

Reforming health care: why we need to learn from international experience

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This paper provides an overview of system reform, using international examples, and highlights both how the health systems of countries at varying levels of economic development can benefit from adopting international good practice and the value of a truly global exchange on health system reform. It serves as a discussion document for an international summit analysing promising health reforms, hosted in partnership with Salzburg Global Seminar and the *British Medical Journal*, to be held in Salzburg, Austria on 7 to 12 November 2010.

Introduction

How best to ensure decent health care for the population is a key challenge for every nation, now far harder to achieve given the global economic downturn. For developed nations with universal coverage the goals are how to maintain equitable access to care, public satisfaction, quality and greater efficiency while controlling costs. Emerging economies face the tough challenge of how to deliver high-quality care at a price affordable to their new middle classes, while in low-income countries the priorities are more profound: how to provide basic health care across as much of the population as possible, for little money.

On one reading, western democracies with well-established health systems have little to learn from countries with less developed systems, and *vice versa*.

But most developed nations are facing a growth in health care consumption, fuelled by individual demand and by suppliers of care, that is in the medium to long term, economically unsupportable by governments, business or individuals. Middle- and low-income countries have never had the resources to support this 'medical-industrial complex'. Instead they have had to develop low-cost, innovative approaches to improve basic health that include a strong orientation around community-based, public health, which can be instructive to wealthier countries.¹ But in turn they can learn from the experience of nations with more advanced health care systems and the resources to try initiatives and assess their impact, in particular to identify those producing higher value and efficiency.

An approach to categorising reforms

With the exception of the US, universal coverage of the population for health care has been in place in most advanced nations since the mid-20th century. Three main models of health systems exist. These are:

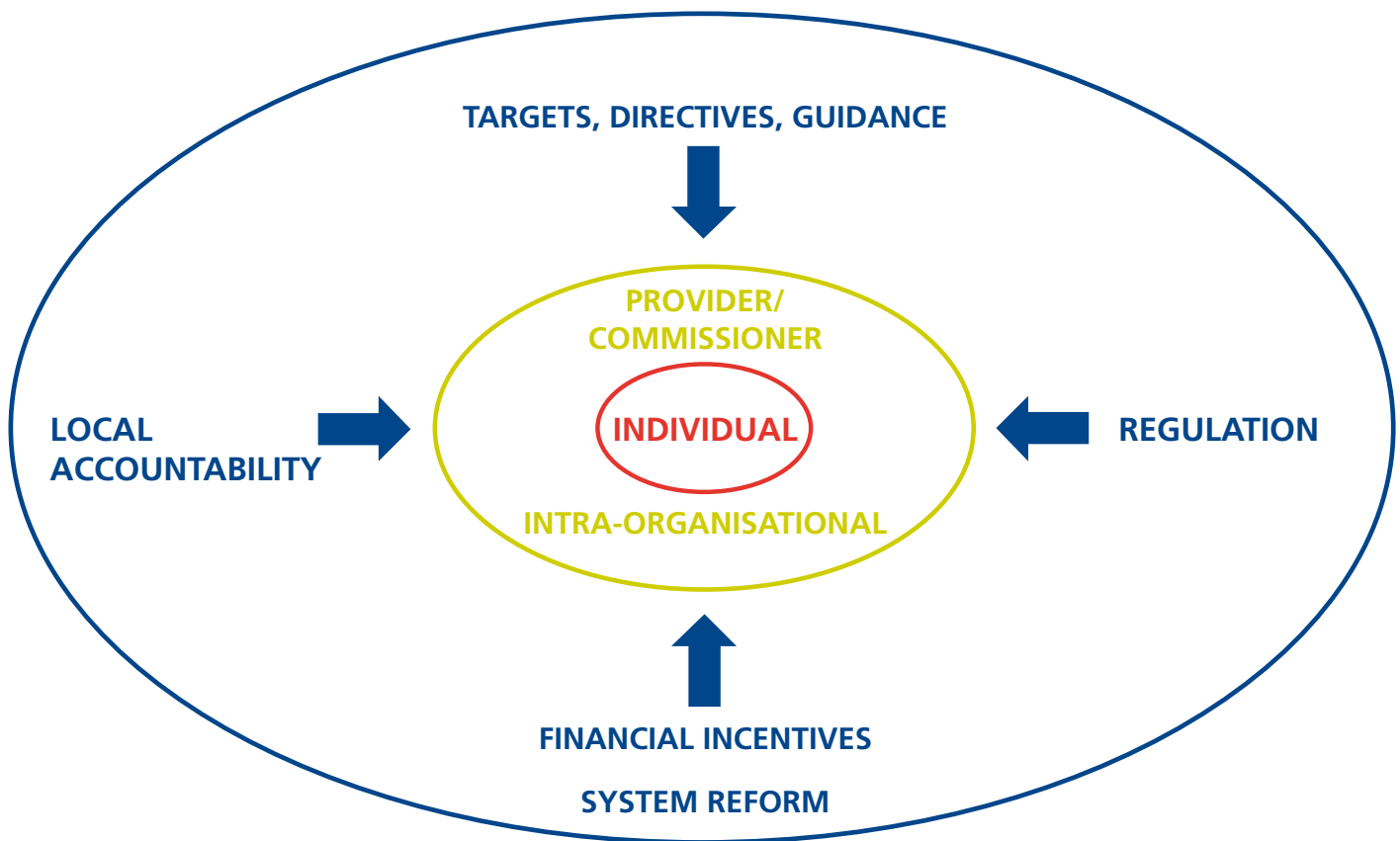
- a social insurance or 'Bismarkian' model (as in France, Germany, the Netherlands, Switzerland and Japan)
- a nationally funded and provided system (as in the UK, Italy and Spain)
- health care funded and largely organised by local government (as in Scandinavia).

Reform of health care has taken the road of expansion (to achieve universal coverage), then more latterly cost containment.² The route taken is highly country-specific – dependent on a unique blend of history, politics, economy, circumstance and the relative power of key groups³ – yet there are similar broad patterns.

Figure 1 suggests some of the main levers used to influence the performance of health care systems, either to improve quality or efficiency, or control costs, and the area in which they have influence. The figure is divided into a 'system reform' area (blue), an 'intra-organisational' area (green) and an 'individual' area (red). They include reforms that attempt to alter the supply of care by providers such as hospitals and general practices, and the demand for care by patients and the public.

In middle- and low-income countries, as much as 80 per cent of spending on health care is met from private incomes and impoverishment as a result of health care expenses is all too common. In recent years, some countries have moved towards an expanded role for government; for example, both Mexico and Colombia have put in place publicly-funded insurance systems.^{4,5} In general, however, reform is concentrated at the provider, individual and community levels, with little observable in the 'system reform' area.

Figure 1. Levers of health care system reform



System reform

The 'system reform' area represents policies that are crafted by governments to influence provider organisations such as hospitals, statutory health insurers in Germany and the Netherlands, or primary care trusts in England. These policies are designed to exert external challenge on an organisation to do better.

National directives

With national targets and performance management, guidance can be reinforced by active management and sanctions for non-achievement. In England over the last decade, this lever has been the most effective in making relatively rapid targeted improvements in the UK National Health Service (NHS), for example in reducing waiting for care.⁶ But many argue that a proliferation of national targets can cramp local initiative, distort local priorities, and lead to perverse outcomes.

Major payers, such as government (in the UK) or statutory sickness funds (in Germany, The Netherlands and France), can issue a wealth of mandatory or non-mandatory guidance to providers, effected through direct performance management or via contracting. These include those issued to primary care trusts (PCTs) and UK NHS trusts by the Department of Health on a range of subjects such as care pathways for common clinical conditions,^{7 8} or by the National Institute for Health and Clinical Excellence (NICE), on which new treatments will and will not be funded by the UK NHS on grounds of cost-effectiveness.⁹ In many countries there have been attempts by government to control more fully the health care benefits paid for from the public purse, thus limiting supply of and demand for these services. For example, earlier this year, the Danish government announced that it would no longer pay for assisted reproductive treatments. Denmark used to offer three cycles of publicly funded *in vitro* fertilisation to all citizens, but the economic downturn has led to treatment only being offered to those with special needs.

Institutional regulation

Public organisations, at arm's length from government, charged with assessing the quality of care in providers are part of the landscape in many countries. In most they simply accredit providers against a basic standard of care rather than aim to improve care directly. In England the Care Quality Commission and Monitor were created to assess and improve various aspects of performance of UK NHS bodies. Here, regulated bodies have shown year-on-year improvement in the areas of care assessed.¹⁰ But as recent high-profile scandals in the quality of care in

several hospitals have shown,¹¹ regulation has obvious limits.

Financial incentives

The last three decades has seen significant reforms in this area, primarily to reduce incentives for the oversupply of care associated with fee-for-service payments to providers. Prospective DRG-based payment for hospitals has been introduced in many countries, initially in the USA and then in Europe, Australia, and Asia.¹² In England Payment by Results¹³ has been associated with modest reductions in length of stay and unit costs.¹⁴

More contentious has been the encouragement of competition between providers (for example in Sweden,¹⁵ Switzerland,¹⁶ England and China¹⁷) and between statutory health insurers (for example in The Netherlands and Germany). The rationale is that external challenge on providers or insurers from competition would prompt greater quality and efficiency. Competition between providers for patients remains contentious; reasons for this include the threat it poses to key interest groups, the potential to reduce equity of access and necessary clinical collaboration in care, ideological opposition, and the absence of hard evidence on impact (although very early signs in England are promising).^{18 19}

Other financial incentives crafted by national policy-makers, or large insurers, have included 'pay for performance' schemes. One of the largest of these in the world is the scheme for general practices in England to improve chronic disease management (the so-called Quality and Outcomes Framework), which has had a positive impact.²⁰ Current initiatives in England to pay hospitals extra for higher-quality care (the CQUIN initiative²¹), or not at all for 'never' events,ⁱ are currently being evaluated. Medicare, the public insurance programme for older adults in the US, also stopped paying for never events in 2008.²²

Local accountability

Attempts have been made in several countries to increase the external challenge particularly on providers by giving the populations they serve more influence in shaping local services, for example in New Zealand²³ and Scotland, where there have just been direct elections of 22 members of the public on two regional health boards.²⁴ In England the Coalition Government has proposed the creation of local health and wellbeing boards²⁵ to hold local commissioners to account and to integrate health and social services. UK NHS foundation trusts must in part be governed by members drawn from staff and the local community, and local health services

i 'Never' events are defined as those reasonably preventable events that (should never) occur during a patient's treatment.

are required to be publicly and formally scrutinised by locally elected councils. The impact of both of these mechanisms in England is unclear.

Intra-organisational levers

In countries where there is no strong role for government, 'system reform' levers may be weak or non-existent. In any case, to many staff working in health care the reality for them is the institution in which they work – represented by the green area in Figure 1. External challenges, coming from regulators, competing providers, direct financial incentives or national targets are at best distractions from the real work at hand – to improve services, or the care for individual patients.

Across more developed health systems, for example in Europe and North America, there has been growing engagement of clinical professionals in improving whole services within, and increasingly across, provider organisations. Professionals have taken on management and leadership responsibility using information to assess and peer review the quality of care provided, using a range of 'improvement' techniques to improve quality and efficiency borrowed from industry.²⁶ They have developed clinical governance and patient safety initiatives, crafting better evidence-based and coordinated pathways of care, and developing incentives to help motivate their peers. The reasons for this include constraints on resources, better information technology and the growing challenge of managing older populations with more chronic disease which requires multidisciplinary working and coordinated care. In the US the Institute for Health Improvement, and in England, activities by the NHS Institute for Improvement and Innovation, the National Patient Safety Agency and NICE have helped to develop clinicians and managers in this way.

In less developed health systems, innovation for improvement needs to a greater extent to come from within organisations. In India dynamic physician chief executives are leading some of the country's most innovative hospitals to cater to the country's new middle class, borrowing techniques from industry, to offer high-quality care in a constrained price environment.²⁷ In poorer parts of India, as in other low-income countries, innovation often comes when a lack of resources meets pressing human need. Aravind Eye Care in southern India developed an intraocular lens for the treatment of cataracts that costs only US\$2 and has since allowed cataracts to be treated in low-income countries across the world.¹

Training community health workers to deliver complex care is another area of intra-organisational innovation that is better developed in these countries than in wealthier ones. In Mozambique, for example, villagers are carefully selected and trained for two years to become 'técnicos de cirurgia',ⁱⁱ with the skills to perform obstetric surgery. Since their introduction in 1984, they have become the mainstay of Mozambique's obstetric service and evaluations have shown no clinical differences in the outcomes they achieve compared with doctors.²⁸

Individual motivation and behaviour

Probably the most potent force to improve care is the intrinsic motivation of clinical professionals to do what they think is a good job, and the intrinsic motivation of patients to improve their own health and reduce avoidable demand on formal health care (this is shown in the red part of Figure 1).

Professional bodies in place in most countries primarily try to improve standards of care that professionals give, but often do not address the fundamental issue of intrinsic motivation. Similarly, in England clinical governance and audit are, as noted above, also intended to encourage reflection by professionals and improvement of care, as are initiatives to improve the analysis by professionals of data on use, costs and outcomes. With relatively little focus and understanding of intrinsic motivation, reforms have tended to focus on institutional competition for resources, or direct financial incentives to shape the performance of clinicians – a largely economic paradigm.

Encouraging patients to take a more active role in prevention of ill health and in their care has been a feature of policy in England as elsewhere, albeit secondary to the initiatives outlined above. There is a huge emphasis on providing more information about self management, choice of care options and supporting individuals make decisions. Rather than a secondary focus, health education is a critical strategy for health improvement in low-income countries. In contrast to wealthier nations, health education in low-income countries tends to be more integrated into community development and is seen as an integral part of developing economic self-sufficiency.²⁹

To help individuals gain more control of their care, pilots in which individuals are given personal budgets to pay for health care are in place in several countries, for example England, the US and the Netherlands,

ii. A 'técnico de cirurgia' is a surgically trained assistant medical officer within the Mozambique health system.

with encouraging results.³⁰ As with clinicians, direct financial incentives have been tried to encourage healthy behaviours with some effect.³¹ This is one area where global exchange has been particularly significant, with Mayor Bloomberg's use of micro-incentives to encourage a range of positive health and social outcomes among low-income populations in New York borrowing directly from Mexico's successful Oportunidades programme.³²

The bluntest tool to reduce demand and contain costs (albeit with possible adverse impacts on health), is to require patients to share the costs of care. Governments unwilling or unable to curb provider incomes directly have often chosen this route for reform because it is easier. Other experiments have been tried in an attempt to reduce the problem of 'moral hazard' in health care – where individuals who do not face the full cost of care at the point of use may demand more care than they need. Medical or health savings accounts have been tried in several countries such as China, Singapore, South Africa and the US – with, to date, only modest impacts on use or costs.³³

Discussion

Because of the strong role for government in health care across many OECD countries, policy-makers in the past 20 years have concentrated in crafting policies in the system reform area of Figure 1 – that is providing external challenge on insurers and providers of care. In countries where government influence over the health system is constrained, such as in many middle- and low-income countries, there has been more action locally in the intra-organisational area, and individual level, extending into the community. Key innovations here include conditional cash transfers to incentivise healthy behaviours, low-cost technological and process innovation, and extensive development of highly-trained community health workers.

The interaction between the system reform levers providing external challenge on providers, and these intra-organisational levers, or on intrinsic motivation of clinicians or patients, is relatively unexamined and unevaluated. Problems occur when there is obvious dissonance between these three domains. With a dynamic intra-organisational environment, the need for external challenge from competition or central directive for example may be less. One argument put forward to explain why high-quality, low-cost innovation is flourishing in countries such as India is the absence of

extensive regulation in the health care sector. In the absence of the system reform layer, entrepreneurial clinicians are freer to pursue new technologies and new forms of care delivery.

While the factors inside organisations associated with innovation can be identified, the strength of intrinsic motivation of professionals to do a good job is critical. But despite its importance, how to enhance this intrinsic motivation of professionals and patients has not, in recent policy discourse, been widely examined. These issues are mainly looked at through an economic lens at present which, while useful, provides only limited insight. It is not known for example the extent to which organisations provide excellent care simply because they attract clinical staff with the 'right ethos', using a 'mission' as magnet, and actively filter out those without.³⁴ It is here perhaps that there may be significant learning from international exchange.

In every country, regardless of its economic position, the future is likely to include severe pressure to increase value for money in health care. Governments will need to respond intelligently, or face public/voter acrimony, a loss of solidarity underpinning health care, and avoidable ill health, that in turn damages economic prospects.

Given the great difficulty of examining the impact of different, often diffuse policies, the necessarily limited evidence base, and the length of time needed to develop policies and implement them, decisions as to the best approaches to reform may be necessarily based more on pragmatism, experience, instinct, and ideology than evidence. Pooling international experience here will be crucial and may help to short cut years of otherwise well-intended but ineffective reform.

More fundamentally it may be that in developed nations, the high-water mark in the development of medical care has been reached and entirely new ways of improving health must be thought of, as are currently seen in low-income nations. As well as paying closer attention to the specific innovations from low-income countries discussed in this paper, there may be a broader lesson for wealthy nations. Low-income countries have retained a closer connection between public health and clinical medicine, largely because of a lack of resources to develop technologically advanced, clinical care. As wealthy nations seek to return care to communities, models from low-income countries may have new relevance.

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This paper heralds an international summit analysing promising health reforms in partnership with Salzburg Global Seminars, to be held at Leopold Schloss, Salzburg, Austria from 7 to 12 November 2010. Summit participants will have the opportunity to debate the topics outlined in this paper; a further publication based on the summit workshops is planned for publication early in 2011.

For more information on the summit and on how to book a place, visit www.salzburgglobal.org

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