

2013

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Recommended Citation

Thomas, Maxwell S. (2013) "A Cross-Cultural Analysis of Health Care Models - Lessons Learned on the Importance of Localized Preventative Care in Reducing Chronic Disease," *Journal of International Business and Law*: Vol. 12: Iss. 2, Article 19.
Available at: <http://scholarlycommons.law.hofstra.edu/jibl/vol12/iss2/19>

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A CROSS-CULTURAL ANALYSIS OF HEALTH CARE MODELS— LESSONS LEARNED ON THE IMPORTANCE OF LOCALIZED PREVENTATIVE CARE IN REDUCING CHRONIC DISEASE

*Maxwell S. Thomas**

I. INTRODUCTION

The United States (US) health care system is riddled with inefficiencies that have led to extremely high health care costs. Understanding the complications and problems in the US health care system, an attempt is made to review the Canadian and Swiss health care systems to construct a cross-cultural comparative analysis; it will result in some recommendations to streamline and improve the current US system. Cultural similarities between Canada, Switzerland, and the US make them useful countries to extract lessons for improvements. The Chronic Care Model offers a framework for strengthening preventative care and reducing chronic illness, while the Kaiser Permanente health system has many evidence-based programs that offer novel lessons for proper chronic care improvements. Health care reform must be carefully executed with preventative medicine as a primary goal to alleviate chronic illnesses in low-income areas.

II. INEFFICIENCIES IN THE UNITED STATES HEALTH CARE SYSTEM

The US remains a leader in many aspects— defense, education, and unfortunately, health-care spending. The Organization for Economic Cooperation and Development (OECD) releases information on its 34 member countries (“About OECD”). In 2010, the OECD reported that in the United States total health care spending per capita was \$8233, which is 17.6% of GDP per capita after adjustment for purchasing power parity (PPP) (OECD, 2012).

Table 1. Average Health Care Spending in the US and OECD adjusted for PPP, 2010

Spending USD	United States	OECD Average
Total	\$8233	\$3268
GDP per Capita	17.6%	9.5%
Public	\$3,795	\$2,400
Private	\$3,189	\$193
Out of Pocket	\$976	\$559

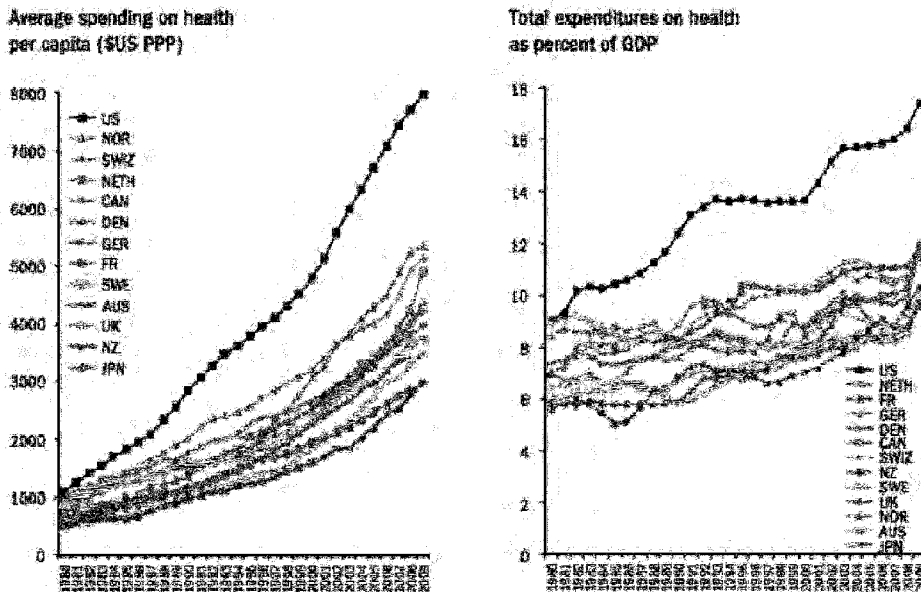
Sources: (Squires, 2012, OECD, 2012)(Squires, 2012, OECD, 2012)

According to Table 1, The US share of spending is the highest among the OECD countries, which is 8 percentage points higher than the OECD average. Total spending is 2.5 times the OECD average (OECD, 2012). Netherlands and France are a distant second (12.0%)

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and third (11.6%) in expenditure as a share of GDP. Norway and Switzerland, the richest countries in the world, have still spent far less on health care at \$5388 and \$5270, respectively (OECD, 2012). Overall, America spends twice as much on health care than other “rich” countries in the OECD.

Figure 1. Total health care spending among 12 OECD nations adjusted for PPP, 1980-2009



Note: PPP = Purchasing power parity— an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned.

Source: (Squires, 2012)(Squires, 2012)

As shown in Figure 1, total health spending has been increasing at an average rate of 4.3% each year from 2000 to 2009 (OECD, 2012). The United States has far surpassed every other OECD country in total spending, and continues to grow at an alarming rate. Based on national income and health spending in other countries, a linear regression can predict a country’s health care spending within a few hundred dollars. However, the United States remains an exception and is well above the predicted spending of \$4849 or 11% of GDP (Squires, 2012).

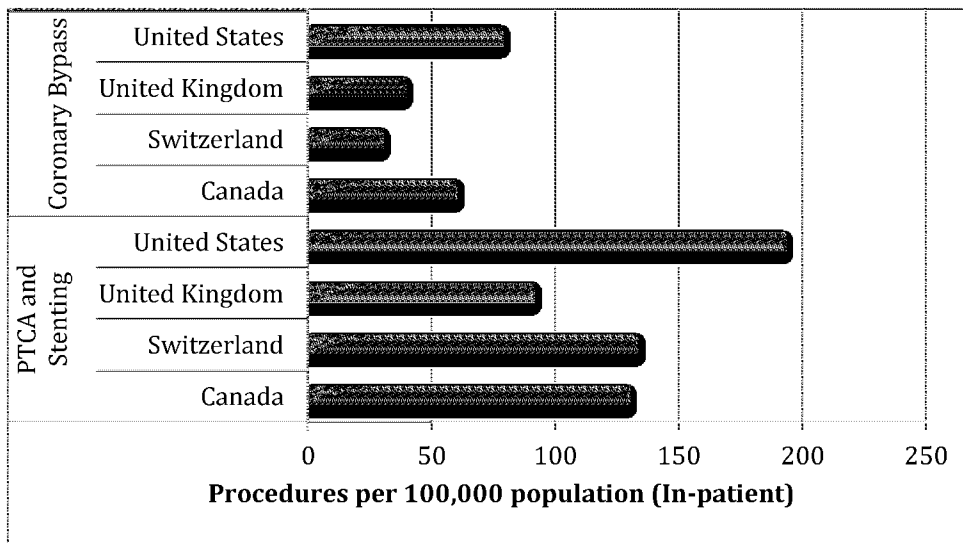
Service Mix as a Cost Driver

A significant portion of health care spending can be attributed to ambulatory care. Ambulatory care has shifted towards late- stage procedures, a service mix that is more expensive than preventative medicine. Late- stage medical intervention refers to invasive procedures that treat patients with complex, usually chronic conditions. For example, bypass surgery is a late-stage procedure for patients with a history of coronary artery disease. Ambulatory care is the fastest growing sector of health care (245 billion) due to increases in

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same- day surgery (overnight) performed by independent physicians (McKinsey Global Institute, 2008). The US spends 75 billion dollars in emergency department visits, 23 billion at diagnostic imaging/ambulatory care centers, and 93 billion at outpatient clinics. Ambulatory care spending can be attributed to high rates of expensive, clinically preventable surgeries. Half of all mortalities in the United States are due to preventable risk factors such as unhealthy dietary patterns and physical inactivity (Mokdad et al., 2004, Hung et al., 2007). Heart disease is clinically known to be preventable with healthy choices and proper intervention for those with genetic predispositions (Mokdad et al., 2004). Illustrated in Figure 2, percutaneous transluminal coronary angioplasty (PTCA) and stenting in the US is 61% more prevalent than in the UK (OECD.Stat, 2012). Coronary Bypass is also performed 53% more in the US with every 100,000 people than in Switzerland.

Figure 2. Preventable late-stage procedures due to chronic illness adjusted for PPP, 2010



Source: (OECD.Stat, 2012)

In-patient PTCA is also extremely expensive in the US; the average cost of a PTCA procedure in the US can be well above \$40,000, while Canadians spend below \$5000 (Thaulow et al., 2002, Russo et al., 2007). These findings shed a major light on a phenomenon that is occurring in the US health care system. Despite heavy spending, preventative care is not adequately supported. The dual effect of the high cost of surgical procedures and heavy use of late- stage surgical procedures has been significant in increasing total spending. Americans are waiting too long for intervention, appearing at hospitals with advanced disease. The failure to prevent complications necessitates expensive late-stage procedures. This resulting burden will be alleviated only with the implementation of careful policies.

High Costs but Low Performance

The general rule with purchasing a good or service is that higher quality goods cost more. This is an intuitive economic phenomenon, where a seller adds more value to the product and sells it at a premium. However, this phenomenon does not apply to the health care industry. High-quality care is *not* synchronous with the higher cost of health care in the US. In fact, it is quite asynchronous in the majority of health care outcomes when compared with other developed nations.

The National Scorecard is a comprehensive assessment that evaluates how well the US provides health care quality, access, efficiency, and equity (Commonwealth, 2011). A total of 42 indicators are present on the 2011 review; the US earned a total score of 64 out of 100 possible points. The five dimensions of outcomes have a low of 53 for efficiency and a high at 75 for quality of care. Interestingly, if average rates of health outcomes reached top performing private US systems (i.e. Kaiser Permanente system), the US overall score would be near perfection. Domestic improvements in health care outcomes are often misleading. Care has improved dramatically due to breakthroughs in medicine, but the US still has stark differences between the best and worst performing health care systems. Hospital care has prevented surgical complications, with an increase from 71% in 2004 to 96% in 2009. Standards of treatment have been effectively implemented for heart attack, heart failure, and pneumonia patients with a 12% increase nationally. Changes in these aspects of quality care are the result of federal policy changes that link Medicare payments to hospital outcome transparency in public reports. Ambulatory care exemplifies the variations in hospital standards and care across the US. Preventable diseases such as heart failure and pediatric asthma have decreased 13% from 2004 to 2007, but this change in the average outcome is offset by two to four times the incidence between the worst- and best- performing hospitals. These changes seem to be national successes, but a large difference remains between the best and worst hospitals in the US.

Overall, the US ranks 37th among 191 countries in health care outcomes (WHO Report, 2000, Murray, 2010). The US is 39th in infant mortality, 43rd for adult female mortality, 42nd for male mortality, and 36th for life expectancy. The United States lags far behind other wealthy nations despite ranking 1st in health care spending. It is important not to dwell on the rankings established by statistical organizations, but rather to understand the overall low performance and unsatisfactory trend of health outcomes that the US holds. There are many lessons to be learned, and vital factors such as quality, access, efficiency, equity, and lifespan are indicative of a proper health care system (David, Schoen and Stremikis, 2010). In sum, a new system can be carefully crafted to be transparent and accountable by properly understanding health care systems in other countries and their similarities with the US.

The US Lacks Accessibility and Preventative Care

The US is the only country among the OECD nations that does not provide health care to all of its citizens. In 2010, 44% of all working adults (81 million) were uninsured or underinsured (medical bills and deductibles are high relative to income) (Commonwealth, 2011). This is a 33% increase from 2003 (61 million). Rates are even higher among low and middle-income adults. After the recession, 40% of people reported medical debt or problems

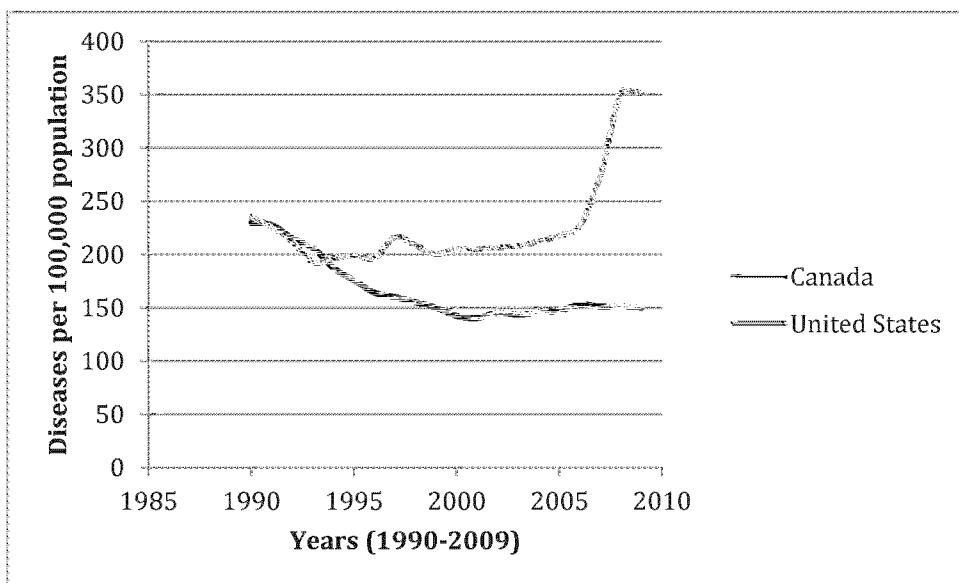
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paying medical bills in 2010. Also, the proportion of families with affordable health insurance premiums (less than 15% of income) decreased from 57% in 2003 to 4% in 2009. Other countries do not face this problem. Affordable care must be addressed immediately in order to improve outcomes. Affordable care carries over to preventative care, which is yet another large failure in the US health-care system. In 2008, 44% of adults under 65 did not have an accessible primary care provider, and only 50% received basic preventative services. These failures are unacceptable.

III. THE CANADIAN EXPERIENCE: COMPARING HEALTH CARE SYSTEMS

The first country that will be examined in this cross- cultural analysis of health care indulgence will be Canada. As the primary focus of this discussion, preventative care is vital to improve health outcomes. U.S. politicians can glean from other countries lessons as to the implications and value of preventative care in cost reduction and national health. After Canada passed health care reform in the 1970s, health outcomes there soon improved; this is exemplified by the reduction in the prevalence of many preventable diseases. As shown in Figure 3, in 1990, the US and Canada had an equal number of nervous system disease cases of 230 per 100,000 people.

Figure 3. Historical outcomes of nervous system diseases in Canada vs. US, 1990-2010

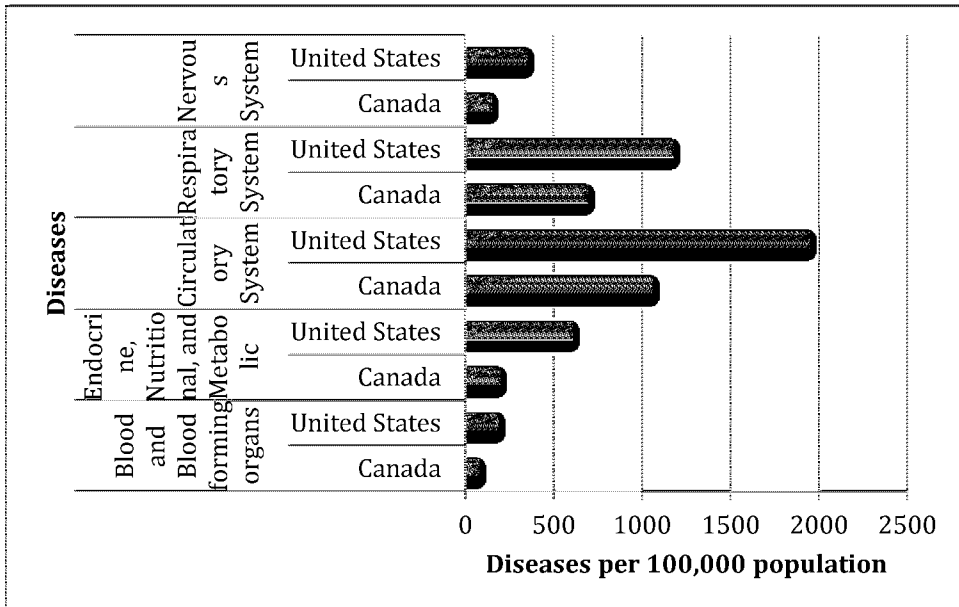


Source: (OECD.Stat, 2012)

Diseases of the nervous system (stroke is a risk factor) can be managed and are often avoided with quality preventative care (Stroke, 2012). In addition, the system in Canada allows for access to high-quality, long-term care for citizens with congenital defects. By 2009, the strong Canadian preventative care system reduced neurological disease prevalence to 150 cases, while the US had 351 cases (OECD.Stat, 2012). In Figure 4, since 1980, Canada

also reduced the prevalence of other disorders highly correlated to preventative medicine such as circulatory (30% decrease), respiratory (54% decrease), and endocrine (26% decrease) disease.

Figure 4. Admission rate of disease amenable to preventative care in the Canada vs. US, 2010



Source: (OECD.Stat, 2012)

In the past 20 years, Canada has seen tremendous improvement in many of its health outcomes with a steady decline in health care costs. Many improvements are due to the existing strong primary care network stimulated through reform. Usual care is not enough; chronically ill patients in the US are not receiving effective therapy, have poor disease control, and are unhappy with their care (Wagner, 1998). Overall, the US is experiencing high costs, especially in the category of ambulatory care. Preventable, late-stage procedures are the significant drivers of health care costs. The Canadian experience provides valuable lessons that policy makers can use to improve preventative care in the US.

Similarities between Canada and the US

Canada and the United States are very similar in many regards. Historical roots of health care policy in both countries are strikingly similar with subsequently matching outcomes. However, Canada was able to lift itself from its low level of outcomes after passing the Canada Health Act in the 1970s (Starfield, 2010). The main question is how has this golden act saved billions of dollars and increased positive outcomes.

This study begins with the various similarities between the countries, including tax structure, population diversity, medical education, and federal policy. Raised as British

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colonies, Canada and the US are English speaking, Anglo-Saxon countries with similar immigration structure (20% foreign born in Canada and 13% in US) (Starfield, 2010). Revenue is raised from personal taxes in both countries (36%) with a similar spread in Canada (46%) and the US (44%). Corporate tax is the same (11%) and social security tax is also similar with the US (only 4% higher than Canada). Medical education is the same in both countries in regards to curriculum and residency. The Joint Liaison Committee for medical education rewards both the US and Canadian medical schools with accreditation. Most notable of all the similarities is the sovereign power of the states/provinces in both countries. The Canadian federal government relays flexibility for policy making to the provinces despite the institution of a universal health care system. These similarities create an ideal mold for a Pareto efficient shift— better outcomes with no increase in cost.

Canadian Health Care Structure

Canadian universal health policy did not originate at the federal level, but was a bottom-up process. Although the government enforces basic universal health care for all citizens, provinces are more pivotal in health care decision-making than the federal government. The US has a historical constitutional adherence to state sovereignty as well. Public hospital insurance was established in Saskatchewan in 1947; public ambulatory care followed in the 1950s for the residents. Other Canadian provinces recognized the obvious benefits of a public health care system and the policies began to take root throughout the country. By 1972, the Canadian Health Act made universal coverage accessible to all Canadians. The act eliminated copayments in an effort to improve health outcomes among lower income families. Health economist Mark V. Pauly developed the ideology behind copayments for health care (Pauly, 1968). He defined ex post moral hazard in health care as a risk-averse reaction to limitless health care. After the fixed cost of an insurance premium is endured, the individual uses unlimited health care. This increases the cost for the insurer as well as premiums for other members due to cost-sharing. Copayments deter unlimited visits and, in turn, decrease preventative care. Currently, Americans have the highest usage of extremely expensive techniques due to complications of untreated and preventable diseases. Americans wait too long (to avoid copayments) for treatment and then require expensive late-stage care, which can become a public burden. Pauly attempted to make everyone “better off” by preventing unnecessary health care, but a service mix without preventative medicine has been a detrimental result. Canada successfully abolished copayments to promote equal access to care and empower the primary care providers.

The Canadian Health Act introduced incentives for primary providers to act as gatekeepers to specialized care (Starfield, 2010). This has fostered the creation of a regulatory primary care network. Canadian law allows individuals to access specialists directly; however, providers earn less compensation when patients see them without referral. Still, specialized care is not much more restrictive in Canada than the US. Forty percent of Americans report trouble in visiting a specialist— 31% due to denied specialist referral or waiting for a referral, 40% due to long wait times, and 17% due to high cost of private insurance (Ross and Detsky, 2009). Canadians report lower statistics for trouble visiting a specialist.

A strong primary network, universal access to care, and localized policies have been extremely effective for Canada. Slow growth in health care costs as well as better outcomes

has been cited by various statistical organizations. More importantly, Canada has been able to reduce chronic illness with both of these approaches, especially among the poorest citizens.

Health Outcomes: US vs. Canada

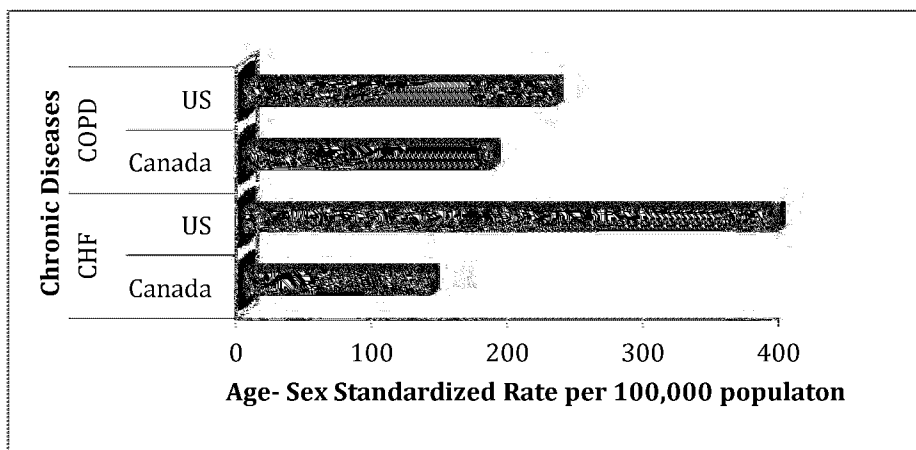
The first difference that must be addressed is the overall fitness of Canadians vs. Americans. Historically, both countries ranked toe-to-toe in health outcomes, until the implementation of the Canadian Health Act in 1972. Most notably, the average Canadian has a longer life expectancy than the average US white male (Kunitz and Pesis-Katz, 2005). That is, the healthiest group of individuals in the US has lower life expectancy than the average Canadian.

The second most cited health outcome is infant mortality. The United States (6.1 deaths per 1000) has one of the highest infant mortality rates in the industrialized world, only marginally better than countries such as Chile (7.9 deaths per 1000) and Mexico (15.2 deaths per 1000) and lagging behind the OECD average of 4.3 deaths per 1000 (OECD.Stat, 2012). Canada has ranked higher than the US on 10 out of 12 health outcome indicators (Starfield, 2010). In addition, many of these rankings are by extremely large margins. The US is known to perform marginally better in the 5-year survival rate for cancer. This statistic is probably due to the availability of better technology in the US; however, this value could be further elevated with better prevention and earlier detection consistent with a solid primary provider network.

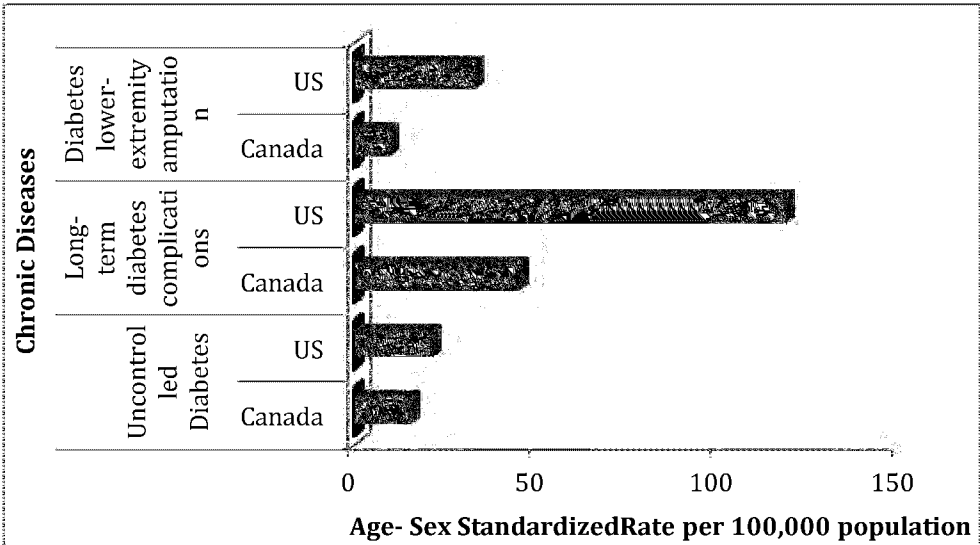
In addition to low life expectancy, Americans also have the highest rates of obesity. Obesity is an epidemic that only adds to the grim statistical outcomes mentioned earlier (O'Neill and O'Neill, 2007). Both health care failures and obesity contribute to low life expectancy in the US. Life expectancy is a multi-faceted problem, but this does not refute the idea that a strong primary care system can be a stimulant for better life choices, especially for those with strong family histories of disease.

The high level of chronic illness in the US is the most important lens of focus. Obesity, smoking, dietary patterns, and other lifestyle choices are risk factors that can be actively managed to reduce the prevalence of chronic disease prevalence. The Canadian health care system has seen steady decline in national prevalence of many types of chronic illness (Figure 5).

Figure 5. Chronic disease prevalence in Canada (2007) vs. US (2008)



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Source: (OECD.Stat, 2012)

Chronic obstructive pulmonary disease (COPD) and Congestive Heart Failure (CHF) are cardiovascular illnesses that can be sidestepped or managed through early and effective preventative care (COPD, 2012, Heart Failure, 2012). Complications in both of these diseases are leading causes of death in the US and must be addressed through national primary care reform. Diabetes and diabetes- related complications have also seen vast improvements after health care reform in the 1970s in Canada. Canada has outperformed the US in chronic disease outcomes across the board; these improvements can be attributed to equal access to care and the creation of a strong primary care network with localized preventative care.

Health Wealth Gradient and Pareto Improvement

The US is on the global forefront for medical advances and proponents of the US system cite that universal health care can reduce monetary incentives for medical technological breakthroughs (Federal Trade Comission and Department of Justice, 2004). Reduced technological advances can keep the outcomes of the entire country from reaching maximum potential. However, it is interesting to examine the other long-term effects of technological advance on income and health disparities. Technology increases health disparities between the rich and the poor. Members of society who are wealthy, educated, articulate, and well connected will have faster access to cutting- edge technology than will poorer, less educated individuals— inevitably widening disparities (Deaton, 2002). This is the case in the US because there is a clear disparity between rich and poor concerning access to health care. Equal, unobstructed access to health care has been a determining factor in increasing Canadian health outcomes.

Income disparity in the US contributes to health care costs. According to the Joint Canada/US Survey of Health, about 11% of Americans do not have health insurance (Sanmartin and Ng, 2003). Sixteen percent of Americans between the ages of 18-44 and nine percent of Americans between 45-64 are uninsured. Only 1% of Americans ages 65 and older are uninsured. One in four Americans (26%) in the lowest income bracket are uninsured; this represents 36% of the total number of uninsured Americans. Two main conclusions can be drawn from these statistics. First, Medicare, a parallel to the Canadian universal health care system, covers Americans above the age of 65 effectively. Second, US citizens in the lowest income bracket do not have basic insurance. It is undeniable that health and income are correlated. The more income an individual has, the greater the access and use of health care. This relationship between health and wealth is referred to as a gradient (Deaton, 2002). The relationship is quite gradual. By creating equal access to care, health will improve among the lowest income citizens. This can cause increases in income for the poor, while the rich are only marginally affected. The gradient effect translates to a markedly greater decrease in mortality per dollar for the poor than for the rich. The correlation between income and health may also have a reverse causation; changes in health cause disparities in income. Ill health causes disability and inability to work—a direct decrease in income. Poor health can also undermine the ability of an individual to progress in a career to achieve higher levels of income. Expenditures on health care due to poor health also reduce effective income level, such that money spent on health care is not available for basic requirements including rent and food.

Faced with widening income/health disparities and high chronic disease, it is important that the US takes lessons from Canadian health care reform to make strategic health care choices. Creating a system of universal care will widen the umbrella of necessary health care to cover not only wealthy Americans but also those in need. Wealthy Americans (often those making the decisions) will probably not feel the effects of reform; however, the sick and destitute in the lowest income bracket will likely benefit tremendously. Reform may not be a Pareto optimal process, but it will be a Pareto improvement.¹ Making health care universally available will enhance the lot of the poor, and maintain the status quo of the upper and middle class. This humane Pareto improvement will chip away at disparities in the US.

The Canadian model has contributed to better preventative care and health outcomes, but it is not a perfect solution to the current crisis in the US. Canada may have better outcomes and cost control than the US, but it is far from the best in the world. The Canadian system has not been able to ensure health outcomes transparency or foster medical excellence. The single-tier, universal-care system in Canada has unrealized gains because providers are not held accountable for malpractice and there is little financial incentive to create superior, private health care systems. Canadian health care is slowly migrating to public funding due to inadequate incentives for private firms. The private insurance model in Switzerland has been successful and offers merit for analysis. An efficient US system must ensure access to care and preventative medicine at the state level.

¹ Pareto Improvement is a change that makes at least one person better off, without making anyone else worse off. Pareto optimal status is achieved when all of the possible Pareto improvements have been made to maximize utility.

IV. THE SWITZERLAND EXPERIENCE

Switzerland has been the poster child for many health care reform plans in the United States. Similarities in culture and ideals make the Swiss model a prototype for the proposed restructuring plans. Indeed, President Obama has imported many lessons from the Swiss system into the *Patient Protection and the Affordable Care Act (ACA)*.

Despite the efficiencies noted by the Canadian health reforms, there are still unrealized gains in Canadian health care that have allowed Switzerland to outperform Canada. Switzerland incorporated major health reform in order to “introduce a perfect managed competition scheme across Switzerland, with full coverage in basic health insurance” (Daley and Gubb, 2013). In 1996, the health insurance law of 1994 (LAMal) was passed to drive down costs and increase efficiency.

LAMal as a model

LAMal was designed to be consumer- driven reform, where citizens would choose their own health insurance plans and providers. Unlike other systems, the Swiss do not leave funding to a third party like employers or the government. Price transparency of available plans allows for citizens to make cost- effective decisions that reflect individual choices and maximize utility.

In accordance with the majority of existing universal plans, Swiss citizens are required to purchase Compulsory Basic Social Insurance (CBSI), or suffer a penalty. CBSI entails various aspects of care deemed necessary by the central government of the Swiss Confederation. Every insurance company provides CBSI. Moreover, insurers must accept all citizens, regardless of health status, and offer the same rate to all participants in the same plan. These ideas reverberate with the ACA plan of individual mandate (compulsory participation), guaranteed issue (health- blind acceptance), and community rating (fair pricing) (Kreier and Zweifel, 2012). The reforms were vital to driving down prices and making health care more affordable for citizens; however, government programs (like Medicaid) were also installed for low-income subsidies. Unlike Medicaid, low-income citizens choose insurance plans from the same list as the wealthy Swiss. Subsequently, the Swiss have enjoyed reductions in both health and income disparities.

Subsidies are distributed by the Cantons, or sovereign states in the Swiss Confederation (similar to the Canadian system and in accordance with US sovereign states). This system is highly decentralized and empowers the Cantons to make major health care decisions beyond the basic provisions mandated by LAMal. In some respects, LAMal is less market oriented than either the ACA or the current US system (Kreier and Zweifel, 2012). The Swiss Cantons run their own public hospitals, nursing care, and home- care; Cantons approve fee schedules as well. The Cantons regulate the prices of pharmaceuticals, medical technology, and physician services. In addition, insurers are not allowed to make a profit on CBSI plans and employers cannot offer basic social plans as an incentive. However, supplemental plans do not follow these strict regulations; employers and insurers can offer these packages as incentives and for profit (Kreier and Zweifel, 2012). Profit- bearing tendencies, such as risk- averse selection of participants, are regulated by a governmental risk adjustment scheme.

The consumer driven scheme of LAMal has been able to install equal access to care without increasing wait times or hampering medical technology. The Swiss system has the 2nd lowest wait time for a specialist appointment and the 3rd lowest wait time for elective surgery among the 11 OECD countries (OECD.Stat, 2012). Unlike Canada and other comparable countries, Switzerland has not suffered from increased wait times since the 1996 reforms. Interestingly, the heavy trend towards excess diagnostic imaging to shield from malpractice claims and profit-bearing late-stage procedures in the United States has not resulted in a large technology gap with Switzerland as expected. Instead, Switzerland is higher than the OECD average and only slightly lower than the US in terms of the use of MRI (OECD average 12.5, Swiss 17.8, US 18.5) and CT scanners (OECD average 22.6, Swiss 33.7, US 40.67) per 100,000 people. This clearly shows that the Swiss have captured the benefits of the consumer driven system as well as covering health care for all its citizens.

Switzerland stands third behind the United States and oil endowed Norway in terms of health care spending per capita (Switzerland \$5270, United States \$8233, and Norway \$5388 adjusted for PPP). Switzerland also spends 11.4% of its GDP on health care, with one of the slowest growth rates in such spending among the OECD nations at 2.9% from 2000 to 2009 and a decrease to 2.4% in 2010 (OECD.Stat, 2012). High spending may in fact be a reflection of citizen preferences rather than waste (Kreier and Zweifel, 2012).

From these statistics, it is important to note that Switzerland has seen low growth rates in terms of health care spending while achieving better outcomes. Swiss citizens have the second highest life expectancy behind Japan. Switzerland has also seen a 24% decrease in infant mortality during the past decade, whereas the United States has seen only a 9% decrease (Switzerland 3.8, United States 6.8 deaths per 1000 live births; 2010). Despite the regulations of LAMal, the US government is considerably more involved in health care structure. Market ideals are obviously absent in the US health system; a significant part (29%) of the US population was covered under government programs in 2008 (Kreier and Zweifel, 2012). This proportion will only increase with the ACA expansion of Medicaid to cover the 40 million uninsured Americans. Switzerland has provided an avenue for better health outcomes with a stronger primary care network at a lower cost.

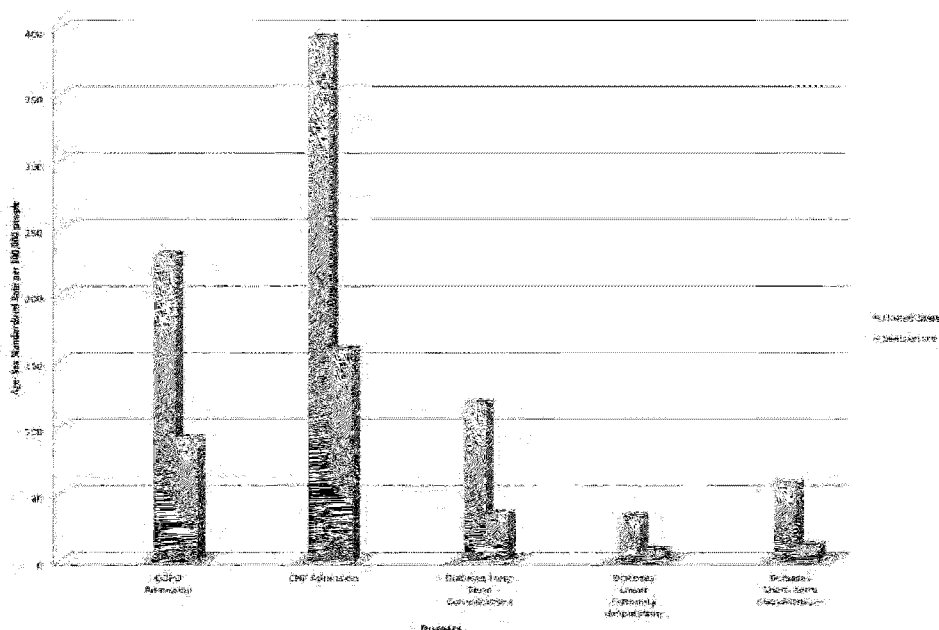
Outcomes: Preventative Care

Switzerland effectively hit all the major points for creating a strong primary care network that focuses on preventative care. Unobstructed access, affordability, equity, and efficiency relay reduced costs with equal or improved outcomes. Overall, Switzerland has better outcomes in many indicators that range from mortality rates to care utilization and resource availability.

Cost control in a health system always begins with a strong primary care structure. By creating a strong universal primary network, health disparities due to income naturally shrink. The Swiss have been successful at stimulating a culture of preventative care and thereby avoiding the service mix that burdens the American system today. Various statistical indicators that illuminate the effects of LAMal on preventative services can be compared. The most pertinent indicator of a useful primary network is the control of chronic illnesses. Admissions due to chronic obstructive pulmonary disorder (COPD), congestive heart failure, and diabetes are shown in comparison to the US with available data from the OECD in Figure 6.

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Figure 6. Rate of Disease Amenable to Preventative Care: US vs. Switzerland, 2008



Source: (OECD.Stat, 2012)

The US severely lags behind Switzerland in each category, from a 60% difference in CHF admissions to an 80% difference in short term complications due to diabetes. Also, there is a general trend towards decreased rates in each of these categories for Switzerland. The United States shows only marginal decreases in CHF, long-term complications due to diabetes, and amputation due to diabetes. Statistical data are not without flaws, but it is reasonable to attribute some of these differences in outcomes to differences in preventative services between the US and Switzerland.

As mentioned earlier, obesity appears to be a main factor affecting the differences in outcomes. Obesity increases the likelihood of complications due to diabetes and congestive heart failure. At the same time, smoking and alcohol abuse are also directly related to chronic disease complications. Switzerland has a much lower percentage of self-reported obese citizens (50% less), but has a slightly higher percentage of citizens who use tobacco and abuse alcohol (OECD.Stat, 2012). Increased tobacco use should result in worse outcomes for COPD admission in Switzerland, yet this is not evident. Obesity is definitely a major problem that must be tackled by the cooperation of the American political and health systems. Still, there is a need for a stronger primary network. By adopting policies that support primary

providers and enable a culture of preventative medicine, the American health system can reduce the problems of obesity.

The Swiss health care system is not flawless. There are areas that require improvement. However, this discussion sheds light upon the usefulness of the Swiss model as a viable alternative to current and planned reforms. The Swiss experience must be observed with a bifocal lens—the short-term gains from improved efficiency and possible areas of weakness in the long run.

Important lessons

Switzerland, Canada, and the US have many cultural similarities, but very different models of health care. Canada and Switzerland have surpassed the US in terms of cost control, health outcomes, and preventative medicine. Both countries used separate modes to achieve these outcomes, but this discussion has highlighted specific policies that were successful. A bottom up approach to creating reform is evident in both the Canadian and Swiss history, and can be an effective method for creating reform in the US. Reform at the state level will allow management of health care according to the needs of local health care systems. Adequate resources to ensure preventative care must supplement localized care. Strong primary care and equal access in both systems have created a culture for preventative care that effectively tackles chronic disease. Simply providing free care is not enough; localized preventative care with strong primary provider networks is vital to combating the high health care costs of chronic illness.

V. A LOCALIZED APPROACH TO PREVENTATIVE MEDICINE: THE CHRONIC CARE MODEL

Health disparities remain a serious financial burden to the American health care system. The concurrence of income disparities with worsening health signals an even stronger need for effective primary care at reduced costs. The Canadian and Swiss experience both offer important lessons on the viability of national reform. The US must implement a localized model and can find important lessons from high performing systems within its own borders.

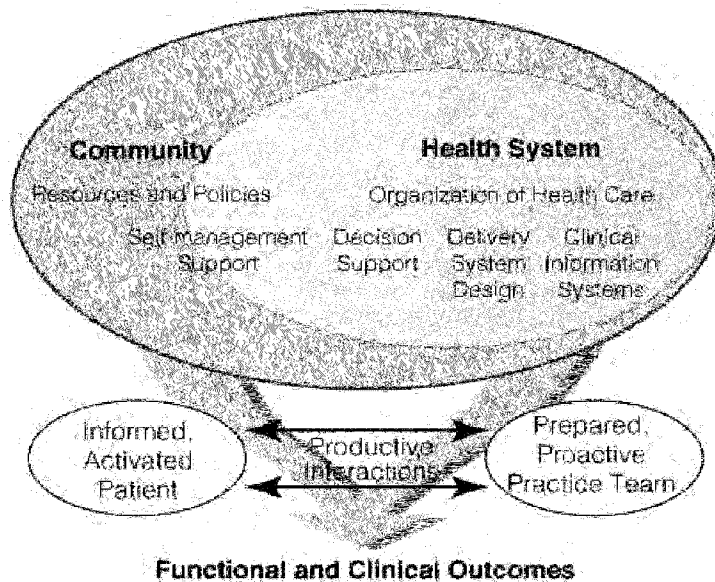
This discussion has focused on chronic illness as a key driver of health care costs in the US. Preventative medicine is at the root of improved health outcomes and as the ACA reform initiatives begin to gain momentum, the US would do well to incorporate lessons from countries such as Canada and Switzerland to reduce chronic disease. Insuring 40 million Americans is a daunting task and must be coordinated and meticulous. Preventative care must be localized, specifically in low-income areas, to reduce disparities. It must be supported by the states through bottom-up initiatives. Finally, transparent and self-sustaining health care systems must be created through proper incentives.

The interactions of these policy recommendations are clearly displayed in the Chronic Care Model (CCM) (Wagner, 1998). The CCM offers a schematic that can improve preventative care, and eventually chronic illness outcomes in the US. Positive clinical outcomes are reliant upon the resources and policies at the community level and efficient organization of health care systems (Hung et al., 2007). The Chronic Care Model (CCM)

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displays the interaction between the two entities and necessary features that facilitate quality care.

Figure 7. The Chronic Care Model



Source: (Wagner, 1998)

Community Resources and Policies

Community resources and policies are at the foundation of preventative care. The Canadian and Swiss systems have been extremely successful at creating access to care, and the ACA aims to create ubiquitous access expanding governmental care to all citizens. Both systems empower primary care providers and support them with resources through health policy reform. Equal access to health care must be supplemented with a strategic localized plan to strengthen preventative care; and the CCM offers an integrated approach to accomplish this. With adequate resources and incentives offered by the state, health care systems can establish efficient local outpatient clinics.

Organization of Health Care

Implementation of universal health care is not a simple fix to the overarching dilemma of access to care in the United States. Access to care is also influenced by the organization of health care. The CCM shows decision support, delivery system design, and clinical information systems under the umbrella of health care organization. Universal

coverage ensures financial support for care, but does not address issues with delivery system design like scheduling ability, wait times, timely appointments, and excellent experience. The Commonwealth Fund case study on the Kaiser Permanente health care system tabulated factors that affect access to care; these results indicate that the Kaiser model offers easier access to care than traditional providers by introducing multiple points of entry like call centers and online self-scheduling (McCarthy, Mueller and Wrenn, 2009).

Kaiser also has two notable policies that have added value to their delivery system design— prepaid compensation and unblinded data (clinical outcomes by individual physicians) (McCarthy, Mueller and Wrenn, 2009). By offering a competitive market-based capitation to its multi-specialty providers, Kaiser Permanente instills responsibility for quality and cost of care. Pre-paid compensation diminishes motivations for over- or under- utilization of resources and provides a foundation for a shared push towards efficiency. The second venerable attribute of Kaiser Permanente is the structure built upon the providers. Kaiser Permanente physicians are encouraged to take leadership roles (one in seven physicians surpass clinical obligations). The core values of “Permanente Medicine” are driven by internal transparency and unblinded performance data. Switzerland and Canada were able to improve outcomes, but had little accountability at the provider end. Kaiser sidesteps this flaw and creates a willingness of peer- review among the physicians.

The US health care system lacks information continuity. Indeed, the US lags behind leading countries, with only 46% of physicians using electronic health records (EHR) (Squires, 2012). The Federal stimulus package included incentives for implementation of EHR, but many systems have failed at adding value. During the 1990s, Ford, Home Depot, and countless other enterprises invested billions of dollars in information technology (IT) that proved to be useless. The important lesson from these classic cases is the need to add value with new clinical information systems. The end- users must find value with the system for any efficiency gains to be obtained. Kaiser Permanente was extremely successful with its centralized EHR system because it was designed and incorporated under the guidance of the physicians who used it. In 2003, Kaiser spent \$4B on an information system called KP Health Connect to link facilities to each other and with patients (largest civilian EHR) (McCarthy, Mueller and Wrenn, 2009). The system has many valuable tools that aid both physicians and patients. The system was only useful because the users themselves appreciated and utilized it.

Primary Care Teams in Low- income Areas to Produce Informed Patients

Decision support with a primary care team in local communities can efficiently reduce disparities and chronic illness. Localized care with a primary care team is more effective at providing well-rounded support. Kaiser has shown that group sessions with multi-disciplinary teams can be very effective at creating informed patients. Regional managers coordinate drop-in group visits headed by a multi-disciplinary health care team. Group sessions enable solidarity with reports indicating fewer hospitalizations as well as better quality of life and ability to manage chronic conditions (McCarthy, Mueller and Wrenn, 2009).

The EHR integrates the entire system to create segue into a multi-tier approach to preventing diseases amenable to health care. At Kaiser, Preventative services are divided into three areas of focus— primary care with self-support, assistive care, and intensive care. Ancillary staff and weekly appointments are used at the first level to ensure optimum care for

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chronically ill patients. At level two, specially trained professionals, such as pharmacists, support the primary care team and transition patients back to level one. Multifit, a cardiac rehabilitation program, is a third-tier initiative that provides ongoing support to make lifestyle changes and reduce risk of future episodes. Using telephone services from clinical pharmacists and ongoing follow-ups, the Colorado region increased cholesterol screening from 55% to 97%, decreased relative risk among 89% of participants within 90 days, and avoided 260 cardiac events and 135 deaths (McCarthy, Mueller and Wrenn, 2009).

Culturally aware local primary care teams are effective at producing active and informed patients. Another notable Kaiser initiative is the Personal Care Model aimed at eliminating health disparities with culturally competent care (McCarthy, Mueller and Wrenn, 2009). By targeting minorities, disabled persons, and women, Kaiser has shown that community efforts necessitate culturally sensitive approaches. Many centers have seen qualitative gains; anecdotal experiences such as disclosures of alternative medicine that interact with treatment. Patients are more willing to comply with these providers, which create more trust and an open environment for enhanced care. Realizing cultural differences and coordinating local outpatient interaction is an innovative joust with health disparities that can definitely translate into good chronic care.

Investment in early care is initially expensive, but long-term cost reductions can be achieved through patients' self-management. Targeting at-risk groups in low-income areas with culturally sensitive medical professionals is a novel but obvious solution to reducing disparities. Primary care teams can infiltrate low-income communities to create well-informed, active patients. Multi-disciplinary teams employed in these areas can help control chronic conditions on a larger scale through group sessions. Other benefits of group collaboration are increased solidarity within the community, and long-term familiarity with outpatient personnel. The public burden from high hospital expenses can be reduced with fewer emergency visits due to preventable diseases. This provides an incentive for activism from local government and medical centers for funding. Of course, national investment in this innovative bottom-up approach to cost control is another possibility. Initiatives to insure all citizens through universal health care is not adequate, but small investments in localized community efforts will result in large steps towards health care cost control.

Concluding Remarks

The cost of health care in the US is too high and health outcomes are too low. Forty million Americans remain uninsured, and many have high deductibles/copayments that bar them from using preventative care. Absence of preventative care has resulted in a rise in the frequency of late-stage, expensive procedures. This service mix has ultimately been disastrous for controlling costs and chronic disease.

Canada and Switzerland have clearly enjoyed positive results from health care reform; they have surpassed the US with cost control and positive health outcomes. Canada, Switzerland, and the US have sovereign states; therefore reform must be from the bottom up. This is a useful approach because statewide initiatives are much more effective at creating local programs. The ACA aims to provide universal care, but preventative care will not be implemented without proper incentives. Although free care is not a facilitator of preventative medicine, a multi-tier outpatient clinic with adequate support from the state is a viable solution for combating chronic diseases.

Localized multi-tier primary care teams can help to control and sustain the long-term management of chronic illness. The schematic offered by the CCM will enable self-management support in low-income communities. Delivery system design and information technology implementation must include user input to add value (i.e., from physicians), allow transparency, and limit expensive care. Finally, decision support must be structured at a regional level, with states offering incentives for localized primary care outpatient clinics. The CCM is a culmination of the many lessons discussed; with the co-evolution of preventative medicine and health system reform, it can convert the US from one of the unhealthiest nations to an exemplary model for quality health care.

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