

**Roundtable/Briefing & Studio Taping:  
Primary Health Care: Spotlight on Innovation and Reform:  
Minister's Policy Roundtable: Current Issues on the Policy  
Agenda  
October 28, 2004**

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**JOHN IGLEHART:** One of the recurring comments of our panel earlier about primary care is the incentive in which they work under. Financial incentives, working conditions, etc. And I would like to turn to Minister Hutton of the UK to ask him what the National Health Service is doing in terms of encouraging the performance of its primary care doctors, both in financial terms and in non-financial terms. So we'll begin that way. Minister Hutton.

**JOHN HUTTON, MP:** Well, John, it is very important in any health care system to get the balance and the package of incentives right so that the system works and delivers a good deal for patients. What we're trying to do in the UK is increasingly focus on this issue as an important part of our reforms in the National Health Service. And in relation to primary care, I think there are two particular issues that are significant here. As has been referred to earlier, we do now have in the UK a new model contract for our family physicians, our GPs, our general practitioners. And that will increasingly over time have a significant impact on the income of each practice in England and across the UK. More and more of the income a GP will earn, a practice income, will be dependent on meeting certain quality standards in a range of clinical conditions. Most of them in relation to chronic long-term illness. So we're looking very closely at things like diabetes,

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hypertension, asthma, epilepsy, one or two other areas where we know we need to focus much more on the clinical outcomes that a patient receives. Historically, most of the funding in this area has been distributed around the system irrespective of any real focus on monitoring outcomes for patients. We have a historic sort of level of funding and that's usually uplifted every year depending on what the treasury settlement is. And it's just passported around the system in that way. We've never really had a focus on rewarding good medical practice and perversely we've usually had a system that's rewarded failure in the system, because those hospitals, those parts of the system that don't focus well tend to get bailed out. And the ones who do really well and use the resources efficiently and effectively, well they might get a letter from me at the end of the year saying what a really good job they've done, but I don't need to tell you what happens to those letters. They tend not to get framed. I think that would be the view. So the contacts are changing for the family doctors. We're right at the very beginning of that process, John, so I'm not really in a position to say anything in detail about how that is going. We're six months into the contract. I think the early signs are encouraging and promising and I think it's certainly led to a very strong focus in general practice now on quality and outcomes. And I think there isn't a practice in England that isn't looking and reviewing its work in those areas. The other

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sort of incentive that we want to get right, because the other thing that we've got to do, we are having now a very strong focus on incentives in secondary care too. We're shifting to a payment by results financial model based on HRGs, DRGs, whatever. Which is going to reward sort of activity and quality, but I need to have a similarly strong set of incentives I think in the primary care setting as well so that the system is balanced over all. We've got that in the new model contracts for GPs. We'll have a second opportunity I think to structure incentives into primary care later next year when practices, if they want to, if they want to go down this road will be able to hold the budget that's relevant to that practice for their referrals into secondary care and maybe reengineer some of the care pathways and so on to provide, hopefully, a better higher quality, more locally convenient service. And maybe also facilitating the shift from hospital based care to community and primary based care as well. So I think we're going down if you like a twin track here in relation to primary care. Incentives around the payment and a greater involvement in general practice, amongst general practice in controlling the overall resource envelope that's there for them in relation to secondary care as well.

**JOHN IGLEHART:** Thank you, Minister. I would ask any of the panelists who care to comment on this particular subject to please do so. I would ask Dr. Clancy to begin and recall your

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comments earlier, Carolyn, about the Medicare Modernization Act including many demonstrations and new initiatives to try to improve the delivery system. Do any of those deal with incentives to improve the performance of primary care doctor?

**DR CAROLYN CLANCY:** Absolutely. First the work that's going on, this docket program, that small scale demonstration in four states being led by the quality improvement organizations is exploring that right now and focusing on selected measures of chronic illness care. That is going to be the foundation for a larger scale demonstration that's part of the Medicare Modernization Act. So I think that we'll have an opportunity to learn a great deal, again reinforcing my colleague from Mexico's comments about the need to understand change management, what incentives work, how they work, and so forth.

**JOHN IGLEHART:** Director-General Knieps.

**DIR-GEN FRANZ KNIEPS:** As I said in the morning, we give financial incentives for the patients and the GPs. If you lower a copayment, maybe up to zero, patients are interested in family care and go to the family doctor first. If they need a referral for the access to a specialist and hospitals, they take the referral. You maybe experienced in the first 6 months of the new regulation the number of patients with the referrals climb up from 60 to 85% and we give also financial incentives for GPs and specialists. We call it fees for quality,

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additional money for those persons who take part in quality circles, who are able to handle standards and so on. The second approach is to rebuild the health care system as a network based on strong family care teams with good access to the best specialists and outpatient practice and also in hospitals. In Germany now hospital physicians are not allowed to treat patients who are enrolled in public funds. They treat only patients who are members of private health insurance companies. We tried to open that for special treatments for best treatments and we tried to combine family care based approach with disease management programs, new models of integrated care. We gave 1% of the money we spent for hospital care and outpatient care for these new models. So funds and new type of providers can take that money for 3 years to have additional money for improving care.

**JOHN IGLEHART:** Minister King.

**HON ANNETTE KING:** Thank you, John. I think the first thing we found important was to recognize primary health care as being a very important part of the health system and to say that this is where we want people to work. We need people to work in the system and the feedback that I'm getting, particularly from doctors is that they like the [Inaudible], they like the fact that primary health care is once again at the center of a health system and the feedback from them is it's more rewarding from them when there is attention on

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primary health care rather than on secondary services specialist services. The second thing is more funding, and obviously more funding always smoothes the way. Something like 1.6 billion additional dollars going in over a 6 year period, which will end up at about 490 million a year over and above what we already put in ongoing each year. But adjusted each year as well for the changes in the CPI. More funding going into improved access, so right away they got extra money to improve access for those people who don't access health services now. That was our first priority, to get people in the system. More funding for health promotion, disease prevention so they got additional payment for that. And obviously more funding to reduce the cost to the patient themselves. We also established the population health goals that we wanted our primary health providers to report on. And obviously one of the key weapons in that, if you like, is public transparency about those goals. And over time ensuring that public know how a PHO is going in terms of meeting those goals. And also we rolled down the track to incentive payments for PHOs to bring them up or down to an acceptable level in terms of pharmaceuticals and laboratories.

**JOHN IGLEHART:** Thank you. Before I turn it over to Minister Shugart, I would like to recognize John Hoff who has joined us. Mr. Hoff is a Deputy Assistant Secretary in Secretary Thompson's Secretary of Health and Human Services.

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Before joining the department, John was in private practice of law and he has a particularly strong interest and knowledge base in long-term care. John, welcome. Minister Shugart, please.

**MINISTER IAN SHUGART:** I just wanted to add in relation to incentives and barriers to expanding primary care, that the incentives and disincentives aren't always financial, although some of them are and they're not just payment approaches. They may have to do with how one helps the physician community, for example, to make the transition from a single practice to the group context or the context of a primary health care organization. Some of these are very mundane, but hugely important things, such as deploying the computer capacity and the electronic health record right into the group practice, for example. Some issues are legal in nature, the way these organizations are constituted in law and so on can be important issues. The scope of practice of one health care provider to another will frequently require legislative and regulatory change. And these are issues where the different professions may not at the outset see eye to eye and so they're important issues for governments to work through. And then finally, the way we train health care professionals I think is an important factor in adopting effective group and interdisciplinary team practice. To the extent that we're training people in professional silos, it is unreasonable to expect that any time

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soon they're simply going to practice in a group context. And that continuum of care that we're trying to achieve in primary health care reform will have to go all the way up stream to how we train our professionals. So the incentives and barriers are not always financial, although those are important. They can be legal and cultural and educational as well.

**JOHN IGLEHART:** Thank you. Mr. Horvath.

**JOHN HORVATH, MD:** Thank you. We've done a number of things, some financial, some not. Of the direct financial ones we've got some practice incentive payments, which we make to participating practices, mainly for looking after chronic disease, diabetes, mental health, asthma, with very specific measures what they must do to get the additional payments. Similarly cervical cancer screening. There are other incentives for chronic care plans that involve across a number of specialties and multidisciplinary plans and also some incentives for taking up IT that I mentioned before. Through the Australian Health Care Agreements, there are 680 million dollars over 5 years to the state with conditions around how that money is spent in the whole quality arena, especially around primary care. Lastly, the government has funded the National Institute of Clinical Studies whose major role is identifying the gaps in the quality delivery of care and then looking at ways to bridge the gaps between evidence and practice. And it's early days for this yet and how this will

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link with the other quality initiative is yet to be seen. So there are a significant number of financial levers being used so that the money being put into primary care has some measurable outcomes. Thank you.

**JOHN IGLEHART:** Dr. Arules?

**DR ARULES:** Well we've been going through a major change in the country. We passed a law a year ago whereby the funding of the health care system is going to be now based on demand and not on the supply side. So that is putting a lot of pressure on doctors and nurses because they know that they have to perform very well in order to have people to come with them. If they don't get people to come to them, they wouldn't get the funding that they have already been receiving by [Inaudible] for many years until now. So that's one incentive, financial incentive built into the system, but we are doing some other things and I will mention a couple of them. One is we have established a monitoring system in about 6,000 units, 500 hospitals and 5,500 primary care units in the whole country. And we are monitoring 17 indicators. Some of them have to do with hypertension care, diabetes care, pregnancy care, and some of our most common infections in children. So through that we are putting the information on the Internet and each unit is seen by everybody else. So the performance of each unit is in the Internet, so that's an incentive for them. They know that they have to perform well; otherwise everybody will see what

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they're doing. Now when you do that, you need to have some sources of reliability, otherwise there is an incentive to say something that is not the truth. So we invited and this is the third mechanism that we are doing, we invited NGOs to join what we called the "National Crusade for the Quality of Health Care." So we are inviting some universities, some social groups, Rotaries or Lions or even the soccer team in the community. So they come to the units. They receive some basic training and they are able to check particularly the intrapersonal quality dimension of care, whether the information that is provided by the unit is okay or not. Whether that's true or not or whether they are coinciding with the information given by the unit or not. So again this is another motivation for health care providers to improve the quality of care, because they are being observed and even they can receive an award from these organizations. They are giving some diplomas to the best nurse or to the best doctor in the unit and that's a way we are moving towards motivating the people.

**JOHN IGLEHART:** Thank you, Dr. Arules. We have questions coming from three sources. One is from questions that web participants have sent along. Two is our questions coming from journalists who are in the room and have certainly questions of their own. And then last, but certainly not least, the questions you all have that you can pose when we get to that

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point. I'll first take a question, or next take a question from one of our web listeners who brings up the subject of the use of primary care nurses, practitioners, and certified nurse midwives in the provision of primary care services in your respective countries. Clearly an important subject. Several of you mentioned the emergence of teams and the value of teams in terms of providing primary care services. This time I'll start on the far right with Dr. Arules, if he would comment on the use of primary care nurse practitioners and nurse midwives in your system.

**DR ARULES:** Well for many years nurses and midwives have been a key element in the primary care provision of care. One of the problems we have now as it happens in many other countries is the fact that nurses are tending to leave the country, particularly to the U.S. and this is one of our concerns. So my answer is yes, we are considering them. This has happened for many years in Mexico. One of our concerns is that they are leaving now.

**JOHN IGLEHART:** Dr. Horvath.

**JOHN HORVATH, MD:** Thank you. Well, it's early days for this in Australia for a number of reasons. We haven't had independent nurse practitioners until about the last 5 or 6 years and they are largely state based. And only in the last really 7-8 months has the ability of a practice nurse, a nurse within a practice been able to generate a fee for the practice.

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So they are early days. I believe that they will expand considerably now that the ability of the practice to generate income for the practice for them, and I think they are going to be essential. I think there are a whole range of specific tasks that they will be able to carry out that will be very beneficial to the patient. There's a lot of evidence in the literature of the different perspectives of practice nurses, whatever you call nurse practitioners, practice nurses, and I think we need to utilize them for the much better outcomes for the patients in the longer term, not just as workforce substitution.

**JOHN IGLEHART:** Minister Shugart.

**MINISTER IAN SHUGART:** Not a great deal to add beyond that. The deployment, the training of health care providers in Canada is the responsibility of the provincial government, so they make the decisions about how to utilize the health care workforce, but the consensus is I would say quite broad in Canada that this is in large measure the way of the future that nurse practitioners work as part of that team. I would say that we're in the early stages of developing that and generating the supply to support that vision over the long term. We also are subject to the mobility challenges, not only with respect to the United States, but even within the Canadian health labor market from one jurisdiction to another. And given that mobility and the demographic issues that we face, one of the

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things that we need to do and have been addressing is to develop better data so that our planning for this in the future can be strong and not subject to mishap.

**JOHN HUTTON, MP:** Nurses have always played a very strong in primary care in the UK and I'm glad to say in the last few years there's been a very significant increase in the number of nurses who are working in primary care. I think something like 11,000 more nurses working in primary care than there was a few years ago. And I think if the focus of primary care is going to increasingly shift into areas like chronic disease and managing that more effectively in a community setting. I think it is clearly I think the case that nurses will play an increasingly strong role in relation to managing chronic disease in the community. It is also in the UK a very attractive place for nurses to work. I think that's also partly why we've seen that shift. It's an area where nurses can practice more independently. We're also extending the role of nurses in the area of prescribing as well, so they can take on more of that function and role as well. And we've got a very strong workforce [Inaudible] in relation to community nursing as well that do the home visits and the home support for people who have been, for example, discharged from hospital as well. So I think the prospects for nurses to work increasingly importantly in primary care are there. Nurses in the UK can work as employers of doctors as well and some of them do that,

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employ doctors themselves. And they can actually be the partners in general practice as well. So that's quite significant reform.

**JOHN IGLEHART:** Thank you. Minister King, please.

**HON ANNETTE KING:** Thank you, John. I agree with John from Australia that nurses are not substitutes for doctors and don't want to be. They've got a specialist area themselves, which is a really important part of the team. We are very lucky in New Zealand. We have a highly skilled nurse workforce from practice nurses to specialist nurses in diabetes and [Inaudible] and well child, public health and district nursing in the home and so on. But in terms of a nurse practitioner, this is quite a new role in our country, like Australia. And we've been developing our nurse practitioner over the last few years. We've got something like 8 or 9 graduated now and 30 coming out at the end of the year. Government passed legislation several years ago to approve prescribing rights to nurse practitioners with additional training. We've provided scholarships now for nurses to have skill particularly in primary health care. So there's a lot of emphasis going on, the skills for nurses, the opportunities for nurses. In terms of midwives, midwives have had independent practice in New Zealand for over 12-13 years and in fact provide most of the maternity [Inaudible] for maternity care in New Zealand. They are a very important part of maternity provision.

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**JOHN IGLEHART:** Thank you. Mr. Knieps.

**DIR-GEN FRANZ KНИЕPS:** The role of the nurses in the primary care system in Germany is traditionally weak. In the past we had churches, Red Cross, and other private welfare organizations, which employed nurses, but most of the services disappeared in the last 20 years. Now the introduction of the long-term care insurance gave an additional push to create a new market of independent nurses and of private nurse companies. And now we have the first examples that nurses also employ doctors in the new networks that nurses can also create as hospital can do or other providers can do. And the second thing is that a lot of additional money is going out of pocket into such nursing services, for example, to have a 24 hours watch on persons who need long term care and it's an interesting market, which changes day to day and year to year.

**JOHN IGLEHART:** Secretary Hoff, do you have a comment? Or would you pass?

**SECRETARY JOHN HOFF:** I thought that was a very interesting comment that the creation of long-term care insurance pushes the demand for nurses as people try to find ways not to go into nursing homes and to stay at home. I add John that as you well know in the United States there are experiments all over the lot on the role of nurses and nurse practitioners. And some states permit prescribing by nurses and some don't. But there's a large movement to creat more

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ancillary workforce. And I would also add that there's another problem which is not just nurses, which is nurse's aids, particularly in long term care and there's going to be a shortage, there is a shortage and there will be a shortage in the coming years as the population ages. We have experimented. We are experimenting with other people in a nursing home to provide care, such as specially trained workers to help at surge time of feeding. So there are a lot of experiments and a lot of different ideas being pursued.

**JOHN IGLEHART:** Thank you. Before we turn to our next question, Julian Le Grand would like to make a comment. Professor Le Grand is the Health Policy Advisor to the UK Prime Minister, Tony Blair. Julian.

**PROF JULIAN LE GRAND:** Thank you very much. I just wanted to raise an issue, which has been alluded to by some of the ministers. A query really as to where we go on it. I was sparked by a comment made by Caroline Clancy about the preferences in medical students. And it reminded me of a group of GPs who came to see me very recently with a particular problem. And the problem was this, that there's people like us, politicians, policy advisors, academics all give a very high priority to primary care. The people who work in health systems on the whole do not, and in particularly within the medical profession. Within the medical profession itself, primary care is low status and it always affects our ability to try and

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raise the priorities given to primary care. And I think it's a real question that we have to address there. What can we actually do about those sort of fundamental status and cultural issues? They're very difficult to [Inaudible]. There are probably a number of reasons why it is that primary care has historically turned to the [Inaudible] status. It was regarded as very hard work, often rather boring work, much of it. There were no opportunities for private practice, at least in the UK; I don't speak for all of the countries to enhance incomes and so on. Now some of those things we can do something about in the UK where we have significantly improved I think the working conditions and incomes of GPs. Franz Knieps was telling us about what they're doing in Germany and improving again those areas. But will factors like that be sufficient to try and shift the balance so the primary care resumes within health systems? The kind of status and priority that we would like to see it have.

**HON ANNETTE KING:** I think that's a really good point that Julian's made. Traditionally, many years ago, in fact GPs in New Zealand had high status. The GP in the community was the pinnacle of status in fact, along with the bank manager. So over time it changed and it seems to me that it changed as we became more specialized in our provision of health care. So to go into a specialty, higher pay, higher status and we marginalized our GPs. Part of what I think we need to do, and

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we're endeavoring to do is first of all as politicians to provide some leadership in terms of recognition of the GP's role and the role of primary health care and I think we are all on this panel singing the same song about the importance of primary health care. So in a political sense we are actually talking up that role as we realize that specialization and waiting until people end up in our hospital isn't going to work for us. So I think we are probably providing some leadership in our speeches and what we're doing in our policy development. In New Zealand we're also talking about how we can ensure that the GP has a broader role to play in terms of a range of services they can provide. They lost a lot of the things they could do over time with specialization. So ensuring that they can actually do more than they're currently doing is also attractive. I can't measure at this stage as to how successful we've been except to say that since we started putting a greater emphasis on primary health care and more money, which does see their income go up, there has been more interest in training to be GP. So this year at our college of GP's training program they've had the highest numbers they've seen in many, many years. So we are hopeful that that sort of leadership emphasis starts to turn the tide of what I think Julian has identified, that we have seen general practice doctors being marginalized over the years.

**JOHN HUTTON, MP:** Just very briefly to add to what

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Annette has said, I think we'd all recognize this as an issue and it's a problem. And I think we'd also probably all want to recognize that there's no fairy dust that we can sprinkle on this that is suddenly sort of going to transform the whole situation. It will take approaches I think on a number of different levels to address those concerns. Some of them are professional. And I think Annette has very well alluded to those. In the UK general practice has been general practice. It's been very broadly based. It's got huge strengths. I always say, it's a cheap laugh I get with this back home, but I am a politician and I quite like cheap laughs, that together the doctors and politicians command the confidence and respect of 99% of the public. I account for 1% of that. The doctors have the other 98% and so as a profession I know there is that perspective of it. It's not shared by the public. The public loves the GPs. The GPs are a force in all of our lives. They are there in times of crisis and everything else. They have a very well respected profession. I don't think we should lose sight of that. So I think it's a combination of professional issues and I think Annette's reference there to allowing GPs and encouraging GPs to develop more specialist areas within general practice I think is a very important sort of attractive feature for how general practice can develop in the future. And I would like to see in the UK GPs taking more referrals from each other rather than referring all those routinely into

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specialist's care in hospitals. I think that is a very important area of reform. I think some of the policy issues, policy levers that we've been referring to are very important to all of our systems one way or another, probably would say if we were being honest that all of the action, all of the focus has been on secondary care. It has been. You just take a snapshot, John, of all of the drama documentaries, the soaps, everything else that portrays the medical profession. Where do these guys work? They all work in emergency rooms. They all look like George Clooney. They are fabulous and wonderful people who date and do all sorts of extraordinary things and if you were watching it, you'd probably think yeah, I want to do that. I can be like George and be successful and attractive and everything else. We used to have a drama documentary in the UK years and years ago about general practice. It was called Dr. Findley's Casebook. Some of you might have seen it. Yes, in New Zealand because we give you all our programs. We take all ours from the U.S.; we give ours to New Zealand. And we had Dr. Findley, the quintessential sort of British general practitioner who you could ring up at 3 in the morning. Ten minutes later he'd be at your bedside. He generally didn't date, actually. He didn't look like he'd had a date for a very long time. But there is that sort of cultural stuff and look, we can't change that overnight. I think it's a combination of things, but I think Annette's absolutely right, it's leadership

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centered, developing a clear focus on primary care. And you know the signs are very promising. In the UK, more people want to be GPs than ever before. We are seeing significant growth in the number of young doctors who are in the process of qualifying. Who want to work in general practice? Now that's a very, very good foundation on which to build I think.

**JOHN IGLEHART:** Minister Shugart?

**MINISTER IAN SHUGART:** I would only add that there may be some element as well of uncertainty about what primary care really meant a while ago. And that may have accounted for a decline in the number of people seeking to do family medicine training post graduation. To the extent that that is true, I think one of the remedies and it fits exactly with what Minister King was saying about leadership. One solution may be consistency. That over time if we can portray what primary care is and continue to portray that and it has some inherent attractions for the practice environment, for the working conditions, for the ability to perform effectively that niche role in health care, then I think the attractiveness of that specialty will increase as well.

**JOHN IGLEHART:** Dr. Horvath?

**JOHN HORVATH, MD:** I think there's some real professional issues here and I think it was alluded to earlier with our German colleague where you can go into general practice without any training. And that clearly leads it to be

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regarded as not a specialty and not an equivalent. In Australia some years ago we in fact made general practice a specialty. For technical reasons it's called "vocational training", but effectively especially with the college sitting around the table with the other specialty colleges, you get a higher fee once you've got your college of general practitioner ticket and more importantly making sure that end of life specialists like myself can't slip off into general practice at the end of life to further devalue it. So raising that stage, but it's going to take some time for all of that to really sink in. And also insuring that a goodly proportion of the time of medical students, up to 25% is spent in a general practice or a community environment. And the university funding be contingent on that.

**JOHN IGLEHART:** Dr. Arules?

**DR ARULES:** We are struggling right now with that very problem and it's a very important one because we want to give a lot more thrust to primary care and we don't have enough well trained and well-respected GPs. And so we established very recently a special commission on that very issue and everything seems to be leading us towards a more marketing approach to the problem because we need role models to change the position of the GP image in the minds of students and that's not easy. Everything leads young students to become specialists, so we are right now in the middle of the struggle.

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**JOHN IGLEHART:** I'll turn now to our second source of questioners. One of the journalists who's here, Julie Appleby who represents really America's largest newspaper, U.S.A Today. Julie?

**JULIE APPLEBY:** Thank you very much. As we all know, vaccines are an important part of primary and preventive care around the world. And from time to time there are shortages of vaccines. And I'm wondering what steps are being taken or incentives offered to ensure an adequate supply of vaccines in your countries?

**JOHN IGLEHART:** Dr. Arules, let's begin down at your end.

**DR ARULES:** Well we've been working together with the rest of the Commonwealth countries. I know that Dr. Frenk has been very active talking with his colleagues in this regard. So we can make sure that we are able to get the vaccines when we need it and so far, fortunately, we haven't had any problem in Mexico with vaccinations. We have about 98% coverage vaccination for children under 2 years of age with a wide spectrum of vaccines, so and in the past 2 or 3 years after 9/11, again, Dr. Frenk was very active getting what we needed in case of an emergency in the country.

**JOHN IGLEHART:** Dr. Horvath.

**JOHN HORVATH, MD:** Thank you. Australia's immunization rates over the last few years have risen to over 90% for a wide

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range of disease. The current problems, of course, around influenza, which I'm sure you're alluding to and Australia is working with the WHO and the other countries. We are fortunate we do have an on site manufacturer and we're working with the other countries and with the USA and others to try and ensure that if a pandemic occurs, we have the right seed virus and be able to make the appropriate vaccine in quantities and time that is appropriate.

**MINISTER IAN SHUGART:** One of the things that is characteristic of the Canadian system is the integration of the public health system with the single payer acute and primary care delivery mechanisms. And I think over the years that has put an emphasis, a predisposition to be ready with public health interventions. We have a tradition partly derived scientifically over the years and partly because of that health care delivery approach, a culture of using vaccines and having public health interventions integrated with the rest of the system. And so we have not had supply difficulties partly because it is a planned function. As John just mentioned, our work on pandemic flu preparation has been very substantial over the last several years, but on the annual cycle of flu vaccine we simply identify early on that that is something that we're going to be using extensively. Increasingly it's been built into provincial systems where there's a strong initiation of the program at annual points in the year. There's data that

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demonstrates that the reliance on emergency rooms goes down. It pays off and people are well aware that it pays off and so it's become an integral part of our single payer system and it seems to work.

**JOHN IGLEHART:** Minister Hutton?

**JOHN HUTTON, MP:** Just two or three things to add to what Ian has just said. We share very similar features to the Canadian health care system. And everything that Ian has said in relation to immunization in Canada, a lot of that applies to us in the UK. We have very high rates of immunization in relation to some of the major health threats that our population faces. And the foundation stone for that immunization policy, I think, rests on a couple of very important features. Strong regulation, we rely heavily on expert advice to ensure safety and efficacy. We have very well organized call and recall systems based in primary care and that's particularly true in relation to children. And crucially it needs to be based on good information for the public so they are aware of the threats that are out there and they know where to go for help and advice if they choose to go down that path. There's a very important extra dimension to all of this, which is international collaboration between countries because some of these health threats, of course, are not going to stop at everyone's borders and frontiers. And that I'm afraid is particularly true in the context of some of the new

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international threats that face all of us now in the current world situation. And particularly the threat of biological terrorism, which we together with our allies have taken very, very seriously and I think we've seen some very significant areas of collaboration in terms of research and development, and a lot of that has been led by the U.S. Administration. I certainly want to pay tribute to them for that leadership that they have shown. And we have taken action and for example in relation to the UK, as many other countries have to try to tool up in relation to particular threats from that source. And that has been a combination of education and training, as well as procurement in relation to vaccines.

**JOHN IGLEHART:** Minister King?

**HON ANNETTE KING:** Our situation is similar to that of the UK and Canada and Australia. In fact, we work very closely with the WHO and Australia, and particularly in relation to any emerging issues. We in general have had no problems accessing vaccines. Like Canada, it is a planned function, except for meningococcal B strain that we have in New Zealand, which is unique to our country and we've had to develop our own vaccine at huge cost. And we're just undertaking a nationwide vaccination program of all young people under the age of 20 in an effort to try and stamp out this dreadful disease. And it's interesting that we don't have immunization rates as good as we would like for the general immunization program. But with the

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high visibility of meningococcal B in New Zealand, we are seeing as we roll out the vaccination program, we are seeing high acceptance by the groups who in the past have not always turned up for vaccinations. So particularly Pacific Island people in New Zealand, Maori people, have seen the impact of this disease and are very keen to have their children immunized. So there are some lessons in that for us. One of our challenges, however, in general immunization is to improve our rates, particularly amongst Maori and Pacific people.

**JOHN IGLEHART:** Director General Knieps?

**DIR-GEN FRANZ KНИЕPS:** I would agree to my colleagues, especially from Canada. We have the same problems. We have no problem with the supply of vaccines, but we have a problem on the demand side, especially with poor people and with immigrants coming in from the East, especially from Russia, bringing in infectious diseases and being not familiar with the German system where the public health service is responsible for vaccination. And it doesn't work anymore because only a few states modernized their public health services, there's less money for that. So now we discussed to start a huge campaign financed by federal taxes and organized by a special agency for health [Inaudible] occasion and the second step, which is discussed in Germany now is to handle it over to the [Inaudible], because they are much more accepted as a communicator for health affairs than the public health

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agencies. And I would also agree that the G-7 summit took over the leadership in the question of biologic terrorism and it's a very important question to our country too.

**JOHN IGLEHART:** Secretary Hoff?

**SECRETARY JOHN HOFF:** Thank you. I would just like first to thank the gentleman from the United Kingdom for recognizing the role that the United States, in particular CDC is playing all over the world in vaccination programs. And of course we are doing vaccinations in the United States. The question comes up I think in the current situation I think about the flu vaccine and I would emphasize as the Secretary would emphasize that we have enough flu vaccine in the United States to vaccinate those most in need. The Secretary from the day that he took office and particularly after 9/11 has been active in trying to develop a more robust vaccine industry and more robust and new research into better ways of making vaccine. We have two issues that need to be addressed and one of them I hope is still unique to the United States, but may decreasingly be unique, which is our malpractice system and the danger of suit and the amount of huge judgments that can be awarded, particularly in something like a vaccine which is given to a healthy person who then allegedly becomes sick because of it. In many cases, not because of it. We have a no-fault compensation system for some vaccines, however, that does not occupy the whole field and it's still possible to go to court.

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Additionally, this is a low profit business and because of the med/mal liability there are fewer and fewer, and because the number of purchasers has been reduced, there are fewer and fewer producers in the field as we all know, and we're going to have to look at new ways to provide financial incentives for more people to get into the business and the Secretary has been working hard on that for the last 3 years.

**JOHN IGLEHART:** Thank you. We have one more question from a journalist from the *American Medical News*. Yes sir. You need to stand up please. Thank you.

**JOEL FINKELSTEIN:** Hi, my name is Joel Finkelstein. I'm with American Medical News. My question is, I'm wondering if your panelists can offer us some insight into why the U.S. spends so much more per capita on health care or for that matter why you spend so much less, when this survey seems to suggest we're not getting a whole lot of bells and whistles for that extra money?

**JOHN IGLEHART:** Anybody care to take that one on? Leave it to the journalist to ask a tough question.

**JOHN HUTTON, MP:** Oh dear, is that the time? Look, I think in any country that you'll have an argument about this. It doesn't matter really to some extent how much you spend there will be people who say you are either spending too much or not enough and you're not getting the result that you referred to. I think it's a very highly critical area of

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policy. People are very interested in pouring over the detail of all of this. Ultimately, these are decisions fundamentally that countries have to make and peoples have to decide how they want to play this. I can't hand on heart and say that every single pound that has been raised in the UK, the additional money for the NHS has produced a result necessarily that I would like. I can't say that. I don't think that is possible for any of us to sit and say that we necessarily get the most efficient use out of every pound, whether it's spent privately, raised privately, or whether it's raised in the public domain. I think there is clearly a responsibility on policy makers and certainly in government and I think we should all accept this that fundamentally it is the job of governments to set strategic direction and to try and ensure that the taxpayer or the patient, however you cut it can get the best possible access to health care that is available within that system. Now that is the discipline I think on all of us. Is any health care system perfect? Well, obviously not. And I don't think we should try and fool ourselves that a state of perfection is necessarily going to be very easy to manufacture here. There are always going to be shortcomings. There are always going to be deficiencies in any health care system that you care to measure and to quantify, but I think the important sense from all of this, and certainly from the survey today is that all of our health care systems have very, very strong areas of

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performance in excellence, whether it's in issues for example of clinical practice or whether it's more widely spread over areas of access and convenience and availability. And I think it's a constant program of work and effort to try and hit the buttons and pull the chains that you want to pull. But certainly I don't think there's any of us here on this panel who couldn't look at that survey today and say there are some very positive things that we can all reflect on in relation to our own health care systems.

**JOHN IGLEHART:** Mr. Knieps?

**DIR-GEN FRANZ KNIEPS:** First I have to make a correction. Yesterday I told you that we spent 13% of GNP. That was not correct. We spent 11%. But for me, it's not the question how much do we spend? For me the central question is, do we get value for money? Do we have equal access for all people? Do the people get the services they needed and they preferred? That's in my opinion the central questions. And I have to remind that as wealthier peoples are, as more they spend for health care and there's a growing market with a growing importance for employment in the health care sector, not only in the traditional cure sector, but on the rehabilitation sector, on the nursing sector, on the wealth scene for that. So that's an interesting fact for me and I can't give any answer. Do we spend enough? Or should we spend less? I am looking for answers to the other questions.

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**JOHN IGLEHART:** Minister King?

**HON ANNETTE KING:** I don't think there is a right level of spending. I think each country looks at what they can spend and what they will spend and make their decisions based on their own country, so I haven't seen where there is a formula that tells us what we should spend and we all get the right results. I think what we all want to do is to maximize the capital human and financial that we put into the system to improve people's health, to reduce waste. And I think all of us have to recognize and do recognize that in health we have to prioritize. We have to prioritize our expenditure and whether we like it or not that's a fact of life. We do have to prioritize.

**JOHN IGLEHART:** Thank you. We'll move on. I would like to turn to the participants to ask questions and make comments from things they've heard this morning. That is really to prompt you. I'll ask a question and then turn to whomever would like to have the floor. If you'd put your sign up this way so I can recognize you we'll go on. But the question I would ask is the following. The survey reported that about a quarter of all Americans spend more than 1,000 out of pocket or did so in the last year for health care. This figure is not a problem for many Americans, but certainly for some Americans it is. And given the trends in the private employer marketplace it appears that the out of pocket number is likely to go up as employers

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shift to a greater responsibility on the individual to recognize the high cost of care. That's not an exceptional trend in the U.S. Indeed, it's happening in other sectors as well, certainly in pensions. But the question I would ask in relation to these trends in the U.S. what's going on in your own countries in terms of the decided emphasis on low out of pocket payments by individual consumers? Whether that trend will remain pretty much as it has or whether you can see any growing reliance on higher out of pocket payments by individual patients as a sign of perhaps incenting them greater individual responsibility, or however you might want to characterize it, maybe simply saving money?

**MINISTER IAN SHUGART:** I could begin the discussion John. I think the key distinction that we would make in our system is between expenditures that individuals might make for what would be classified as medical services or health care expenditures and those, which are more narrowly defined as medically necessary. The praise of our system is that we have first dollar coverage for insured services, medically necessary insured services, and therefore the classification is important here. In free societies, in societies where there's more information about health than ever before, good and bad information, people are going to make choices and there is nothing stopping people, of course, from paying out of pocket for certain health related services. And I think the better job

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we can do of identifying those services that are going to have a health benefit, the better informed the choices will be by consumers. One area that we've been giving particular attention to is in pharmaceuticals. And recently our first ministers have committed themselves to the development of a policy broadly to improve the utilization of pharmaceuticals in our health care system, cost containment of this fastest growing element of the health care system in Canada, improving the cost effectiveness evaluation of medicines that we provide and use, but also importantly declaring that no one should suffer undue financial hardship because of the cost of pharmaceuticals. Coverage for pharmaceuticals in our system varies considerably in distinction with countries in Europe, for example, where it's much more closely integrated into the system. So we have more work to do there, but I think the real distinction is not how much an individual consumer will spend, but whether for the medically necessary services there is adequate coverage in our countries, and whether the information that consumers are using is reliable and backed up by good evidence.

**JOHN HORVATH, MD:** The question of out of pocket expenses is a mixed bag in our system at the present and we're looking at different levels. Certainly for the underprivileged, the chronically sick, and the elderly there are moves to remove most if not all copayments, or certainly reduce them to a very small amount. There have also been

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moves to look for mainly the chronically ill for the out of hospital copayments with subsidies. On the other hand, looking at some price triggers around the pharmaceutical benefits scheme, looking at some higher copayments there to try and bring those more into line over the last decade, the copayments for pharmaceuticals have gradually declined as the bill has escalated considerably. So it's a mixed group of attempts. Certainly looking at our poorest group, the indigenous Australians there is certainly a lot of programs to roll up pharmaceuticals and virtually all forms of care so there is no copayments at all to try and lift the health status of that most vulnerable group of people.

**JOHN HUTTON, MP:** Just very briefly. Health care systems are not just buildings are they? They're not just people. They represent a set of values, all of them, and it's up for countries and nations to decide the values that they want in their health care system. In Europe we've generally tended to follow very strong models of socialized medicine where access has been very important to us. And access on the basis of need, not ability to pay. But these are political decisions and obviously I don't want to get into the merits or demerits of that today. There will be other occasions when we can do that. We are not planning to extend copayments. We have elements of copayments in our system around the use of prescribed medication, for example, they tend to be means

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tested so the poorer the patient is, the limited means and wealth they have at their disposal, the less likelihood it is that they will be asked to pay anything. I would just sort of lobby in one observation on this and I think that it's an issue for all of us wherever we are in the world and whatever our health care systems are and what values they represent, and it's this. I'm not a physician; I'm not a doctor. But what I do know about technology, innovation, research, the development of health care systems lead me to one basic conclusion. I think the cost of providing high quality care is going to rise. It's not going to diminish and that therefore is a very fundamental issue for all of us in terms of access and equity. I would argue very strongly that that makes the case for socialized medicine, because if the principle that you want to pursue is access on the broadest possible level then it's very hard to see in my head how that can be achieved by more and more copayment because by definition copayment, we know this from all the international research, tends to have an aggressive impact. It tends to affect the poorest the most and they will have by and large the greatest health need. So that is just something that I want to introduce. I know it's highly controversial, but I think it's a very important issue for all of us.

**JOHN IGLEHART:** Mr. Knieps?

**DIR GEN FRANZ KНИЕPS:** In Germany we come from a very

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low level of copayment and out of pocket payment. The discussion is focused only on copayments and not on other fields, for example, wellness as I mentioned or alternative medicine. Germans are spending billions for alternative medicine out of pockets with no evidence, with absolutely no evidence. And in the past, 50% of the drug prescriptions were excluded from copayments, so the blue-collar workers say we have to pay twice. We have to pay copayments and we have to pay the copayment reductions for the others via our contribution. So we had a strong discussion about the distribution effect of copayments and exemptions, just to handle the question John Hutton mentioned. I can confirm the trend is going very, very slowly, but the trend is going from the employers to the employees and from the insured to the patients. But we do it on a very low level again and we have to handle it with care that no one or no instrument blocks the equity and the access to all services, which are needed.

**JOHN IGLEHART:** Professor Laudebach, do you want to speak on this particular point?

**PROF LAUDEBACH:** Yes, just a brief comment. In Germany we actually have two health care systems in parallel. The private system and the public system. And what Minister Hutton was saying is actually of interest to our experience. The two systems are in competition. They have the same benefit package, but there are much bigger copayments in the private system. The

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private system uses all forms of incentives, for example, larger copayments, deductibles or the reimbursement rather than direct pay. Nevertheless, for the last 10 years there was not a single year in which the costs in the private system have not risen more quickly than in the public system. So from the German experience we have no evidence whatsoever that more copayments and more financial responsibility better feeling what's clear it really is costing produces any worthwhile cost containment or improvement in quality of care.

**JOHN IGLEHART:** Professor Anderson. And please, as you ask your question identify yourself so the panelists know from whence you come.

**JERRY ANDERSON:** I'm Jerry Anderson, Johns Hopkins University in Baltimore, Maryland. And my question is, what incentives do you give to specialists to engage in care coordination? Somebody who has multiple chronic conditions is going to be seeing multiple specialists, maybe going to the E.R., maybe having home health and a whole variety of other sets of activities. Why should the specialist want to participate with the primary care physician whoever is doing the care coordination function? What financial incentives? What non-financial incentives are there in your countries for the specialist to want to play?

**HON ANNETTE KING:** I can't directly relate our system to what you're saying, in that most of our specialists or our

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patients actually specialist service in the public system although they can receive some services in the private system. Most New Zealanders receive the specialist services in the public system.

**JERRY ANDERSON:** Let me explain my question. By specialist, what I meant was an endocrinologist, a nephrologist, an oncologist, whatever; they're going to need a number of different physicians involved in their care. And getting them all to work together is what I mean by care coordination here.

**HON ANNETTE KING:** Right. Well I don't have a quick answer on that. I think it's a problem. I think coordination of care is a difficulty. I think we are inclined to have our specialists working in what we call "silos", which has different incentives in terms of where funding goes, where the priorities are, and I think that that is quite a difficult issue to get coordination of care around a patient centered approach. And I know in some areas that can work quite well and others it's not well developed. And I'd be interested in the ideas that people have how you can make that work more smoothly. I can see better coordination occurring between the primary sector in New Zealand and a specialty, but you're talking about relationships between specialists themselves and probably some of that I imagine can be helped through strong information technology within a hospital system of specialists

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for example. Being able to transfer that information easily between the practitioners must be a help. But no, I don't have an answer for that.

**JOHN IGLEHART:** Dr. Ruehaus, and then we'll turn to.

**DR RUEHAUS:** I'm a bit puzzled by the question because in our country we are seeing things differently. I wouldn't ask what to do to incentive specialists to coordinate care, but what to do to incentivate the general practitioner to coordinate the care. And that has to do again with the comment of Julian Le Grande, what we are trying to do is increase the status of general practitioners so they can coordinate the care in a wider way and spectrum rather than have the endocrinologists who take care of the diabetic patient or the cardiologist of the hypertensive patient. We are trying now in a couple of states of Mexico a new system design where the GPs have that role and we are putting the money on them so that they can actually transfer the patients where they think it's appropriate for the patient to have a more comprehensive care.

**MALE SPEAKER:** I agree entirely with Enrique. I think the question is which end of the patient navigating through the system do you look at and I think the key question is whether or not the advocate for the patient, the mechanism, the responsibility of coordinating the patient's need is nested in the primary care function or elsewhere in the system. If it's nested in the primary care function it may not be perfect. I

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think there are challenges to that seamless provision of care for the patient. But I think more effectively that's where it needs to start with the available tools of the electronic health record and so on available to that primary care organization.

**JOHN HUTTON, MP:** I think this is a very, very important issue actually because I said earlier that of course any health care system, whoever is paying for the health care the incentives have to be right across the piece. I think in the sense that as I understand your question, this relates Professor more to some of the organizational structures that we've all created, and we are very good at creating boundaries in between primary and secondary, for example. And that therefore raises the issue about well, okay, if you've got a group of specialists working in the secondary care sector who clearly have an interest in doing more hospital based medicine and so on, and a group of physicians and maybe health policy commissioners who would rather those patients weren't necessarily always treated in a hospital if there's a more appropriate and more effective and usually cheaper health care, so delivery system for them outside the hospital. How those two bits of the system, how are they going to work together to provide a seamless and patient centered sort of experience? Well I think one of the things that we are interested in looking at in the UK, I wouldn't pretend that we've got all the

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answers to this, I'm very interested in how I can shift some of that activity out of the hospital setting into a primary care setting. And where the financing of the care package and providing a more streamlined patient sort of pathway, if we can do it more efficiently the savings, the profit can be shared between the secondary and the primary care sector. Now I think we should look at those kinds of models. We're very good at setting boundaries between various component parts of the health care system. Most of those actually don't help the patient at all. They've been designed for sort of provider convenience, not for best care for the patient. I think we should shake that tree. I think we should look very critically at who does what and where. And I don't think it's a simple case of simply saying that the care can then simply be delivered by GPs. I don't think the GPs would argue that either. The specialists that you've referred to I would like to see in the UK working alongside GPs in partnership models and practice models and so on. I think that's the way to tackle this problem. The patient generally doesn't like the organizational divide. The beauty about the National Health Service is that we are probably, better place to change some of those structures than in other countries where there's multipayers, a different system where if you like a national sort of core and heart, beating heart to the service, but I think it's a very, very important issue and in most health care

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systems that I've looked at, most of the incentives draw patients into the hospital sector. Well we've got to challenge that. We've got to do it in a realistic way where the specialist in the hospital doesn't say, hang on, I don't want to do that because that's my income being challenged. We've got to think creatively about that.

**JOHN IGLEHART:** Let me turn to, Sir, do you have a comment?

**MALE SPEAKER:** As Ted Mamer from Yale mentioned, if you have a message to a doctor write it on a check. So in Germany, too much specialists get too much money. So we tried to change the fee schedule. Give more money for communication, for cooperation, for coordination. We tried to convince the specialists to come in to the disease management programs, define a new role for them in these programs. And mainly the specialists are the founder of new networks. They are younger. They are more flexible than most of the family doctors in our system. We have some good examples for organized coordination between family doctors and specialists, especially with the cardiologists, but a lot of bad examples.

**JOHN IGLEHART:** Sir Liam Donaldson.

**SIR LIAM DONALDSON:** Thank you, John. I'm the Chief Medical Officer in the Department of Health in the United Kingdom. And my question is about what sort of primary care system we need in the future. And I've got 3 brief observations

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to make before I pose my question. The first one is that health care in developed countries is dominated by the needs of older people. And in Julian's metaphor if primary care has the status of Cinderella, then care of the elderly is the pumpkin. Really it isn't something that people aspire to and yet the skills that are needed are predominantly in hospital and in primary care the skills in caring for older people. The second point is that most health care systems in the world would collapse without the input of families and caregivers because they are providing particularly for older people a big element of the care that's needed and the support that's needed to enable them to remain independent living rather than admitted to hospitals and nursing homes. And thirdly, some of the most passionate doctors I've heard talking about quality since I've been in post in the last 6 years, burning passion have been doctors talking about the care of their older parents and the concerns they have about it. So my view would be that primary care of the future. We've been talking very, very much about the medical aspects or the integration of primary and hospital care and so on. Essentially I think we need to look at it needs based. And if you look at it needs based, then the problems that you're confronted with trying to solve are about coordination of care, how to engage informed partnerships with families and caregivers. How to provide people with roadmaps to access services, which aren't just about specialist

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interventions, but are about that range from benefit support to rehabilitation to choices on long term care options. So my question would be, is that vision of primary care, which is much more an integrated medical and social model of primary care what people think we need for the future? Or am I wrong?

**JOHN IGLEHART:** Dr. Horvath?

**JOHN HORVATH, MD:** I think you're absolutely right, Liam, except I would put a further layer over it that the elderly certainly in the Australian context, not only expect to be elderly, but elderly healthy and robust. And I think that the chronic diseases we are talking about are cancer, chronic depression, and cardiovascular disease. They're all common in that group. So as well as all the problems that you pose, which I agree with you entirely and need to be dealt with, those other diseases in that group will need to be managed also. So it is a very complex situation we're looking at.

**HON ANNETTE KING:** I'd agree with you Liam. I think that it isn't a [Inaudible], but I'd add something to it. And that is, that we need to be planning for it right now. And we've put together what we call "Ageing in Place" strategy in New Zealand because we recognize that this is a challenge in the future and that the planning for such an integrated approach has to start now because all us baby boomers are going to be just as John said, we're very demanding, we're going to live longer, we know what we want, and we're going to advocate for it, so it's no

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good us waiting until it hits us and then say, now what are we going to do about it? And I'd add one other thing, I think that as already has been pointed out, chronic diseases are the problems in the mind for elderly people and prevention, prevention, prevention has to be part of our mantra, I think. If we look at New Zealanders and one of our big problems is the growing number of older people with diabetes and the subsequent problems from that, trying to get ahead of that has to be part of what we're doing. We just would not be able to afford to wait until we have to give high-level intervention at high cost. So part of that planning for aging in place has to be that mantra of prevention.

**JOHN HUTTON, MP:** I usually get to ask Liam the questions, actually. It's the first time I think he's asked me one and it's a hell of a question. I think in the UK, we are going down that path. This is a conscious decision that we've made to integrate not just primary and secondary, but health and social care as important components in improving the quality of the service we provide to our patients in the public. I think in relation to care, which I think is a very important package, a very important element of the service. What I think would be a huge mistake would it be as it were to try and nationalize or take into sort of the public domain the service that family members provide to their loved ones. This is a civic thing. This is a very important social function that

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is being discharged by people in the family setting. I think it's not the job of the state as it were to supplant that role. It's the job, I would say, of government to support that role. I think in relation to primary care it's very important that family doctors actually see the career as part of the equation. And I think that we've all got I would say more work to do on that as well. Because if their informal care package collapses then usually the cost to the public purse will be very, very significant indeed. So we've got to do more on that side. And I think particularly in relation to the integration of health and social care. In the UK we've tried to cut through some of the boundaries that separate health and social care. Health is a central government function in the UK, to which I and my boss are accountable. The social care component is a local authority responsibility to which I am not responsible. But again, it comes back to what the professor from John Hopkins was asking earlier about incentives. These sort of organizational separations between health and social care structures I think really must never be allowed to get in the way of the overall objective in the policy, which is an integrated approach. Orthopedic surgery I think Liam is absolutely right. He always is about these things. And I think in the UK certainly at least we're very clear that his vision of more integration, within the health care sector, but across and outside that into other areas of public service is a very, very important direction for

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primary care.

**JOHN IGLEHART:** Jonathan Lomus?

**JONATHAN LOMUS:** Thank you. Jonathan Lomus from the Canadian Health Services Research Foundation. Before Sir John Aldam left he gave me a task to make one comment to people, so I am merely his inaudible here. Which was to point out that it's not enough to just tell people to change, but you should also support them in that change. And that may well relate to the nature of the question I have which is really directed at the three countries that have had a concerted primary care reform agenda for a number of years, Germany, New Zealand, and the UK. I think that one of the things that we know about the health care system that it's second only to the university sector in being intransigent and resistant to change. And as such I think that might explain why we have a lot of people saying they're very interested in change management in the health care system. With that in mind, I wonder if for those 3 countries, Germany, New Zealand, and UK, what would you point to as being your most successful change that you have achieved in primary care over your concerted campaigns? And I'll leave you to define success in whatever terms you wish to define it. And just reflect a little bit on why that was a successful change in that area. What were the circumstances and conditions surrounding it?

**JOHN IGLEHART:** We'll begin with Mr. Knieps.

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**DIR GEN FRANZ KNIEPS:** It's not easy to answer this question because the only success we had was to stop the declining of the primary health care system and that for us it was a success because we foresaw the process was going on and on, and under the circumstances [Inaudible] described it was a horrible vision for our system to have no primary doctors anymore in 20 or 30 years. And we could see how it happens in the former East Germany and the former GDR because the family doctors are elder than the specialists and the younger ones go to the West because they don't want to live in such surroundings in the rural areas with the unemployment rate of 20% and more, with right wing parties growing faster than the democratic parties and so on. So I can't report on success, I just can report that it becomes more attractive for family doctors. They are paid well, paid better than they were paid in the past. In 1990 we had only 3 chairs in general medicine. Now we have 37, but we have still obstacles. For example, a chair holder is not allowed to treat patients, because he is civil servant so he works in the university, he's employed, and employees are not allowed to treat patients in our patient care. So we have to do a lot of simple, but very sophisticated work, step by step. Very small steps to preserve family care system and to build a new system, to build new networks.

**HON ANNETTED KING:** I think probably the most encouraging thing with changes has been the acceptance by the

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health sector of the need to change what we were doing and the acceptance of the primary health care strategy, which we put out as a high level document that said this is what we want to do. It's going to take us 10 years to do it. This is our blueprint for change, and I think the success has been the buy in to that change process by doctors, nurses, pharmacists, you name them in terms of the health professionals, but also researchers and academics and others. So I think that there is the thing that I'd point to most. The arguments however from then on have been about the detail of implementation. Who should get the money first? Should it be based on socioeconomic status? Illness? Should it be individuals and so on? So really the argument, since acceptance of the strategy has been around detail, and I think in many ways that's easier to argue than getting acceptance in the first place to make a change in what you're doing.

**JOHN IGLEHART:** Minister Hutton.

**JOHN HUTTON, MP:** I think the most important advances we've made in primary care have been those that doctors themselves have engineered, rather than the changes that have been required as it were from the center. And John Alder, as many of you will know, has led the primary care collaborative approach to spreading best practice in England. And it's had a number of very significant changes. And I hope because it's been more bottoms up than top down, I have every confidence in

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believing that those changes will be sustainable. I think there are 2 particular areas where I think we've seen clear signs in the UK of progress and advance in primary care. One is the issue about access. I don't think it was necessarily fully reflected in the survey, but John has led work for us with GP practices and improving access to primary care physicians. We want everyone in the UK if they need to, to be able to see a doctor within 48 hours. A lot of people said it was impossible, it couldn't be done, there's just no way that could be structured. Well the GPs have pretty well done that and they've done it themselves working together, looking at the way they schedule appointments and organize their diaries and so on. That has been a very, very significant organizational achievement. And I know there will be some physicians here that will say, look, why is that an important clinical issue? Aren't there more important priorities for you in primary care? Well if we can just all suspend maybe our professionalism here and approach this as patients. When you want to see a doctor you can't. That's the major quality issue for you. It will sort of perpetuate doubt, uncertainty, anxiety. None of those are good things for patients to experience. I think here, rather than look at it simply as a professional issue, I think we should just take this as an issue where we do need to respond to what patients are saying to us in the public and they want to see their doctors and they want to see them as quickly as possible.

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That, for me, actually is quite an important clinical issue. I think the other area that we have seen progress, and I think, I hope we'll see more of this is the work that John has been leading around the management of some chronic disease and illness in primary care, which the new contracts, I hope, will support and sustain. But there is I think growing evidence certainly practice focus on managing chronic disease and primary care. And that is something that John has led for us and done a brilliant job.

**JOHN IGLEHART:** Steve Schonwell?

**STEVE SCHONWELL:** Steve Schonwell of the Commonwealth Fund. I have a somewhat more general question and it builds off the fact that there's been relatively little quantitative data about performance either within or between countries. We've seen some very nice survey information this morning. The countries represented on this panel have done some really impressive work on developing quality indicators between them and that work is now extending throughout the OECD. What I wanted to ask you is to be sort of futurists around the quantitative aspects of care either within or between countries. And to give some projection of what you think are the most important quantitative parameters to be tracked within your countries and across countries, and the degree if you will to which you're likely to see improvement in those over let's say the next 10 or 15 years. In a sense, or would like to see

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improvement. What goals you'd really like to see met quantitatively in improvement of these various systems?

**MALE SPEAKER:** I'll go first and perhaps use that to be the briefest. I'd like to hope that there isn't too big a gulf between what we need to do in the future and what we've started to do now, because I think in the development of information and the development of comparable indicators so that across jurisdictions, within Canada in our case, but internationally as well we can be speaking the same language and comparing things appropriately. We have conceptualized three categories of indicators. Health status, and I think that helps us to know over time whether the nature and the kind and the quantity of expenditure in health care is actually improving the health status, and it allows us to deal with the issues of disparities of health status among subpopulations. Health outcomes, so that we can increasingly assess with intelligence and on a consistent basis the impact of the interventions that we are making within health care. And health system performance. And health system performance, of course, is huge and has a number of dimensions. Quality access, equity and so on. If we think of those things over time. I think it's a fairly robust framework for making policy decisions, for addressing quality issues, and preserving the kinds of values that John Hutton referred to earlier and maintaining the confidence of our public in the

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systems that we have.

**JOHN HUTTON, MP:** Steve, as I understood your question, you were talking about quantitative measurement. To be honest, I'm much more interested in qualitative measurement of performance in primary care, and of course the health care system as a whole. We spend most of our time measuring things precisely from that perspective. We measure quantity all the time. I count the number of paper clips. I count the number of manilla folders and CD roms and everything. I can measure everything in the service pretty comprehensively. What we're not so good at is measuring the quality of the care and that's where I think we've got to focus. I think in relation to quantitative measures, however, I think one of the most important issues for us and I suspect maybe for my colleagues is how we measure productivity in health care systems. This is a very significant challenge, because certainly in the UK we have no measurement of productivity that currently allows us to say anything sensible at all about quality or about access to health care. We've reduced waiting times for secondary care treatment significantly, but that doesn't show up on my productivity measurement at all. I've got more surgeons. I've got more family doctors. I'm spending more on the staffing of my health care system. That usually for most of us means that our productivity declines, not gets better. And how useless

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is that as a measurement? When I've got the job, and my colleagues have, of justifying the expenditure. It's a real problem for us. So I'm very interested in work that is being done around the world and I'm sure in other countries represented here on how all of us can get a better handle on saying something sensible to those who fund our health care systems, in the case of the UK our taxpayers about the productivity that this extra investment is introducing. And I've yet to see any work that properly factors into those sorts of measurements. The things that often really matter for patients, how long they wait and so on. But I think in terms of quantitative measurements, we're pretty well tooled up on that in the NHS. I think where we need to do more is on the qualitative side.

**HON ANNETTE KING:** Thank you, John. I think if I was to identify three areas, I'd say improved access to primary health care by the population of New Zealand that does not access regularly their primary health care. I'd like to see improved health status for all New Zealanders, but particularly for our Maori and Pacific Island people. And thirdly, I'd like to see a better informed population to be able to self manage chronic disease.

**DIR GEN FRANZ KNIEPS:** It's not easy to say, but Germany is a developing country handling such problems. We have a lack of real data. And if we have data, they are all input oriented

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and not output oriented. And if we have data, we don't use it for day to day practice to formulate goals, for example, and to measure whether the goals are fulfilled or not. So my vision and my scenario would be to develop indicators, to develop parameters only a few ones, and then to use it for political decisions and for practical work in a day-to-day business. But I'm not sure that I will be in office or in another position when such a vision will take part and will come in.

**FEMALE SPEAKER:** I would agree with a number of sentiments just expressed, particularly the first that said we've pretty much outlined a number of good indicators. I don't think we're actually suffering from a measurement deficit. I think where we have challenges, frankly, is closing the gap between the kind of care that we could be providing at a very high level and what's actually happening as your chart books have shown from the Commonwealth Foundation, our quality report has shown and Beth McKlin's study and so forth. If there are 2 measurement challenges I think that persist, one is how do you present this information in terms to the public that's meaningful to inform choices? Right now we give the public a lot of very clinically detailed information and in some ways there's actually a push to make it even more detailed. Whether that's meaningful or at what level we should aggregate I think is clearly issues we're struggling with in our National Quality Report and would certainly welcome insights from others as we

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move forward. I would also echo what Minister King mentioned about trying to assess how activated and informed patients are. I mean every model or sort of idealized construct of how we could improve chronic illness care includes a very strong emphasis on patient self-management activated, informed patients. We have a number of studies that suggest that those patients have better outcomes. The question is, how do you actually know when a patient has achieved that? And which patients need the most assistance in achieving that kind of readiness if you will. I don't think it's about knowledge. A number of studies, notably Kate Loreg and others, have I think really cast very strong skepticism that this is about knowledge, even though that tends to be how we educate people. If you knew as much about your illness as I know then you would be activated and informed. I think it's much more about self-efficacy and I think we have a lot to learn there.

**JOHN IGLEHART:** Well, the hour of noon has arrived and so we have run out of time. I want to thank the panelists particularly for their candor in responding to these various questions. I'll turn it back to Robin Osborne for any announcements or logistics here. Robin.

**ROBIN OSBORNE:** Great. Thanks very much. I'd like to add my thanks to our panel, our Ministers panel, and to John Iglehart for his directing this session. And to all our participants as well for your comments and insights. It's been

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a very rich and very productive morning that I think has covered the waterfront on issues in primary care. And it will certainly provide a frame of reference for all of the sessions and discussions that follow. In terms of logistics, we now move back to the St. Regis Hotel and we have a bus waiting outside. For those who prefer to walk, just ask someone to point you in the direction of 16<sup>th</sup> and Kay. That should more or less get you there. The afternoon is broken up into 3 sessions in the Crystal ballroom, which will be the first panel "Redesigning Primary Health Care Systems for Quality, Access and Health Promotion." In the Chandelier room we have "Electronic Medical Records in Primary Care: Going to scale, connectivity, access and quality improvement." And in the Potomac room we have "Primary Care Quality Improvement Case Studies on Innovations, Impact, and Sustainability." Lunch will be served in each of the separate breakout rooms beginning at 12:30 and then the panels themselves will begin at 1:00. So we look forward to seeing you then and to a very exciting and interesting afternoon. Thank you.

[END RECORDING]

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