



THE CENTER FOR
Health Affairs

Achieving Universal Health Coverage:

Solutions From at Home and Abroad



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The good news is, if you live in America, you reside in the home of some of the most sophisticated, medically advanced healthcare in the world. And for most, namely the 84 percent with some form of health insurance, the healthcare system in America generally works.¹ They are able to receive the care they need, usually at a cost they can manage.

The bad news is, for many other Americans who are uninsured or underinsured, the healthcare system does not work. The facts in this case speak for themselves. According to the latest Census Bureau report, 45.7 million people do not have health insurance, creating a tremendous barrier to their access to care.² Approximately one in three adults without insurance suffers from at least one chronic illness. Out of this group, almost one in four admits they have not seen a health professional in over a year.³ These individuals, who often have conditions that could be effectively managed with proper healthcare, forgo treatment due to cost.

One result is that uninsured adults face a higher likelihood of death before the age of 65, accounting for close to 18,000 excess deaths in America each year.⁴ Another result is long-term disability that could have been prevented. Obviously, the system does not work for this population, and the burden of their poorer health affects everyone. The cost to the nation of the poorer health status of the uninsured ranges between \$65 billion and \$130 billion *each year*.⁵

As the cost of insurance continues its steady incline, both for individuals and employers, many peoples' ability to maintain or acquire health coverage will be compromised. Just over the last seven years, health insurance premiums have risen 78 percent. At the same time, workers' wages have only increased 19 percent.⁶ If these trends continue, the ranks of the uninsured are likely to continue to grow over the long term, as health coverage becomes increasingly unaffordable.





Cost, access and quality are like the three legs of a stool; they are the three elements that must be considered in any healthcare system, and they exist in a balance. An ideal system could be defined as one with completely unfettered access, where people could have on-demand care for their every health need great and small; one with perfect quality, with the best, most-advanced procedures and technologies and flawless quality control systems; and one that is able to do all of this at bargain prices. Clearly, compromise is unavoidable, and any existing health system or proposal for reform must weigh these three elements and make choices regarding cost, access and quality to create an approach that is best suited to those being served.

Safety-net providers as well as government-funded programs will do all they can to ensure that everyone who needs care can have it. Unfortunately, state and federal budgets are already stretched thin during the current tight economy while at the same time the number of people in need of assistance is growing. The financial strain of treating the uninsured presents an increasing challenge for the hospitals that often serve as the provider of last resort for this population. The current trajectory of our healthcare system indicates it is only a matter of time before more and more Americans will fall through the cracks and those who are currently happy with their healthcare will join those who have none. Considering all these factors it makes sense to talk about alternative models of healthcare delivery as well as reform models that are already being implemented.

Cost, Access and Quality: American Healthcare Delivery Today

A helpful concept in evaluating the success of alternative healthcare delivery models is the cost-access-quality triangle. Each of these facets must be considered, and a balance must be achieved, in any healthcare system. Before we begin to examine alternative healthcare delivery models, let's take a look at America's current system and how it looks through the cost-access-quality lens.⁷

Cost

As in any healthcare system, managing cost has been a significant issue in the U.S. In fact, it could be argued that rising costs and spending are the most significant factors currently driving healthcare reform in this country. Compared to other nations, the U.S. has one of the higher levels of health spending, with about \$1.86 trillion spent on healthcare in 2005, about \$6,401 per person. In comparison, the United Kingdom spent \$101.5 billion, or \$2,724 per person; Canada spent \$128.2 billion, or \$3,326 per person; and Germany spent \$230.3 billion, or \$3,287 per person. A country with very high overall health expenditures but relatively low per capita spending was Japan, with \$39.15 trillion in total spending and \$2,358 per capita.⁸

The Important Distinction Between Cost and Spending

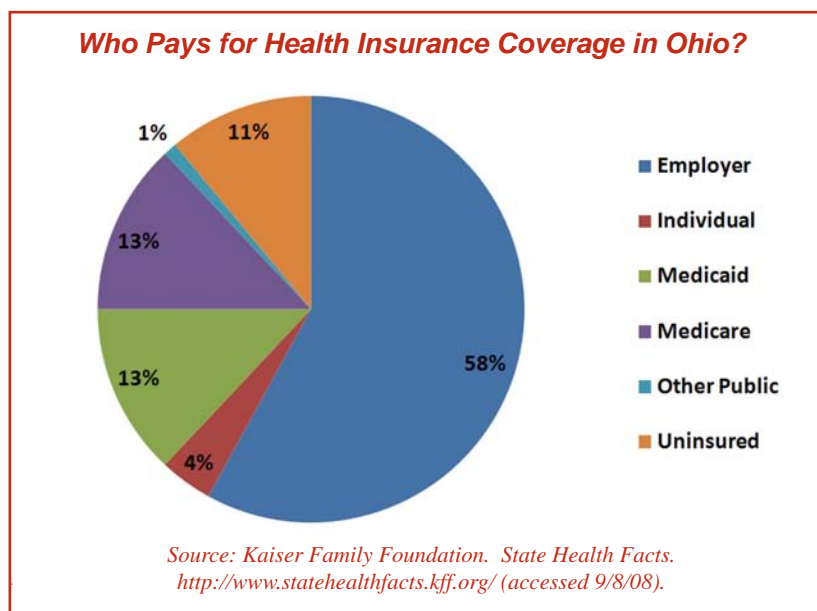
The terms spending and cost are often used interchangeably, but there are important differences. The cost of a healthcare service typically denotes its price. Healthcare spending is influenced not just by changes in costs, but also by the type and amount of care being provided.

There are a variety of drivers of healthcare spending in the U.S. The cost of the services themselves has risen. Two of the most influential factors here are the constant stream of new technologies and the cost associated with maintaining a highly trained, specialized workforce, especially given the current shortage of healthcare professionals needed to work in our healthcare facilities. Also contributing to increased spending is a higher level of consumption of healthcare services. Again, technology and medical advances are factors here. There are treatments available today that were not available in the past, and thus there are more services being provided and paid for.

Another driver of America's high healthcare costs that is sometimes overlooked is the health of Americans, in general. For instance, obesity is widely known to be detrimental to one's health and as it stands today, only 37 percent of Americans are not currently overweight or obese.⁹ What's more, if current trends continue, by 2048 all American adults will be overweight.¹⁰ With spending on medical costs related to obesity averaging \$258 per person in 2003, it goes without saying that American culture itself plays into the high cost of healthcare.¹¹

High healthcare costs and spending have significant consequences for individuals. Families today face insurance premiums almost double those they paid just seven years ago.¹² Those without insurance can face even greater challenges, especially if they encounter an unexpected catastrophic illness or accident. Even a relatively minor accident that requires a simple overnight hospital stay can create a serious financial hardship for those without insurance. Reports indicate that rising healthcare costs are a problem for more than just a small percentage of Americans. In 2007, almost two-thirds of adults were either uninsured at some point during the year, were underinsured, had difficulties paying medical bills or chose not to get necessary healthcare because of cost.¹³ Hospitals often work with patients to mitigate excessive financial burden; however, charity care is not a solution to the increasing financial burden facing Americans, especially considering the growing number of people in this difficult financial position.

How Does Ohio Fare?



If you live in Ohio you have a higher likelihood of having health insurance than a person in the general population of the United States. As costs continue to increase, the share that individuals and employees can contribute toward health insurance will decrease, putting even greater pressure on government-funded programs like Medicaid. Without changes to the system, the number of the uninsured is expected to increase in the long run.



Health and Culture

Indicator	Ohio's Rank*
Obesity Rates	17
Hypertension Rates	17
Children's Obesity Rates	21
Medical Costs of Obesity	11
Adult Tobacco Use	11
High School Tobacco Use	9

Source: Trust for America's Health

*In comparison to the rest of the states in the United States

Access

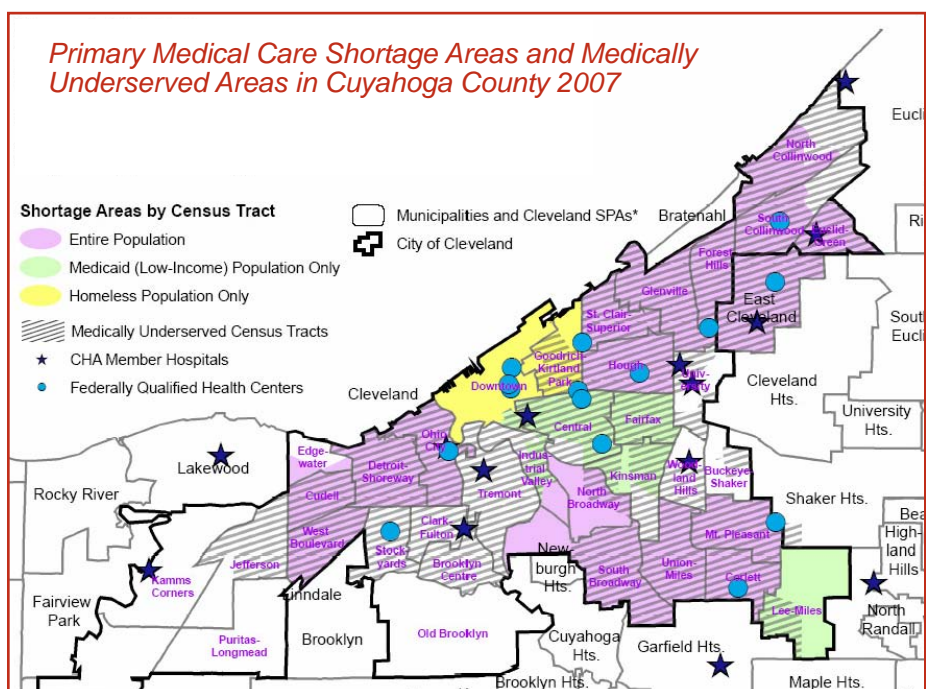
The Institute of Medicine reports that the United States is the only wealthy, industrialized nation in the world that does not provide universal coverage to its citizens.¹⁴ That essentially means that for many Americans, access to the American healthcare system is seriously compromised. Often, it is assumed that those without health insurance coverage fall into two major categories: those who are young and healthy and feel the cost is not worth the benefit and those who are not employed. While these two categories of uninsured people do surely exist the reality is, most people without insurance, about 80 percent, are from working families.¹⁵ Often these workers are in jobs where health insurance is not offered. For others, health insurance is offered but at a cost too high to afford. In addition, people who once had insurance coverage can lose it when they turn 19 or graduate from college, get divorced, retire, or if the policy holder dies.

Having access to healthcare is about more than having health insurance. In order to get healthcare services when they are needed, there must be a place to get them. Geographically speaking, people who live in rural areas face the obvious challenge of commuting long distances to get needed healthcare. But surprisingly, people from urban areas can also face challenges regarding the availability of health practitioners. Northeast Ohio has a number of Health Professional Shortage Areas (HPSAs), or areas that have too few primary medical care physicians. The Center for Health Affairs Community Needs Assessment pinpointed HPSAs in three counties (Cuyahoga, Ashtabula and Summit) and noted that the situation is especially difficult in some areas such as in East Cleveland, where the entirety of the city is an HPSA.¹⁶

Compounding the current shortage is the steady decline over the last several years in the number of medical students choosing family practice residencies. This trend is likely to continue considering the salary disparities that exist between family practice physicians and specialists.¹⁷ A study released in September 2008 in the Journal of the American Medical Association reported that only 2 percent of fourth-year medical students interviewed planned on pursuing a career in primary care. That represents a 7 percentage point decrease from a similar study conducted



in 1990.¹⁸ As a result, the situation in regards to HPSAs is expected to get worse. The negative effect of these barriers to access cannot be overstated. Without access to a primary care physician, people are likely to enter the healthcare system only when their illnesses have escalated significantly, leaving them with poorer outcomes and higher costs.



Source: The Center for Health Affairs, "Community Needs Assessment," prepared by the Center for Community Solutions, 2007.

The Center for Health Affairs Community Needs Assessment revealed that there were Health Professional Shortage Areas (HPSAs), or areas with shortages of primary medical care physicians, in three of the 13 Northeast Ohio counties it examined: Cuyahoga, Summit and Ashtabula. A Medically Underserved Area (MUA) is similar in concept to an HPSA but is determined using a different set of statistics. When using the MUA criteria to examine physical barriers to access, the Community Needs Assessment revealed MUAs within Cleveland’s borders of Cuyahoga County and in portions of Lorain, Summit, Portage and Trumbull Counties.



Transparency has become a buzzword in healthcare. After all, it is difficult to evaluate quality when consumers do not have sufficient information to draw conclusions. Recognizing the importance of comparative information for consumers as well as its eventual positive effects on healthcare quality, the U.S. Department of Health and Human Services launched a Web site called Hospital Compare (www.hospitalcompare.hhs.gov) in 2005 that allowed consumers to see whether their hospital performed above or below the national average for several indicators. Just this year, the site was updated to provide much more detailed information including easily comparable data about performance. The most recent update includes hospital performance in regard to care received by children. The goal of the site is to inform patients, increase transparency and improve quality of care.

Quality

According to an article published in the *Lancet* in 2006, survival rates for certain cancers in the United States are the highest in the world.¹⁹ There are likely a number of reasons for this trend but perhaps the most salient is the importance the United States' healthcare system places on quality of care. The U.S. is well known for medical advancements, innovation and its willingness to seek every treatment avenue available in pursuit of improved health. Hospitals strive to provide quality care because doing so is a pivotal part of their missions and because providing quality care in an age of increased transparency allows them to stay competitive.

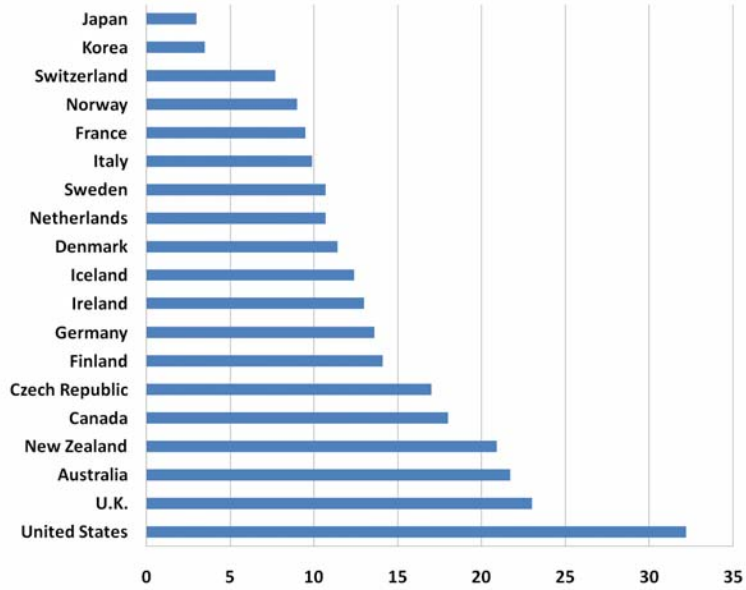
Despite this commitment to quality, the United States ranks relatively poorly overall among other industrialized nations in terms of health system performance, according to the World Health Organization.²⁰ The notion that the United States fares so poorly in these rankings can be somewhat puzzling. After all, America is an international leader in health technology and medical research. Its advanced facilities are capable of attracting the best physician talent in the world. So where do these poor rankings come from?

The truth is, regardless of how sophisticated our medical establishment is, it operates in a healthcare system that can sometimes make optimal quality outcomes extremely challenging to achieve. As it is, our healthcare system suffers from a shortage of nurses, which forces providers to do more with fewer resources. The payment system, until recently, has been quality neutral, providing reimbursements regardless of outcomes. At the same time, healthcare consumers have had very little information about provider performance.

Also important to note is the differentiation between the quality of healthcare services and the general health of the population. Critical reviews of the U.S. healthcare system sometimes make the mistake of pointing to the population's poor health status as an indicator that there must be a problem with the quality of care. However, in order to most effectively develop strategies for improving the U.S. healthcare system, it's important to distinguish between the quality of care provided by our healthcare practitioners and the overall effectiveness of the system, which encompasses health status, public health initiatives, research, preventive care, our financing structure and a whole host of components in addition to the quality of hospital and physician services.

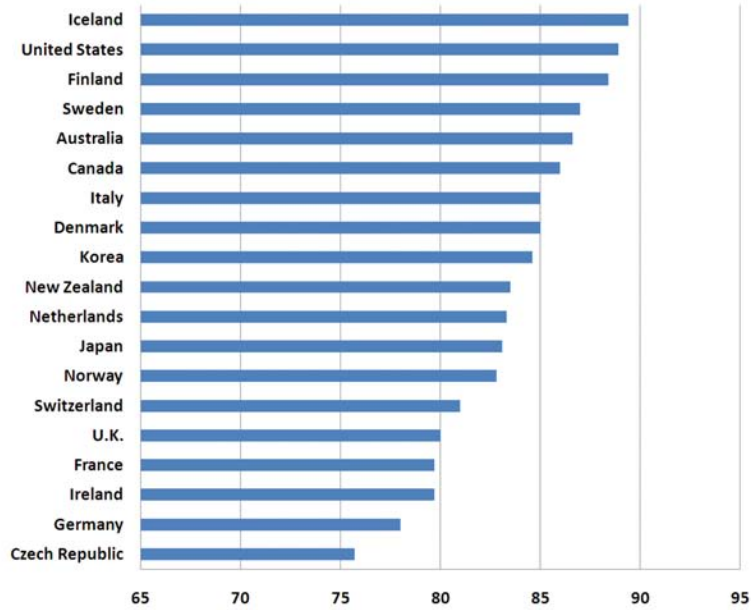
Data from the Organisation for Economic Co-operation and Development (OECD) help to demonstrate the difference between health status and quality of care. For example, while the U.S. is a world leader when it comes to the percentage of the population that would be categorized as obese, an indicator of health status, it is also a leader in breast cancer survival, an indicator of quality of care. The distinction is important because to be effective, a healthcare system has to be good at not just treating illness, but preventing it as well, and this is where the other resources described above, like research and public health, are especially important.²¹

Obesity as Percentage of Population, 2005



Source: Organisation for Economic Co-operation and Development, Health at a Glance 2007

Breast Cancer 5-Year Survival Rate, Latest Year Available



Source: Organisation for Economic Co-operation and Development, Health at a Glance 2007



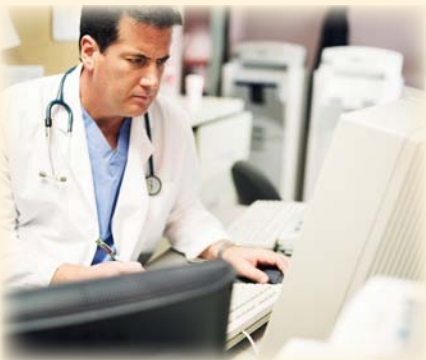
Other stakeholders also recognize the importance of quality reporting and began to demand it. In 2003, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an independent organization that accredits hospitals, began requiring hospitals to report quality data as part of their accreditation process.

Increased awareness of the challenges related to healthcare quality has prompted the development of a number of innovative quality improvement programs in the United States. In response to the nursing shortage, legislation known as the Nurse Reinvestment Act of 2002 was passed to provide funds to encourage recruitment and retention of nurses and included provisions to bolster nursing education.²² Hospitals in Northeast Ohio and across the country are engaged in their own efforts to ensure an adequate supply of nurses in their own facilities including tuition reimbursement, flexible scheduling and the active promotion of nursing careers to young people, just to name a few. The end result of these programs should be an adequate supply of nurses to staff America's healthcare facilities, which will in turn ensure high-quality care.

Recent changes to the U.S. healthcare reimbursement structure also speak to its commitment to quality. The Centers for Medicare and Medicaid Service (CMS), the federal agency that administers those programs, initiated a quality reporting program for hospitals in 2003 that tied a portion of their annual payment update to their participation in quality reporting. In fiscal year 2007, 95 percent of eligible hospitals contributed data and qualified for their full update.²³

However, the most recent reimbursement changes go beyond simply reporting quality information to actually providing payment based on quality. As of October 1, 2008, CMS no longer reimburses hospitals for care provided as a result of adverse, preventable medical errors such as objects left in the body after surgery. Pilot projects are also currently underway that financially reward physicians for improving quality of care and have shown promise in meeting their objectives of improved quality.²⁴ Many private insurers have followed the lead of CMS on these pay-for-performance initiatives, particularly when it comes to refusing to pay for care provided as a result of medical errors.

The proliferation of these programs demonstrates that the United States is a country that cares a great deal about the quality of its healthcare. Central to this understanding though, is that quality considerations cannot be evaluated in a vacuum. Just as cost and access invariably affect one another, they also affect quality. Restricted access often means people do not receive care when they should, which negatively affects overall health as well as long-term treatment outcomes. In addition, the initial cost of medical innovation is high but also has the potential to improve quality. The same could be said of quality initiatives. While these types of initiatives certainly have the potential to improve quality they can be administratively complex and resource intensive.



Alternative Models of Healthcare Delivery

The challenges seen in the healthcare delivery system in America are growing more acute. Costs are mounting just as access is becoming more limited. At the same time, ensuring the highest quality healthcare almost always implies higher costs. For the American healthcare system to be successful, the key is balancing cost, access and quality in a way that will provide the highest quality care to the most people at the most reasonable, sustainable cost. Around the world, other nations have their own unique healthcare systems, all of which are balancing cost, access and quality with differing levels of success. Likewise, in response to the imperfections often seen in the American system, some states and even some localities have taken on the challenge of making systemic changes to healthcare delivery. As the nation settles in post-election and adjusts to the new administration, perhaps it is a good time to see how these other models do in terms of cost, access and quality in order to more objectively evaluate any future healthcare reform proposals.

Though nations around the world have seemingly endless versions of healthcare delivery, most systems are built upon the fundamental frameworks outlined below. Unlike other countries that have one unified healthcare delivery model for all of its citizens, the United States uses all four models for different segments of its population.²⁵

<i>The Beveridge Model</i>	<i>The National Health Insurance Model</i>
Used in the U.K., Scandinavia, Spain and New Zealand (and for American veterans)	Used in Canada, Taiwan and South Korea (and for elderly Americans with Medicare)
Healthcare is delivered and paid for by the government	All citizens pay into the healthcare system where the government is the sole payer
Hospitals are largely owned by the government	Healthcare facilities operate in the private sector
Doctors can have their own private practice but are still paid by the government	Costs are controlled by limiting the number of services that are covered
<i>The Bismarck Model</i>	<i>The Out-of-Pocket Model</i>
Used in Germany, France, Belgium, the Netherlands, Japan and Switzerland (and to some degree, for Americans with employer-sponsored health insurance)	Poor nations without a nationwide health delivery system such as rural Africa, India and China (and uninsured Americans)
Funding for insurance is shared between employers and employees	The poor cannot afford healthcare and they do not get it
The insurers have to cover everyone	The rich buy the healthcare they need
Insurers cannot make a profit	
Tight regulation of insurers by government allows a great degree of cost control	

Source: Frontline, "Sick Around the World."



Healthcare Delivery Around the World

The United Kingdom

The healthcare system in the United Kingdom differs greatly from America’s and is perhaps the most well-known version of the Beveridge model. The government pays for the healthcare services of all of its citizens through taxes, including doctor visits and hospital care. Dental and vision services are included for certain groups such as “pensioners” and children.²⁶ Hospitals are, in large part, owned by the government and doctors are mainly independent contractors paid by the National Health Service (NHS). The World Health Organization (WHO) ranks 191 countries on various aspects of their health and health system performance. The United Kingdom’s health system ranks 18th in overall performance, its level of health ranks 24th, and its health expenditures per capita rank 26th. In comparison, the United States ranks 37th, 72nd, and 1st, on these same measures, respectively.²⁷

Health Performance by Country

	Overall Health System Performance	Level of Health	Health Expenditures per Capita
United States	37	72	1
United Kingdom	18	24	26
Germany	25	41	3

Source: World Health Organization

**Taiwan is not included in The World Health Organization rankings*

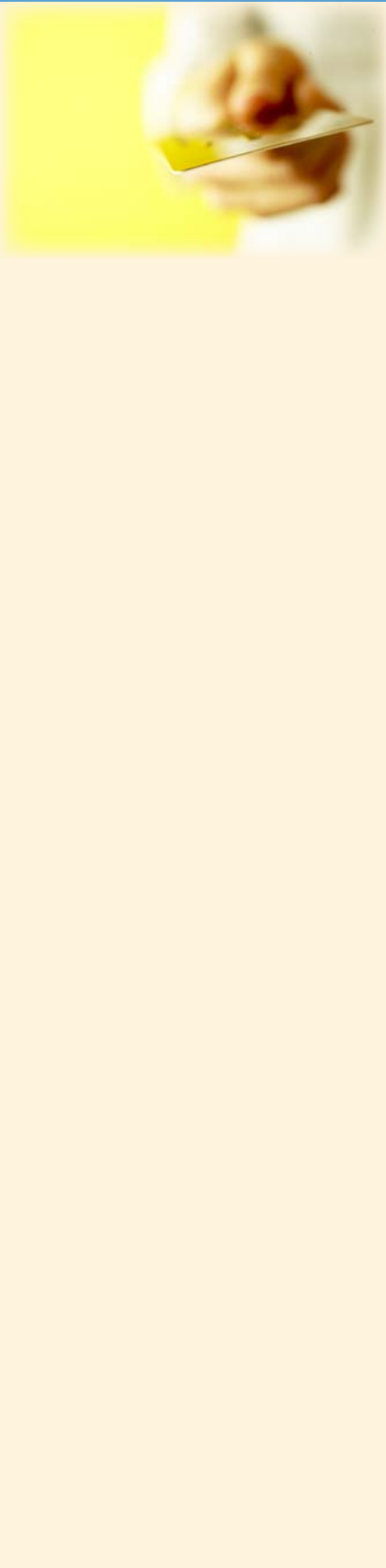
One important tenet of healthcare delivery in the U.K. is the role of the general practitioner (GP). All care is coordinated through a primary care doctor who must be seen in order to obtain a referral for a specialist. GPs are paid by the National Health Service at a rate that is generally higher than that paid to specialists²⁸ and are financially incentivized to keep patients healthy. As a result, Britain is seen as a world leader in preventive care.²⁹ In addition to prioritizing preventive care, the U.K. also relies on the Healthcare Commission, an independent, nonprofit organization charged with monitoring quality and safety, as a component of ensuring quality. The Healthcare Commission also plays an important role in boosting transparency by providing information to patients about provider performance.³⁰

These differences in healthcare delivery yield different results in terms of cost, access and quality than what is seen in the United States. The most obvious difference relates to cost. Because the government is the sole payer, it has a high level of control in determining what doctors can charge and what services they can offer. Having only one payer also means greater administrative simplicity, another source of cost savings. As a result, the per capita cost of healthcare in the United Kingdom is low compared to the United States. Health spending in the United Kingdom as a percentage of Gross Domestic Product (GDP) is about half of what it is in the United States: 8.2 percent versus 15.2 percent, according to the latest comparative data available.³¹ Cost, in terms of out-of-pocket expenses paid by citizens, also stands in stark contrast to that of Americans. British citizens pay no premiums and nothing out of pocket for most healthcare services. Co-payments are required for some dental services and eyeglasses. Prescriptions require a 5 percent payment contribution, though young people and the elderly are excluded from this requirement.³²

Britons' access to healthcare also stands in stark contrast to that seen in the United States. Everyone in the United Kingdom has access to basically free healthcare. It is important to note that looking at access in this light alone can be somewhat deceptive. Wait time is one notorious complaint about the British healthcare system that clearly demonstrates restrictions on access. If a patient needs healthcare but must wait an extended time to get it, that patient does not have "access" to the healthcare system at the time that healthcare is needed. This type of access problem happens much less frequently in the United States. In addition, the NHS holds costs down by limiting the types of services provided. Medicines and treatments that do not substantially improve long-term outcomes are simply not covered. For instance, extremely expensive drugs that have only been shown to extend life by two months would most likely not be covered. The British mentality is that healthcare dollars are limited and would be better spent where they will have the greatest long-term impact.³³ In other words, access to healthcare means access to care that the National Health Service deems worthwhile and chooses to pay for.

It is impossible to untangle these notions of access from quality. The United Kingdom is essentially rationing care which means, despite the fact that there may be treatment available, sometimes receiving it is not an option. Recent studies on international cancer survival revealed that England and Wales ranked in the lower half of all countries studied. The United States, on the other hand, ranked in the top three for the percentage of people who survived at least five years after breast, prostate or colorectal cancer diagnosis. Some experts argue this difference in quality outcomes is the result of the emphasis the United States places on providing the most cutting-edge, advanced care rather than limiting treatment options to reduce costs.³⁴





Taiwan

Implemented in 1995, Taiwan's healthcare delivery system is an example of the National Health Insurance (NHI) model and is similar to that of Canada. There is one national, government-run insurer that covers all of the citizens in Taiwan, all of whom are mandated to participate. Those who are employed share the costs of premiums with their employers while those who are not employed pay flat rates for healthcare, often with the help of government subsidies. The comprehensive healthcare services provided under NHI carry a small co-payment, including 20 percent cost sharing for pharmaceuticals.³⁵ Healthcare providers operate in a market-driven delivery system where some hospitals are private and some are public. Physicians are either employed directly by hospitals or operate as private, fee-for-service practitioners. Physicians not employed by hospitals do not have admitting privileges and as a result, often maintain a small number of inpatient beds in their primary care clinics.³⁶

Another notable component of health reform in Taiwan was the implementation of a broad, electronic infrastructure, accessed by patients with a "smart card." Patients present their smart card to practitioners in order to receive services. But the value of the card goes beyond the simple purpose of identification. First, it is used by practitioners to pull up health information about patients such as allergy history and long-term prescription history. Practitioners also use the card to bill the NHI for reimbursement. The Bureau of National Health Insurance (BNHI) is able to monitor each citizen's use of health services and thereby intervene when a patient is using the system excessively. Finally, the smart card can be used for purposes of public health information like immunizations and organ donation instructions.³⁷

In many ways, Taiwan's healthcare reform movement has been a success. Within one year of implementing NHI, 96 percent of Taiwan's population had enrolled, reducing the uninsurance rate by 40 percent.³⁸ With this increased level of access came modest gains in life expectancy, most notably in populations that had once been the most marginalized.³⁹ What's more, these gains have been accomplished without costs spiraling out of control. Health spending as a percentage of GDP is only 6.23 percent, a mere drop in the bucket compared to America's spending. Though there was a sharp cost increase in 1995 (the year the NHI was initiated), spending has stabilized and has not seen increases beyond what would have been expected prior to the NHI.⁴⁰

With both access and cost issues plaguing American policy makers, the success seen in Taiwan begs the question: How does Taiwan keep costs so low while expanding access to almost 100 percent of the population? The answer, of course, is not straightforward. One piece of the answer lies in the administrative simplicity of a single-payer model. Healthcare providers do not have to wade through multiple payers, denials and other administrative hurdles to get reimbursed. In fact, the single-payer administrative structure, in tandem with the electronic smart card system, makes reimbursement and administration so efficient that Taiwan enjoys administrative costs of less than 2 percent – the lowest in the world.⁴¹

Using the smart card not only allows for more efficient administration but also allows for easier, more efficient communication among different care providers. Better care coordination serves to eliminate excessive, repetitive tests, overprescribing and drug interactions and as a result brings down cost. Another piece of the answer may lie in the fact that Taiwan's health delivery model emphasizes the importance of preventive care. Though most medical services require co-payments, preventive services are provided for free which means oftentimes, diseases can be detected in early stages or are prevented altogether, both of which have the benefit of being less expensive than treating an advanced illness.

Though cost and access are two areas of healthcare delivery in which Taiwan excels, the systemic picture is incomplete without a look at the third side of the triangle: quality. Taiwan's healthcare system once again demonstrates the interconnected nature of the healthcare triangle and how trade-offs must always be part of the equation. The sparse attention given to the quality side of the healthcare triangle is another reason the cost of healthcare is so low in Taiwan. Taiwan simply does not collect any comprehensive information on the clinical quality of care. There is no mandatory hospital accreditation program (though a voluntary one was created in 1998) and there are no regulations mandating systematic reporting of clinical performance, patient outcomes or adverse events. Hospitals are not required to have uniform clinical record systems and some argue that Bureau of National Health Insurance (the agency that administers the NHI) has not done enough to encourage adoption of advanced medicine and cutting-edge procedures.⁴²

Germany

The healthcare system in Germany would look a little more familiar to Americans than those in the United Kingdom or Taiwan. Like many Americans, Germans depend upon insurance to help cover their medical costs. Also like Americans, German citizens share the cost of insurance with their employers, usually a 50/50 split. The majority of hospitals in Germany are nonprofit, both public (about half of all beds) and private (about one-third of all beds). For-profit hospitals also exist and account for about one in six hospital beds.⁴³

Despite these similarities, drastic differences do exist. Perhaps the most striking difference is that insurance companies are nonprofit entities administered by the state. These sickness funds, as they are known, cannot deny coverage based on pre-existing conditions, and their fees are regulated by the state. Market competition within the healthcare system is valued but rather than the for-profit insurance structure seen in the U.S., German funds compete with one another for enrollees. Sickness fund managers are paid based on the number of people they cover.⁴⁴ This market focus on attracting people rather than increasing profits means that sickness funds must continually strive for ways to appeal to citizens. Germans are free to choose their own sickness fund as well as their own care providers, almost all of whom accept all of the roughly 400 sickness funds. One choice Germans do not have, however, is whether or not to carry insurance in the first place. Health insurance is compulsory. For those who are unemployed or financially unable, the government covers the cost of insurance.⁴⁵ Those who are wealthy have the





Taking a Regional Approach

Uninsured people in Ohio sometimes have no means of obtaining healthcare without facing financial ruin. Frustrated for lack of state and national reform on behalf of these marginalized citizens, some localities are taking matters into their own hands. Lucas County coordinated a network of medical volunteers, hospitals, clinics and referring community service organizations to provide primary care, specialty medical and dental care as well as affordable prescriptions and reliable transportation for medical appointments. CareNet, as the program is known, has enrolled over 14,000 people since it began in 2003 and has succeeded in significantly improving the health status of its members

Continued on next page

opportunity to opt out of the state system and buy private insurance, though only about 25 percent of those eligible choose to do so.⁴⁶

Quality is high on the healthcare priority list in Germany. Acute-care hospitals are required to report on more than 150 indicators, 30 of which are made public. Feedback on these measures is also given to each individual hospital in order to facilitate quality improvement. In addition, all providers are required to adopt a quality management system. Physicians must participate in continuous medical education and all prescriptions and medical technology are subjected to assessment by the Institute for Quality and Efficiency. Despite these rigorous quality measures, hospital accreditation remains voluntary.⁴⁷

As a result of the compulsory nature of insurance coverage as well as government subsidies for the poor, Germany has achieved nearly universal access to healthcare. In addition, the numerous mandated quality initiatives have resulted in a system of healthcare that is renowned for its excellence. Germany's high quality and high degree of access, not surprisingly, distort the other side of the healthcare triangle, cost. Germany ranks third in the world for the cost of its healthcare system per capita and spends 10.7 percent of its GDP on healthcare.⁴⁸

In addition to the cost associated with such a high degree of access and quality, one major cost driver merits a closer look. Germans, like many Americans, self-refer to specialists without the need to contact a general practitioner. As a result, Germans choose to use specialists excessively. One study that examined healthcare delivery in a number of countries found that Germans visit specialists more than twice as often as any of the other countries studied, including the U.S.⁴⁹ Despite its high costs, Germany still spends significantly less than the United States yet has a higher level of health.⁵⁰ Germany's costs differ from those of the U.S. for a number of reasons including "limited access" due to long wait times, tighter regulations placed on insurance companies, and the nonprofit nature of sickness funds.

State Initiatives

Massachusetts

In 2006, Massachusetts passed health reform legislation that enacted an individual mandate for insurance coverage. The legislation included a number of tools in addition to the mandate to help achieve its goal of near universal coverage. First, it expanded its Medicaid program to include children with family incomes between 200 and 300 percent of the Federal Poverty Level (FPL). Second, it provided subsidies for low-income earners and their families in order to make participating in the private insurance market more affordable. Third, it imposed penalties on companies that do not offer health insurance to their employees.

The legislation also created an "insurance connector," which is an insurance purchasing pool that allows individuals and employees of small businesses to purchase insurance from a centralized location. The connector also consolidates the

individual and small group insurance markets in order to achieve a larger risk pool intended to result in lower monthly premiums. As further incentive to participate in the mandate, residents are required to document their health insurance status on their state tax forms. Those who do not are not permitted to claim a personal tax exemption and are also subject to a financial penalty equal to half the cost of an affordable annual premium.⁵¹

In terms of the healthcare triangle, Massachusetts has made a clear commitment to expand access and has been successful in this endeavor. One year after it was enacted, the Massachusetts reform law (also known as Chapter 58), had reduced the number of uninsured in the state by half, to only 7 percent. At the same time, the number of adults reporting that they went without healthcare due to prohibitive costs declined by 5 percent.⁵²

Beyond expanding access, Chapter 58 also contains a number of other noteworthy quality elements. In an effort to improve quality and mitigate disparities, the Massachusetts health reform model includes pay-for-performance measures targeted at eliminating disparities. This groundbreaking quality initiative is the first of its kind in the nation. Chapter 58 also created a Health Disparities Council charged with making recommendations that will serve to reduce and eliminate racial and ethnic disparities. Also created under Chapter 58 was the Quality and Cost Council, the aim of which is to develop and coordinate health quality improvement goals that will simultaneously lower the cost of healthcare and increase the quality. Some of the policies enacted by this council include gathering cost and quality data from insurers and hospitals, launching a Web site to report this data, and formulating an official plan to eliminate serious reportable events in hospitals by 2012.

Despite its many successes, opponents of Chapter 58 point out that costs have risen substantially, surpassing initial estimates significantly. The governor's budget request of \$869 million for 2009 was almost \$400 million more than in 2008. Many policymakers believe that even with this substantial increase, funding will still fall short in 2009. Other states' health reforms, such as those in Tennessee and Oregon, when faced the same challenge, eventually collapsed under the overwhelming cost burden.⁵³ What this means is that Massachusetts must find a way to balance the three elements of the healthcare triangle. In order to maintain the gains made in terms of access and quality, policymakers in Massachusetts must find a way to reign in cost.

Continued from previous page

with diabetes and high blood pressure. Another successful CareNet strategy was to encourage members to use a system of primary care management rather than going to the emergency room to meet their healthcare needs.⁵⁷

Access to Care is Summit County's version of healthcare reform and is in many ways similar to CareNet, connecting uninsured residents with volunteer medical providers. It represents a collaboration of 38 community organizations dedicated to providing all Summit County residents with high-quality affordable healthcare.⁵⁸



Vermont

In the same year Massachusetts passed comprehensive health reform legislation, Vermont passed the Health Care Affordability Act. Like Massachusetts, Vermont wanted to increase access to care by making insurance more affordable. Toward that end, Catamount Health Plan was created as an affordable insurance plan open to all uninsured residents with the state providing subsidies for all people making less than 300 percent of the FPL. Vermont will also give subsidies to residents who make less than 300 percent of the FPL to help them afford the premiums from their employer-sponsored insurance plan. To encourage businesses to offer health benefits, the new legislation assesses a fee of \$365 for each full-time employee who is not offered health insurance or who does not accept the offer of health insurance. Unlike Massachusetts, health insurance remains voluntary in Vermont.⁵⁴

To be sure, Vermont aimed to reduce the number of uninsured residents when it crafted its health reform legislation; however, spending was equally important. The primary vehicle for keeping spending under control is the reform’s focus on disease management and prevention. Known as Blueprint for Health, this expansive statewide initiative was designed to better manage the healthcare of people with chronic conditions. This initiative goes beyond patient education to involve all stakeholders in the healthcare system. The logic behind the plan is that when people better manage their chronic conditions, it results in a healthier population and creates a decreased demand for medical services.⁵⁵ Also written into the legislation is a fall-back plan that allows the state to take control of administering benefits if the plan is not cost effective.⁵⁶ This tenet of the legislation provides incentive for the insurance companies currently administering the plan to provide cost-effective benefits.

Data is scarce on whether Vermont’s efforts have reduced the number of uninsured in the state. It’s also too early to tell if the reform’s cost-containment measures have been successful. If Vermont’s reform does prove to be successful, components of the legislation might be useful to consider in national reform conversations.

Blueprint for Health: Engaging the Stakeholders

Patients	Provided with information and support to manage their diseases
Providers	Encouraged to adopt clinical guidelines and best practices
Communities	Asked to develop physical activity and wellness programs
Payers	Required to develop chronic care management programs to align with Blueprint for Health

Source: Kaiser Commission on Medicaid and the Uninsured

Conclusion

There are few people who would argue that America's healthcare system would be best left alone. Limited access, high costs and inconsistent quality all point to the need for our nation to seriously consider major changes to our current system. Some might argue the current period of economic instability will force us to reconsider our ability to initiate health system reform. However, poor economic conditions accelerate the factors that are already driving a need for reform. As corporations tighten their belts, insurance coverage could become increasingly expensive, and less accessible, to workers. The economic crisis also suggests that individual states will be hard pressed to do more than they already are. Any significant reform will need to come from the federal level.

The value in examining alternative healthcare delivery models lies in our ability to pick and choose the best parts of each model while staying away from what does not work. If the United States were to use this approach, what would reform look like?

The United Kingdom excels at keeping costs low by emphasizing the importance of primary care. Strengthening the role of the primary care physician in the United States would likely prove to be beneficial in our healthcare delivery system. The United States' shortage of primary care physicians could benefit from the United Kingdom's policy of paying general practitioners more generously. Additional financial incentives for general practitioners that keep patients healthy might also be a useful policy in America. To further strengthen primary care, the United States could look to Vermont's Blueprint for Health, which emphasizes chronic disease management with the help of all stakeholders. Massachusetts' initiative that ties payment to mitigating inequality in healthcare performance could serve as a model for the U.S. in terms of mitigating health disparities.

Taiwan has valuable lessons for America, as well. As the United States continues to increase its use of health information technology, looking to Taiwan and its success in this area may prove instructive. The simplicity and inter-operability of its infrastructure simplifies administration of the healthcare system and serves to both bring down costs and foster better coordination among care providers. Germany and Massachusetts serve as useful models of what reform might look like if the administration chose an individual mandate approach to healthcare reform. Germany also teaches us that excessively seeking out specialist care is very expensive and can create a cost burden on a healthcare system.



Let's first take a lesson from Taiwan, which may be the most important one of all. In response to its very poor healthcare system, Taiwan radically and fundamentally changed healthcare delivery. The lesson is, healthcare reform can occur.



Keeping an eye on the success and outcomes of current reforms helps guide us in our decision-making tomorrow. Perhaps the key to reform, which is often left out of the conversation entirely, is the concept of compromise. The reality is, for any healthcare reform to succeed it absolutely must compromise somewhere. If there was a health delivery system that allowed high quality and universal access all for a low cost, the whole world would employ it; however, the differences witnessed around the world are a testament to compromise. In general, health delivery systems with universal access and very high quality are very costly whereas those that are the least expensive tend to be lower quality and can afford to cover everyone. It boils down to the triangle. A health system that optimally balances the triangle provides the best chance we have at successful healthcare reform.



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