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Learning From Other Countries' Health Care Systems: Is Change Possible?

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Executive Summary

In a recent Senate Subcommittee hearing, Senator Bernard Sanders (I-VT) opened the discussion with this simple thought: The United States has a federalist system of governing where it is common that states learn from what other states are doing, but as a country we do not use that same principle to learn from the experiences of other countries. Senator Sanders made the statement with respect to what we could be learning from other countries' health care systems. Specifically, he stated that "other countries are doing very positive and interesting things," and in his view, "we have a lot to learn," with respect to health care. In that light, he noted that when it comes to cost of and access to health care we spend much more than other countries and relatively, "our outcomes are not particularly good."

While the applicability of other health care systems has long been a topic of debate in this country, it is interesting to pose the question as it was posed in this hearing: What can be learned now that we have passed health care reform and implemented the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148)? In other words, while the debates surrounding health care reform and especially the implementation of a single payer system are not novel in any respect, now that the ACA has been enacted and implemented how can this debate impact the debate about the efficacy of the ACA or the future of our health care programs overall?

Introduction

A closer look at the expert testimony proffered and the role partisan politics seemed to play during the Senate Subcommittee hearing is telling as to how underlying principles of other systems may be integrated into our current systems to achieve a more balanced and, perhaps, a more widely-accepted system. Yet, this in-depth analysis also reveals the sharp partisan lines that so obviously have been drawn, which may impede any attempt to integrate what can be learned from other countries' health care systems. Expert opinion from the individuals that testified at the hearing, however, illuminate how, despite these political obstacles, it is possible to learn from models used in other countries and how those models are already in place to some extent within the U.S. model. In that light, it is possible to consider to what extent these models could be expanded to play a larger role in the American system.

The Senate Subcommittee Hearing

Chairman Sanders made these comments during a Senate Subcommittee on Primary Health and Aging's hearing entitled, "Access and Costs: What the U.S. Can Learn from Other Countries." Several experts were invited to this panel to provide testimony on the topic and, in particular, identify the specific aspects of other countries' systems that would work in the American system. The hearing also consisted of additional comments and questions submitted to the panel by subcommittee members Senator Richard Burr (R-NC) and Senator Michael Enzi (R-WY) as well as Senator Charles "Pat" Roberts (R-KS). While Chairman Sanders approached the hearing as a way to examine how to address the statistical discrepancies between cost and access to care in other countries as compared to those measures in the U.S., Senator Burr's approach to the topic stemmed from the presumption that the ACA was broken and ineffective. In his opening comments he stated that before the ACA was adopted he, "warned it was the wrong direction for our country. Health care was broken before [the ACA] but four years later the American people are experiencing first-hand how the new law made things worse." Characterizing the reform as "unprecedented government intervention" into the health care system with "unsustainable costs," he implied—unlike Chairman Sanders who suggested "we have a lot to learn"—that the experiences of other countries might be examples of what not to do. In that light, he argued "the experiences of other countries will reinforce what many Medicaid patients already know, that coverage does not always translate into timely access to care." Although neither Chairman Sanders nor Ranking Member Burr espoused an opinion on what models should be adopted or what specific principles of other systems were a good fit for our country, it became clear even in the difference in opening comments between the two committee members that partisan politics would function as an obstacle in the discussion of what was to be learned by the experts.

The Single Payer Model, Variations and Counterparts

Before considering the experiences of foreign countries in providing health care to citizens and what principles experts have argued may potentially be integrated into further health care reform in this country, a brief review of different health care models is in order. Perhaps what was most widely discussed with respect to health care reform pre-ACA was the notion of a single payer system, that is, a system in which a public agency organizes the public funding of health care for the entire population but where the providers of health care remain private. Yet, many experts have pointed out that a single-payer system is not necessarily subject to one single definition and not many countries can be characterized as pure single payer systems.

The testimony provided to the Senate Subcommittee by Tsung-Mei Cheng, LL.B., M.A., a Health Policy Research Analyst at the Woodrow Wilson School of Public and International Affairs at Princeton University, is helpful in differentiating between this model, its variations, and its counterparts. Cheng identified many examples of each model both abroad and within the U.S. While many might think of the single-payer model as socialized medicine, Cheng points out that a true system of socialized medicine exists when the government both funds and provides health care. A foreign example of this model is the inpatient sector of the British National Health Service, while the Veterans Administration is the manner in which socialized medicine has manifested itself in this country. Variation to a single-payer system, on the other hand, is created with the mixed delivery of health care services from government owned-facilities, private not-for-profit providers, and private for-profit health care providers. Both Canada and Taiwan have adopted these types of variable single-payer systems and, in the U.S., traditional fee-for-service Medicare as well as Medicaid are also examples of this model.

In the single-payer model's counterpart, the multiple-payer system, the government financing aspect remains and, in most cases, funding is based on payroll contributions or per capita premiums. Yet, a health insurance system consisting of multiple carriers that compete with each other for patients, also exist in these models. Cheng described a sub-set of this system, the all-payer system, in which countries such as Germany and Switzerland have regional associations of insurers that negotiate with providers for common fee schedules. In these countries, carriers are prohibited from earning profits from those covered by social insurance but can produce revenue through the sale of supplementary insurance. This system is mirrored by Medicare Advantage, or Medicare Part C, and Medicaid Managed Care. Finally, Cheng describes the easily

recognizable private health insurance system of the U.S. pre-ACA, in which private insurers sell insurance to individuals or as employment-based group policies. As the ACA imposes additional government oversight, the individual mandate, and expanded social single-payer and multiple-payer initiatives, Cheng notes that there is truly no one U.S. health care model but simply "a pastiche of different systems."

What Can We Learn and How Can We Learn?

Cheng's testimony before the Senate subcommittee focused on the potential advantages of a single payer system. Specifically, she highlighted that such a system guards against financial ruined caused by medical bills as these systems are usually financed by taxes that are assessed based on an individual's ability to pay instead of an individual's health status. Cheng also pointed out that a patient in single-payer systems enjoys free range of choice when it comes to providers and because the "money follows the patients" providers are forced to compete not based on price but, rather, based on quality of services and patient satisfaction. Among the other notable points in Cheng's testimony of the advantages of a single payer system were that: (1) insurance is portable from job to job and through unemployment and retirement, (2) total health spending is easily controlled, and (3) the single payer system lends itself to a uniform electronic health information database that may be used to analyze and measure quality controls.

All of Cheng's testimony, however, was prefaced with the idea that single payer systems are ideal *if* "equity and social solidarity in access to health care and financing health care [are] fundamental goals of a health care system." In an interview with Wolters Kluwer, Cheng described three other specific factors that may constrain what can be transferred from one country to another in terms of health care models. First, Cheng noted that "the dominant theory of justice," that is, the ethical considerations that are embraced by individuals and must be reflected in a health care system, may play a part in limiting the applicability of certain models. She also noted that "path dependency of health systems," meaning the notion that "at any given time, a country's health system is the product of historical, cultural, legislative, and commercial developments of that country," also potentially constrains paths to change. Finally, Cheng noted that a country's system of governance, including the manner in which laws are passed and interests are represented is a major factor that limits what principles from other models may be adopted in a health care system.

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In a similar vein, during the Senate subcommittee hearing, Victor Rodwin, MPH, Ph.D., Professor of Health Policy and Management at New York University, mentioned the following qualifier before describing the potential benefits that may be reaped with an analysis and adoption of certain aspects of the French health care system: "Health systems cannot be transplanted from one country to another, nor should they be. Looking abroad, at best, can inform policy debates at home." Rodwin went on to testify that three particular aspects of the French system translate into political values that many Americans embrace, namely liberalism, pluralism, and solidarity. Those aspects are as follows: (1) the free choice of providers, (2) the delivery of services by a variety of types of providers from private to nonprofit, and (3) the notion that those with greater wealth and better health finance the system to a greater extent than those with less wealth and poorer health. Rodwin also provided information in submitted written testimony that highlighted more specific characteristics of the French system, which Rodwin describes as "an example of public, social security and private health care financing, combined with a public-private mix in the provision of health care services." Specifically, reimbursement to providers according to nationally set rates, extensive co-insurance and voluntary health insurance, and the development of annual health care expenditure targets were noted by Rodwin to be among those principles that could "contribute to the discussion" of what may be learned from other health care systems.

In interviews with Wolters Kluwer, both Cheng and Rodwin provided further and more concrete examples

of how exactly change could be or, more pointedly, is currently being integrated into the U.S. health care system. Interestingly, both experts pointed to initiatives in the U.S. in response to questions about what kind of changes could be enacted and how. Cheng described the all-payer system that has been adopted and operated for some time in the Maryland hospital system when asked what models would work well in the American context. To address the qualifiers that Cheng identified as political and structural obstacles for the adoption of a new system, she noted: "Maryland's all-payer system is something not totally alien to the rest of America. It is a home-grown system and anyone can easily visit to see and understand…"

Similarly, when asked whether the future of a strong health care system for the U.S. meant overturning the ACA, Rodwin responded that the current reforms in Vermont were informative. Rodwin did not advocate for the re-drafting of the ACA but for reconsideration as to how it is implemented. Specifically, Rodwin noted that "the ACA does not address the American problem of allowing too much choice of insurers and their health provider networks… there is too much emphasis [in the ACA, and in the U.S. more generally] on choice of insurer and not enough emphasis on choice of provider." He went on to assert that "it is a bad idea to be giving people too much of a choice of networks that keep changing and are difficult to understand for those not well versed in the details of health policy." In Vermont—where the governor signed a bill that will introduce a single-payer system within the state by 2017—Rodwin noted, people would not have to choose among different provider networks.

The specifics of the Maryland all-payer system and the potential adoption of a single-payer system in Vermont will be focused on below. For now, Cheng's and Rodwin's comments are useful in thinking about whether change is possible in the U.S. system.

Is Change Possible?

The expert testimony at the Senate Subcommittee hearing provided brief overviews of the principles of other systems. Further analysis and interviews by Wolters Kluwer reviewed what principles of other models might be especially applicable to the U.S. system. The question of whether these policies will even be considered on a national scale, however, is highlighted by the dynamic exhibited on the floor of the Senate Subcommittee. When presented with the question of whether health care should be a universal right, one of the six experts on the panel answered that it should not and another answered that it was a universal right but should be free of government intervention. If these experts represent political opinion—and it should be noted that all three Republican senators that spoke in the hearing openly endorsed the work of the expert that did not endorse health care as a universal right—the answer to that question alone forecloses the consideration of any of the models discussed by Cheng and Rodwin as well as any other country's model that was mentioned in the hearing. With continuing debate over the fundamental question that must be answered in the affirmative before considering how exactly changes informed by other countries may be adopted, the chances of enacting such change seems slim.

Yet, the models adopted in certain domestic jurisdictions and referenced by both Cheng and Rodwin indicate that change is possible. Indeed, Rodwin argued, that "the fact that it is done in Vermont shows it's possible." While Cheng predicted that adoption of another type of health care system in the U.S. would not occur "because the supply side of U.S. health care is very powerful." She also stated that "increasingly, providers, payers and policy makers in the U.S. recognize the urgent need to make our health care system more efficient. I think there is shared recognition now that failure to achieve meaningful reforms will cost America as a country dearly." Rodwin further opined that change in regard to how the current system is to be implemented is "largely in the hands of the states." In that light, even if certain obstacles exist when considering other countries' models, perhaps the powerful forces of federalism that Chairman Sanders referenced in his opening remarks to the subcommittee could function to spread change from the small experiments in states and special sectors to the adoption of new national model over time.

While questions remain as to whether fundamental differences drawn along partisan lines will even allow for the consideration of other countries' health care models, the existence of other models within the American structure should be investigated. The following sections will review both the Maryland hospital all payer system and the single payer system that is expected to be implemented in Vermont within the next few years. In addition, the extent to which those models reflect the structure of health care administration of other countries and also what principles guiding those systems, both foreign and domestic, can be incorporated into the national structure of the health care system in the U.S. now that the ACA has been implemented will be considered.

State Experiments Using Other Countries' Models

Both the Maryland all-payer system and the approved-but-not-yet-enacted Vermont single-payer system are examples of other health care payment systems that reflect principles evident in other countries' models. The experts that testified at the Senate subcommittee shed some light on how these U.S. models illuminate the way in which other countries' systems could function within the U.S. An evaluation of these models as well as certain other reimbursement-based health care coverage in the U.S. is also important in considering how the ACA may be re-conceptualized in order to better integrate certain aspects of other countries' models.

Maryland Hospital All-Payer System

Maryland operates an all-payer hospital rate regulation system under a 36-year-old Medicare waiver allowed under section 1814(b) of the Social Security Act. Under this system, which is the only one of its kind in the country, the state of Maryland sets uniform rates for services that all third parties must pay and is exempt from the Inpatient Prospective Payment System (IPPS) as well as the Outpatient Prospective Payment System (OPPS). Tsung-Mei Cheng, LL.B, M.A., a Health Policy Research Analyst at the Woodrow Wilson School of Public and International Affairs at Princeton University stated in her written testimony submitted as part of the Senate subcommittee hearing that Maryland mirrors the all-payer models that have been adopted in Switzerland and Germany and characterized this model as "close cousins of single payer systems."

Specifically, Cheng classifies this all-payer model as a type of multi-payer social insurance, which is either funded through gross wages, as is the case in Germany, or through per capita premiums, as is the case in Switzerland. However, the defining characteristic of the all-payer model is that, according to Cheng, "regional associations of health insurers… formally negotiate with counter-associations of providers common fee schedules that then apply to all insurers and providers in the region…" In these models, the negotiations over fees are "subject to oversight by the relevant governments which may set an overall global budget for the negotiations." Cheng also draws parallels between the Swiss, German, and Maryland model and the Medicare Advantage and Medicaid managed care systems in that all of these models use funds collected from taxes to support the programs but the purchase of services, claims processing, and negotiations of fees are the responsibility of either private for profit or non-profit insurance carriers.

The discussion of the Maryland all-payer system, however, is especially pertinent to the discussion of what can be learned from other models now that the ACA has been implemented because, this year, CMS announced that Maryland and CMS would be partnering up to modernize the all-payer system by adopting "new policies to reduce per capita hospital expenditures and improve health outcomes as encouraged by the [ACA]." Specifically, hospitals in Maryland will set goals to reduce 30-day hospital readmission and hospital-acquired conditions rates as well as to limit per capita hospital growth. CMS has predicted that this model will save Medicare an estimated $330 million over the next five years and also has announced the intention that these updates will create an "all-payer system for hospital payments that that is accountable for the total hospital cost of care on a per capita basis," which may serve as a model for other states that are considering adopting a similar system.

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Vermont Single-Payer System

In May of 2011, the Vermont state legislature passed Act 48, which "puts Vermont on a path to a single-payer system." However, this system, called Green Mountain Care, is only scheduled to take effect after ACA waiver requirements are completed, the Green Mountain Care Board proposes a budget and ensures minimum requirements of the system are met, and the Vermont General Assembly approves the budget for the system. This process may be completed by 2017. Just as is the case with the Maryland all-payer system, the Vermont

program represents the adoption of a model that is employed in several other countries. Cheng notes that the single-payer model is present in both Canada's provincial health insurance system and Taiwan's National Health Insurance (NHI) program. Cheng also notes that both traditional, fee-for-service Medicare and state-based traditional Medicaid can be classified as single-payer models, in which the government owns and operates the health insurance system but services are provided by a mix of for-profit and non-profit privately owned entities.

In a recent article in the New York Times titled, "As Vermont Goes, So Goes the Nation?" the future of the Vermont single-payer system, which is largely thought to be the brain-child of the Vermont Progressive Party, is considered. When discussing the potential for success for Green Mountain Care in Vermont in the upcoming year, that report implies that despite the historical opposition to the single-payer system, the adoption of the model in one state could prove to have a positive effect on what is possible for the nation as a whole. Indeed as the New York Times piece notes, "[t]hat's how national health care happened in Canada. A third party's provincial experiment paved the way for national reform." However, during some of the testimony before the Senate Subcommittee the view that Canada and the single-payer system is an example of what not to do to in the U.S. system often prevailed.

"What Not to Do"—The Canada Debate

The potential downfalls of a single-payer system were illuminated by the testimony of Sally Pipes, President, CEO, and Taube Fellow in Health Care Studies at the Pacific Research Institute, who is also a native Canadian. Pipes noted that Canada is one of just a few countries to have a "bona fide single-payer system." Yet, ultimately Pipes asserts that despite the calls for this model by many Americans, "the Canadian system is one that would not be suitable for America… If you're looking for lessons from healthcare systems abroad, Canada shows us exactly what not to do." Specifically, Pipes highlights excessive wait times blocking access to care due to the rationing of services that is necessary in a true single-payer model such as the Canadian structure. Testimony from another Canadian expert, Dr. Danielle Martin, Vice President of Medical Affairs & Health System Solutions at the Women's College Hospital in Toronto, Canada, attempted to dispel this characterization stating that, "When it comes to urgent necessary care, Canadians are not waiting substantially longer than peers in other countries, including the United States." However, Martin did acknowledge that in terms of elective medical care including diagnostic imaging, non-urgent specialist visits, and elective surgeries—including cataract surgery and hip and knee replacement—wait times were significantly longer. Yet she maintained that access to timely care to specialists is also a problem in the United States.

Cheng's testimony on the single-payer system also acknowledged the potential disadvantages of this model with a special emphasis on access to care. She described the process that often results in excessive wait times in a single-payer system as "rationing by the queue." That is, when jurisdictions employing the single-payer approach attempt to control total health spending and to avoid the waste of excess capacity, some choose to put "constraints on the physical capacity of their health system," in the form of limiting certain resources such as inpatient beds and MRI scanners. Cheng compares this rationing to the rationing that is inherent in the U.S. system, which is, of course, limitations imposed by price and ability to pay. In her discussion of the American system, Cheng noted although it is a common to believe that rationing only occurs in systems where the "government is involved in allocating scare resources," rationing by price and ability to pay in the American system has caused citizens to be priced out of health care coverage. "For example, 58 [percent] of uninsured Americans reported not to have seen a physician when sick or did not get recommended care because of cost, contradicting assertions that the uninsured in the U.S. do not have problems accessing health care."

Discussion

The downfalls of single-payer systems discussed by both Pipes and Cheng, and in particular the issue of barriers to care in the form of wait times, has recently emerged regarding health care services for U.S. veterans. A report published by the Veterans' Affairs Office of Inspector General (VA OIG) on May 28, 2014, substantiated some of the controversial allegations that have recently been made of the Veterans' Health Administration (VHA). Specifically, the report verified that excessive wait times lead to significant barriers to care for veterans. The report and underlying investigation was executed as a response to allegations made to the OIG Hotline that specified certain patients were effectively blocked from making primary care appointments and that, in some cases, this led to the death of some veterans. The report,

which is part of an ongoing investigation, confirmed that over 1,700 patients were inappropriately excluded from the electronic wait list (EWL) in one VHA location. Similarly, the VA OIG found that the average wait times for those who were included on the EWL was 115 days. The VA OIG, in turn, opined that the failure to include these individuals, who were supposed to be on the queue for primary care appointments, on the wait list had a significant impact on the access to care for many veterans.

Some sources have noted the effect the VHA situation will have on the health care model debate. For instance, one report suggested that the VHA controversy will fuel the fires of those who oppose the single-payer system, such as the one that is set to be implemented in Vermont. However, as that article later notes, this argument is misplaced as the VHA system is not truly a single-payer system but simply an example of socialized medicine. As Cheng has explained, socialized medicine is a model in which the government both funds and organizes the financing of health care and owns and operates the facilities producing health care." Cheng adds: "Most remarkably, although one commonly finds 'socialized medicine' condemned in this country as second rate, Americans have reserved the purest form of socialized medicine for their military veterans, namely the [VHA]."

Although it is important to note that the VHA is an example of truly socialized medicine which is differentiated from the single-payer Canadian model and presumably Vermont's future Green Mountain Care, the VHA example does bring to light the dangers that could potentially be associated with constraints on the capacity of a single-payer model. In other words, if the VHA problems are found to stem from the rationing of health care for veterans, it is possible to see how this could be a similar problem in a true single-payer system. If and when Green Mountain Care proceeds in Vermont, the resulting access to care statistics could be telling on this point.

Yet, the Maryland all-payer hospital program, which has been at work in the U.S. for over three decades, remains as another example of a unique and dynamic option. While that model may not be as stream-lined as the more simplistic single-payer model, and may not answer the prevailing critique of the ACA as too unwieldy or complex, its future re-conceptualization under the ACA has the potential to embody the characteristics that many Americans look for in their idea of an appropriate health care system. That is, if the all-payer system can effectively incorporate both the positive aspects of models that are successful in Switzerland and Germany, such as competition for price among associations with some government oversight, as well as the principles that underlie the ACA (reduced health care expenditures coupled with improved health outcomes), this model may prove to be one that could be considered on a national level.

The U.S. system has already incorporated single-payer and multi-payer systems to some extent.

Conclusion

While it is difficult to overcome the initial political obstacles that were apparent in the Senate Subcommittee hearing and that seem to apply to any discussion as to what can be learned from other countries health care models, the inclusion of these models in some existing and future aspects of the pastiche that is the current American system is notable. In other words, despite the existence of fundamental political positions that would make adopting the premise of most other countries' models—that health care is a right of all individuals—the U.S. system has already incorporated single-payer and multi-payer systems to some extent. When evaluating these models, the over-30-year reign of the multi-payer system at work in the Maryland hospital system stands out in particular. The future of this system after the changes that are to be implemented to incorporate reduced expenditures and improved health outcomes will be worthy of evaluation as to whether an American, ACA-driven version of this model borrowed from other countries' could be expanded beyond one sector in one jurisdiction and used on a larger scale.