

**Roundtable/Briefing & Studio Taping: Presentation of the
2004 International Health Policy Survey of the Public's Views
of Primary Care in Five Countries
October 28, 2004**

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KAREN DAVI: Good morning. I'm Karen Davis, President of the Commonwealth Fund. I'm delighted to welcome you here today and to thank you for joining us for the Commonwealth Fund's 7th International Symposium on Healthcare Policy. We are particularly grateful to the Kaiser Family Foundation for making this lovely facility available, as well as its superb technology and we're web broadcasting this morning's session, so that the discussion can reach a broad international audience.

We are joined here in the room and over the network by reporters from the US and from other nations. Those of you who are joining us through the Internet, you may submit questions to our experts today by sending them by e-mail to webcast@cmwf.org. Today's broadcast will also be archived in the kaisernet.org later on today. Study documents that are being discussed here today are available on the Commonwealth Fund website at cmwf.org.

This annual event brings together health ministers, senior government officials and leading international policy experts to share strategies and spark creative policy-thinking in response to pressing healthcare issues that are common across our healthcare systems.

As US Secretary Tommy Thompson said at our opening event last evening, "Great medicine is the hallmark of a

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compassionate society." The Commonwealth Fund, since 1918, has supported independent research on health and social policy issues, recognizing that many of the issues of greatest concern to the Commonwealth Fund, including improving the quality of care and access to care, are matters of concern to other industrialized countries, the fund established an international program in health policy and practice directed by Dr. Robin Osbourne.

The program is premised today on the belief that while all systems are influenced by their individual histories, the cultures in which they operate and the manner in which physicians and other healthcare providers are educated and patients accommodated, there are lessons that can be drawn when policymakers, researchers and journalists look beyond their own borders at the experience of other countries.

Pleased to be joined today by Dr. Uva Rinehart, Professor of Political Economy at Princeton University and Internationally recognized health economist, who chairs the International Coordinating Committee that planned today's symposium.

This year we're joined at our symposium by Ministers and Secretaries of Health and senior government officials from Australia, Canada, New Zealand, the United Kingdom and the US, which form the core countries of the Fund's international program, as well as officials and experts from Mexico, The

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Netherlands, Germany and Sweden.

We are particularly pleased to have the strong endorsement of our board of directors for moving forward with our international work and for expanding the program to learn more about experiences from all of the countries who are joining us here today. I am particularly delighted that John Iglehart, who is the founding editor of Health Affairs, is also a partner with this symposium. He will moderate our opening panel, at which we will be pleased to present the findings from the Commonwealth Fund 2004 International Health Policy Survey on Primary Care in five Countries. They are being released simultaneously this morning in a Health Affairs web-exclusive article.

The theme of the Fund's annual international survey and the symposium itself change from year to year. But we try to address a broad range of issues integral to healthcare system performance. We chose primary care as our focus this year because it stands at the center of medical care systems, providing an entry point, delivering core medical and preventative care and helping patients coordinate and integrate care.

When it works well, each of these dimensions is instrumental in improving health outcomes and cost performance. Primary care also has the potential to reduce disparities in care and to give people the opportunity to live healthy,

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productive lives. We all share the challenge, all of us who are participating in this symposium, at how to make primary care more accessible, continuous, coordinated and most importantly, patient-centered.

I think the survey findings that you will hear today provide important, comparative data on primary care systems that suggest there are missed opportunities, errors and gaps. But there are also opportunities for countries who are performing well and offer a unique opportunity for cross-national learning.

I'll now turn the program over to John Iglehart. But just one note since we are web-broadcasting this session, I do ask that you press your buttons when you speak on your microphone, and then remember to turn them off when you're finished. With that, John Iglehart.

JOHN IGLEHART: Thank you Karen and good morning ladies and gentlemen. Let me add my thanks to the Kaiser Family Foundation for providing us access to this state-of-the-art venue. I'd also like to remind our audiences that are joining us on the web, as Karen said, that you are welcome and indeed encouraged to submit questions to the presenters at the website, webcast@cmwf.org. Also, I would remind you that there will be a transcript of this session archived and will be available later today, I believe, on the kaisernetwork site. And that additional background material, as Karen said, will

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also be available on the Commonwealth Fund website, which again is www.cmwf.org.

Before we begin, I would like to introduce our distinguished guests, who are leading officials in their own countries. And I'll begin on my left and introduce Dr. Carolyn Clancy, who is the Administrator of the US Agency for Healthcare Research and Quality. Next is Franz Knieps, the Director-General of the Ministry of Health and Social Security of Germany. Third, to my immediate left, is the Honorable Annette King, who is the Health Minister in New Zealand. Following that, is the Honorable John Hutton, a member of Parliament and Minister of State for Health in the United Kingdom. Following that, to his right, is Ian Schugart [misspelled?], Assistant Deputy Minister in Canada at the Ministry of Health. And next is Dr. John Horvath, who is the Chief Medical Officer of the Department of Health in Australia. And the last, but certainly not the least, of our panelists on the right of me is Dr. Enrique Ruelas, who is the under Secretary of Health in Mexico.

With that, I would like to introduce our two presenters, both of whom are Vice Presidents at the Commonwealth Fund. The first of the two will be Cathy Schoen. She will open with comments about the public's views of primary care in five countries, as they have studied and analyzed it and following Cathy's presentation, Robin Osbourne will

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conclude with the formal presentation. And then we will move on to a reactor. Dr. Andrew Bindman of the University of California, San Francisco. And following that, we will have the reactions of the ministers. With that, Dr. Schoen.

CATHY SCHOEN: Thank you John. I'm delighted to join you this morning to present the results of the 2004 Commonwealth Fund International Health Policy Survey. Conducted by Harris Interactive and country affiliates from March through May 2004, the survey provides a very current comparative view of country primary care performance from the perspective of patients.

Robin and I will share the presentation of findings this morning, but we would also like to thank our co-authors at Harris Interactive and the Fund and to give a particular thanks to Humphrey Taylor, the Chairman of the Harris pole who is sitting here in front of me, for his both being an inspiration and a real pioneer in international surveys.

The study findings, as John and Karen indicated, were published this morning in Health Affairs. They draw from a random sample of fourteen hundred adults in each of the five countries. There was also an over-sample in the United Kingdom to allow further analysis - future analysis - by countries that comprise the United Kingdom.

In each country, this was a random representative telephone sample. As Karen mentioned, primary care is

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instrumental to country performance and helps patients integrate across complex or multiple sites of care. The survey findings that we will present indicate there are shortfalls, both in accessibility, coordination, safety and patient-centered care in all countries, but also notable country variations.

We began the survey this year, as we have in the past six years, where we've done three general population surveys with a contact setting question on overall system views - how well does the public think their healthcare system is working? This year, as it has for the past six years, each of the three surveys, the United States adults are the most dissatisfied. Dissatisfaction rates are up since 2001, returning to levels we saw in 1998.

At the other end of the spectrum, the United Kingdom are the most satisfied, the least likely to call for rebuilding their system, the most likely to say the system works basically well, a pattern that has persisted over six years, but has grown more positive since 2001. Views have also grown markedly and steadily more positive in Canada and New Zealand, with a market decline and the votes to rebuild the system. Australia's views have fluctuated over the six years. I might note, however, that in no country is the majority of patients, or adults, satisfied. Most indicate there's a need for substantial reform.

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Turning to access and primary care - in all five countries, the vast majority of patients say they have a usual doctor or a place they see as their usual source of care. However, the US is an outlier compared to the other four countries in the longevity of these relationships. In the US, only a third of patients had been with their doctor five years or more, where it's the majority of patients in the other four countries who have had long-term relationships.

We also found very marked differences on access to care when needed, as measured by how quickly patients can get an appointment with a doctor when they're sick. Australia and New Zealand stand out, with half or more saying they were able to get an appointment on the same day the last time they were sick. At the other end of the spectrum, the United States and Canada were the least likely to get rapid access and also the most likely to say they waited six days or more. This long waiting time is up in Canada and the United States compared to 2001.

In all five countries, adults tell us that they have difficulty getting care after hours, at nights or on weekends. With half or more in Australia, Canada and the United States saying this is a problem - difficulty is a problem. But even in the best of the countries, New Zealand, a third said after hours care is difficult. Some countries, notably the United Kingdom, had put in place a help line that's available at all

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times of the day and the week to call for advice and consultation. Canadians also have these in some provinces and the US has them in some health plans. We found when asked about any use of a help line in the last two years, rates were highest in Canada and the United Kingdom.

Costs affect access and here we see quite stark country differences that reflect the insurance systems and comprehensiveness of benefit packages, particularly coverage of physicians and pharmacy care benefits. The US stands out as the most exposed - patients as the most exposed to medical bills when seeking care, with a quarter more of all US adults saying they spent more than a thousand dollars on medical bills, out of pocket medical bills, in the past year.

On the other end of the spectrum, the UK stands out at the most protected, with the majority of patients saying they had no out of pocket cost. New Zealand and Australia are relatively more exposed than Canada, which is also quite protective in its benefit structure.

We found when asked about how costs affect access, that cost is an access barrier, particularly in the United States, where two out of five adults said they had either not seen a doctor when sick, not filled a prescription, skipped medications or not done followup care - gotten their diagnostic care that was recommended because of cost. Rates were highest in the US on each of these three indicators. Going without

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care due to cost was also high in New Zealand, particularly for doctors and medication. Canadians and the United Kingdom, again, were most protected.

In all five countries, adults with incomes that are below average were most effected by out of pocket cost. Again, in the United States, low-income adults were most at risk, with nearly sixty percent saying they'd gone without care in the past year. This reflects very high rates uninsured in the United States, as well as cost sharing within insurance plans. But I might point out that in all countries, low-income populations were more likely to go without care if faced with cost than higher income.

We asked several general questions about care and choice and access experiences, particularly choice, since this is a policy issue in all five countries. These countries are quite different in the way they're structured and people are assigned or choose their physicians, yet we find very similar patterns when asked about satisfaction with the amount of choice in seeing a doctor. In no country is more than a minority dissatisfied with choice, but is in no country a majority satisfied.

Asked about quality of care information, interested in quality of care information when seeking a new physician, we find that the US has this most on their radar screen when seeking a doctor and high expression of interest in quality of

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information. This is also high in Canada. However, it's not as much on the radar screen of the public in the other three countries, at least not yet.

In all five countries, patients expressed extraordinary interest in access to their medical records. Those who do not currently have access, the majority in every country - a significant majority - said they would like to have access to medical records. In contrast, there was interest, but to a lesser degree, about access to doctors through e-mail. Among those who don't currently have such access, there is a group that would like access, but it is not the majority - at least not yet.

Turning to emergency rooms - we included emergency rooms in the survey of primary care because they are our basic support system, both for adults in need of crisis care, but also as the backup system for primary care doctors. We found significant rate differences across the country in how often adults had gone to an emergency room in the past two years and whether they'd gone at all. The United States and Canada were significantly more likely to have gone to the emergency room. They were also more likely to have had multiple visits to the emergency room than the other three countries.

Asked about when they went to the emergency room if they could have been seen by their own doctor if available - were they there for care that could have been provided in the

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community? The US and Canada also stand out on this measure as the most likely to say they went to the emergency room because they didn't have access in the community. I might point out that these were the same two countries least likely to have same-day access to their doctors. So we are finding a strong access measure here.

In the emergency room, waiting times were very variable within countries and across countries. Starting from a high of almost half of Canadians saying they waited at least two hours or more to be seen in the emergency room, with much lower rates in the other countries. But waiting times were often long across the countries, indicating variation by emergency room and by adult's experiences.

Asked about pain management within the emergency room, two countries, Australia and the United Kingdom, had at least half of adults saying the emergency room staff did everything they could to control pain. These rates were much lower in the other countries, again, a strong country difference.

Overall, we find the quality of emergency rooms could be much improved. We have strong minorities in every country rating emergency care as fair or poor, with rates of negative ratings highest in the United States.

And now I'd like to turn to Robin Osbourne, who will pick up on doctor/patient experiences. Thank you Robin.

ROBIN OSBOURNE: Thank you Cathy. The next part of the

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survey shift from access and emergency care to the doctor/patient relationship and communication. When it comes to doctor/patient communication, the findings are mixed.

On two important questions and measures of patient-centered care, doctor listens carefully to you and doctor always explains things so that you can understand, doctors in all countries received high marks, with six in ten or more saying that their doctor always does. A majority in all countries also reported that their doctor, except the United States - a little bit less - also reported that their doctor always spends enough time with them.

In terms of country variation, the pattern is consistent with our earlier surveys, Australia and New Zealand doctors getting the highest ratings on measures of patient-centered care; the US doctors receiving the lowest.

Doctors in all countries however, missed opportunities to engage patients in care by not giving patients clear instructions about what they need to know, what to do, what symptoms to look for, not making clear the specific goals and plans for treatment. What stands out as the most serious failure though, is the number of doctors who don't involve patients in decision making. One-third or more in Australia, Canada, New Zealand, one-half in the UK and the US, said their doctors did not tell them about treatment choices and did not ask for their opinions.

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A substantial proportion in each country also left their doctor's offices sometime in the past two years without getting important questions answered. The US shows the greatest deficiency, with one in four not getting questions answered, as compared to one in eight in the UK.

We asked if there was a time in the past two years when patients didn't follow their doctor's advice or treatment plan. Again, the US did most poorly on this measure, with thirty-one percent saying they didn't follow doctor's advice, as compared to fourteen percent in the UK. Specifically, what kinds of advice didn't they follow? Prescription drugs was the front runner, with one-half of those in the UK and New Zealand and about a third in Australia, Canada, the US not taking medicines as prescribed. The second most cited are of non-adherence was not surprisingly advice about lifestyle changes.

We know the health and economic consequences of not making the lifestyle changes, but it's worth noting that non-adherence to medications is also costly, with about five percent of hospital admissions attributed to drug non-compliance or inappropriate use. The number one reason for non-adherence was that patients disagreed with the doctor's recommendations or didn't want to follow them. Patients were also pretty consistent across countries in saying they didn't follow advice because it was too hard to do. Costs were a further obstacle in the US and New Zealand, particularly when

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we broke out the data by income. Not surprisingly, non-adherence was higher for patients who had left their doctors' offices without getting important questions answered.

As in our 2002 survey of sicker adults, we saw problems with coordination of care, a core function of any primary care system. Test results or medical records were not always available at the time of an appointment, doctors had to order duplicate tests, patients received conflicting information from different doctors. One in four experienced at least some kind of coordination of care problem.

Prescription drugs appear as a recurrent theme in this survey in terms of access, adherence issues and here shortfalls in doctor/patient communication and coordination of care. Across countries, forty percent or more reported that their regular doctor had not, in the past two years, reviewed all of the medications that they were taking, including those prescribed by other providers or neglected to explain side effects of prescription medications. This raises concerns both for the potential for medical errors and also for adherence issues. The UK stands out at having the greatest problem in this area.

We also saw coordination and communication problems around diagnostic tests. One in five adults in all countries, except Australia, reported that they were not told the results of their lab or x-ray tests or the results were not clearly

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explained to them - a missed opportunity for engaging patients in their own care.

A striking finding and a surprise to us was the number of adults who reported receiving incorrect test results or delay in being told about abnormal test results. It's highest in the US, where it was one in six. While most of the emphasis on medical errors has been around prescription drugs, I think this finding points to other system failures that may have serious consequences.

In terms of coordination of care, the lack of effective links between different sites of care undermine coordination and continuity of care in all countries and the delivery of what would be considered high-quality primary care. It was not uncommon for patients who had been hospitalized or who had been to the emergency room to say that their regular doctor was not informed about the treatment that they had received or the followup plans.

We heard a lot from Secretary Thompson last night about the importance of reorienting our healthcare systems to preventive care. His comments are reinforced by the striking deficiencies that we see in the survey in the area of preventative care. Given that ninety percent of those surveyed have a regular doctor or regular plan [inaudible] of care, more than eighty percent of those surveyed had at least one doctor visit in the last year. It's apparent from the shortfalls that

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we're seeing that preventative care is not being routinely incorporated into the primary care visits that we know are happening. These shortfalls are clearly missed opportunities.

For example, one-half [inaudible] or more of doctors hadn't sent their patients reminders about preventative care. One-half of those surveyed in the US, to almost three-fourths in the UK reported that their doctors did not, in the past [inaudible] screened effectively by asking just a few simple questions.

In this survey, fifty percent of those responding across countries reported having had at least one chronic illness. Yet more than one in three across countries - one in two in the UK - said that their doctor had not given them a plan for self-management of their condition at home. Based on a large body of evidence of managing chronic illness, we know that self-management is a critical component of the successful models, again suggesting here an important missed opportunity in primary healthcare for health promotion.

The point about missed opportunities is further underscored by some common measures of preventative care that we asked about. The US stands out for doing the best job on clinical preventative measures in this survey, but I think the message is that in all countries, a substantial number of adults are not getting the preventative care that's recommended in their country's treatment guidelines.

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As a side note, I would just mention that in looking at the findings, we tried to tease out the extent to which the US uninsured - in this survey, twenty-six percent were uninsured at some point during the year - were a factor in the US performance. To do that, we broke out the US findings and compared, for the under sixty-five populations of all five countries, the US uninsured with the other countries, effectively creating a level playing field.

Taking out the uninsured, the US performance did improve, but looking at, for example, same-day appointments, coordination of care problems, while the findings improved, the story didn't necessarily change for the US. The problems were still apparent, and the US ranking compared to other countries didn't actually change. Even on cost-related access, having insurance improved access, but for US adults, it didn't eliminate the financial barriers to care. This is not to minimize the access problems in disparities and care for low-income an uninsured, which are dramatic, but to confirm that the US primary care system has problems, even for those with insurance.

The policy implications - there are fundamental shortfalls in primary care in all countries on patient centeredness, access, safety, coordination and prevention. There are also country variations in primary care system performance, which suggests that differences in primary care

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infrastructure, the way primary care is organized, delivered and financed can result in better or worse outcomes.

Access is a good example, where countries provides more ready access to primary care, which we see in Australia and New Zealand - same day appointments, available when needed, better after hours coverage, which we saw in New Zealand and the UK. There's lower ER use and less demand placed on what we already know, from our physician and hospital chief executive surveys, are overburdened emergency services.

Where countries have less cost sharing, less out of pocket costs and most notably in the UK and Canada, patients have better access and are less likely to forego needed medical care, followup treatment and prescription drugs. While most of the focus on patient safety has been in the hospital setting, the primary care setting offers a unique set of challenges, particularly around medication errors and diagnostic tests, highlighting the need for IT systems that track patient's medications, draw doctor's attention to abnormal test results, have a mechanism to confirm the test results have been communicated to patients. And clearly, IT systems would help improve coordination between sites of care.

In all countries, there's work to be done to address the gaps in preventative care and to encourage primary care doctors to incorporate preventative care into routine visits. And centers to do this have been built into the formulas for

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New Zealand's primary care organizations, into the new UK GP contracts. In the US, we have also seen how the impact of heatus [misspelled?] measures introduced a decade ago, targeted at clinical preventive services, as well as national policies and targets, have likely contributed to high US screening rates.

But I think the encouraging news is that the shortfalls that are highlighted in this survey are amenable to policy action and we have a great opportunity. Over the course of this morning, we'll be hearing from ministers at their policy roundtable, and over the next two days, to learn about policies and initiatives the countries have undertaken to address these concerns, from innovative delivery models to provide 24/7 care and the use of incentives in primary care to change practice to the implementation of electronic medical records.

We also have the opportunity to use this survey as a baseline and to assess the impact of country initiatives and reforms over time and in subsequent [inaudible]. Thank you.

JOHN IGLEHART: Thank you Robin. We will now turn to the reaction of Dr. Andrew Bindman of the University of California, San Francisco. Dr. Bindman is a Professor of Medicine, Health Policy, Epidemiology and Biostatistics at the University. Dr. Bindman.

ANDREW BINDMAN: Thank you. Good morning. It's a real pleasure to be in a position to be able to address you this

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morning and to talk a little bit about this really wonderful survey. This survey will no doubt generate a very rich discussion throughout this conference and I think for the weeks and months ahead, as there is just a wealth of data and there to begin to understand some of the differences and similarities in the provision of ambulatory and primary care across out countries.

My task with you this morning is to really try to provide a framework or a perspective through which to look and begin to compare these data. As I said, they are very rich and I think there will be many really useful comments to come, but I want to try to provide some organizational framework for you to begin to think about some of the comparisons that were laid out before you.

What we have of course, through this survey, is information from the patient's perspective of primary care. And I think to begin to understand those perspectives, we should pause for a moment and talk a little bit about what primary care is and then to think a little bit about, in our comments ahead, whether primary care can contribute to the performance of a healthcare system and where does primary care fit in our ongoing attempts in each of our countries to redesign our healthcare systems for improvement.

Well, let's talk about what primary care is. Is it simply the activities of primary care doctors? To some extent

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I guess it is. But as this photograph implies, things have evolved. We don't just have primary care doctors walking around with black bags out in the countryside, there are basic functions that are imbedded within the primary care functions. These have been talked about in the survey, and I think it will be useful for us to try to bring these out more explicitly and to emphasize them.

Before doing that, I do want to provide some structure around what primary care, as a workforce, looks like in the countries that have been surveyed by the Commonwealth Fund. This chart - this table - shows the number and percentage of primary care doctors by country. And you can see there is quite a range. The top row is primary care doctors per one hundred thousand. In Australia, we have as high as a hundred and twelve per hundred thousand to the United Kingdom, which is the lowest of the countries, at sixty-eight per one hundred thousand. And the others falling in between.

Now also, in addition to the differences in absolute numbers of primary care physicians, there's quite a difference in terms of countries, in terms of their allocation or distribution of primary care doctors, so that the United States, for example, which was in sort of the mid-range at eighty-seven per one hundred thousand is actually different when you look at it as a percentage of all the doctors in the country - the United States about a third of doctors are

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primary care physicians, as compared to the other countries, which are closer to a fifty-fifty ratio, is the only one at forty-one percent and Australia at the highest, at fifty-six percent.

What about the roles that primary care doctors play? Well, a couple of things. First, about the workforce. In all countries but the United States, there's actually just a single specialty of primary care physicians. In the United States, it's actually made up of multiple physician specialties. I'm, for example, by training a general internist, although I'm happy to be a card carrying member of the primary care physician workforce - in the United States, general internists and general pediatricians, as well as general practitioners, family practitioners, are included in the counts of primary care doctors. This is quite different in all the other countries that have been surveyed and may have some implications for the political impact of that workforce and how it is regarded within the healthcare system.

Also the functions of primary care doctors are somewhat different in the different countries. Aside from the United States, primary care doctors play the role as gatekeepers. However, in the United States, except in managed care during the growth of managed care in the 1990s in which there was an increased use of primary care gatekeeping, this role has, if anything, been on the decline in the United States. And that

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US patients in fact do have, in many cases, a lot of direct access to specialists in the community. And this is quite different in the other countries that were surveyed as a part of the Commonwealth survey. So primary care gatekeeping is an embedded function in all countries, but in the United States, where it is still used to some extent in managed care, but is on the decline.

The other thing that has changed from that photograph that I showed you of the primary care physician walking with his black bag in the countryside is that the primary care physicians these days is increasingly embedded in a system of care. That system of care includes being wrapped with access to information technology, and with systems and teams and different ways of being able to reach patients with increasing complexity in paying greater numbers of needs in the ambulatory care setting.

And one of the questions I think we want to consider - and I'll come back to toward the end of my comments - is the degree to which these information technology and systems of care are either supporting, or in some cases, potentially directly competing with, the functions previously played by the primary care physician.

Let's pause for a moment and talk a little bit about what some of those basic functions are of primary care. I think we've heard them alluded to by both Cathy and Robin in

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their comments about the survey, but I want to sort of emphasize these a little bit. These are some of the core functions or elements of primary care. The definition of primary care has evolved a bit over time, but I think these core functions remain very much at the heart of what primary care is about in our healthcare systems.

Accessibility addresses that issue of first contact, of welcoming patients into the healthcare systems. And primary care plays a very important part of helping patients enter into the healthcare system and to appropriately treat them or to triage them to other healthcare providers in the system.

Communication was emphasized in the comments by Robin Osbourne. Communication addresses those issues of educating patients about how to improve their health, how to self-manage their health when they have chronic conditions, and so forth to help explain, doctors as teachers to help patients be able to manage their own healthcare conditions. And primary care physicians play an incredibly important role in communicating to patients in ways that they hopefully can understand about how to manage their health conditions.

Comprehensiveness deals with the issue of the range of health needs that patients have, from preventive to chronic care, and everything in between. So that the kinds of problems that come in first contact with the healthcare system, the full range of the needs of the patients can be addressed by the

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front-end, by the primary care system.

Coordination of care is the issue of being able to help the patient manage and work and get information in a coordinated way as they move through the healthcare system. And the gatekeeping role is one example of that, where the primary care provider may help the patient come in coordination with needed specialists. But it's also that issue of coordinating the results of tests, coordinating the use of pharmaceutical interventions in conjunction with different healthcare needs that the patient may have. So it's coordinating and guiding the patient through the healthcare system and insuring that the information that is being gathered about the patient is being organized in a way that is useful for maximum efficiency and usefulness for the patient.

And finally, longitudinality addresses the issue of getting to know and to interact with the patient over time, as time is an important way of forming judgments about the patient's healthcare condition and understanding that in a patient's centered way, the needs of patients as they evolved through their own lifespan.

What is so special about this Commonwealth Fund International Health Survey is that it really provides us with unique insights into patient's perceptions of primary care in their own country. We have very little other information that helps us understand primary care from the patient's

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perspective, let alone being able to do this across our different countries. So it's really a wonderful tool and gift that's been given to us to have this opportunity to kind of share these experiences. And I think what we learned from this, as is brought out by the data, is that the countries do vary in meeting the different domains of primary care.

And I just want to summarize some of those things that just went past you in this deep wealth of data, but I think try to bring out some of these themes in terms of primary care constructs. I've lumped together, for purposes of trying to be brief this morning, the issues of accessibility and longitudinality.

What I read from these data is that, for example, the United Kingdom has the least financial barriers to access and the longest primary care relationships. Australia and New Zealand, on the other hand, provide the most rapid access for sick patients. This may speak to differences related to financial barriers that the UK has addressed, versus capacity issues that Australia and New Zealand may be better able to manage with regard to sick patients.

On the other hand, US and Canada have the heaviest reliance upon using places like emergency rooms for providing first contact care for patients, and while on the one hand we might regard that as a choice in terms of the fast paced lives that people from those countries may live, the reality is that

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we also learn that patients don't like their care there very much and that the patients from the United States and Canada in fact rate their experiences in the emergency department the least positively. So it may not be a choice so much as one of the only options available with regard to accessibility in those countries.

What about communication? Well, we learned for example, that Australia and New Zealand have the highest ratings with regard to providers being good at explaining things. It's very important of course in terms of patients understanding things because one of the things that we're trying to accomplish in the healthcare setting is for patients to be adherent to the kinds of advice that providers have to offer to patients.

What we learned is that just explaining things may not be enough to get patients to adhere. For example, the United Kingdom, the patients are most adherent to their advice. They are least likely to say that they have unanswered questions and they are least likely to report that cost is a barrier to following the advice. So this introduces the concept that adherence is partly about communication, but it's also partly about having the means to be able to execute the plan that was agreed upon between the patient and the provider.

On the other hand, US patients are least adherent to advice, most likely to report they have unanswered questions

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from the healthcare interaction and the most likely to report that cost is a barrier to following that advice. So even when patients may agree with the plan with a doctor, they may not always have the means to follow through on it.

Comprehensiveness - well I would say that all countries have much room to improve with regard to things like health promotion and self-management. The ratings in these areas were among the most dramatic with regard to areas that could be addressed.

US patients report the most health promotion and self-management for chronic disease. But again, I think there are much room for improvement there. The US was also a leader with regard to cancer screening, but I would say that, although I think Robin emphasized, that there was an underuse of some of the systems tools available with regard to reminders and so forth with getting patients to do cancer screening, if you look at the absolute rates of screening, they were all - for cancer anyway - they were all in about the eighty to ninety percent range, which I think should cause us to reflect a little bit about, well while the systems tools can be very important, I think it also should be seen in the context of how much extra benefit are they going to offer in certain kinds of situations in which we may already be accomplishing some of our goals. It isn't to say that we shouldn't be trying to reach a hundred percent, but if we're not fully meeting some of these issues

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of use of care management strategies, we want to look at it with regard to what the need is in a particular situation.

And what about coordination of care? Ambulatory setting is less coordinated in the US. For example, if you judge this by patients saying they were more likely to report that test results were lacking or duplicate tests were performed. So within the ambulatory setting itself, it seems that the US has the most difficulty of getting all the information organized at the time that that patient is coming in contact with their primary care provider.

However, the US does seem to be doing a little bit better job than some of the other countries with regard to integration across the different spheres of care. There is more integration between hospital and ambulatory care in the US, as judged by patient ratings. For example, fewer US patients report that their regular doctor was uninformed about hospitalizations. And this may speak to areas where there could be improvements, as compared with the US with regard to linking primary care and hospital-based care.

And then what about another place of coordination between the primary care physician and the emergency department? Well, these ratings were quite poor, I would say, in almost all of the countries. Approximately one in three patients in each country reported that the primary care doctor was uninformed about emergency room visits. I would say that

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this is quite common in my own personal experience with regard to my patients going to emergency departments.

I want to also reflect for a moment about the validity of the results. After all, we are going here by a very important witness, if you will, the patients that use our healthcare systems, but nonetheless these are patient's perceptions. And I think in some ways, we have to reflect on to what extent do they match a reality?

One of the pieces of data that were in this survey that were not presented this morning was reports by patients about whether they rarely or never had enough time with the doctor. And it was in fact the patients in the United States who were most likely to say they did not have enough time, followed by patients in the UK and then there was sort of a tie between New Zealand and Australia being least likely to say this.

Now in some separate work that I've been able to have supported by the Commonwealth Fund, we've been able to take advantage of a common tool that's been used by physicians in each of these countries and which they're reporting on primary care visits from the US, the UK, New Zealand and Australia. And in that separate survey, physicians actually reports of the length of their time with interaction with patients - and so this doesn't include administrative time - it looks like actually in the United States, it's the longest amount of time that doctors are spending with patients - 16.8 minutes. The

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UK, it's 9.4 minutes. In New Zealand and Australia are just about 15 minutes each. So this isn't to say that doctors are right and patients are wrong, it's just to say that there may be different perceptions of what is actually happening. In part, it brings out that patient's expectations are clearly part of what would drive certain kinds of perceptions about the healthcare system.

Now, what about other ways of trying to validate these results? Are there other kinds of cross-national measures of primary care? Well in fact, there isn't. And that's again why it's so important and wonderful that we have this survey. There is no standardized reporting of primary careness, if you will, of our healthcare systems. There are no standard measures of accessibility coordination comprehensiveness and so forth that are reported each year by our countries.

However, the Commonwealth Fund's findings are consistent with separate studies that have been done by Barbara Starfield and her colleagues at Johns Hopkins in which Dr. Starfield has made a really rigorous attempt to try to look at some of these constructs of primary care across different healthcare systems. And she has developed a system of trying to rank healthcare systems internationally from most to least primary care oriented and according to her ratings system, the United Kingdom is the most primary care oriented, followed by Australia and New Zealand, followed by Canada, followed then by

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the United States.

And what's been interesting in some of Dr. Starfield's work is that these rankings have been positively associated with health outcomes, such as longevity, birth outcomes, important indicators of the health of the populations in each of our countries, as well as value. That is, looking at the efficiency of using the healthcare resources in each of our systems. Speaking to that the importance of primary care as an important way to make efficient use of resources in each of our healthcare systems.

Finally, I want to bring up one other issue related to the primary care workforce and the evolution of primary care functions. I think there is a great challenge before us today, as systemness, the use of IT is being introduced into our healthcare systems. As I said, this could be a set of tools that could support primary care providers to perform primary care functions. It may also be, in some cases, a challenge to the role of the primary care physician.

And I think one of the things that we might want to consider to discuss and to look at over time is the degree to which these systems are in fact supports versus direct competition with the primary care provider. Interestingly - again, these are separate data regarding the use of computers in primary care practice. Unfortunately, I was not able to get information, in this case, from Canada, but looking at

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Australia, New Zealand, the United Kingdom and the United States, there are in fact rather dramatic differences in the introduction and use of information technology in the form of computers in the different countries, so that the United States, which in some ways is the least primary care oriented of the countries, you might have thought, "Gee, maybe they have leaped to a different place by using more computers as a way to - and information technology - as a way to replace the primary care provider role." When in fact, it's quite the opposite.

The use of computers, information technology if anything, is more advanced than Australia, New Zealand and the United Kingdom, compared to the United States with regard to primary care functions. And you can see this with regard to using information technology for prescribing and at least for partial use and electronic records, where again, the United States lags behind some of the other countries with regard to use of information technology.

So I'm going to close by really trying to have you both reflect on what we've seen and to think as we move forward in this conference, about some of the questions that might come up with regard to primary care in our healthcare systems. Where does primary care fit in healthcare system redesign? I think there is great cross-national interest of course in improving the equity, quality and value of healthcare systems. I think that we have an opportunity here to consider whether the

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strategies that we're all designing in each of our countries to meet these goals are reinforcing or undermining primary care principles, as these principles I think are very important for the patients in each of our countries.

And I think we also want to consider whether healthcare redesign should be building upon a primary care led healthcare system or whether in fact these redesign will in some way bump aside or replace the role of the primary care provider.

And then finally, again, I think I want to congratulate the Commonwealth Fund because I think they've hit upon a very important issue, which is that there's a wonderful opportunity here for cross-national comparisons to reveal variation in the approach that is being taken to redesign our healthcare systems and that we have much to learn from the different ways that we're each approaching primary care and healthcare redesign. Thank you very much. [Applause]

JOHN IGLEHART: Thank you Dr. Bindman. We will now move on to the reactions from our seven panelists. Before we turn to that though, I would like to remind the participants who are watching us on the web cast that you are encouraged to submit questions to the panelists and those questions can be submitted through the address cmwf.org.

We'll turn to Dr. Carolyn Clancy on my far left in terms of the panelists, who is Administrator of the US Agency for Healthcare Research and Quality for her comments. I would

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just remind the panelists, we have about thirty-five minutes before we're scheduled to take a break, so if you would limit your comments to three to five minutes, we'll finish on time and we'll have ample time following the break to ask you questions and to get the reactions of the other participants. With that, Dr. Clancy please.

CAROLYN CLANCY: Thank you. First I'd like to start off where Andy left off, which is saluting the Commonwealth Fund for this effort. This is quite incredible - a very, very important topic and one that I think is of high priority to all of the nations represented here today. I'm particularly pleased that you included the intersection, if you will, of primary care practice with the emergency departments or emergency rooms as well as hospital care.

So I will take it as good news, particularly on behalf of Secretary Thompson, who is quite passionate about prevention, that the US did relatively well in terms of the use of selected preventative services. I'm not completely convinced - I know why, that is - indeed for all of access problems in terms of primary care. One might wonder how much of this is patient-driven, but we'll take good news where we can get it.

The other findings are clearly of concern and very consistent with studies being recently published in this country. For example, one published a couple of weeks ago by

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Dana Saffron [misspelled?] where older patients report decreased quality of interactions with their doctors. In general in our country and I would guess in other countries as well, older patients tend to be far less skeptical of healthcare and healthcare professionals in general, more positive about their doctors. And they have reported that the quality of their interactions has decreased quite substantially. And this is both for patients enrolled in managed care plans, as well as seeing doctors under fee for service arrangements. So it seems to be - whatever is not working here seems to be fairly pervasive in cuts across very different types of settings.

And this is of particular concern to the US as we begin to implement a new plan for the Medicare program. What many of our visitors may not appreciate is that the new Medicare bill, the Medicare Modernization Act, which I expect Mark McClellan will talk about quite a bit this evening, is not just financing for a drug benefit, which I think we would all agree is long overdue, but also includes a number of demonstrations and specific initiatives for improving chronic illness care. Some of these are initiatives that will strengthen primary care practice through the use of health information technology and will I think provide a great opportunity to work with the American Academy of Family Physicians and others who have been leading the way in this area. And that's all good news, but

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it's I think a bit hard to look at these findings and not wonder if we don't have a demoralized workforce.

I think the issue of coordination of care, particularly for people with one or more chronic illness, is the one that is the highest priority for all of our countries. Certainly in this country, we know that that's where people with chronic illness care - that's where we both spend the most money and provide the worst care. And given the rate of increase in spending in this country, that continued trajectory simply won't be tolerable.

I'm pleased that we did a little bit better in this country in terms of coordination of care between the hospital care and ambulatory care. I'm not completely sure if that is a proactive specific approach that the US is employing or whether that just means that we have been slower to adopt hospital lists. I'm not sure. But again, underneath each of these findings and differences, I think there is a huge opportunity to learn why some countries appear to be doing better than others and what it is that the others can learn from that.

So let me just close by saying, I think this is not only interesting and incredible work, I think it's urgent to all of our healthcare systems. All of our countries have a population that's getting older where there's significant demographic changes and a growing proportion of folks with multiple chronic illnesses. This is a good think and a

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testament to the power of life-saving interventions that have been deployed. But we don't have a healthcare system certainly here, and I don't think in any country right now, that is prepared to meet those needs.

Two other issues I just wanted to mention briefly, and that is, in this country, interest among students in primary care practice has continued to decline over the past several years. And recently, Jordan Cohen and Mike Whitcomb from the American Association of Medical Colleges - our sort of umbrella group for medical schools - put forward an interesting premise, which is perhaps the decline in interest in primary care is precisely because about ten year's ago, we started pushing it so hard. And their point was that students actually don't have an opportunity to see primary care practice that works. So I think it was a real challenge. I think the findings from this survey will give us a lot of insights about some steps forward. Thank you.

JOHN IGLEHART: Thank you Dr. Clancy. Our next panelist is Director General Franz Knieps from the German Ministry of Health and Social Security. Mr. Knieps.

FRANZ KNIEPS: Thank you John. Also we have enough detailed information on our primary care system. I'm sure we share the problems and the challenges in our system. Our primary care system has become weak over the years. And there are many reasons for that. Some Carolyn mentioned. The fees

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were lower than the fees for specialists in our system. So the image of primary care become worse and worse. Younger doctors like to become a specialist because they earn more money and have a better image than primary care doctors. The training conditions were bad. The training in Germany is organized in hospitals only. And there is no interest for chief physicians to train family doctors who will leave the hospital two year's later.

And until the late 90s, no additional training was required for general practitioners. Everyone could become a general practitioner after he or she has finished medical examinations. And that creates a bad image for those doctors in our society, especially in urban areas and major cities where we have an oversupply of specialists and the lack of primary care doctors. And German patients can directly go to which doctor they want. They can go to a family doctor, to a specialists, a hospital or an ambulatory care. They don't need a referral in the past.

And the working conditions were bad. Family doctors have to work sixty, seventy hours a week. They have to work during the nights. They have to work during the weekends. They have to travel to their patients, especially in rural areas. So a lot of initiatives were needed and we started it in the late 90s. We built their own budget for family care doctors and introduced their own payment systems.

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We improved training conditions. Give additional money. We allow training in single practices in primary care practices just to rebuild the professional image of family care doctors and primary care doctors. We merged family care doctors and general internal physicians to a new professional image. We give incentive to patients to go to primary care doctors first. They don't have to pay co-payment, or they have to pay a lower co-payment if they take the family doctor first.

And we reinvent the referral system using smart electronical cards and we try, like the US Administration does, to coordinate different care types to what's integrated care. So I hope the conditions in 2010 would be much better for primary care doctors and their patients than they were in 1990. Than you.

JOHN IGLEHART: Thank you. Our next panelist is Annette King, who is the Minister of Health in New Zealand. Minister King.

ANNETTE KING: Thank you John and can I thank the Commonwealth Fund for the opportunity to be here and also for the survey. I think it does serve as a benchmark on performance for our individual countries and an opportunity to compare. Of course, New Zealand is a small country with a lower of GDP than most here, but our people like to compare ourselves with the countries who are here. And so performance in terms of our health service is important to them.

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And I think what is valuable about the survey is to get the patient's perception of how well we're doing in our individual countries and even for us to do that comparison.

We have recognized in New Zealand that we needed to change our approach to primary healthcare and have [inaudible] to make changes to make it more accessible and more affordable. And what the survey tells me is that accessibility is good in New Zealand comparatively. But we still have barriers and a major barrier for us are financial barriers to accessing primary healthcare. There are also some non-financial barriers, but I'll talk first about the financial barriers.

You will note in the survey it shows up that New Zealand is found the cost of excess to pharmaceuticals and to the primary health provider was something that was a barrier to them. So in our changes, we sit about on the first instance to provide more affordable primary healthcare, starting off with low-income. New Zealand has those who are the poorest and the sickest first. And over a five-year period to roll out access to all New Zealanders, lower cost access to all New Zealanders to try and break down that barrier - that financial barrier.

And so the biggest change happened in July this year. So it's after the survey. So I'll be looking forward to next year's survey to see if it comes through. We make these changes and we hope they're going to work and obviously measuring, evaluating, research is part of any changes you

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make. And we haven't got those results yet. But in July this year, our over sixty-five year olds became eligible for low-cost access to primary healthcare. And ninety percent of new Zealanders are over sixty-five are now accessing our low-cost primary healthcare. So hopefully, that barrier for our older people will be reduced by 2007 for all New Zealanders.

I feel that we are inclined in primary healthcare to put too much emphasis on our doctors and not enough on multidisciplinary teams in primary healthcare. And when we looked at our changes, we have built it around a multidisciplinary team, rather than just around our general practitioners. Having said that, our general practitioners are incredibly important and they are one of the two building blocks, along with nurses, to primary healthcare. And I agree with Franz that morale and the way we have valued our general practitioners in the past has not been good enough, particularly in our own country and we have taken steps to value the more - to make sure that they're at the center of our activities and that's already paying off in terms of increased interest in training to become GPs.

But in terms of primary healthcare deliver, I believe that if we don't include in that mix, the emphasis on nurses - a whole range of different nurses - our pharmacists and so on, then I don't believe in New Zealand we will be able to achieve the goals we want to. Take chronic care management for

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example. Most chronic care management in our country would be managed by our specialist nurses - diabetes nurses, esma [misspelled?] nurses and so on. And so in terms of approach, I think that the multidisciplinary team is important. It will be interesting to survey where they fit into a primary healthcare approach in the future.

The non-financial barriers are mentioned. Financial ones are very obvious. The non-financial ones are least tangible and we are undertaking more research in that area. We think some of it is around the way we deliver care that's not, say, culturally appropriate. It's not accessible to people in some communities. I think we need to do further work on that. But I think probably that's enough. Thank you for the opportunity, for the survey and to comment on it.

JOHN IGLEHART: Thank you Minister King. Our next commenter is the Honorable John Hutton, who is the Minister of State for Health in the UK's National Health Service.

JOHN HUTTON: Thank you very much John. And like Annette, I'd like to thank the Commonwealth Fund for organizing this event today and also for providing us with I think a very useful set of findings to tell us some very important messages about our own primary healthcare systems at home.

Andrew Bindman asked I think for philosophers and probably for politicians as well. As always been a fascinating question about whether there is a difference between perception

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and reality. It's always been my view in politics that probably there isn't a difference between perception and reality. I suspect the same is true when it comes to healthcare.

So when we ask our patients - our population at home - about what their experience has actually been like and they tell us the message, I think we should listen to it. So I think when it comes to healthcare, I'm not sure there is a difference really between perception and reality. And I think for us in the UK, this, as you would expect - like all of us here - all of the countries represented in the Commonwealth Fund - a mixed bag of messages here. Some very positive ones in relation to the UK in terms of access and support for the values based in our primary care system. Well I think support for that at home has always been very, very, very strong.

We regularly survey patients in the UK and they tell us a pretty similar sort of bag of messages too. But clearly, they also tell us that they have concerns about certain aspects of the way the service is delivered. We have no barriers, I'm glad to say - very few barriers in relation to cost, which we know is a regressive issue, particularly impacting on families with low incomes. And our mission at home I think is very simply to improve the health of the poorest people at the fastest possible rate that we can because they have the biggest journey and the biggest amount of distance to make up.

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But clearly there are concerns about aspects of the way our service is delivered. And I think there were three things that featured very prominently I think as far as the UK is concerned. We've got to do more in relation to health promotion and we accept that and we will be publishing a new set of proposals later this year, which I think will address some of those concerns.

We've got to do more in improving faster access to primary healthcare services. I'm in the very fortunate position of being able to say that primary care back home in the UK is growing more quickly than it's ever done before. We have more GPs in practice, we have more GPs in training. And I think all of that is very, very positive.

And we've got to do more, as I think all of us accept in relation to managing chronic illness in primary care settings more effectively. Five percent of the patients in the National Health Service take up forty-two percent of the hospital beds. And those are patients with chronic illness that we haven't been able to treat and manage properly in a community setting. So we recognize the need to do more on that.

I think in the wider context together Andrew was asking us to reflect upon. I think there's little doubt certainly in the UK, and I suspect this will be true elsewhere that we will see an increasing shift of services from the secondary or

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tertiary centers into a primary care community setting. And I think that will be a very good thing, both in terms of efficiency, in terms of quality, and in terms of accessibility and all those things of course for those of us who are charged with the responsibility of managing public resources and taxpayer's money in this way are very important issues for us.

So my overall sense of all of this is that certainly in terms of the UK, the situation is improving. It's not perfection, but we are heading I think very positively in the right direction. We should certainly value primary care more and a number of my colleagues have already mentioned the importance of how we structure primary care training in terms of postgraduate medical education and training. In the UK, every doctor in the future will spend a period of their time postgraduation in a primary care setting, and I think that will be a very helpful thing for us.

One final reflection, John, and I just wanted to allude to in all of this. In relation to chronic illness and public health promotion where clearly, from the findings of that survey, we clearly have more to do. I just want to sort of maybe add a bit of context into that for the discussion later. Clearly, we all expect our primary care services to deliver preventative services.

Many of our health promotion programs are actually delivered on a population-wide basis in the UK rather than just

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in primary care settings. For example, in relation to the services we provide to help people give up smoking, those services are organized in community settings rather than primary care.

Similarly, we have introduced an expert patients program to train patients with chronic disease in managing their own conditions more effectively. This is organized as a program with patients themselves acting as leaders and trainers. So if we ask in a survey like this the classic sort of question, "Did your doctor do something for you?" "Did your doctor tell you this or any other?"

I don't think those questions are likely to take into account properly some of the programs that we are organizing on a wider population basis. And I think perhaps we should think about that in designing future survey instruments as well because I don't think those questions if you ask patients just about what their doctor did to them, are likely to give you the full flavor of the services that are provided to patients. Thank you.

JOHN IGLEHART: Thank you Minister Hutton. Our next presenter is Minister Schugart of Health Canada.

IAN SCHUGART: Well let me add our thanks to the Commonwealth Fund for this opportunity and for the annual picture that we get of our own performance as countries.

I want to pick up on a comment that Robin Osbourne

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made, where we take some encouragement from the observation that that the shortfalls that each of us encounter in this survey are, for the most part, amenable to the appropriate policy responses. And one of the values of coming back to this each year and learning from each other is to know whether in fact the progress is in the right direction.

The second point I'd make is that the aspect of coordination, which has been a feature of this year's survey, connects so directly to the other elements of equity and access and quality. We have a lot of work to do on coordination and as we improve that, I think the survey shows that we will improve in some of those other measures as well.

We have been, in Canada, particularly focused recently on issues of access. There has been recently across the provincial and federal health discussion in our country, targeted efforts at improving wait times in a variety of settings. We have certainly identified health human resources, not only physician supply, but importantly nurses and not only the supply, but the use of professions in the team context, the deployment in primary care settings and so on as a critical success factor for improving both coordination and wait times.

The demographics that we talk about are not affecting only the population, but the health workforce as well. And whether it's because of workplace health issues for healthcare providers or the forthcoming retirements of some of the health

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workforce - these are issues of concern and we know that we have to address this and efforts have been made in this regard. This of course is a very long-term proposition.

We also share the concern that has been referred to by a number of colleagues in respective family medicine. We also face the trend of declining enrollment in the postgraduate context in family medicine and we need to find collectively solutions to that and we'll be watching other countries progress in that area.

The issue of coordination I think can be assisted in a very significant way by the development and the deployment of the electronic health record. The use of information technology across our healthcare systems, the capacity of information technology to bind together the different care settings, pull together the patient and the provider; pull the providers themselves together in a more effective team context is something that we have been developing now for a number of years and we'll be talking a little bit later in the program about the acceleration of those efforts. But the electronic health record offer enormous potential, both for providing the information to patients and providers as the patient navigates through the system, as well as the coordination of the system overall.

And primary care organizational reform is of course something that we have been working on for some time. This is

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also a long-term proposition and it's one that we cannot address through annual fashions. It really does have to be a commitment over many years. In our country of course, with healthcare delivered at the provincial and territorial level, this will take different forms and one of the things that we can contribute to that in settings like this, but also within Canada at the federal level, is to understand what is working, find the evidence and translate that evidence across different practice settings.

Finally, I'd say that the improved use of information, whether it's researched the evidence that we gather in the practice setting, the electronic health record can improve the quality of care and I think that it is encouraging that quality is a particular focus of attention and the policy context is going to be very healthy for our system. The Commonwealth Fund has made this an area of focus over the years and I think that can only be helpful.

The other thing is that as we improve information and evidence and its dissemination across the system, whether research or administrative data, we will close that gap between where patients think we need to be, any gaps between perception and reality, although I echo the comments of our colleague from the United Kingdom. When the patient itches, we need to be prepared to scratch there, but with the right policy solutions that will support reform in the long-term. Thank you.

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JOHN IGLEHART: Thank you. Our next panelist is the Chief Medical Officer of the Department of Health and Aging in Australia, Dr. John Horvath.

JOHN HORVATH: Thank you John. And again, thank the Commonwealth Fund not only for an excellent study, but from Australia's point of view at a very timely period in the changes that we are making.

It's interesting - the study was done at a time of heightened awareness of interest in health in Australia, with a federal election where health was one of the two major points between the two parties. During the year in fact, a large number of changes were introduced, therefore I think the next survey and the survey after will be very important [inaudible] to Australia to see whether in fact we did the right policy label.

To touch on a few, out of pocket expenses, which over the years have clearly been rising and the current survey indicated that we had the second highest out of pocket expenses. A number of changes were made, including putting in place a safety net so that the maximum out of pocket expenses for out of hospital fees were ranging between three hundred and seven hundred dollars as a maximum per family.

There are other changes to the pharmaceutical benefits also. So these were major changes with the aim of reducing out of pocket expenses. Similarly, for consistent card holders,

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these are usually the chronically ill and the elderly, there were financial incentives made to the primary care physicians to encourage them to have no out of pocket expense at all. That is to bulk and bill them and to increase the bulk billing rate. Both of these have been progressively introduced over the last twelve months. And it will be very interesting to see whether they have the desire to fit.

We feel reasonably well on access, but that's overall and we still have difficulties with after hours and with rural and remote. Australia being such a large country, and if you can't see the sea and have a cappuccino, you don't want to practice there. So there is a lot of incentives needed to be able to ensure that we can deliver medical care appropriately in the country, especially out in the rural and remote areas where there's a high indigenous population.

And again financial incentives have been built in, in various packages to encourage primary care physicians to relocate and to give them higher financial rewards. And again, over the next twelve months, it will be interesting to see whether these in fact have the desire to fit.

Taking into account that primary care is multidisciplinary and not the doctor with a black bag, for the first time, Medicare benefits are payable to a range of other healthcare providers within a general practice framework. That is practice nurses, allied health professionals and even some

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dental work can be accessed through that. This is again a new initiative.

The workforce is a problem. We are looking at after hours clinics and how they should be financed and resourced. Call centers are being looked at in how they should be integrated within a primary care setting, with the aim of further reducing the reliance on the ER.

Training is an issue and there's a task force to report to ministers next year on substantially relocating training, not only for primary care, but for specialists who are looking after the bulk of the chronically ill into the community to general practice. And this is going to have a fair amount of challenges for funding and other issues.

Lastly, I think we have major challenges like other countries around the boundary issues, with chronic disease strategies to make sure that patients can move seamlessly between primary care, tertiary care when needed, secondary care and I think the electronic health record and other issues around that are going to ease it. But I think there's got to be a lot more work on how we actually move patients seamlessly.

We were interested in seeing the data around tests results. And again I think those and medication areas will need to be looked at, not only in the context in an electronic health record, but in streamlining some of those boundary issues. Thank you very much again.

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JOHN IGLEHART: Thank you Dr. Horvath. Our next panelist is Dr. Enrique Ruelas, who is the Under Secretary of Health in Mexico. Dr. Ruelas.

ENRIQUE RUELAS: Thank you very much John. And I want to thank you to the Commonwealth Fund for the invitation as well, and to congratulate you for this study. I would start by saying that we share most of the problems that you have in these countries. And I have some thoughts about what I saw.

First of all, I would like to share with you one of our concerns in terms of cultural variations of perceptions. And I would like to tell you one of our interesting findings. About two year's ago, we did a survey on waiting times. And we found in some communities that the question, "Did you wait too long?" was not enough. We had to ask another question, "Were you happy with this waiting time?" and the answer sometimes was "Yes." Even though they considered the waiting time too long.

The reason being that for some people that traveled one or two hours to get to one of our clinics, they need some rest. And if they are not in serious condition, for them waiting is fine. On the other hand, sometimes they have friends and they meet their friends in the clinic. So they like to be there. So again, there are some cultural variations in the perception of quality.

I have some other thoughts - and I share this thought with some of the comments that I heard. When I was looking at

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the images saying doctors - the questions on doctors - my thought was is primary care just doctors? And I'm sure it's not. And if not, the next question is, are the teams working as such if they have to in order to provide better care at primary care level?

Then one of the things that we are facing in Mexico and I would think we are not the only ones, is that when you see these findings, the thing is not only system design or redesign, but change management. Perhaps we have good ideas of how to improve what we are seeing and I am sure that we have some answers to the questions that were posed here. But again, it's not only how should we design the system to meet the expectations and the needs of the population - and even of healthcare providers - but also, how can we change the whole situation? How can we manage those people? How can we communicate the vision, particularly when we have sometimes millions of healthcare providers in a country?

Are they aware of these figures for example? Do they know what they have to improve? Most of them may know it, but some others don't. How can we change that behavior if they don't know exactly what is expected from them? What are we doing in terms of health professions education? Do we link the education to the performance of healthcare providers? And the opposite - do students know what they will have to be doing in the future in order to meet those expectations?

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Anyway, again I think it's a matter of analyzing more the management of change. We have to learn more of incentives for change and how those incentives operate. So I think we have a lot of information. I am very glad to be able to see this information because again, we share many of your situations as well in countries like Mexico and I'm sure that we can learn a lot along with you in order to improve the primary care of our countries.

JOHN IGLEHART: Thank you Dr. Ruelas. We have just several minutes before our scheduled break and perhaps time for one question, which I will ask. Referring to a comment that Minister Schugart made about electronic health records. You heard Secretary Thompson last night express great enthusiasm, as has all of the Bush administration about the potential for electronic medical records - health records - over the next decade or so to really improve care, its coordination, its quality, its access and its policies reflect that.

At the same time, there's really I think an open question, at least in the United States about who should finance the creation of this electronic health record infrastructure. Should it be left mostly to government? Or is this an opportunity for the private sector to weigh in, either in a commercial fashion or some other fashion to finance the creation of this expensive, but potentially very useful infrastructure?

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So my question is really to the panelists of the other countries, is what's going on in your own country in terms of the financing of the electronic health record? Is it being done mostly by government? Being done in cooperation with the private sector? What's going on? And I'll start with the Director General from Germany, Mr. Knieps.

FRANZ KNIEPS: Thank you John. In Germany, it's the largest IT project in Europe. And it's financed by taxes for the first steps and then the funds have to pay it. They must build up the infrastructure and they get the profits of that because they have the chance to save money in the system. They have the chance to get more information, to reorganize the care system, to give incentive to the patient, to use more efficient ways of care, so they should pay for that.

JOHN IGLEHART: Minister King.

ANNETTE KING: It's been done in a cooperative way between the public and private sector. For example, the district health boards who have the governance over our health system in New Zealand are funded by government and electronic records and IT systems are funded by government. The relationships with the private practice, general practitioners, is important. We put some funding into electronic records, but so do the private practitioners. So basically it is a joint approach.

JOHN IGLEHART: Thank you.

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JOHN HUTTON: Well in the UK, there's a major sort of government funded initiative underway to wire up the entire national health service and make it a digital organization. It's never been there before. We're doing this in conjunction with obviously private sector partners who we have led to major contract with to help us implement the program. Implementation itself is, as you can imagine, a complicated exercise, but there is a significant degree of collaboration between the public sector and the private sector in relation to the implementation of our program.

Our view of all of this - and I know there's a session later on today where we will be able to explore this in more detail - but the national health service will not become the service we want it to be in the UK without a new foundation of the latest technology that's available to us in IT. We can improve quality, accessibility, convenience. We can deal with the whole issue about medication errors and everything to do with that if we have the right foundations of IT in our system.

So Franz mentioned in Germany, it was the largest program in Europe. I kind of thought mine was, but there we are. Maybe that's usual politicians exaggeration. But obviously I have to reflect on what he said.

JOHN IGLEHART: Minister Schugart.

IAN SCHUGART: In Canada, it's also a joint approach. We'll actually have the opportunity here later from the CEO of

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a non-profit company that has been created in Canada capitalized by the federal government as a broad infrastructure investment throughout the system in Canada. That funding is used in cooperation with the private sector, as other colleagues have said, and then of course the operationalization of this is going to take place over many years where the federal government will continue to invest, but that will also have implications for regional health authorities and provincial governments. So it's very much a joint approach.

JOHN IGLEHART: Dr. Horvath.

JOHN HORVATH: In Australia, it's almost entirely government funded with a high level of cooperation between the federal government and the state governments, with a lot of resources being put in by all parties. At the present time, the federal government's spending a fair amount of resources wiring up all primary care physicians to a broadband system and there is a national task force looking to try and tie the whole thing up with the rest of the healthcare providers, contracting a lot of work to the private sector, but the money is coming from the public sector, hoping that the rewards will come back at some future time.

JOHN IGLEHART: Dr. Ruelas.

ENRIQUE RUELAS: Well the funding is basically a public funding and we are doing it through the federal government and the state government.

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JOHN IGLEHART: Thank you. With that, we're a little bit over time, but pretty much on schedule. We'll take a fifteen minute break. Thank you for the ministers and to the vice presidents of the Commonwealth Fund for their presentation. [Applause]

[END RECORDING]