provinces regulate prices opt-out MDs can charge)
 - Only a miniscule # of doctors opt out

Health sector = 10.4 % GDP (2008)

TAIWAN



- 1995 - replaced patchwork of separate social health insurance funds with single payer
- Uninsured pop. fell from 41% → 4% in <1 year
 - Mandatory enrollment
 - Gov't, employers & insureds share costs
 - Global budget payment system
- HC delivery system predominantly private
- Closest analogues: Canada or U.S. Medicare
- **Health sector = 6.2% of GDP (2004)**

Uwe Reinhart's 3-legged stool

1. **Universal mandate**
2. **Subsidies for those who can't afford ins**
3. **Insurers must accept all comers**



Canada

Private hospitals
Private MDs
Public funding

France

Public /private hospitals
Private MDs
Public Funding

Taiwan

Private hospitals
Private MDs
Public Funding

Netherlands

Public/Private Hospitals
Private MDs
Private Ins

Germany

Public/Private Hospitals
Private MDs
Private Ins

U.S.

Private Hospitals
Private MDs
Private Ins

Sweden

Public hospitals
Public/private MDs
Public Funding

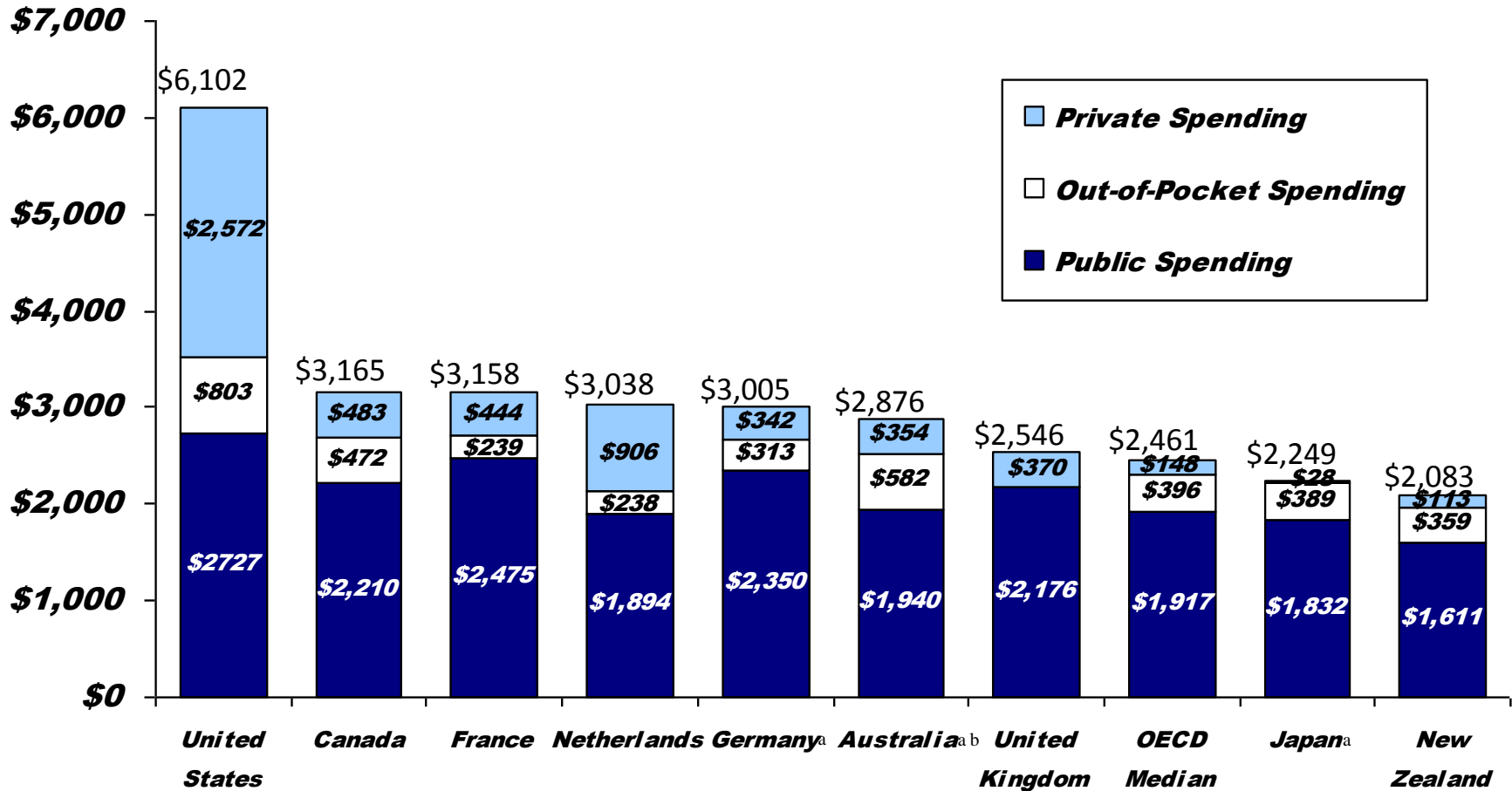
U.K.

Public Hospitals
Public MDs
Public Funding

Think in Terms of a
Spectrum

Health Care Expenditure per Capita by Source of Funding in 2004

Adjusted for Differences in Cost of Living

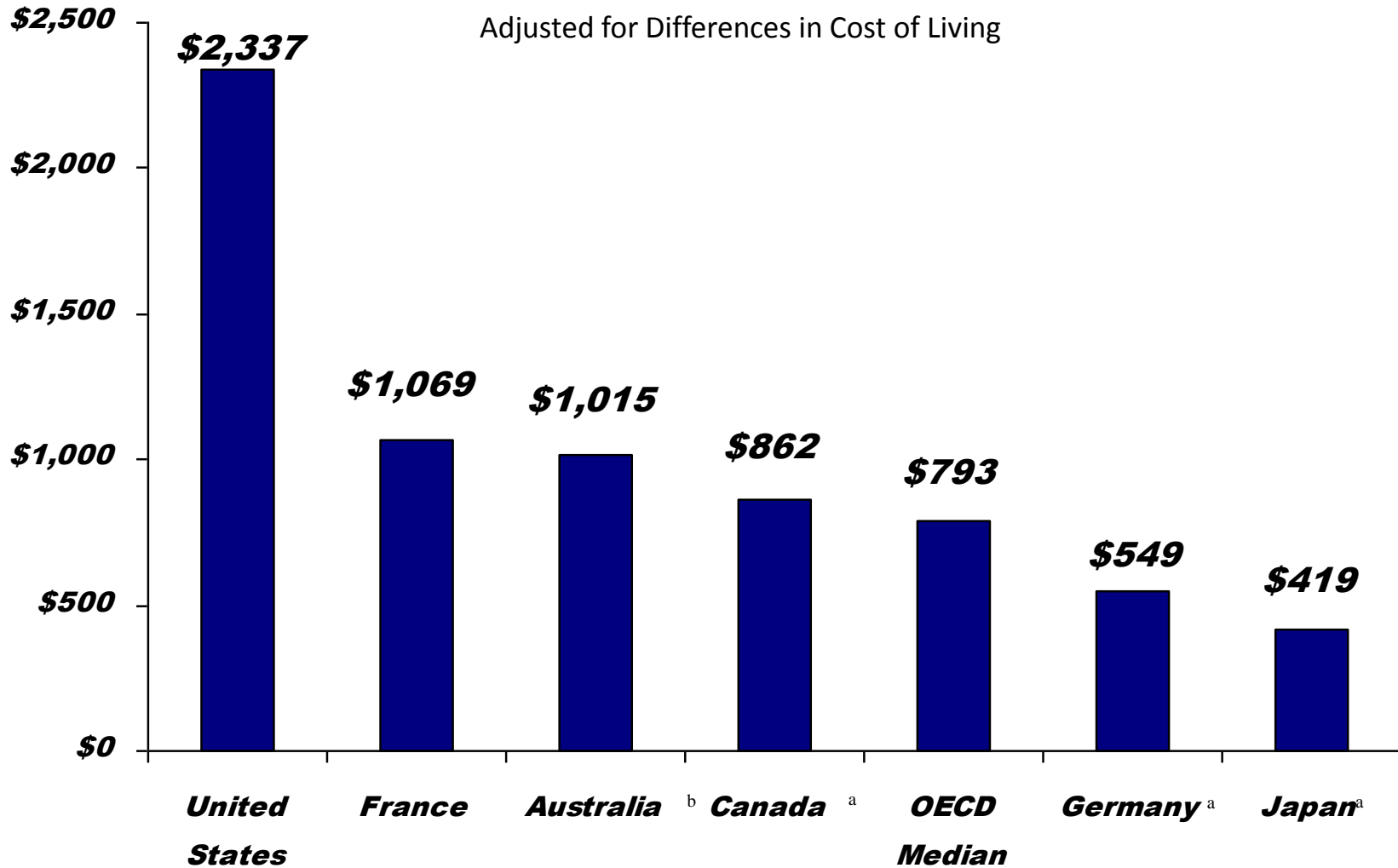


^a2003

^b2002 (Out-of-Pocket)

J. Cylus and G. F. Anderson, *Multinational Comparisons of Health Systems Data*, 2006 (New York: The Commonwealth Fund, Apr. 2007).

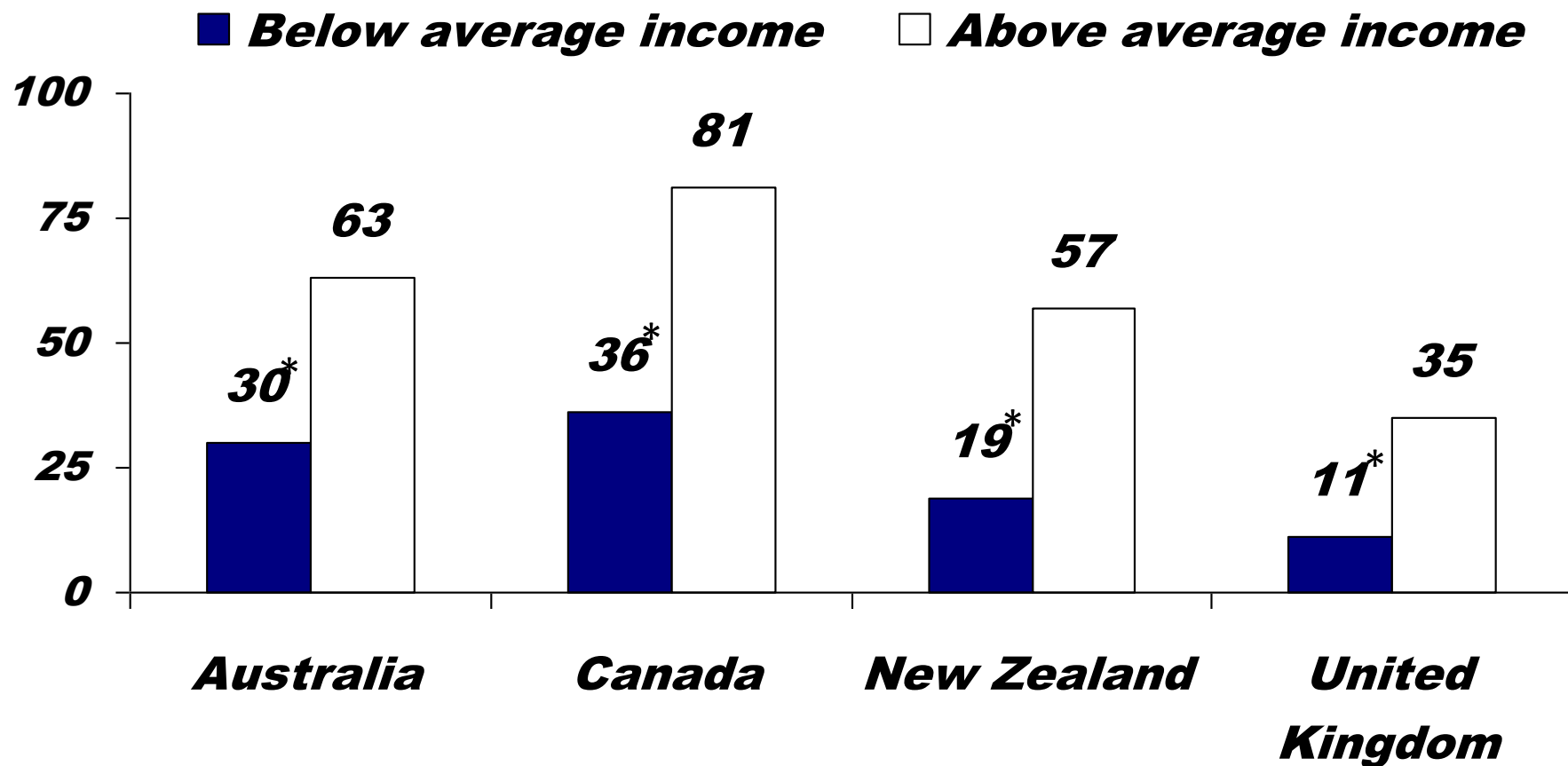
Hospital Spending per Inpatient Acute Care Day in 2004



^a2003
^b2002

Private Insurance in Four Countries with Universal Coverage, 2004

Percent who have private insurance in addition to public

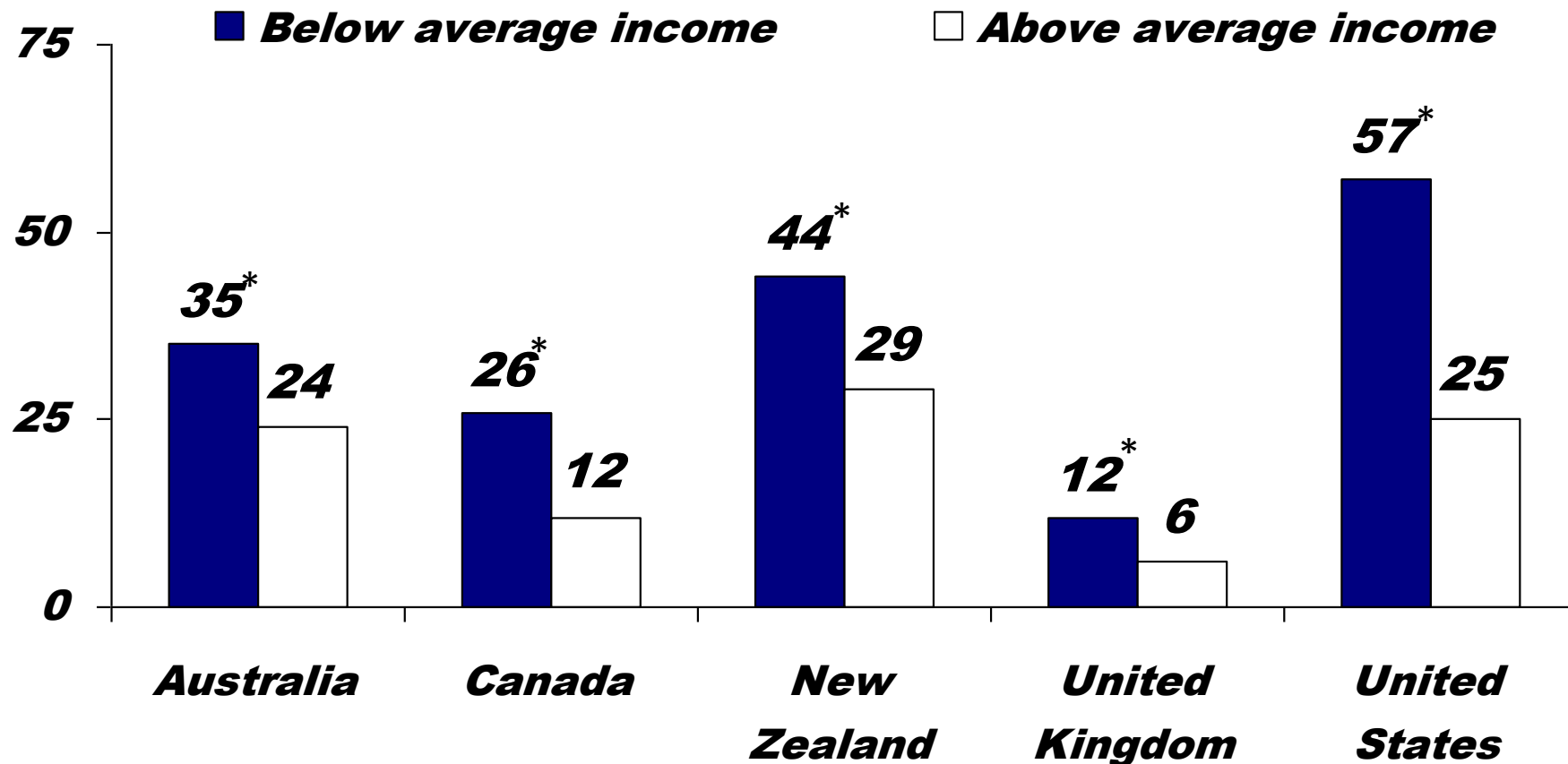


* Significant difference between below and above average income groups within country at $p < .05$.

Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).

Cost-Related Access Problems, by Income, 2004

Percent reporting any of three access problems because of costs[^]



[^] Access problems include: Had a medical problem but did not visit a doctor; skipped a medical test, treatment, or follow-up recommended by a doctor; or did not fill a prescription because of cost.

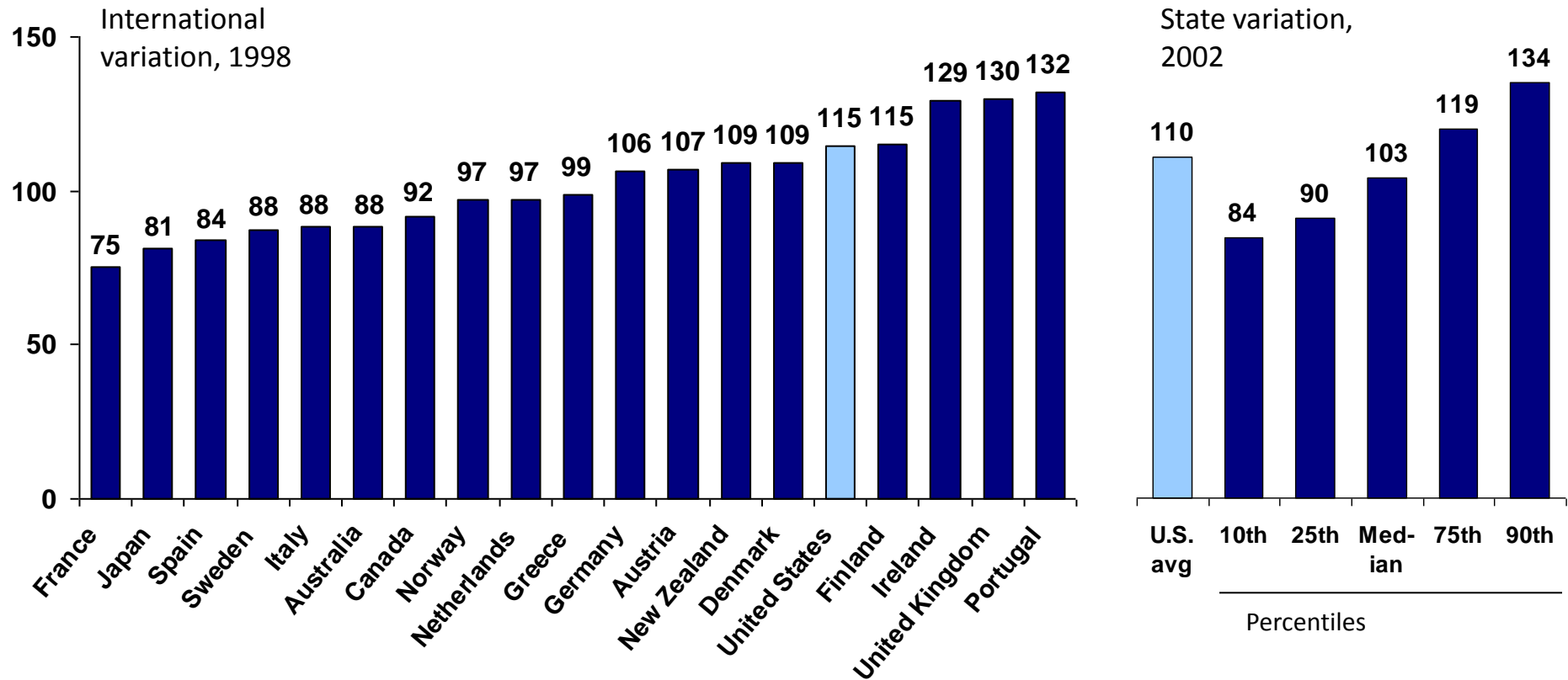
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Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).

Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

Deaths per 100,000 population*



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.

See Technical Appendix for list of conditions considered amenable to health care in the analysis.

Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003);

State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006

Bottom Line

- Countries with arrangements to counter inflationary medical care trends can keep expenditures within limits
- The US, regrettably, has few such arrangements
- “Pharmaceutical companies led by [Eli Lilly & Co.](#) are trying to eliminate the Independent Payment Board, a panel aimed at controlling Medicare spending, seven months after they supported the health-care overhaul that created it.” *Bloomberg News*, [Nov. 15, 2010](#)



Health Care Delivery Will Always Be a Moving Target

The search for closure is the delusion of a passive approach to health policy

