Health Care Challenges Similar All Over the World

BY ERIK GOLDMAN
Contributing Writer

WASHINGTON — The globalization of health care is creating challenges for health care systems worldwide. Though the systems themselves may be very different in terms of financing and administration, the problems they must address—aging populations, increasing chronic disease, shrinking budgets, extreme mobility of both patients and health care professionals—are very similar.

Health care analysts, administrators, and providers compared notes on these challenges at the fourth annual World Health Care Congress, sponsored by the Wall Street Journal and CNBC.

"Despite the fact that health care may be organized and financed very differently in different countries, and there may be cultural differences, there are . . . a lot of common themes, and shared objectives for high-performing health care systems, innovation, and sustainability," said Robin Osborn, director of the International Program in Health Policy and Practice at the Commonwealth Fund.

Simon Stevens, who served as a health care advisor in U.K. Prime Minister Tony Blair's cabinet, said the United States is not alone in confronting a major health care crisis. Single-payer national health systems of the sort found in the United Kingdom and all over Europe make the dynamics a bit different, but they certainly do not avert the crises.

"Despite differences in financing mechanisms, the challenges are similar across all industrialized nations. Tobacco, bad diet, lack of exercise are driving the conditions that result in the greatest consumption of health care resources, and tensions are erupting across [health care] systems due to changes in financing. The U.S. is not the only country debating these issues. The challenges are the same regardless of how you choose to finance the health care," said Mr. Stevens, now the CEO of UnitedHealth Group's Ovations, a health plan for individuals over age 50.

Aging populations are the juggernauts straining health care systems in nearly all industrialized countries. Over the next 30 years, the dependency ratio, an expression of the number of elderly nonworking dependents versus younger working people, "will grow rapidly in the U.S., Western Europe, Japan, and China. And this will radically change how health care is financed," Mr. Stevens said.

He added that while American corporate leaders have been screaming the loudest, the issues around employer-funded health care are not uniquely American.

In a number of European countries, corporations are footing the bill for significant chunks of health care spending. "In the U.K., 52% of spending is private sector spending, despite the fact that the delivery systems are government funded."

Across the globe, health care is increasingly a transnational endeavor, with immigration, relocation, medical travel, and multinational business blurring borders. The establishment of the European Economic Community, the paragon of economic boundary breaking, has created an interesting health care quandary, said Mr. Stevens.

"In the earlier days of the [European Union], many had hopes that the confederation would lead to harmonization of health care benefits. Not so. Per capita spending on health care in Eastern and Western Europe is fourfold different. Western Europe spends way more. It is implausible to have a set of uniform benefits that are acceptable in Germany but unaffordable in Slovakia."

Migration also has an impact. Whether for employment opportunity or in pursuit of leisure, more people are living outside their countries of origin, and this makes for some peculiar health care dilemmas.

Mr. Stevens noted that in many parts of the world, national borders are blurred. "In California, for example, we know there are 8 million Hispanics living in border counties. Many have dependents across the border in Mexico. How do we handle that? Can we mandate that dependents of U.S. employees only be treated in clinics in Mexico?"

At the other end of the socioeconomic spectrum, there are thousands of retired U.S. citizens living in Mexico, Costa Rica, Panama, and other Central American countries. They're eligible for Medicare, but unable to get coverage for medical services or drugs they obtain where they live. "Does this mean these people must fly back to the U.S. every time they need medical care?"

Physicians, nurses, and other medical personnel also have become highly mobile, often moving far from their countries of origin to countries of perceived opportunity. Citing only one example, Mr. Stevens said there are more Filipino nurses, born and trained in the Philippines, working in the United States than there are in the Philippines. In the European Union, there are significant migratory flows of health care professionals from east to west.

This can result in shortages of qualified professionals in many countries, hindering the growth and development of their medical systems.

Ironically, it is the influx of international patients seeking lower-cost health care that will be an important driver for the development of hospitals and the retaining of health professionals in nations such as Thailand, India, Hungary, and many Latin American countries.

Health plan administrators are struggling to figure out ways to do business without borders. The challenges are daunting, said UnitedHealth Group's Ori Karev.

Speaking specifically of coverage for Americans obtaining care outside the United States, he noted, "There are a lot of complicated issues involved in this: transportation issues, authorization issues, tax issues in terms of the ways in which the IRS will treat medical travel expenses."

As countries such as India, Thailand, China, Brazil, and others become more affluent, their health care spending will increase, as will the number of risk-sharing plans. ■

Patient Sociodemographics Affect Physician Quality Scores

BY DEBRA L. BECK
Contributing Writer

TORONTO — Physician practices treating higher proportions of less-educated patients have consistently lower performance scores, reported Dr. Mark Friedberg of the division of general medicine at the Brigham and Women's Hospital and the Harvard School of Public Health, both in Boston.

In fact, an increase of one standard deviation in the proportion of non–college graduate patients is associated with a significant Health Employer Data and Information Set (HEDIS) performance score decrease of as much as 2.5%.

"Our concern is that practice sites caring for disproportionate shares of vulnerable patients may be penalized by public performance reporting and pay-for-performance contracts," said Dr. Friedberg who presented preliminary research at the annual meeting of the Society of General Internal Medicine.

"Without adjusting HEDIS scores for patient sociodemographic characteristics—or adjusting some aspect of the way these scores are used—physicians may feel an incentive to avoid patients from vulnerable populations," he said.

The measurement of primary care quality for public reporting has become a hot issue in recent years, with physicians who care for minority patients and those with lower incomes worried that they may be at a disadvantage in a system with a one-size-fits-all approach to quality measurement.

Dr. Friedberg noted a recent study (Health Aff. 2007;26:w405-w414 [Epub doi:10.1377/hlthaff.26.3.w405]) that found that 85% of physicians polled agreed with the statement: "At present, measures of quality are not adequately adjusted for patients' socioeconomic status."

Fully 82% were concerned that measuring quality may deter physicians from treating high-risk patients.

Dr. Friedberg and his colleagues used the Massachusetts Health Quality Partners (MHQP) statewide reporting program, which supplied data from commercial insurers aggregated at the physician level on eight HEDIS measures: breast cancer, cervical cancer, chlamydia, asthma controller medications, HbA_{1c} testing, cholesterol testing, eye exams, and nephropathy.

MHQP is a statewide collaborative that includes the five largest health plans in Massachusetts, contracting with 90% of state primary care providers and covering 63% of Massachusetts residents, or about 4 million people.

Data were collected from 241 physician practice sites (including 1,489 physicians) that provided adult primary care to insured patients during 2004.

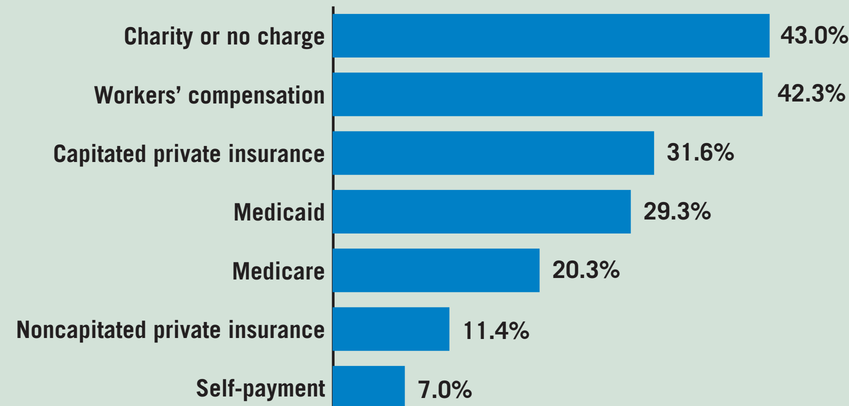
These data were linked to patient responses from the 2002-2003 Massachusetts Ambulatory Care Experiences Survey to calculate the prevalence of sociodemographic characteristics (age, gender, race, ethnicity, and education) within each practice site's patient panel. Practice site was used as the unit of analysis.

Median site-level HEDIS scores ranged from 94% for HbA_{1c} screening to 43% for chlamydia screening in women aged 21-25 years.

In bivariate analyses, lower site-level proportions of college graduate patients were significantly associated with lower HEDIS scores on all eight measures. These associations remained statistically significant for seven of the eight measures even after multivariate adjustment. Significant bivariate associations between sites' HEDIS scores and the age, racial, and ethnic composition of their patient panels existed for chlamydia screening, but these ties did not remain statistically significant after multivariate adjustment. ■

DATA WATCH

Percentage of Physicians Who Refuse New Patients Based on Payment Source



Note: Based on a 2003-2004 survey of office-based primary care physicians.
Source: Centers for Disease Control and Prevention

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