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Health Affairs Interview: Interview with Cathy Schoen and John Hutton October 28, 2004

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LARRY LEVITT: This is Larry Levitt from Kaiser Network.org. Today the Journal Health Affairs published an article on line looking at the views and experiences with the health system of residents in five countries. To discuss the findings of this survey, we are joined in our studio by the lead author of this study Cathy Schoen of The Commonwealth Fund and by the Honorable John Hutton a member of the Parliament and Minister of Safe for Health in England. Cathy Schoen, Minister Hutton, thanks for joining us.

Cathy, let me start with you give us the sense, particularly from the perspective of a U.S. policy maker of the key messages in this survey that you released today.

CATHY SCHOEN: This is a survey that focused on primary care in each of these five countries and we surveyed a general population of adults. I think what was striking is that in all countries we found shortfalls in the system and particularly when you think primary care is people's first contact with care and can help them coordinate care, we found that access wasn't always there when people needed it. It wasn't timely. There are safety concerns in the primary care system and care is not always well coordinated or patient-centered.

From the U.S. perspective, we look particularly bad, especially when you realize we spend more than any other country in the world, both as a percent of income and per

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person, but we don't get access. It's notable that we wait longer to get in to see the doctor than the other countries. In fact, we in Canada are much more likely to wait 6 days or more where in Australians get in the same day. We spend much more out of pocket and we have more access problems due to cost than the other countries. We have less safe care meaning there were higher lab errors rates. We have less coordinated care, more coordination failure, and our doctors get much lower ratings than the doctors in other countries. I think it is quite remarkable, the good lesson here is that we have four other countries with some quite interesting models and there are policy variations and we have an opportunity to learn from them.

The one area the U.S. did well was clinical prevention, but I think we can turn it over to the U.K., which on many perspectives did better than the U.S. particularly around the primary care issues.

JOHN LEVITT: Minister Hutton, I mean, you come out quite well in this survey in fact. We're here in town to respond to the results. Although I think in some ways the results might be a bit surprising to many in the U.S. where the perception is that a publicly run system like the British National Health Service delivers inferior care. In fact this came up in a recent presidential debate when President Bush suggested that federally controlled systems like the National

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Health Service leads to poor quality care. As a policy maker in the U.K. and a visitor in the U.S. how would you reconcile maybe the perceptions of people in the U.S. and your experience?

JOHN HUTTON, MP: I certainly don't want to contradict the President, I don't want to get into that debate right now. Primary care has always been a very, very, important part of the National Health Centers back home. It was the foundation center of the NHS when we set it up 50 years ago and it's going to be crucial to its future as well. From this survey, I think two or three really, really, important emerge from our point of view. We know that people back home value their relationship with their GPs, they get to see usually the same GP and have a relationship over many years. That continuity in care is very, very important. Very like the crucial aspect of the system which is that everyone is covered and everyone gets it as part of the contract of citizenship if you like. So we have pretty well universal coverage and it's free at the point of use service. There is no co-payment in terms of access and that is very, very well supported back home. And rightly so, because I believe very strongly in socialized medicine in that sense. But look there are two or three things, at least, from this survey that give us reason to say, "Look there's more we need to do." Some of those have been referred to.

Access remains an issue for us. Two-thirds of

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patients can probably get to see their GP within two days, but I'd like that to be 100%, so we've got some ground to make up. We still need to do more in relation to health promotion than we are currently doing. That is going to be an increasingly important issue, I think, for every developed health care system, if we want to use our resources efficiently and effectively particularly in relation to secondary care and how we utilize that resource. I think, thirdly, we've got more to do in relation to chronic illness and managing long-term chronic illness where there should be a natural focus for that work in primary care. Sadly in the U.K. it's not as developed as we would like it. We are working on that, we've got some major programs coming and I think in the next two or three years, that I hope will make a big difference. It's a mixed message, there's aspects of primary care back home that are very well supported and I think give it real strength and a unique opportunity to influence the shape of our health care system but it's not perfect.

LARRY LEVITT: You mentioned promotion or prevention, which I think, was one of the challenges that came out in this survey for the U.K. Where it possibly didn't score as well as some other countries on access to preventive care like blood pressure checks or mammograms. What do you attribute some of those challenges to?

JOHN HUTTON, MP: I don't want to be too defensive

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about this but I think you always have to look very carefully at the small print in this type of work. I made that the point in the formal presentation this morning, I think if you ask a range of questions about, "Did your doctor do this?" Or, "Did your doctor tell you that?" People will think about well, what did the doctor say and they will focus very much on the services that the doctor provides. We provide a range of health promotion managing chronic illness programs that are in the community but they wouldn't necessarily be done by your family physician, there'd be other agencies, other services providing that. I think I would say by way of my defense that there are other aspects of our work in health promotion that may not have been fully captured in the survey. So but having said all of that, I think it's a fair comment and a fair reflection of where we are in the NHS back home and in primary care, there is more we need to do. Our new contracts for family physicians, I hope, will facilitate some of that focus chronic illness. We need to get much more into the business of managing disease [inaudible], being much more proactive in interventions when it comes to checking on a person's well being, particularly for people like diabetics and so on, people with asthma, hypertension. These are all areas where I think we can do more using the primary care infrastructure as our base for that.

LARRY LEVITT: You also mentioned cost sharing. What

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patients pay and Cathy Schoen mentioned that as well, the results really stand out dramatically on that measure, well over 50% of people in the U.K. report that they paid absolutely nothing for medical care in the last year, contrasted with roughly 10% of people in the U.S. Is that financial protection would you characterize that as a core principal of the system in the U.K.?

JOHN HUTTON, MP: Well I would, yes. I mean, right across here we have taken a different approach. We feel very strongly in the principals of socialized medicine, universal coverage and that care being free at the point of use or free at the point of need. My concern is particularly right now in England with the health of the poorest in the community. Who, despite universal access, universal coverage free upon use, who still have significantly poorer health outcomes, shorter length of life span than wealthier citizens in the U.K. I personally don't -

LARRY LEVITT: Even in a system where everyone has care and the same access?

JOHN HUTTON, MP: Yes, indeed. We shouldn't sort of pretend that once you guarantee universal access you guarantee universal outcomes, you don't. You can significantly improve things but the gap between rich and poor in the U.K. in terms of outcomes has not changed in 50 years of National Health Service. That is a big a challenge for us, those of us

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who espouse the principal of socialized medicine. This is a failure in the system that we've got to address. We need a much stronger on the public health of promotion equity argument here. The HS, although it's significantly more socialized than many others around the world, is still not a perfect system.

LARRY LEVITT: And Cathy Schoen let me return to this issue of cost. If anything things are moving in the opposite direction in the U.S. with employers shifting costs to workers, the introduction of health savings accounts along with high deductible health plans, is there anything in the survey which points to some of the implications of that kind of cost sharing?

CATHY SCHOEN: I think throughout the survey we're picking up what looks like a very corrosive impact of that. You not only get a high percentage of the U.S. population, in fact it is 2 out of 5 every adult in this survey, said there was a time in the last year that they didn't go to the doctor when they were sick, they didn't take their medicine, or skipped it because of cost. Or they didn't get the diagnostic that the doctor recommended.

We also find people go to their doctors and you ask them, "Did you follow the doctor's recommended advice? Did you adhere to it?" And the U.S. stands out as the least likely to follow their doctor's advice and the most likely to say the reason they didn't is they couldn't afford it. We find people

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ending up in the emergency room. The uninsured and the partially uninsured, sporadically uninsured, are more likely to go to the emergency room and suffer long waits, but they are also less likely to get their lab test results back. They wait a long time, their pain is not seen to, and you see the cost factors of delays in getting tests and not getting your test results back, not seeing specialists is quite pervasive. I am concerned because we are already an outlier on out of pocket costs. We lead not just way ahead of the U.K., but we lead all the OECD nations in out of pocket costs and it seems to be erecting barriers to care with no real change in the rate of increase of U.S. inflation.

LARRY LEVITT: Minister Hutton, let me turn back to you. You mentioned some of the challenges you face. In spite of coming up pretty well in the survey all is obviously not rosy in your country. Some of the challenges in the news recently, for example, about access to GPs – General Practitioners –after hours or home visits. There have been some controversies about recent policies or recent proposed changes. Describe for that a little bit and how you look to address it going forward.

JOHN HUTTON, MP: It's very important that there should be out of hours access, around the clock, 24/7 access to primary care and family doctors. We're not changing that basic design feature in our system. We have a problem, most

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developed health care systems do, recruiting doctors to work in primary care. There are competing areas and issues and so on that affect all of that. Back home, what doctors have been saying to us consistently for many, many years is, "Look at the moment we have this legal responsibility, a legal responsibility, to actually provide 24/7 cover for our patients. Around the clock, no exceptions." Now that is a huge and onerous burden for a physician to take on. I want to make primary care an attractive place for doctors to work, I don't want to make it the place of last resort. So we have looked at these contracts again and we've moved the responsibility for organizing the out of hours care to the local National Health Service, the local NHS. Doctors will still be involved in it. They will contract with their local NHS organization, primary care organizations, to deliver that service. We'll use other family physicians on a locum basis if necessary but we will have a wider range of health care professionals involved in the out of hours model. We'll have paramedics, emergency care practitioners and so on. Very much like the range of fields that you would see in the emergency room. You got to an emergency room and access an emergency department; you don't necessarily see the specialist. You might see a nurse practitioner or someone else. Now that model can work very well in primary care. We need to talk to people about it and explain it to them so they understand the change

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but we will still have a model of around the clock, out of hours access to primary care. Again, free at the point of need. But we have made some organizational changes in who has got the legal responsibility for organizing it, but and that's difficult. We've had that system for 50 years, we're changing it, people will obviously get anxious about it and there are always those who will be prepared to present this as a retreat or you know, you won't be able to ring up at midnight and get the advice of a doctor. You will. We've taken steps to make sure that that is the case.

CATHY SCHOEN: This issue you're raising, the U.S. does so much worse on this measure in terms of asking about difficulty after hours. We don't have this foundation that the U.K. has started.

LARRY LEVITT: I'm not even sure the expectations are there.

CATHY SCHOEN: There is no expectation, but we get two-thirds of U.S. patients saying that they have difficulty getting any kind of care on nights, weekends, or holidays. There isn't this requirement of having a 24/7 supported system.

JOHN HUTTON, MP: Well Cathy we've got to manage this properly because, you know, along side the changes in primary care and out of hours, we've got a major investment program going to our emergency room departments in our acute hospices. I want people to be seen quickly, much more quickly in

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emergency rooms. Now if I can't get the out of hours service properly organized people will go to AE because there will be nowhere else for them to go. A lot of that attendance will be inappropriate. Of course if you need to be in an emergency room you should get in there as quickly as possible. But it shouldn't be the case that you go there because there's a gap in the service provision. We're trying to be alert to that. We're trying to make sure that we manage that change to the new system in a sensible way.

LARRY LEVITT: And the one thing we're facing here is diminished capacity in emergency rooms, in part an outgrowth of the private system we have here. Is that something your -

JOHN HUTTON, MP: We are investing in emergency room capacity at the moment very, very significantly. As a result the average waiting times for patients in an emergency room department is plummeting. There is a sense always, you know, if the service is noticeably improved people are going to say, "Hey that looks good. I wouldn't wait 12 hours, I think I'll go there because I can get seen in an hour and a half." Obviously all of that has to be sort of managed effectively as well, I mean the resource is there for people who need it. It really shouldn't be used by people who can be appropriately treated elsewhere. So all of this has got to be properly managed. But no, we're not pulling out capacity in the emergency care departments, we're putting it in because we are short in that

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department.

LARRY LEVITT: In terms of managing the system, I mean, there's a lot of talk in this country about bringing health care information, electronic information, out of the dark ages. And investing in electronic medical record systems and tracking systems. Is that something you are also pursuing?

JOHN HUTTON, MP: It's a major piece of work. I think it's true here in every developed health care system we are all looking at these things. We're building 21st century hospitals in the U.K., lots of them. We've got a hundred new major hospital programs on the way. You still go around those hospitals and you'll see guys dragging trolleys full of cardboard files, so you know, it is still primitive in that regard. IT is the platform for the future in terms of quality, safety, convenience. And also in empowering the patient, I mean, the one thing that came through I think very strongly from this survey, still at home people don't really feel that they get access to their medical records. It's very important they should do, it's an entitlement. I want to see what's written about me. I think everyone does. We don't score too well on that. I think having an electronic platform for medical records, which patients will be able to access through smart card technology. I think this is going to be a very, very important part of the new relationship that needs to be there between the doctor and the patient. It's a fundamental

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part of the system, I think.

CATHY SCHOEN: My understanding is that you'll be able to integrate, doctors will be able to talk doctors.

JOHN HUTTON, MP: Yes.

CATHY SCHOEN: And to hospitals, in the approach you're taking.

JOHN HUTTON, MP: Yeah, that's essential too.

CATHY SCHOEN: Which is not necessarily what is happening in the United States.

JOHN HUTTON, MP: It doesn't happen in the U.K. either at the moment. For 20 years we have spent a fortune on IT and we had to, but I've got 5,000 different systems in the U.K. most hospitals can't communicate and transmit data on to the other. We've got very low usage of the new picture archiving, the digital technology around imaging and so on. All of this is going to change. The NHS, I think, is probably unique. We are the most integrated health care system, probably in the world. Primary and secondary, single payer, everyone in the country, cover the whole population coverage. If IT can really make a difference, if you could really quantify what they system where IT would work it will be the NHS and U.K.

LARRY LEVITT: Is there flipside challenge to that, that being a public system your funding has to go through the annual budgeting process as well so it's a political decision as well.

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JOHN HUTTON, MP: Yeah, well health is all about politics, isn't it really? But we don't have an annual budget; we have three yearly budgets now. We had a five year settlement overall. Within that it gave us a huge opportunity over the medium term where we had not been able to do before. We are investing a very significant part of the growth in NHS resources into laying the foundations for this new IT system. Yeah, it is at a big cost but you can't do this reform without utilizing every potential lever. We all know that IT is fundamental to this. It is money that is upfront and of course I could spend in other things, if I want to, I can't spend the same pound or dollar twice I wish I could. Some of my political opponents think they probably can [laughter] but I won't go there. So you have to make a choice on this. The results said I've got be less immediate, more medium term, and of course implementing big IT programs is a major challenge. You've got to get everyone involved from feeling that they want to be involved in the program and understand it and feel it's relevant to the workplace that they inhabit and not something that I, or someone else has created and imposed on them. They're complicated reforms. On one level they're not really about IT at all, they are about people and engaging people and professionals in all of this. We're working very hard to try and do that.

LARRY LEVITT: Minister to wrap up, you spent the

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morning listening to colleagues from other countries, researchers like Cathy Schoen talking about the results of the survey, as you head back to England what lessons do you take back from everything you've heard that might help you do your job back there?

JOHN HUTTON, MP: I've been here for a week now actually and we've talked to a number of U.S. health care providers. I think really in relation to the fundamentals, we believe very strongly in the National Health Service as a platform. So we haven't come here to learn lessons about how you finance health care. I don't think so. We've come here more to look at innovation and clinical developments, where in many respects the U.S. does lead the world. That is true not just in aspects of primary care but in secondary care, increasingly so. Public health management screening and so on. These are very, very important things. For us to learn pathology, the way that this has become a much more industrialized process with rapid access. One thing that did surprise me from the survey actually was the level alleged of sort of misreporting and inaccurate results on path testing. I didn't expect that to come through. Obviously that is an issue for us. But we've come here to listen and learn and there are many, many parts of the practice of medicine, many aspects of it you guys still lead the world. That's why we're here.

LARRY LEVITT: Cathy Schoen bringing you back home to

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the U.S. as a policy analyst here, in hearing the other ministers this morning and looking at the survey, what lessons do you think it has for U.S. policy makers?

CATHY SCHOEN: I think this morning's discussion was particularly exciting because we really do have national experiments going on and sub-national experiments. We heard each of the ministers talking about, not just the national programs but collaborative primary care collaborators trying both to redesign and to come up with something that fits this century rather than old century. I think we often looked inside ourselves in the United States and knowing that there were initiatives where we could look at how that makes a difference. For example minister, passed over it quickly, but the fact that U.K. patients are with their doctors for a long time is very different than the U.S. and I think we've got some lessons to learn about what that continuity means. We don't stay with our doctors often because we can't stay with our health plans. You see some very positive effects of doctors knowing patients and knowing more things about them by that continuity. I think this has really provided us an opportunity to say, "Where can we look at something working better and learn?"

LARRY LEVITT: And certainly vice versa. Cathy Schoen and Minister John Hutton thanks for speaking for us. Thanks to you all for watching. I'm Larry Levitt and this is Kaiser

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