

Do ideological differences between America and the UK limit opportunities for cross-national learning on delivering value in health care?

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There are many differences between the American and UK health systems when it comes to organisation of care delivery, mechanisms of payment and the roles of providers. One of the most fundamental differences is ideological. In the UK healthcare is seen as a core citizenship right. In the US it is rather viewed as a privilege earned by individuals through hard work, a service to be purchased and consumed (1).

The principle of healthcare for everyone which is free at the point of delivery is so ingrained in our society that it is easy to take for granted. Say to an American that the average Brit has never seen a bill for their medical care and you'll be greeted with astonishment. The disbelief grows when you explain that this covers a lifetime's worth of care for chronic conditions and not just emergency care.

We pay for our health care via taxes which are generally progressive (the richer you are, the more you contribute). Individual Americans pay a substantial amount for their health care (2), both as insurance premiums and out of pocket costs though overall health outcomes are worse (3). If you have money in America, the experience of receiving health care is pretty incredible, especially to Brits used to the NHS. The hospitals and GP practices are grand and shiny, the waits are small, you don't need to go via a GP gatekeeper to see a specialist, the tests are quick and the treatments available are myriad. Whilst there are problems with unfettered provision of the latter two (oversupply of ineffective interventions and healthcare cost inflation), the system allows and encourages the patient to behave as a consumer. Basically, in America, the more you pay, the more you get. However, if you don't have health insurance, your options are few, the personal costs can be astronomical and while you have some access to emergency care, good luck finding any ongoing treatment for long term conditions. Bargain basement insurance is not much better, with lots of things not covered and big upfront costs to the insured (e.g paying for the first \$5000 of any treatment) (4).

There is a focus globally on increasing the "value" of healthcare in response to aging, sick populations and spiralling healthcare costs. Value can be defined as the ratio of the outcomes of providing a 'unit' of healthcare to the cost of producing that same unit (5). How one defines a 'unit' of healthcare varies by context but if maximising value is the ultimate aim of most countries then perhaps nations can learn from each other's successes and failures?

But when comparing the US and the UK, there are differences in the way value is conceptualised. In the US, costs can often be considered solely from the perspective of the organisation providing health care (independent of access) whereas in the NHS costs have to be considered from multiple perspectives and at a population level.

The patient as a consumer drives the value equation in the US. Increasing value by lowering costs that might reduce the consumer experience, such as limiting the grandeur of hospitals, introducing gatekeepers to specialist care for the purpose of rationing or increasing wait times for non-urgent care, are all off the table. They are so far off the table, that they are not even acknowledged as options, even though a minimal change in outcomes coupled with a

bigger reduction in costs could significantly increase value. The value of providing healthcare to those who are uninsured seems to be considered relatively rarely as they are not able to take a role as active consumers.

The first reaction might be to say “well of course rationing or reducing consumer experience are unacceptable” except that in the NHS this is exactly what we are doing. We have a mandate to provide healthcare for all and we have a constrained budget. We have prioritised overall population health outcomes for many years and the simplest way to achieve value has been to cut costs that less obviously affect outcome – e.g. we have longer wait times for non-urgent care, infrastructure is often shabby and staffing is strained at capacity. To emulate the US, we could increase and formalise the role of private insurance in the UK. Essentially, create a two or three tier system that gives priority to those who will pay and charging them a lot. Those who can afford it get treated more quickly and in nicer surroundings. By shifting costs onto wealthier consumers and away from government and by charging enough to generate a profit, might money be generated for more staff, more equipment, more GPs and thus increase the overall value of health care in the UK? The trade-off (and it’s a big one) is in equity and compromising our belief that access to healthcare should be allocated according to need not wealth.

It is likely that many of you winced at the phrase “generating a profit”. We wince too and this is where we suggest the differences at the heart of the US and UK health care actually can limit opportunities for an exchange of health policy ideas. In any discussion of increasing value in the US system, the (paying) patient as a consumer is at the heart of the system. In the UK, the non-negotiable red line is maintaining equity of access over everything else and a principle that we support ideologically. It is almost inevitable that this means different solutions and constrains the likelihood that any US blanket solution works in the UK and vice versa. Perhaps the most useful lessons that the systems can learn from each other are in approaches to improving quality outcomes through local innovation. Value is achievable in both systems but the mechanisms to get there and the trade-offs are different.

References

1. Reid TR. *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*. Reprint edition. New York: Penguin Books; 2010. 290 p.
2. Collins SR, Gunja MZ, Doty MM, Beutel S. How High Is America’s Health Care Cost Burden? [Internet]. 2015 [cited 2017 Feb 6]. Available from: <http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/how-high-health-care-burden>
3. Squires D, Anderson C. U.S. Health Care from a Global Perspective [Internet]. 2015 [cited 2017 Feb 6]. Available from: <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>
4. Ashish Jha. I’ve put my family on a health insurance experiment. It’s been a challenge [Internet]. STAT. 2017 [cited 2017 Feb 13]. Available from: <https://www.statnews.com/2017/02/06/health-insurance-high-deductible-experiment/>
5. Porter ME. Value-based health care delivery. *Ann Surg*. 2008 Oct;248(4):503–9.