

VIEWPOINT

HEALTH CARE REFORM

The Role of Government in Health Care Reform in the United States and England

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In the past, stark differences between the pluralistic, market-driven health system in the United States and the single-payer, centrally managed system in the United Kingdom have resulted in rich opportunities for those interested in comparative health system analysis. These differences are real but look like they are becoming less marked as a consequence of recent trends toward direct governmental intervention in the United States and the use of market forces in the English National Health Service (NHS). In this respect, England contrasts markedly with the devolved nations of Scotland, Wales, and Northern Ireland, which to a greater or lesser extent have rejected a role for competition in their health services.

The apparent convergence of health policies in the United States and England is principally driven by a pragmatic desire to address the challenge of increasing value by improving health care quality while at the same time controlling medical costs. The challenge is common to both countries, but its antecedents differ. In England, policy makers have regarded inertia, a lack of patient-centeredness in how care is delivered, and strong professional vested interests as their main challenges. Therefore, they perceive competition as a reasonable solution. In the United States, policy makers view a lack of planning, unacceptable inequalities in the care received by patients, high costs, and strong corporate vested interests as their main challenges. Consequently, they see governmental intervention as the answer. In both countries, the relationship between government and the health system is changing in ways that are likely to be far reaching.

Perhaps a convergence between public and private does not require the United States or England to change their health systems as much as is popularly perceived. Most physician groups and hospitals in the United States are privately owned. However, public programs—primarily Medicare, Medicaid, and the Department of Veterans Affairs health system—provide coverage to more than one-third of the population.¹

If the health system in the United States is not wholly privatized, then it is equally misleading to characterize England as having a purely public system of health care delivery. Since its inception, the NHS accepted a role for a private sector, allowing most non-hospital-based clinicians to work as independent contractors to a centrally managed service. In 2011, approximately 13% of all elective (nonemergency) surgical procedures among residents of the United Kingdom were privately funded.² In the early 1990s, a sharp focus on competition was introduced into the NHS with the establishment of an “internal market,” which separated the role of the NHS as a payer for health care services from its role as a

provider of these services. For most of the last decade, there has been a consensus across the political parties in England in favor of the use of the private sector in health care. The political argument has been about how much. More recent policy initiatives continue to actively encourage market forces, in particular the 2012 Health and Social Care Act, which established a legal basis for competition between organizations that provide publicly funded health services.³

Governments have a central role in determining the public-private balance of their health systems. They can attempt to exert an influence in several different ways. First, they can determine how much of the costs of health care is budgeted from the public purse. The Patient Care and Affordable Care Act (hereafter the Affordable Care Act) in the United States has increased public funding marginally but less than critics claim. The Affordable Care Act has expanded public and private coverage and, depending on the number of states that eventually opt to expand their Medicaid programs, is expected to increase the percentage of Americans with public coverage by a few additional percentage points.⁴ Despite policies promoting the private sector, in the English NHS between 1997 and 2011, the percentage of private health expenditure shrank from 19.6% to 17.2%.⁵ Overall, the government in both countries seems reluctant or unable to use its role as payer as a major lever for change.

Second, governments can influence the balance between public and private ownership of physician groups, hospitals, and other entities that provide health care. In the United States, there is little interest in changing the overwhelmingly private ownership of health care provision. In England, there have been a few instances in which private organizations have secured contracts to operate public hospitals and primary care clinics, and some of these experiments have resulted in high-profile failures.⁶ Again, the government in both countries seems to have little interest in exercising much influence in this area.

Third, governments can alter the ways in which physicians and hospitals are organized. It is ironic that, in both countries, this role is the area in which governments have the least authority and yet are exercising the greatest influence. In the United States, the Affordable Care Act has contributed to major organizational changes, with the consolidation of organizations that provide health care and a much stronger focus on integration between medical groups and hospitals. Similarly, in England, a combination of national policies and economic pressures has led to an increase in mergers of both hospitals and general practices and the emer-

gence of new integrated models of care (eg, where acute care hospitals assume responsibility for managing primary or community services). In summary, despite different policy approaches, the United States and England seem headed toward similar health care landscapes characterized by some competition among a limited number of integrated providers.

Irrespective of their market or governmental orientation, policy makers in both countries are reconsidering the relationships among payers, physicians, hospitals, and primary care clinics in their pursuit of higher-value care. In England, the emphasis on increasing value has, at least until recently, been more on quality than on cost. For example, the Quality and Outcomes Framework, established in 2004, tied a large portion of payment to primary care physicians to their performance on a range of quality indicators. This framework has had a substantial effect on the way that general practice is organized and delivered.⁷ In the United States, the emphasis on value has focused more on lowering costs. The Affordable Care Act directs the Medicare program to pursue alternative payment models, such as shared savings for physicians and hospitals participating in Accountable Care Organizations who meet quality standards and are able to lower costs. Medicare has set a goal of having 50% of its beneficiaries receiving care from physicians and hospitals who are reimbursed through alternative payment models that hold them accountable for quality and cost by 2018.⁸

In the United States and England, these new payment approaches have had mixed success,^{7,9} suggesting that to achieve

the goal of higher-value care policy makers will need to take additional steps beyond aligning the financial incentives among payers, physicians, and organizations that provide health services. In particular, policy makers will need to actively promote the components of their health system that enable change, including better integrated data systems, a workforce that has the capacity and capability to work effectively, and organizations that value a spirit of inquiry and a commitment to continuous learning. Governments should also help payers, physicians, and hospitals to prioritize their key challenges. They should ensure that the focus of resources is in the right place, namely, away from the provision of acute care and toward the provision of preventive care and primary care.¹⁰

Faced with similar challenges and goals, as well as uncertainty about the best policy solutions, the United States and England have much to learn from each other in reforming health care. For example, the United States needs help in establishing policies that will encourage a primary care workforce that is as well developed and geographically distributed as the workforce in England. England also has much to learn from the experience in the United States of delivering population-based care management through Accountable Care Organizations. Ultimately, success in both countries will depend on, first, an unremitting focus on promoting collaboration among payers, physicians, organizations that provide health services, and the people who use health services and, second, a consistent commitment of policy makers to support rigorous, timely, and independent evaluations of health care policies.

ARTICLE INFORMATION

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