Lessons on Coverage from Abroad: Do the Dutch, German and Swiss Health Care Systems Do It?
Alliance for Health Reform and Commonwealth Fund
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LISA SWIRSKY: My name is Lisa Swirsky. I am the senior health policy associate at the Alliance for Health Reform and I am going to do my best to stand in for Ed Howard today. On behalf of Ed and the Congressional Leadership of the Alliance, Senators Collins and Rockefeller, and on behalf of the Alliance Board of Directors, I want to welcome everyone today.

We are actually still waiting on a couple of our panelists so what we are going to do is I will introduce our first round of speakers and then we will introduce Robin Osborn of the Commonwealth Fund, who is our cosponsor today, who will talk a little bit about the Fund's interest, and then move to our commenters. I wanted to first of all actually thank the Commonwealth Fund. They have long sponsored work in the area of International Health Comparisons and as I said before, Robin will tell you a little bit more about that when she gets here.

Also, just a couple of matters of quick housekeeping before we begin, everyone, I just want to direct you to some items in your packet. We have our green question and answer cards. When we get to the Q&A session at the end of their formal presentations, you can either write your questions on here for the panelists or find your way to one of the, I guess, three microphones we have in the room.

We have a lot of people here today. It's a great turnout. Thank you for coming out in the rain, but that also means that your chances of getting this question answered if you put it on the card is diminished. So if you really want to have your questions answered, I recommend finding your way to one of the three microphones.

And also, please, please fill out one of these blue evaluation forms. You can either leave it on your table or you can turn it in on your way out. It really helps us improve our programming so we would appreciate it if you would fill it out. Finally, if you haven't already done so, if you could please turn off any cell phones, blackberries, or other beeping or potentially disruptive items, we would appreciate it.

Our first panelist is Reinhard Busse, professor and department head for health care management at Berlin University. We actually are welcoming Reinhard back. He joined us for a panel on this topic just this past spring, so welcome.

REINHARD BUSSE: Yes, thank you. I have a few minutes here to talk to you on the German system and clearly in eight minutes one cannot do a whole lot. It is important when you think about health care systems and how they struggle with achieving the coverage, choice, quality and cost containment as in the case of Germany to have a good framework and it's useful

to think of health care systems as a triangle and we have the population which we want to cover.

On the one hand, we have the providers, meaning out patient physicians, hospitals, and so on in the other corner, and we have the third party payers, your insurers, in the system on the third hand. It is then useful to actually think that the role of who collects the resources in the system and who pays vis-à-vis the providership is separated and then clearly a very important actor also in the system is the regulator and the regulator will in many cases be a governmental agency, the Ministry of Health, and so on.

But in the German case where we now come to Germany as the system is now set up, one of the characteristics which separates the German system from the other European systems is the high degree of what we call delegation so the government, the legislator, the parliament has written into law that many of the decisions are actually taken by actors inside the system, often jointly, meaning the providers and the insurers come together in committees and make those decisions which affect the whole system.

As payers, we have 240 roughly, now down to 210 what we call sickness funds. These are statutory bodies created to be the third party payers and these cover in what we call the social health insurance about 85-percent of the population. I will give you a better breakdown in a minute. And besides that

we have a second system with 50 private health insurers which cover around 10-percent of the population.

The population, clearly both inside private but also in the public statutory system, they have a choice among these 240 funds. They pay a wage related premium, meaning that they pay a fixed percentage of their wages towards the sickness funds while those covered in the private health insurance pay a risk related premium, so a fixed amount per month which is not income related.

As clearly the money collected in the system is not equal to that what the sickness funds need to fulfil their role as payers, there is something which we call a risk structure compensation so sickness funds which have better earning members need to give money to sickness funds with higher number of elderly, chronically ill, and so on.

I will talk also in a minute a few seconds about that, then we have what is also important on the provider side. We have a mix of public and private providers and when we say public we don't mean governmental. The federal government doesn't run any hospitals in Germany.

About 50-percent of the hospital beds are run by local governments, then we have about one third not for profit beds, and about one sixth is for profit beds. All of these are contracted by the sickness funds, usually via collective contracts. While in private health insurance there are no

contracts, and people have choice, so whatever sickness funds you belong to you have choice among all providers. There are no waiting lists in Germany so the excess is really very good.

Looking at the composition of the population in a bit more depth, we see that 85-percent are socially insured. Important is that 9-percent of them are voluntarily insured. They could go private but they stay inside the public system which is for the public system an obligation to be attractive.

And the other thing what we see here before the last reform, which introduced coverage also for the uninsured, we had about 0.4-percent uninsured in Germany, which we feel has risen because it used to be only 0.2-percent, then it came up to 0.4-percent and now the government has introduced reforms to give everybody coverage.

You have this slide here which compares the two systems. I only want to point here that the benefits covered are very broad, making the public statutory system very attractive and basically that no matter whether the hospitals and the physicians are private or public, that people in the statutory system have access to all providers.

We have cost effectiveness has always been a problem. I think this is actually my old presentation here. I will now have to do something here.

Cost effectiveness and I will rush through this, and quality has been a problem, even though we have thought that we

had a very good system, we were a bit shocked by later reports that quality especially for chronically ill persons is only average, and we have introduced several measures actually to do something about it.

One is that for all, around 2,000 hospitals in Germany, it is mandatory to collect data on quality and to report this back to the hospitals and so we can measure very closely the progress which is achieved over time as we see here, hip replacement, antibiotic prophylaxis in the hospitals in the state of Hamburg and how it has improved.

While in the past, quality data were only published in an aggregate form, so you could not see which hospital is how good, this has changed since last year. The hospitals in their quality reports which are mandatory, have to report on 27 of these outcome indicators so then other people collect it in the Internet so you can actually compare all hospitals.

The other thing which probably stands out in the German quality initiatives are the disease management programs which have been rolled out since 2002 in a very broad manner and as you see at the end of last year, 5.5-percent of all insured were actually enrolled in one of these programs for diabetes, asthma, COPD, coronary heart disease, or breast cancer, and we are about to collect figures on how this works, and early indications show that results will be quite good, even though I

must emphasize this is not severity adjusted here so it could maybe over state the success.

This is the old one. Okay, the risk structure compensation, why is this important? If you have 200 sickness funds, the risks will not be the same among the insurers. These are data from Germany and we see here 5-percent of all insured are responsible for more than 50-percent of costs, so it is important to have an equalization scheme which gives more money to sickness funds which care for these persons.

So, the thing then is for such a mechanism to work, how can we really predict who these people are? The main decision, and this is the delegated decision making, are taking in what we call the federal joint committee, which is made up of people of the providers, meaning hospitals and physicians, the sickness funds, and patient representatives, and this is where the benefit package is decided and we have the Institute for Quality and Efficiency which helps the federal joint committee to make its decisions on which benefits are useful.

The last slide here shows that all this is done at very low cost increases. In Germany over the last ten years, we had compared to other countries the smallest increases in expenditure and when you look at the top row which is the U.S., the increase in the early 2000's was in the U.S. about four times as rapid as in Germany. Thank you.

LISA SWIRSKY: Thank you very much, Reinhard. [Applause] Our next panelist is Robert Leu, the head of department of economics at the University of Bern. He has served as the economic advisor to the executive and legislative bodies at all levels in Switzerland, as well as the World Health Organization in Geneva. Thank you.

ROBERT LEU, Ph.D.: Thank you very much, so I will give you some major characteristics of the Swiss system. Okay, the major characteristic of the Swiss system is that it's highly decentralized, so in that sense I think it may be comparable to the U.S. The federal government acts mainly as regulator and supervisor, hardly any financing from the federal level.

The cantons which are the states here, there are the states, just a little smaller; they are responsible for the provision of care. Switzerland is a rich country so if we look at it we can see that there is high physician and bed density. We have 350 hospitals to care for 7 million people, which is a lot. There is a wide availability of up to date medical services in high quality, and of course this also makes the whole system a little bit expensive.

Now, if we look at the outcome side, I mean health systems should provide good outcome. There is a very good performance with respect to certain indicators like life expectancy, life expectancy is 81 years, 83 for women and close to 80 for men.

There is also a very good performance with respect to equity criteria, which means health is less unequally distributed than in other countries. The wealthy are always more healthy but the distribution in Switzerland is less unequal than in most other OECD countries, and also there is equal access to care. The low income people use hospital care and outpatient care as often as do the rich people, controlling for health status, which is important because poor people have worse health status.

There is also high patient satisfaction in the system and overall the big problem is relatively high costs. For you that sounds maybe like a marginal problem. It is 11.5-percent of GNP. Now in the insurance market we rely on a concept that is called regulated competition. It is the same as the Dutch use, and it is imported from the U.S. [inaudible] and we export it and now it seems to the U.S. again, so health insurance is an individual mandate, completely independent of employment.

Employers play no role in this system. There is universal coverage and the number you see is not a printing error, the share of insured people, uninsured people, is below one per mill. There is an extremely comprehensive benefit package. The insured have free choice between, the consumers have free choice between the competing insurance companies and contract options, but the insurance companies are regulated and so are the contract options. Then, the consumers have free

choice of physician and have direct access to specialists and they have free choice of hospital.

On the side of the insurance companies, there are a large number of competing predominantly private insurance companies. There are about 65 independent insurance companies, again a very large number for the small population, and they must be not for profit. This is in my view a construction error of the system but they are not allowed to be for profit.

Then, there is open enrollment, meaning that the insurance companies have to accept anyone who wants to enroll independent of his health status, of his risk. There are once or twice in the year you can change your contract, depending on the contract you have.

Then, there are community rated premiums. They differ only between regions. There are high cost regions and low cost regions and they are lower for children and people below 18, young adults. The insurers set their premiums themselves so that they just cover their costs and there is tight control by the Swiss federal office of health.

Now, if you have community rated premiums, you need two additional instruments and one is premium subsidies for lower income people. You cannot just have mandatory insurance. You have to make sure that people can afford this insurance.

So the premium subsidy is paid out of progressive income taxes and the full subsidy, the people with very low

income or no income, get the full subsidy, covers the average insurance premium. And then with increase in income, the subsidy decreases and eventually phases out. About 40-percent, on average 40-percent of all households touch a subsidy and in some cantons it's up to 60, 65-percent. That is one thing.

In addition, you need, as Reinhard already said before, you need a risk equalization scheme, because if you have community rated premiums the insurers are tempted to do risk selection. Switzerland is an example that you have to be very careful and have to design a risk formula. If you have a risk formula which is not differentiated enough, there will still be a lot of risk selection going on.

In Switzerland at the moment, we have only age and gender per region in this formula and that is clearly not enough, and so we see a lot of risk selection going on. You will just hear afterwards how it can be done better in the Netherlands.

We have extended cost sharing; one aspect is that we have a variable deductible. You can choose a deductible, deductible means up to the amount that you can see there. You have to pay the bills yourself. And the insurance kicks in after the deductible is used up, so it can be between $270 and over $2,000. If you choose the deductible of $2,000, that reduces your premium by half.

If insurance kicks in, there is a coinsurance rate of 10-percent with a stop loss amount of $600. If you go to hospital, this coinsurance is replaced by per diem of $9 a day. The studies that we have indicate that these deductibles can reduce utilization because the patients have to pay more, so it changes behavior or it can be that the good risks just select themselves into these high deductibles, and you can see here it is between 15 and 50-percent is change of behavior.

The main problems that we face, we have unsatisfactory governance. We do not have provision on the constitutional level, which fixes competencies and responsibilities between cantons, between the states and the federal level in a satisfactory manner, then there is a fragmentation of responsibilities and we have too much power given to the states. You have to be careful how much power you give to the states.

Then there is inefficient regulation, like in every health care system there are wrong incentives. There is limited selective contracting and so on. The cantons are too small, you must imagine our smallest canton has 250,000 inhabitants, compared to California and you see a little difference. Then, quality monitoring on a national level is just beginning and incentives for disease management are absent, and therefore disease management is not yet fully done.

The good part of the lessons that you can maybe take off this Swiss system, basically you can see how regulated competition in an insurance market works in a satisfactory way. You can, in particular, you can see that health insurance as an individual mandate can achieve high insurance coverage. You have seen everybody is actually insured, and another lesson that one can take from the Swiss experience is that you can combine cost sharing with premium subsidies and so you have no negative affect on access.

Decentralization is an important issue. I think decentralization is a good thing. You just have to be careful not to give too much power to one of the parties involved. Okay, thank you very much. [Applause]

LISA SWIRSKY: Our next panelist is Diana Monissen. She is the director general of Curative Care of the Dutch Health Ministry. From December 2005 to April 2080, she was a member of the board of directors of one of the larger health insurers in Netherlands. Thank you for joining us.

DIANA MONISSEN: Thank you. First I want to thank you for the invitation and that is why I brought some tulips, a major product in Holland. We are a country with 16 million inhabitants. First of all, universal coverage is crucial to ensure access to a good and affordable health care system. These are the topics of which I would like to address today.

Need for change, around the globe, we face the same challenges. Our population is getting older and the demand for health care rises. We all know that new technology brings more opportunities. People also expect more often state of the art treatment of course, and chronic conditions urge to rethink the way care is organized.

We need to focus on coordination and integration and more transparency is needed to empower patients to make their choices, and at the same time we are confronted with two shortages, on the first hand, money, and on the second, people. In the Netherlands, 10-percent now, and 14 to 15-percent of the GDP in 2040 are the expected health expenditures.

Another challenge will be the human resources and we have one question we need to ask ourselves, do we have enough people in the future to work in health care? It is a difficult question to answer.

We ask ourselves with these challenges in mind how can we create a sustainable health care system that is universal, affordable, and ensures good quality of care, that was and is the underlying question of our health care reform. We have chosen to do so to managed care the same as they did in Switzerland, and this year opportunities and responsibilities of all stakeholders are clearly defined.

When I talk about stakeholders, I am talking about providers, insurance companies, the government and patient

organizations, opportunities to innovate and compete, freedom of choice in a transparent market, and creating a level playing field and responsibilities of care providers and insurance in terms of taking risks, and the duty to deliver good quality, and last but not least allowing people to take responsibility for their own health care, we expect patients and their organizations to play a role as a third party next to providers and insurance and the need to empower them.

Before and after the introduction of the health insurance with universal coverage is one of the steps we undertook. Two quick slides, I am talking here about this part.

Before 2006 one third of the Dutch had private health insurance and two thirds had mandatory health insurance through the so called sickness funds that was here, what this resembles, one third and this two thirds. Privately insured had more choice and financial responsibilities but they also had to cope with risk selection and rising premiums as they got older and when I say older, I am talking about people above 45 years old. Mandatory insured had universal coverage but not a lot of choice and cost sharing, we had two different insurance schemes with totally different incentives.

The solution, as of 2006 there is a level playing field in the Netherlands with opportunities and responsibilities and

also with checks and balances. Managed care competition can be realized without additional regulation and oversight.

And our model insured a free to choose and change insurance company. They can change every year. Health care insurers compete on premium, quality, and services, and health care providers compete on price and quality.

What are the five cornerstones of our insurance system? Dutch citizens have an individual mandate to take out private health insurance. Second, the coverage of the health insurance is set by the parliament and includes all essential curative care. You saw it already two slides before. I am talking about hospital care, primary care, pharmaceuticals, and mentally cared.

CERT insurers must accept every applicant regardless of age and health status and every applicant pays the same premium for the same health problem. Fourth, in order to avoid risk selection, insurers are compensated for their high risk patients according to a risk adjustment scheme, and last but not least, an affordable care.

Every insured over 18 years pays a premium through the insurer. Low income groups receive a tax credit for their premium. They are compensated. If the insured people has an income, for instance work, he or she pays an income related contribution through tax and that is compensated by the employer, and these income related contributions I am talking

about the contribution for the under 18 children are used to front the risk adjustment scheme.

Basically in the Netherlands, we created a big risk pool, the more people in the system, the better we can maintain universal coverage. The system of risk equalization is a core element in this. Here is an example to show you how it works.

On the left hand you see the criteria and then you can see how it works out and my colleague from Switzerland already told so, we have more criteria than they have in Switzerland and the pharmaceutical cost group and diagnostic cost group criteria are the most substantial predictors.

Regulations and boundaries, we can't have a system without regulations and boundaries, so we have three important organizations. First, the National Expectorate for Health Care, they look out for quality. Second, the Health Care Insurance Board looks after the coverage and risk equitization system, and third the health care authority looks after market regulation and competition. These governmental independent organizations, these are independent organizations that fulfil the tasks for the government but they are independent.

Then, we have to answer the question where do we stand almost three years later after the introduction, after the reform? Choice and mobility, the first year 20-percent population changed health insured or health plan. In 2007 and '08, 4 to 5-percent changed, so the system works. Every Dutch

citizen is aware that he can choose their health plan insurer every year.

Second, uninsured and defaulters, the current number of uninsured and the defaulters of 3-percent is in concern and I say for you it's not much in 3-percent, but from our point of view we like to work on it in the coming years.

Third, cost and quality, it's too early to see that the Dutch insurance system results in lower costs or better quality, but I can say several things about it. What we do see is that the costs are rising but we expected it.

For three years in a row, premiums have been lower than projected and competition between insurers has driven premiums down. Although it's not possible to state the quality of care has improved in a manner we want to know it, we can say that we have a strong focus on quality and to be made several systems to measure quality. Perhaps afterwards, if somebody has a question I can point it out.

The health care reform, I can assure you that reform of health care systems has a big impact on society. If you want to do this year, you must have that in mind. Looking back at the return in our country, I would like to highlight some of our lessons. First, often incremental approach is okay but sometimes you really need a big step to get to the other side.

You need to [inaudible] that. Communication is, I know the time is up, but two things left. Communication is a key

issue and maintaining the status quo is everybody's second best, but reform has at least one party.

We have been there in the Netherlands, long discussions, heated debates, multiple blueprints, and so on, but in the end we succeeded, although it is still work in progress. Keep working on universal coverage is an important step to achieve a better performing health care and a healthy society, and I wish you good luck to do so. [Applause]

LISA SWIRSKY: Well, I want to thank our panelists for their presentations and I will turn to the second part of this panel. Before we turn to our commenters, we are going to turn to Robin Osborn of the Commonwealth Fund who is going to explain to you a little bit of the Fund's interest in this work. Robin is an international health policy expert in her own right and she has worked with the Alliance for many years to provide congressional education on international issues and thank you for joining us.

ROBIN OSBORN: Thank you so much, Lisa, and I appreciate very much your and Ed Howard's efforts and the Alliance in organizing this program. I want to say first of all how delighted I am to be here and to thank you for joining us for this briefing cosponsored with the Alliance for Health Reform.

As many of you know, the Commonwealth Fund's mission is to promote a high performing health care system that achieves

better access, improved quality, and greater efficiency. And as part of that, a core program that the Fund has is an international program in health care policy and practice.

And the aim of that program is to spark high level policy thinking, creative policy thinking in exchange between industrialized countries and to learn what we can, lessons across countries about improving health care system performance. And in relationship to that function, we also support research, cross national comparative research that lets us see how the U.S. compares to other health care systems and can be used for benchmarking

And I will just mention in your packets today are two articles, one the Fund's most recent international health policy survey, which compares the views and experiences of chronically ill patients in eight countries, and on access, out of pocket cost, pharmaceuticals, medical errors, coordination of care, and the second, the 11th in the series in health affairs by Gerard Anderson and colleagues at Johns Hopkins looking at OECD data and this one is health spending in OECD countries obtaining value for dollar, and maybe there is less.

But a kind of conventional wisdom in the United States, and this operates in other countries too, a belief that we had the best health care system and best health care system in the world, and appealing that and looking at the data what we have really learned is that no country is the best or the worst.

Each performs well on some measures and shows room for improvement on others, and part of what that means is that there are a lot of opportunities for learning from other country innovations and policy approaches.

Certainly insuring access and improving quality and efficiency are driving concerns of all industrialized countries. Similarly the theme of getting value for money, and for the U.S., those sorts of themes resonate loudly now as we are on the threshold of a new administration and anticipate the possibilities of a health reform effort, but in that context it is worth just thinking about the fact that the U.S. per capita spending on health care is more than twice the OECD average and despite outspending every other country in the world on health care, we often deliver performance that is certainly not at the top of the ranking.

In a recent study by Noltke and McKee Publishing Health Affairs, the U.S. ranked 18th on mortality amenable to health care so these are deaths that could have been prevented by the health care system, bacterial infections, treatable cancers, diabetes, deaths before the age of 50. And in the most recent Commonwealth Fund international survey, the one I just mentioned that is in your packets, out of the eight countries where patients were surveyed, the U.S. often also ranked poorly and at the bottom on measures of access, patient safety, coordination of care.

One third of those surveyed in the U.S. said they felt the health care system should just be completely rebuilt in this country and that was just far higher level of dissatisfaction than we saw in any of the other countries.

So we really thought it would be interesting this afternoon to have a chance to look at three high performing OECD countries, their respective approaches to insurance and coverage. All three provide universal or virtually universal coverage.

They spend significantly less than the U.S. does on health care and often have better outcomes, and they garner much higher satisfaction rates from their public so these country examples include different models of coverage, different approaches to who is covered, employer and employee contributions, premium rate setting, caps, public private mix of insurance, individual mandates, scope of coverage, all of what you have just heard about, and I would ask you, we have a very distinguished panel of reactors.

Lisa will make an introduction in a second, but I just also ask you to take a critical look at what you have heard, strengths and weaknesses, and think about what principles or features of these systems might be relevant to the U.S. as we contemplate strategies for reform and expanding coverage. Thank you.

LISA SWIRSKY: Thanks very much, Robin. Now, we will hear from two distinguished panelists from our own shores, and they hardly need introduction. Mark McClellan is director of the Engelberg Center for Health Care Reform at the Brookings Institute among the many other hats he wears. He is also obviously the former administrator of CMS and the former commissioner of the FDA. Welcome, thank you for coming.

MARK MCCLELLAN: Thank you. It is a pleasure to be here. I want to give my thanks, too, to the Commonwealth Fund and to the Alliance for health reform, for brining us all together, for what is clearly a well timed meeting. It is not just the economy in the U.S. and around the world, but it is also a very strong emphasis.

Are you all hearing me? How is this? Alright. Usually I can project to a room this size. I'm disappointed in myself.

But, what I was saying is that it is not just the economy or it's not the concern about the economy in this country, I think elsewhere, extending the anxieties about rising health care, costs, and the affordability of care, because it has such an important economic impact in all of our countries.

And as Robin said, we are at a point where there is a lot of debate and discussion looking ahead to next year about next year being a potentially major health care reform year,

and these are certainly some very relevant countries for considering how health care reform might work in the United States, so there are some important differences as well, and I would like to thank the three presenters, I'm always impressed with people who can come over this six hour time difference, and speak concisely and effectively in a foreign language about their health care system, so thank you all very much.

There are some big differences between our countries and I think there are some limits as to what lessons can be drawn and from one versus another, for example our cost levels as I always point out are substantially higher here. That has a lot to do with price differences, drug prices, brand name drug gets a lot of the attention, but in terms of quantitative importance, the difference in pricing for hospitals and for physicians and other health professionals is actually much more important.

There also are some big differences in health, and as Robin pointed out, much of those are not amenable, are not directly related to health care anyway. If we really wanted to do something about some of the health problems and health disparities in our country, probably the best investments we can make aren't in health care, but they are in things like early education, and community development programs, and things like that.

But there are some common elements as well, especially in the trends that our countries are facing, with all of us having a changing demographics with rising age and facing on the one hand some growing opportunities for our medical technologies to make a difference in people's lives, but on the other, along with growing opportunities, rising costs, and increasing challenges of affordability.

We are all facing similar problems of rising health care costs and making sure that everyone has access to affordable quality care, and we certainly have some room for improvement. There also is I think a common growing interest in addressing the quality of care and the effectiveness of our delivery systems, not just financing issues, not just getting people into coverage, but making sure that money is being spent well, that we need value for the money being spent, increasingly important as health care costs keep rising.

So with that in mind, I just wanted to mention three points quickly about comparisons across countries, particularly ones that may be relevant for our own coming health care debates here related to reforming insurance coverage. All of these countries are and probably will continue to rely on choice, certainly seems to be likely in the United States.

The key question is what dimensions of choice are part of these competitive systems? Where does competition exist? And I want to talk about benefit design, provider payments, and

the financing of competition itself, those areas where differences may exist across countries. These are very important decisions for how competition may work out.

First of all with benefit design, you heard a lot of discussion or some discussion about differences across these countries and how they rely on out of pocket costs, how they rely on the consumer side of cost sharing for influencing care, with it being relatively important in places like Switzerland and relatively unimportant other places.

Out of pocket payments can matter, but to the extent that benefits are standardized, there may not be as much of a range of choices about how out of pocket costs can influence care as health care insurance programs continue to develop.

I would like to make a contrast between traditional insurance, where you have a deductible and then catastrophic protection after that, like we heard about in Switzerland, versus what is becoming more popular in competitive programs here in the United States and that is tiered benefits.

For example in medicare Part D, one of the main reasons the costs have turned out to be lower than expected is that nobody at this point is enrolled in a standard benefit design that was included in the 2003 law which has very much that traditional insurance structure, you know, deductible, catastrophic coverage on the back end, coinsurance in between, plus the famous donut hole because of the inadequate funding

for a comprehensive benefit, nobody is enrolled in a benefit like that.

They are all in plans that have generic drugs on Tier I which are basically free, preferred brand name drugs on Tier II, most other drugs are covered. The actuarial value of the plan is the same at least as the traditional insurance design but the difference is that consumers can save a lot more money and also potentially end up paying less out of pocket while meeting their medical needs and the result has been a huge shift in the kinds of drugs that are purchased, or much more use of generic drugs in most other countries and much of us switched from non-preferred to preferred brand name drugs.

Also, benefit design may matter in supporting new kinds of services. For example, wellness programs or internet based services, things that aren't traditional health care but may well be an important part of personalized prevention oriented medicine in the 21st century. If competition among health insurance plans is restricted so that they have to follow a standard set of benefit design features, you can lose out in some of these important innovative benefits.

Second issue is provider payment and an emphasis here, I wand to particularly focus on performance and quality and value.

Here in the U.S. there has been a lot more attention towards trying to measure what we really want in health care,

which is not more volume intensity of services but higher quality at a lower overall cost. And the issues that we are facing here are very similar to what's going on in some of these other countries as we try to move from payment systems that are based on fee for service towards payment systems that are based more on value.

These other countries have moved toward more types of bundle payments, DRG's, things like that, maybe even capitated payments for some types of services and that may be where the United States is headed as well, but we are also seeing here a lot more interest in value based payment systems.

For example shared savings payments where providers in a group get paid more if their patients have better overall outcomes at a lower overall cost. It is a different kind of payment incentives for a provider and once again if you don't encourage competition in that direction by making available effective quality measures, by making available consistent measures of cost of care as well, you may not get the promotion, the competition on value that can really help systems improve.

Finally, I wanted to mention the financing of competition. One thing that all of these countries emphasized was the importance of promoting competition based on value and not based on selecting the healthiest patients and that is an issue even if you have completely standardized benefits, there

will still be selection problems based on quality or based on provider networks or things like that.

So all these countries have emphasized the importance of risk adjustment and other steps like mandates or steps to get a broader population into coverage to promote competition based on value, and in the U.S. the medicare system does this now. We have full risk adjustment of payments in the medicare program and we are struggling with issues related to an individual mandate.

It's not just a matter of “requiring coverage,” it's a matter of what steps we are taking to make coverage seem affordable for people through subsidies or other steps, income related subsidies and the like, and what kind of penalties might be used as well. That's another issue that all of these countries are struggling with, too.

Finally, what I would like to emphasize is that as we get better and better data on how care is actually being delivered, I think there are going to be more opportunities for these kinds of meaningful comparative analyses about how health care systems are actually functioning, with more comparisons at the level of how health problems are prevented and treated.

I think we are going to have more opportunities to learn from each other and this meeting is certainly an important step in that direction. Thank you. [Applause]

LISA SWIRSKY: Thanks, Mark. Our next panelist is Michael O'Grady. He is a senior fellow at the National Opinion Research Center at the University of Chicago and principle of O'Grady Health Policy. He is a veteran of health policy, having spent 24 years in congress and the Dept. of Health and Human Services where he served as an assistant secretary for the planning and evaluation and he has a long history as a staffer, a senior staffer, on the hill as well. Thank you for joining us.

MICHAEL O'GRADY: Thank you very much. I would like to talk on a number of issues. There are a number of things that have been brought up today that I think are important lessons for the U.S. to consider. Before I start, though, I do want to take a little, a second to make a note on international comparisons.

This is not really a foreign policy competition, and I've been working in this area for a number of years and when I was in the government, I had the OECD as part of my portfolio when I was an assistant secretary for planning and evaluation.

And the danger here is you get into this kind of competition, this got you, whether it's percentage of GDP or it's number of uninsured or whether it's waiting times, and to put this somewhat less diplomatically it's important to sort of keep the state department and the foreign ministries out of

that, my apologies to anyone in the audience who are from the embassies or what not.

There are important lessons to be learned from other people who are experimenting with different things. If the French use our DRG system, that's not a win for us. That is just we were helpful to a friend. We worked that out. If we end up using components or all of the Dutch risk adjustment system, that's just thank you very much for trying it first so we can learn from your lessons, so some is transferrable, some is not, and you have to learn how what you think is likely to work in your system, not this is not scoring points with the other guy.

So, we have heard a number of ideas put on the table, as we sort of go through these different countries and some may or may not have applicability for the United States, and I want you to consider two things please, one is the technical could we do it here sort of questions.

The other is do we have a consensus to do this sort of stuff here? So when you do the post mortem you look back 12 years or so and you look at the Clintons and what they tried to accomplish, what worked, what didn't. Part of that post mortem would say they sort of went beyond where the country was ready to move.

They went a little bit beyond where there was a consensus that would support their efforts, so as this congress

thinks about what they want to do, this new administration thinks about how it would like to move forward, it is important to keep in mind where do you have kind of the consensus behind you to make those moves?

So, we heard individual mandate. It's an important issue. It comes up in this country. It has come up in all these countries. We can do it. Technically, we can do it. We know that there are some enforcement questions. We heard today. We also know the folks in Massachusetts are dealing with some enforcement questions, but we also know that it involves making younger people who are often lower income subsidize older people who are often higher income.

Now, personally I am comfortable with that subsidization but you need to sort of think that one through and know that's what you're doing. It is the young immortals, as long as they don't fall off their motorcycle, they never really have much use for the health care system, and they prefer to go uninsured, so you are asking, you are forcing them in, you are asking them to subsidize but you are doing that, so just be quite aware that is what you are doing.

Risk adjustment, we are very well positioned on risk adjustment as Mark says. We do it with our medicare plans. We do it with our Medicare Part D plans. We do it, many of the states are doing it with medicaid. Would we need to do some

additional work there? But, we are very well positioned to be, we are doing much more in many of our areas than age and sex.

We are well beyond that and certainly we could do that. And there is very little there. That cross subsidy I'd say there's a fairly strong consensus on, in the idea of healthier people subsidizing sicker people. I don't think that's a too controversial area in terms of when you think about coming to a social or a political consensus.

Plan competition, the good news here is we already do much of this in different parts. This is basically the same. It's the FEHB model. It's what the skeleton of the way of doing things where you allow plans to compete is what the Clinton Administration called managed competition, what congressional republicans call the premium support, but it is that notion, a hybrid system, the government has certain roles, the market has others.

In the democratic version did the government have a little bit more role and the market a little bit less? Yes. In the republican premium support, was it the other way around? Yes. But these are all things you can dial up and down. We know how to do this. We can do it. We have done it for 40 years for the federal employees.

Now, there are certain things that you want to think about how you would want to do that and how you would want to

move forward, but that sort of, like I said, the skeleton is in place if we thought we wanted to move that direction.

Insurance protections that are used in these countries, guaranteed issue, guaranteed renewability, community rating, technically again doable. We can do this and again are you comfortable with the cross subsidies you are talking about. Again, it tends to be between these different sub populations. Some people are.

Supplemental coverages are used in most of these systems. I think in a technical sense anyway, those who study these questions as a design issue are not that comfortable with many aspects of what we do in this country right now through Medi Gap. The beneficiaries of Medicare love their supplemental coverage.

It would be a political, very heavy lift to ever get rid of it. At the same thing, I think most actuaries would tell you it is disastrous in the aspect that it undercuts the actuarial logic and foundation of the Medicare fee for service program.

So, how you do supplemental coverage when you get into these questions, I think I would personally defer heavily to the actuarial community on those sorts of issues.

The role of employers, I think there are some fascinating things that were in the write up about how the Dutch do it, and again how you think of subsidy, how you want

to do this, what you want to tax, what you want as a contribution, are certainly all things we can do and it comes out to how you want to do.

Now, a tough issue here that wasn't directly brought up in the presentations but it is in the material and I encourage you to take a look at it, is most of these systems talk about universal coverage in terms of residence. They don't talk in terms of citizens, and that is an important thing and it's a delicate topic and you have to be careful how you do it, but roughly 20 to 22-percent of the uninsured population, according to census bureaus, are not citizens.

Now we don't know how many are legal, how many are illegal. Clearly, when the survey guys come around, you don't say yes, I'm here illegally! So, we don't really know what those splits are. But when we come to this question of who we subsidize and who we don't, you have again is there a consensus? Do you have the political ability to move forward in this area?

As long as I think you are talking about employers, I think you probably do. If I am working for GM and the guy next to me who is here, is not a citizen, is working for GM, if we are both putting in 40 hours, we both have the rights to that contribution. I don't think there is much controversy about that. But when you are talking taxpayers' money, I think it's

not clear that there is a consensus on how to move forward into that area.

So, I guess to sum up quickly in terms as we think about these things, what is applicable, what transfers and what doesn't, think about it's not so much the mechanics and the design characteristics as it is the social consensus in some of these areas, that we have a very different social and political culture here.

We are not Europeans, although some of us actually look quite like our European cousins, but we are not, and we have a different notion of how central control from the government operates. We have a very different notion about individual responsibility versus group responsibility, and that comes into many of these things about what Americans are comfortable subsidizing and what they are not comfortable subsidizing.

An American public policy whether it's health care or otherwise, there are strong subsidies for disabled people, for children, for people who take care of children, and for the elderly. There is not really very much subsidy at all for anyone who is considered able body. It is sort of our Calvinist past. And that is a bipartisan kind of thing, it is in welfare policy, it is in health policy, and that is a tough issue to wrestle with.

So, there is a number of this idea that you need to think about who you are willing to subsidize, some of the big

ones are this notion of what are you going to do with a low income population, whether they meet these criteria that we currently subsidize on, and what are you going to do about citizen versus non-citizen? But this is all very encouraging. These guys have tried a lot of interesting things. They have had a lot of success and I'm pretty optimistic about where we can go from here. Thank you. [Applause]

LISA SWIRSKY: Thanks, Mike. Our last commenter is last but certainly not least. We are very honored to have with us the Swiss secretary of state for health and director general of the Swiss federal office of public health, which I think translates to secretary of HHS roughly in these parts. Thank you so much for joining us today, and you are next.

THOMAS BJORN ZELTNER: Well, thanks a lot, and thanks to give us a chance to be here with you and sharing some of our experiences is our exciting times in this country and I think you have a lot to discuss among each other and I share completely what Michael just said.

It doesn't make sense just to look at other systems and not taking into account what is the social network, what is the social reality in these countries, and to think well, we can just technically copy that, and so that will not work, but you have really to think about what is the status you are in, in this country, and what could be the next steps?

I would like to address three points briefly. What I think needs to be done to be successful when you come or you try to reform the health care system and it is a difficult task. The first one is and we had discussion on that among the different countries being present at the meeting of the Commonwealth Fund, you need a long term vision.

You need a long term consensus on where to go, and I can actually just mention a couple of things, you need to think of how do we integrate prevention and health promotion in the planning, because you are facing a population which is getting elderly, you are facing a population where the chronic diseases will increase, so you need to think of what kind of system do we want to build in long term?

Interestingly enough, the U.K. now talk about how to implement reforms in tenures. The Netherlands were the champions in this. They are talking about where to go, the roadmap until 2040, and I think they have a good reason to do that because the major challenge many countries will face is not even so much the financial crisis but the crisis when it comes to health care professionals. We are running out of health care professionals.

And, if you want to deal with that, you have to plan for this 20 years ahead. So, you need a long term vision and this long term vision actually needs to be shared and there must be a consensus, a minimum consensus, because otherwise you

make the first steps and then two years later you say oh sorry, that's wrong, and to change again and again and again.

So that is one of the difficulties and I think that is one of the problems you are facing. I don't believe that you have right now this long term perspective and the consensus on this long term perspective and that will be one of the major challenges of the new government to see how can we build on that, because otherwise, you may be wrong with the first step.

The second point I would like to raise is what are really the steps? All of them have been brought on the table right now. I mean probably everybody would agree that you need to reduce the number of uninsured, whether you come down to the numbers of Europe, I guess it will be difficult, and Michael eluded the question of immigrants. We have 20-percent of immigrants in our country and we have quite a number of illegal immigrants in Switzerland and do deal with that was a very tough thing. We ended up with saying yes, we give them health insurance, but that is a societal choice.

Secondly, you have to tackle the problem of the underinsured. Again, that is a question of the benefit package, how to define that, etc, and I think that is a completely separate issue.

Thirdly, and I come here again back, I think your system has a problem when it comes to the employer based health insurance. I know that nor McCain or Obama has addressed that

question but I think you need to reflect once again on that because I think the negative effect of having employer based health insurance is big and how the financial crisis right now has shown probably one has to reflect on that again and I say that may be in the very long term. We are talking about, I'm talking about 10-15 years on the roadmap on that and eventually that may be one of the avenues you have to reflect on.

The last point I would like to make, who should do what step? The nice thing for a Swiss coming to this country and probably for U.S. citizens coming to Switzerland is you understand the system right away. And why do you do that? Because Switzerland actually has copied the U.S. constitution so the responsibilities between what the central government does and states do is very similar in Switzerland as it is in the United States.

And what I would like to invite you is not just to think of what does the central government, what does Washington do, but really to look into what kind of regulations do we need or do you want on state level and what regulations do need to be done at the central level?

In our perspective, and that was our story of success, it was easier to move on, on state level, and if you have a national framework where to go, a national vision, then you probably can implement reform state by state and that is easier, at least in our perspective it was so, and that also

means that building this framework doesn't mean that you need to take a lot of money in the central government to implement the reforms. Thank you. [Applause]

LISA SWIRSKY: Thank you to all our fine panelists and now I will turn this conversation over actually to you all. Please make your way to the microphone and find some of our staff who will be circulating to pick up your cards.

MALE SPEAKER: Thomas Zeltner certainly gave us some key points but I'd be interested to hear from different panel members what kinds of things, features of your programs would you most recommend that we take into account in the U.S.?

DIANA MONISSEN: I agree with Thomas Zeltner, the first is the long term vision. We also had a long term vision but there was actually there was not a point and it was the urgency to change. We had a big urgency to change and it was filled by a lot of stakeholders, and we used this urgency of change and we communicated a lot with all the stakeholders and the stakeholders were not only the politicians, was of course the parliament, but also were the people.

We feel the providers with the insurance companies, the patient organizations, and so on, so we pointed this out and used this time after time in our communication was the second point. And, this long term vision is necessary, even nowadays we use it because we did a great job on the reforming of the health insurance act but actually now we started to reform the

exceptional medical expenses; it means the extra for the long term care.

It's also necessary, but we walk on step by step to make it happen, so step by step is my certain advice, and when we introduced the reform, we also had a lot of money to make it happen, and it was four or five years ago when we started it and then the economy was a little bit different as it is now so in your case it's more difficult I think, and what is necessary when you have this vision, a holistic approach, so when you have this vision go step by step the financing and the responsibilities of the diverse stakeholders, go on and on with it.

Yes, I think, and last but not least is the responsibility of the government and I also can agree with Mr. O'Grady and with Mr. Zeltner, I think the role of the government is perfectly the same in our country as it is here but one thing I must say to you, we found a solution for the Dutch reform in our country, in our culture and with our problems, and so while you can't copy it but you can use it.

ROBERT LEU, Ph.D.: I would come back to Michael's suggestion that the problem is not mechanics and design but it's social consensus so I can only say what I would think first about it, if I were you, and I think in the first place there's a question of at least a minimal benefit package. It doesn't have to be a comprehensive benefit package, as most

European countries know it, because you have some disadvantages with that, but I think a minimal benefit package would be helpful.

You know, I just believe that consumers have a problem when there are too many options that they can choose from, and so choice is only on paper and not reality so I think there is a problem. Then, it's clear, if you want to increase coverage, then you have to think about how you make sure that people with lower incomes can afford this coverage. It doesn't have to be one of these forums how we do it. There are all kinds of possibilities how one can do that, but definitely and you have forums of that in other areas, I know that, so but you have to think about that.

And then I think and this would be things that are regulated at the federal level, yes, I mean I think that I would guess would be regulation on a federal level, and the third issue would be that you say something about open enrollment in a regulation and about risk equalization. I think that is necessary for competition to produce the results we really wanted to produce.

ROBIN OSBORN: If I could just jump in and make one quick comment in response to that about a benefit package. Looking at our survey that was just released and these are chronically ill patients who are the highest users of health care and I am sorry we don't have Switzerland in this

particular survey but we do have Germany and the Netherlands. In both countries the majority of people spent less than $500 out of pocket during the course of the last year, so the benefit packages are really very extensive.

REINHARD BUSSE: I just want to add one thing, what I emphasized with a delegated decision making. I mean, we in Germany, unlike maybe many of you think, we also have some distrust in a too strong government. And so the regulation says that the actors inside the system have to make a decision on what is necessary on quality assurance and they all need then to stick to it, but it's not the government who sets the minimum benefit catalog.

But in this federal joint committee they said it and this is then the benefit basket which is for all as you would say for all plans which then has to be fulfilled, and that could be a model that basically those who pay for it and those who provided us or have the finances in view and of the government has to decide you know should there be more benefits, then everything is more expensive, but you combine the two sides in one committee.

ROBERT LEU, Ph.D.: Can I say one word still, communication, communication, communication, you can kill the best plan without explaining it and trying by communication also to find a consensus so that I think is something we learned, too.

ANN MARCUS: Good afternoon. My name is Ann Marcus. I am the associate professor in the Dept. of Health Policy at the George Washington University here in Washington and I also happen to be a Swiss National. I have two questions.

One is for the Swiss delegation and it relates to health care reform, since it was enacted in '94, there was immediate cause for revising the legislation and over the years a push was made for a single payer system which failed a couple of times I believe, but currently what you cited some problems in your presentation, what are currently some of the revisions that are being considered, particularly in the area of cost containment which is not very strong, and Switzerland is there for example talk of the federal agency having more power to control the increase in premiums on an annual basis when the agency is reviewing the premiums submitted by the insurance companies?

My second question relates to the pediatric benefit and you talked about the basic benefit package just now and how those are set and I consider that to be sort of a sentinel benefit on how a health care system is designed and much of my work focuses on maternal child health, Medicaid, and CHIP, the child health insurance program here in the U.S. and the quality of pediatric care.

So my specific question, and that's for the panel representing the three countries here as how does each system

view the pediatric population, the benefits that you receive, and do you know anything about the quality of those services provided and how they compare to each other?

And I am asking this because CHIP has been mentioned as a potential first step towards a more comprehensive reform effort in the coming year or so. Thank you.

ROBERT LEU, Ph.D.: To your first question, what did we do recently to kind of fight against the increasing costs, so you have maybe seen on the slide there was something about increasing coinsurance rate for brand name drugs, unless the physician insists on the drug, if there is a generic available, and this led to a tremendous increase in the demand for generics. I can recommend that very much.

Then we are presently introducing DRG's, it's actually the German version, which is modified because for the Swiss it's never perfect enough so we have to modify it, but it's a different DRG from what you have in the U.S. and it's different from Germany but it eliminates some inefficient incentives like that the hospitals are paid by the lengths of stay of the patients, which creates and incentive to keep the patients as long as possible which is ridiculous.

Then, what else do you have, we are trying now to introduce disease management which is pretty much absent so far for those 20-percent of the population which account for 80-percent of the costs. We believe that there, I mean here we

can see it if we look at Kaiser Permanente or similar organizations we can see and learn how one can do that. We are just trying to do it on a country level.

The last point, we are in a moment reducing or trying to keep down the opening of new physician offices because there is some kind of physician induced demand.

REINHARD BUSSE: Concerning your question on pediatric care, I can't even given you too much new enlightenment except saying that we with other European countries, are looking into how can we improve medicines for children and the whole question of off label use and how can we improve actually, improve medicines for children, and we will do a major reform on that soon.

DIANA MONISSEN: As I can agree with you, we started to actually several months ago we started a network in the Netherlands to improve the medicine for children. You can compare it with the network that exists in the U.K.

FEMALE SPEAKER: To switch gears a little bit, when you look at the OECD data, one of the comparisons where the U.S. stands out is on administrative costs for insurance, and I don't think we've touched on that at all, but in terms of health care system efficiency, can you say something in each of your countries about the role of regulation in terms of insurance and not for profit versus for profit insurance and

how that is, the implications of that for efficiency of the health care system?

REINHARD BUSSE: Maybe I start, I mean as you have seen we have these two systems which also gives us the opportunity to compare the statutory insurance system and the private health insurance system and in the statutory system we have about 5 to 6-percent administration costs and the law says that the share of administration can not rise.

So administration costs can only go up as much as overall expenditure goes up. When you look in the private health insurance, then their administrative costs and this is not surprising to you, are about three times as high, so we have about 18-percent in our private health insurance, so that is already a difference of 12-percent which goes out of the medical expenditure, what you call the medical loss, the private companies call it here.

ROBERT LEU, Ph.D.: Okay, I continue with Switzerland, there is as I said tight regulation of insurance companies and of the premiums they enhance for their subsequent year, so the federal office of health is monitoring that, these premium increases remain close to costs. Then the administrative costs are about 5 to 6-percent, actually around 5-percent now in Switzerland. Without that, it's regulated, so it's not regulated but it's still so low, well okay.

DIANA MONISSEN: In our country, the administrative costs are about 6-percent of the health insurance companies and we have strong regulation to look after appraise in what they offer through the health care authority as shown on one of the slides.

MALE SPEAKER: You solved my administrative cost question. About three years ago, there were two articles published I think in the *New England Journal*, describing the RAND study on the effectiveness or competence of doctors. One was internal medicine adult doctors and the other were the pediatricians.

The doctors were, what was examined were five very simple tasks, like having an aspirin after a heart attack, checking diabetes, hemoglobin A1C three times in two years, whatever, very simple things that any doctor should do, and there was also that only 56-percent of patients received quality health care, that is half the doctors didn't do Doctoring 1:1.

Similarly when they looked at the performance of pediatric physicians, allergy treatment, immunizations, the same thing went ahead, about 50-percent of the patients were inadequately treated, which is an unbelievable indictment and embarrassment to the American health care system and clearly that raises great expenses down the line.

So my question is have you examined your physicians for their quality and the other add on question is to what extent are any of you using electronic medical records to also keep the communication, talking, talking going to decrease costs?

DIANA MONISSEN: I can answer this question, we are working, I already told you about a better quality system, but we are doing or we did something. First, we are setting [inaudible] that can use by physicians and also we are creating [inaudible] for look after coordination for instance when you are talking about patients with diabetes.

Second, we are developing and using guidelines and we look very strong after the implementation of guidelines and we think nowadays it is the role of the government. Second, CERT we introduced outcome indicators and it's also a program ran by the ministry and the inspectorate of health has a big role in it.

Then, we are measuring experiences from patients on through assessment health plans so every year I think you will note it, then we are measuring effects of our new system by the health care authority I already told and we measure experiences with providers and insurance through the national patient and client federation, and then last but not least it is very important for us.

We stimulate innovation and we created a national innovation platform and it needs to give information to all the

health care providers where are the best practices and so on, and then we have some national surveys based on a scientific way of acting, how can we compare GPs all over the country for instance.

REINHARD BUSSE: I'm not a politician, I'm a health care researcher, and clearly that is a problem everywhere. I've shown you some things where we concentrate on the hospital sector which is then clearly limited to the hospital space. We now want to do it on more longitudinal things.

When you look at administrative data, which exists in Germany, because the data which are given to the secular funds for lower common format, and so we could examine some of these things and for example when you look at how persons after an acute myocardial infarction, which drugs they actually get after three months, one year and so on.

clearly we are in the same, you know, after two years at least we are in the same range, so I think the problem is there everywhere in spite of what the countries are trying to do and we I think in all countries we need to have a better closer continuous monitoring of what is actually going on longitudinally, not only for short term space.

ROBERT LEU, Ph.D.: Maybe I say a few words, too, Switzerland quality monitoring as I said in my presentation is one of the weak points. It's in its infancy. We are presently trying to set up quality standards for hospitals to start with,

kind of common indicator set for all hospitals, but it is in its development phase.

Use of E-health is also in its infancy. I mean, using E-health doesn't provide you from failing as the bank system has shown, but still it will be very helpful if we have more E-health planned in the health sector. Quality can be too health exploratory studies, but it's not a systematic monitoring which actually is desired.

REINHARD BUSSE: Can I just add two things? We try to go further there very pragmatically and again probably because the situation between your country and my country is rather similar what we try to do is really in the very costly areas like HIV AIDS to get these people in disease management programs and to take other areas like diabetes with complications, very complicated cases of neurology, et cetera, into disease management programs where we really try to get in touch with university centers, though they continue to be treated at the family doctor's level.

Secondly, yes we do a major investment now in post-graduate and continuous training of medical doctors in order to keep them on track and there of course E-health is a major instrument.

ROBIN OSBORN: I will take one of the questions that came in on a card, how do physicians fit into each of the three systems, how are primary care and specialist physicians paid?

And, a follow-up question on how that ties into quality and efficiency, which I think has been partly answered.

REINHARD BUSSE: Well, in Germany we have the two sectors, hospitals, and all hospitals basically work with salaried physicians, whether they are public or private, so the hospital is paid from the sickness funds and then they employ their physicians.

In the outpatient sector, it is going through physicians associations so all the physicians in private practice are a member of their regional physicians association and the physician association gets the money from the sickness funds and distributes the money to both the GPs and the specialists according to a fee schedule.

And a certain percentage of that money, roughly 40-percent, is reserved for the GPs and roughly 60-pecent for the specialists because in previous years the specialists extended their share on the account of the GPs. Now these percentages are frozen and the fee schedule is fee for service but it gives mainly the point so it's a relative fee schedule and if there are more services produced then the relative amount in Euro is a bit decreased.

ROBERT LEU, Ph.D.: In Switzerland, in the hospital sector, physicians in the public hospitals are salaried. In the private hospitals, they are working on their own. It's like the U.S. I think mainly that the hospital just offers the

infrastructure and the physicians come in and deal with or treat their patients.

The tariffs are negotiated between the hospital association and the association of insurers so each year, these tariffs are negotiated. In outpatient care, physicians are paid fee for service and the fee for service reimbursement is also negotiated between the association of physicians and the association of insurers on a state level.

DIANA MONISSEN: In our country, we have two systems, but the GPs and the hospitals are paid after negotiating with the insurance companies. GPs, they have payment based on totally different criteria, then the payment we give all the insurance companies pays to specialists.

And within hospitals they negotiate a certain amount of money and a part of the money is for the association of the specialists. And nowadays we are changing the system because of CERT next year, 35-percent of the total amount of money what's for the hospitals will be based on totally free price and quality negotiations.

So the insurance company and the board or somebody of the hospital they are free to negotiate about price and quality. They make some different appointments, date of the big change next year.

MOLLA DONALDSON: This is Molla Donaldson, I do health services research and public health planning, I have a question

for any of the presenters including Dr. McClellan if you would be willing to reflect on the lessons that we might learn about what you would do differently if you were starting again, that is what have you tried that has not worked?

MARK MCCLELLAN: Me go first [laughter], I guess I would reinforce some of the points that were made earlier that the more broad based the support for health care reform is, the easier it is going to be to implement, the less it becomes political issue from the beginning.

Beyond that, I think one of the main features of health care is that it is complex and that it is changing. And I think a common experience here and in other countries has been that you typically don't make once and for all reforms. It is important to have a long term vision for where you would like to head and have as much shared support for that in society as possible but it's going to keep evolving with the nature of health care and with the challenges facing the country and so even major reform legislation tends to get revisited fairly frequently.

In Medicare we seem to do a big bill every six or seven years or so, probably about due for another one again, and in the other parts of our health care system we tend to implement steps that might seem incremental but hopefully with that broader vision in mind can add up to fundamental changes.

For example, right now, I'm encouraged that there seems to be a lot more bipartisan interest in making, improving the way the health care system works, a key and fundamental part of health care reform efforts this time around, so expanding coverage to more people is very important, dealing with the financing, moving the dollars around is a key element, but there's also a lot of interest in changing and supporting positive changes in the way the health care actually works, quality improvement, value.

Senator Baucus' proposal earlier this week focused very much on that, and that's I think a good and new kind of basis for bipartisan support, broad based support for health care reform, but it does keep changing and it's not a once and for all settled issue.

DIANA MONISSEN: I can give you an answer. Don't let the moment slip away, because in our country we tried several decades to make this reform happen and it didn't go in the right direction, and this work because we had this moment of change, this urgency of change, we had an awareness that we needed to do it, and I think nowadays in your country you have the moment too, and sure you have to have this long term vision and all the things we said, but there is also a moment that you need to keep in your heads.

REINHARD BUSSE: I start very far back, I mean when Bismarck started our system in 1883, it was originally only for

the blue collar workers so it affected only 10-percent of the population and it took decades and decades to add one group after the other and still, every reform since then, because we never had this universal coverage notion from the beginning, only now in the 2000s.

After 125 years we said okay, we really need universal coverage and probably one of the main problems from the beginning was that the civil servants, because they already had pretty good coverage from the government when the system started they were kept outside the system.

And I think it shows that when you do certain mistakes, right, at the outset it can take ages and generations to make up for it, so at least you need to have a good blueprint that even if you cannot cover everybody immediately that you say okay, it might take us 10 years or something but that you have a good plan that everyone will be in it at the end, which we did not have.

ROBERT LEU, Ph.D.: I give you another key point, I think, in that case, again a little bit to the point of Michael. You know, the health care sector of course is also a phenomenal market and you can earn a lot of money, so what I would try to do better is really when it comes to negotiations between for instance the medical association and the health insurance companies, they fix the prices.

The losers in that system and that could be foreseen are the cheapies and the winners are the specialists, but that was a construction error done when the law was made because it is clear that if the two have to sit together on the table, one will win, so I think what you need to do is really look into where are the cocktails, where are the strong people, and where is the public interest and where is the public health interest, and then to try to balance out the system so that you don't get the point that the richer get richer and the poorer get poorer and the system doesn't improve.

MICHAEL O'GRADY: I'll jump in on this, when we think about this whether in the United States context or in foreign, there are a couple of things to think about in terms of flexibility and sort of how you design something and how you can change it because all these systems are going to need midcourse corrections, so we know some mistakes we have made along these lines.

Having it require an act of congress to change the Medicare deductible, not probably the best design work was ever done. The notion that how it moves over time, how you think about these things, but you do have your core elements that you really do require that kind of level of consensus that it really should pass both houses and it should be signed by the president if you are going to make that big a change. It also draws us to some of the things about these hybrid models.

Figure out those things the government does better than the market, figure out those things the market does better than the government. The government does a great job in determining eligibility. They do a great job, certainly Medicare Part B premiums; the social security administration is excellent at collecting that.

Setting prices in 3200 counties around the country for 10,000 different items, the market seems to do a better job on that, so think about where your real strengths are. Think about how you can make these midcourse corrections and that is how you have this more living kind of policy that doesn't require that you go back to the original, the full act of congress, unless it's really changing a fundamental.

LISA SWIRSKY: We have time for one last question.

LISA SUMMERS: Thank you. Lisa Summers with the National Partnership for Women and Families, one of the things that we are talking a lot about in this country is the provision of primary care and trying to fix our system to be better at providing primary care and the mix of primary care providers, and in one of the many discussions about the medical home.

In this country one of the speakers had made a comment that I was surprised to hear, he made the comment that every child in Switzerland gets pediatric care and 85-percent of that care is provided by pediatric nurse practitioners. And I'm

very familiar with the maternity care system in the Netherlands and I know that the vast majority of births in the Netherlands are attended by midwives.

So I would be interested to know your comments about the mix of primary care providers and whether or not that has changed throughout your reform efforts, both in terms of you've mentioned a little bit the specialists, generalist physician, but also with regard to providers other than physicians?

DIANA MONISSEN: I think the next primary care providers as you call them, they need to work together. We don't have I hope in future they work together, for instance you have a physician, you have a nurse practitioner, there's physical therapy and so on. And I hope and that's why we like to give a priority to the financial system that even specialists who are together with people for primary care and that's where we are working on.

It's also necessary because of all the people that have chronic diseases so in primary care we need to offer integrated programs, for instance for people with diabetic, COPD, or heart failure, and so on. And that's what we are working for, the first and integrated primary care and integrated as I mentioned several backgrounds, and also integrated with secondary care as specialists who come into primary care and on the CERT hand, we need to change the financial system to make it happen.

ROBERT LEU, Ph.D.: We have seen mainly over the last 15 years that the specialists, the number of specialists have grown and the number of GPs has not really kept up so I think we have now too many specialists maybe and the cheapie carrier seems to be less and less attractive and then some rural areas we begin to have problems filling up vacant positions. Otherwise, the students just choose their speciality themselves so there is not that much of a guidance and the outcome is then more or less preference of the students.

REINHARD BUSSE: In Germany, one has to remember first of all patients have free choice, they can go to a specialist directly. They don't have to go through a GP, and we believe an incentive is there so that sickness funds will offer models where their insured inscribe into voluntary gate keeping programs, in return they usually pay lower copayments which is then strengthening the GPs.

But as in Switzerland and many other countries, we see that especially in rural areas that the job of a German GP which included traditionally many house calls. So they would visit their patients and the fewer GPs there are, the more home visits they have to make and especially for that area that we now increasingly rely, even though it's still debated on the exact rights of these persons, that we create a new profession of nurse practitioners who basically are not as independent as in some other countries but which work under the supervision of

the GPs but extend their reach into the rural areas and do examinations and so on, on behalf of the GP practice to which they are linked.

LISA SWIRSKY: Does anyone have a last comment, because we are actually officially out of time. I wanted to thank everyone for coming out on a rainy day. We are impressed with your perseverance and Reinhard thank you for giving us some perspective, 125 years; I'm not sure whether that should depress us or cheer us. [Applause] But, thanks everyone.

[END RECORDING]