GAIL WILENSKY, Ph.D.: I'm Gail Wilensky. I'm a senior fellow from Project Hope. I spend most of my time on U.S. health policy issues, but, increasingly, have been involved in international health care and I'm a commissioner on the World Health Organization Commission on the Social Determinants of Health, which Sir Michael Marmot chairs.

And I'm delighted to have this opportunity to speak with you today and talk about issues in terms of how you are trying to move forward your own countries in terms of achieving a high-performance health care system. I'm gonna just introduce each of you to those who are listening.

We have here the Hon. Patricia Hewitt from the U.K., the Hon. Pete Hodgson from New Zealand Ministry of Health, and the Hon. Hoogervorst from the Netherlands, Minister from the Netherlands. Thank you.

And we'll keep this very informal, an opportunity to share among yourselves what you're doing and, as importantly, to share with our listeners what is going on in your country.

The theme of The Commonwealth Fund meeting is on achieving a high-performance health care system and what I'd like to use most of this time is talking about what that means for each of your countries and how you're doing and any specifics that you might be able to share about what's working and, if you're so inclined, what you've found doesn't work very well. So that would be a way for the rest of us to try to learn from areas where you've either had success or stumbled a bit.

There are so many changes that need to occur in trying to move from where we are, no matter which country you are, to what we would agree is a high-performing health care system. So maybe you can share just, first, what are your priorities and how do you deal with the issue of achieving balance between the various priorities since you can't do everything at once? You want to start?

HON. PATRICIA HEWITT: Well, thank you, that's an enormous question.

GAIL WILENSKY, Ph.D.: Yes.

HON. PATRICIA HEWITT: But, you know, we have a system that has always been rated very highly in terms of equity and universal accessibility, because it's funded by

taxation, it's free at the point of need and we are determined to keep it that way.

But within that, we have a very large problem still of health inequalities. We need to shift the emphasis of the system much more towards prevention and public health instead of having it completely dominated by the need to treat illness. And we want to reduce, as far as we can, enormous variations in care between our best hospitals and lesser public hospitals.

And, for us, one of the keys to doing all that is to give patients themselves more choice, more control over the health care that they see, but also support that by having the general practitioners, the family physicians and the local primary care trusts, the population-based entity that holds the NHS budget for that population. Both of them really being much more focused on how they get the best results for their patients and their local people from the budget that we've entrusted to them. We think that will drive a lot of the changes that we need.

GAIL WILENSKY, Ph.D.: I'm gonna come back in a minute and talk in a little more detail about information and choice and financial incentives, but I'd like to hear what

the Netherlands is doing and Minister also of New Zealand as well.

HON. HANS HOOGERVORST: Well, I think a problem that we all struggle with is lack of cost-consciousness in the health sector. Because everywhere you go, the system is heavily insured or it's the government that picks up the bill. And among patients and, therefore, also among doctors, there's very little cost-consciousness. And what we are trying to do in our system is to introduce more financial incentives for patients to look for an insurer that delivers the best quality for the lowest premium and for the insurers, in turn, to put more pressure on health providers to deliver better quality for a lower price, to deliver more value for money.

And what we have done is that where we have a system, an insurance system which was dominated by income-dependent premiums, which, of course, did not give any incentives to people to look for a better premium, because it was taken out of their wages anyway. We went to a premium which is fixed by the market, more or less, which is not income-dependent. And then we -- to make it possible for the lower incomes to buy that premium, we give them separately an

income subsidy. And what has happened is that, between the insurers who execute this new insurance system that -- a tremendous competition has evolved and 20 percent of the population has switched insurer and that, where everybody expected the premium to be very high, that it actually went -- was much lower than we had anticipated.

So the first signs are good, but we are not even -- we are still far from being satisfied with the result, because what has to happen in the end is that both patients and insurers put more pressure on providers to deliver better value for money.

GAIL WILENSKY, Ph.D.: Minister?

HON. PETE HODGSON: It's an interesting question, because you can answer it in so many different ways. But I found myself -- as I thought about my answer to the question, I found myself coming up with an answer almost identical to Patricia's or at least the first part of her answer. That is, that a high-performing health system is one that's going to be accessible to everyone. We're talking about universality.

We, Britain and New Zealand, both happen to use a taxation model unlike like, say, the Netherlands or Germany

or other countries that use a social insurance model. And so that means that the language is different, as each country speaks of its health system.

And also quite strongly agree with Patricia that high performance means heading towards greater equitability in health outcomes. We've all got our populations, the various gradients that exist in society, we have our share of those in New Zealand. And so that means putting disproportionate effort into those who have poorer health or are at risk of poorer health.

And the third point of agreement between myself and Patricia is the attention not just on personal health but on what we call population health, where the primary sector is charged with and actually incentivized towards proactively improving the population that they service and that includes health promotion and reaching out and asking folk to come in to see them, rather than simply waiting for the door to be darkened by those patients who do come to see them. And preventative health, which sometimes gets called public health as well, which is attention to a whole lot of things that are further and further away from the doctor's rooms; in other words, the things that go on in a

vaccination program or in an effort to improve the water quality of the country or whatever it's to be.

The point of disagreement between New Zealand and Britain is around the word "choice," where in the primary sector, we have always had choice and no one wants to take it away and it seems to work. You know, you can go to this doctor or that. But the geographic reality of New Zealand is that choice is actually not achievable, because there aren't a lot of big cities. There's one hospital here and the next hospital is going to be 50 or a 100 miles or kilometers away or further.

And, also, that -- you know, given that geographic reality where you can't have choice in New Zealand, we then accord ourselves the privilege of saying that choice is probably not such a good thing, because the better thing would be to have -- pay attention to having no bad hospitals in the same way that one would hope that there was a bar below which no school would fall and so we tend to approach the issue of choice differently and for those reasons.

GAIL WILENSKY, Ph.D.: Let me try and hone in a little more specifically on what I think about when I say "high

performance." I don't want to, in any way, take away the importance of universality and access; that's clearly a serious issue. But the focus, at least in the United States, when we use that term, has been more on trying to promote the best clinical outcomes in an efficiently provided health care system and also being concerned about patient-centeredness, so what the patient wants and needs.

So the -- I guess the question I'd like you each to think about and share with me is, given that all of our countries know that there are problems with regard to quality, both patient safety at the lowest end, but, at the other end, just achieving better clinical outcomes including the social determinants associated with them, but doing so in an efficient manner. So I'd like you to share, if you are using financial incentives to try to drive change in clinical outcomes and efficiency and, if so, have you found it possible or necessary to balance what it is you're rewarding. We're concerned, as we talk about these issues, that -- about the need to include measures of each for fear of being too successful, that providers and institutions and clinicians might respond too well and, if

you only reward one aspect of high performance, that's what you're liable to drive the system to.

So what would be good to share with us is: Are you using financial systems? I know the U.K. is, in terms of their general practitioners, but to what extent beyond that? How successful, if you are? And do you think this problem of balancing what it is you're rewarding is important or is your experience not so important? And --

HON. HANS HOOGERVORST: Well, we don't have any specific financial incentives at this moment. What we are trying to do, the first thing to do is to make quality transparent, because the naked truth is that a patient has no idea what kind of quality he's getting. If he is sick and the doctor makes him better, he feels very happy. If the doctor does not feel -- make him better, then he thinks, "Well, that was all in the game, because I was sick to begin with." And so it -- for the patient, unlike a customer in a car market who can discern quality very well, it's almost impossible for him to discern quality.

What we are trying to do, and I think all of us are trying to do, is to make quality transparent. Our health inspection has developed a set of, I think, 35 indicators

of clinical excellence and all hospitals are filling these indicators in and we put them on the internet and the newspapers are making lists of hospitals that do well and hospitals that are not doing so well.

These lists are all still very primitive and very unfair, but they work like how, because the -- all the hospitals want to be on top of the list, so they're all trying to do better. And the financial incentive that hospitals have is that more customers -- the patient is becoming more and more empowered.

They're consulting the Internet, they're consulting their newspapers, and they are starting to make choices and their free choice is becoming very important, although I can understand the limitations that you have in a country like New Zealand, with its remote areas. But then choice becomes extremely important in terms of driving quality improvement. And if a -- in the Dutch financial system, hospital system, if you lose customers as a hospital, you also lose budget.

So you have a strong -- although you don't have specific incentives for improving quality, the financial system in itself is driving the quality.

GAIL WILENSKY, Ph.D.: Minister Hodgson?

HON. PETE HODGSON: You know, it's a similar answer to where I was in the first go at this. That, in the primary health care sector, where choice exists and where people are paid according to how many people are enrolled on their books, then if a patient travels, the doctor misses out or gains, depending on whether the patient's gone away from them or towards them. And, furthermore, that -- in the private -- in the primary health care sector, New Zealand GPs are financially rewarded for quality which is measurable and which is known as a performance management system in which they're currently measured against 14 different things and they'll be measured against more as we go.

They're not paid very much, but they enjoy the idea of trying to improve. In other words, it's -- there's quite a lot of professional support for the idea, because people do like to get better. This -- you know, this is -- despite all the perversities in health, people who work in the health system get out of bed each morning to assist humankind and hopefully make a pretty serious bit of money while they're doing it.

Now, in the secondary sector, however, we don't have the opportunity of choice. We've been through an era in our economy in the last ten or twenty years when we've been very focused on price, on efficiency, on, in fact, a commercial model, a somewhat commercial model where chief executives have got a lot of their -- of their own salaries at risk and where the government's required a return on capital and all sorts of wonderful things as far as hospitals are concerned, which I would assert didn't work.

I would assert caused quite a lot of, I suppose, competitive behavior with hospitals as people tried to seize services of one another and have patients follow, even though it was going to be quite a long distance. A lot of parochial resistance to, well, you know, raiders coming from other neighboring provinces and on it goes to take their heart patients away or whatever it was to be. So a parochialism that resisted that.

But, also, I'm sorry to say, no significant efficiency gains. By contrast, if you can get a collaborative approach and, in a country as small as New Zealand, that is possible, with only 21 district health boards who, to give you an example, about a month ago, decided that they would

collectively purchase insurance. Within a year, they were self-insured. You can't do that if you're in an intensely competitive model.

And so we think -- I mean, we have -- we enjoy a lot of competition in the New Zealand economy. It's a very open economy. But, in health, we've always been -- or, in recent years, anyway, been somewhat resistant to a fully competitive model.

Now, as far as quality is concerned, I think that you're right when you say that quality is a difficult thing to make transparent. And we've got a bunch of things that we can do. We've got a bunch of measures that we're putting on our hospitals this forthcoming year that will affect -- they're going to affect the key performance indicators and they're all clinical. And that is one way of managing it and we will punish them, albeit slightly, financially, if they fail to meet, as we do already.

However, we, in New Zealand, need to do more about that than we're doing, and I do think that we have avoidable infections, avoidable missed medications and so on, which we are going to have to pay quite a lot more

attention to and I've just spent two days in Boston learning a bit more about how to do that.

GAIL WILENSKY, Ph.D.: Mm-hm. Minister Hewitt?

HON. PATRICIA HEWITT: I'm just going to have to stop and sneeze for a moment, sorry about that.

GAIL WILENSKY, Ph.D.: Okay.

HON. PATRICIA HEWITT: Too much air-conditioning and dried air.

GAIL WILENSKY, Ph.D.: Well, and we're going to talk in a minute more about the medical error and I do think that is clearly a part of quality. For me, it's the lower end, making sure you do no harm, and then we want to worry about making sure we have the best and most appropriate clinical outcomes, which is sort of the positive end of quality.

Since Minister Hoogervorst raised the question about having the transparency and information available and I know that the U.K. has been aggressive in introducing pay-for-performance for its GPs, maybe you can share, in addition to this issue about balancing, how you try to make this information available and used by the population.

HON. PATRICIA HEWITT: We're doing it in a variety of different ways. When it comes to hospitals, we're gradually

introducing what will be free choice of any hospital for any elective procedure and with a very different geography for New Zealand, that, we think will work very well. And already we're seeing patients making very conscious choices to go to one hospital rather than another. We think that will not only meet different individuals, different needs, some people will want to have an operation further away from home in order to be near their own family, but it will also, we think, help drive up quality.

But we're reinforcing that -- for instance, all patients now, if they have been referred to an elective operation, get a leaflet just giving them information, which is also on the Web, about what different hospitals offer, what their waiting times are and what their MRSA rates are. So it's quite basic information, but it's on things that really matter to patients.

Alongside that, we have just published, in the last week, the first-ever benchmarking across all hospitals in the NHS and that is showing some really very large and quite unacceptable variations in care for fractured hips, for instance, from an average of ten days in our best hospitals to over 30 -- in a few cases, over 40 days for a

patient with a hip fracture. Now, that immediately tells a board and the leadership of those hospitals they need to change. And when you back that up with the fact that we now pay our hospitals, for most of their work, on the basis of pay-for-performance, so there is a tariff for each sort of group, each health-related group, each health resource group, they have an absolute necessity, as in the Netherlands, to see where they are comparing badly with their peers and get those inefficiencies out of the system and get their costs down.

And then the other kind of information that's just starting to be made available, we've got the Royal College of Surgeons has now created a sort of value-added index, a value-added benchmarking system for heart surgeons. That's now available on the Web. It takes account of case mix, 'cause if it doesn't, then the raw data report is quite meaningless. But that's very powerful, I think, to health professionals who are very interested in comparing themselves with their peers and then wanting to do better, but it's also quite useful for hospital managements and for the commissioners as well as potentially for patients themselves.

GAIL WILENSKY, Ph.D.: Did your physicians, in this case, cardiac surgeons, resist having that information there? Some -- this has not been universally embraced by hospitals and physicians in the United States, the notion of having this kind of data made available.

HON. PATRICIA HEWITT: This was controversial stuff. It was very, very important that it was clinically led, not government-led, and the Royal College of Surgeons took quite some time not just to overcome the resistance, but really to persuade those heart surgeons that these were going to be value-added indicators. So, you know, actually the most expert surgeons dealing with the most complex cases would have the fact that they were dealing with the most complex cases really taken into account, because, otherwise, the raw scores of survival of their patients would actually have given a completely wrong indication of the expertise of those individual surgeons. But I think, now they've done that, we've got much more possibility of seeing similar benchmarking data made available to other people.

GAIL WILENSKY, Ph.D.: Let me spend a few minutes on information technology. We talk about it a lot here in a

country that's as geographically and payer, multi-payer as the United States, geographically diverse, it has been proving to be quite the challenge, in terms of setting standards and debating who should pay and how they should pay.

Each of you and each of your countries have had discussions on the same issues. Anything to share about how you're using the IT system to improve quality and what your strategies and timeframes are in terms of getting to the point that you think -- not to the ultimate endpoint, but getting to a point where you think the information technology will be important and useful in getting where you want to go?

HON. HANS HOOGERVORST: Next year, we hope to introduce electronic -- a national electronic medical -- not medical, medication file, which is accessible to doctors across the Netherlands. So that's -- we'd get fewer mistakes with medication, application of medication. It's -- we do it by a mixture of top-down and bottom-up. We set standards top-down, the IT standards, we set them down from -- on a national scale. But the implementation is a thing, a

responsibility of the doctors, hospitals and the drugstores themselves.

So we have a little bit of legislation, making it obligatory to participate in this electronic medication file, but we also leave quite a bit to the private initiative. It's a tough job. Whichever way you do it, in the United States, where it's mostly private, I think it's done very well in the commercial hospital chains, but other parts of the country do not participate at all. And you do it, obviously, in a national health service, you do it top-down, but that also take a lot of investment and it's difficult for all of us.

And that's another -- a bit of a market failure in the health care system. If you compare -- if you see how important it can be to elevate the quality of health care, then it is just astounding that these investments have not been done spontaneously. They are not being done spontaneously because there is no market reward for it ... [CROSSTALK] and that's --

GAIL WILENSKY, Ph.D.: It's -- yeah, the -- I mean, the reason it doesn't happen is that you don't, in fact, rece-- get reimbursement or haven't, in the past, for the kinds

of outcomes that would make it worth your while to invest --

HON. HANS HOOGERVORST: Exactly.

GAIL WILENSKY, Ph.D.: -- in computerized order entry systems that some -- I don't know where you were in Boston. I spent most of the day at Brigham Woman's Children. They have a very elaborate electronic system, not just for medication safety, but much broader in terms of their information systems.

HON. PATRICIA HEWITT: Well, we have an enormous central IT program going on in our National Health Service. At the moment, indeed, I think it is the largest civil IT program in the world and we're investing centrally over six billion pounds.

MALE SPEAKER: That's an enormous amount of money.

HON. PATRICIA HEWITT: Enormous amount of money, over more than 10 years, so this is -- this is not all in one year.

MALE SPEAKER: Oh, okay, okay, all right.

HON. PATRICIA HEWITT: I really do stress that. But, nonetheless, what we're seeking to do, we're putting very

high-speed broadband to link up our entire infrastructure. That's just the sort of basic foundation for everything.

And then, onto that, what we're seeking to build is a whole series of applications -- an electronic patient record, for instance. Electronic prescribing, which is already happening and growing fairly quickly. Not just reducing patient errors, but also making it much easier for patients to get their prescription filled at the pharmacist, for the pharmacist to do the repeat prescribing and so on.

We're rolling out, quite rapidly, a very good digital imaging system that is getting rid of the old X-rays, for instance, making it possible for a GP or a remote physician or specialist to view the same image as the hospital consultant. That's very good.

We're seeking to put in quite a complex set of connections between the GP's own surgery and then the booking systems for the hospitals for consultant appointments. And we have the piece in the middle, but it's actually very difficult getting the pieces at both ends to join up and to get all that working, but we're starting to

make some progress, but that has been one of the most difficult ones.

But there's no doubt, I mean, the power of this stuff, if we can really get it connected across the system. And then I think, potentially, moved into patient's own systems, so that, increasingly, patients will be, via e-mail or via text-messaging, linking in, particularly with their primary care physician. I think that will -- it will transform, potentially, the quality and the safety, in many respects, of the health care people are getting.

MALE SPEAKER: Absolutely.

GAIL WILENSKY, Ph.D.: Minister Hodgson? In a remote area of the -- and diverse population mix that you have in New Zealand, what are you doing on this issue?

HON. PETE HODGSON: There would be all the more reason for using electronic ... [CROSSTALK]

GAIL WILENSKY, Ph.D.: Exactly, exactly.

HON. PETE HODGSON: So we -- it's interesting that these three countries have just been measured for their primary health care IT standing and we're the best. So all three countries here have done very well in that regard and --

HON. HANS HOOGERVORST: Well, congratulations.

HON. PETE HODGSON: And New Zealand has had the benefit of a national health number, national health unique identifier for 24 years now, 25 years coming up. So we started quite early with the use of IT, but we have, in more recent times, fell behind in capital investment and so I've significantly increased capital investment in the last few months and that's taken it up to a new plane, which we will continue to invest quite heavily in IT.

What areas? Well, pretty much the same as what you've heard from -- it's driven, at least in part, by the availability of technology, so we shouldn't be surprised that countries have got similar viewpoints. Yes, it was Brigham & Women's that I went to see yesterday, precisely for the reasons that you laid out. And --

I mean, the only other thing I would say is that we -- I think probably all countries do this. We just use a mixture of top-down and bottom-up. You cannot do it without a strategy and without a number and without a standard and a few other things that you need from -- and some central funding, because some of the benefits accrue to society and some of them accrue to the provider and unless you're going

to reward the provider precisely for the societal benefit, as you said in your introductory remarks, then you're going to end up with hybrid funding as well.

So I don't have much more to add than that, except that we've got committees from here to Chris- -- from here to, you know, and road maps, and Venn diagrams and goodness-knows-what. It's a very complicated issue, even for a little country of 4 million people and we're making satisfactory progress, is what I would say.

GAIL WILENSKY, Ph.D.: Well, I hope, next year, we'll have more than our 30 minutes that we had this year. We had a longer time last year. I think we could go. There are several other issues I wanted to ask you about, but Minister Hewitt, I know you have to leave and we are also out of our web time. So thank you very much for participating and I hope the people listening to us have learned something as well.