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When we wrote this article just before the turn of the millennium, we believed and argued that resistant American policymakers had much to learn about health policy and management from the international community. About that time, we founded the firm.

Our core beliefs were consistent with our article thesis. Claims of professional expertise ought to be met with skepticism. Expertise is not intellectual brilliance. Expertise is developed by an approach that is open-minded, truth-seeking, and mindful of the power of collaboration.

Over a decade of experience working with our colleague-clients has changed much of what we think, but not how we approach the effort. Good reading.

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# Global Dimensions of Domestic Health Issues

Marian Osterweis
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*Editors*

# 4. Learning About and Learning From Others' Experiences

THEODORE MARMOR AND JOHN PAKUTKA

THE SEARCH FOR NEW WAYS OF THINKING ABOUT health care policy and management today arises in part from the struggle of academic health centers to remain fiscally solvent while working continually to improve the quality of clinical care, research, and teaching. All these efforts must be made despite these difficult times of managed care and the Balanced Budget Amendment freeze. Indeed, much can be learned about global health care policy experience from the experiences of other countries. However, there also is great danger that nothing useful will be learned from the effort. We also should realize that translating the lessons into action does not necessarily require a change in national policy. An academic health center, on the other hand, can adopt internal policies that ensure that international cost control successes can be replicated.

However, using the proper approaches, we can apply the lessons learned from other systems to our own. The discussions during the early 1990s about health care could have benefited from less indulgence in the myth that the United States is unique. We would have been better served by

opening ourselves to the idea that the United States has a great deal to learn from other countries. We should have been drawing on successful foreign and historical experiences, and setting about the serious work of revising and adapting suitable financing arrangements for today.

Nothing in the United States makes universal health insurance impossible to implement. However, propaganda, funneled through a largely uninformed media, has managed to spook the politicians. This occurred despite the polls indicating public support for the idea of universal health insurance. So it was that the great debate over national health insurance, which was revived by the Clinton Administration in 1993, died a quiet and disappointing death by the summer of 1994.

The fate of U.S. health reform under the Clinton Administration is not the subject of this paper, but the debate over universal insurance is an illustrative case in which cross-border learning, although needed and available, was both wildly unreliable and unhelpful in the distorted presentations traveling across borders.

## LEARNING FROM OTHERS

Comparative policy studies such as these are subject to two fallacies, either of which may distort the subject. One, which may be labeled the World Cup fallacy, is the notion that cross-national learning is like picking the best soccer team: The task is to find the best model (technique, system, payment policy) from around the world, and then transplant it elsewhere. This approach is basically foolish. No institution, policy, or program is directly transferable in such a simplistic way. Nonetheless, we continue to see a market for one-size-fits-all reforms. They continue to be the topic of articles, speeches, and, most of all, conferences about the state of health care.

The other danger when conducting comparative policy studies is the opposite fallacy: The notion that, since nations always differ in some respects, we can never learn policy lessons from one another. This might be called the fallacy of comparative difference. It is a familiar weapon in the policy wars of any nation. Fortunately, between these two extremes lie other, more reasonable approaches. These methods for policy analysis, explained below, enable us to develop realistic uses for reasonable comparative analyses.



## LEARNING FROM OTHERS: TRANSPLANTABLE GENERALIZATIONS

There are two possible bases from which we may draw strong policy lessons from the experiences of other countries. One is to consider what can be learned from similar nations. If conditions in another country are broadly comparable economically, politically, and/or culturally, one can be reasonably confident that a particular policy in that nation would be applicable within one's own society. That is, Country A's policy could be implemented in Country B with roughly the same results. Policy transplantability is closely linked to structural similarity. (To an outsider, the Nordic nations appear to provide many examples of this process.)

This method of learning from others, however, has certain limitations. The primary problem is that sometimes the most promising, appealing, or compelling answers to a particular policy question can be found elsewhere, in a very different sort of society. What, then, are we to do? Not a thing, necessarily, other than to be aware that this may be the case. In other words, we must strive to keep in mind that learning about another nation's experiences is not the same as learning from them.

There remains one other form of lesson-drawing that is rare, but powerful. Some describe it as generalizing from the widest variety of cases. It is the very opposite of a "similar system" design. That is, if a policy generalization holds true over many divergent cases, we may conclude that a powerful factor is at work—a factor that policy makers and administrators ignore at their own (and their constituents') peril. The logic behind this theory is straightforward: If Q follows from policy X in countries A to T, why should another nation (e.g., the United States) believe its experience will be different? This is the point of view behind the theory of transplantable generalizations. Just as the most similar design narrows the range of findings, so too does the most different design narrow the scope. However, in the latter instance, we are narrowing not countries but the likelihood of encountering a large number of such transplantable generalizations.

For example, let us consider the cost of implementing new policies that almost always turns out to be significantly higher than the policy advocates predict. Another example is the proposed wholesale transformation of the

ways in which doctors are paid (a goal cherished by most health policy analysts) that, in fact, is almost never a practical option. Realizing and accepting this lesson regarding transplantable generalizations has important and very pragmatic implications for the debates about payment policy and its proposed reforms.

We begin by examining the most serious barriers to cross-national learning that, once they are removed, would substantially simplify the task of learning about and then from other cultures. After considering these barriers, we will learn about others by examining the set of existing data on health system performance in selected Organization for Economic Cooperation and Development (OECD) nations. We will study the data so we can understand the range of experiences among these nations. Third, while continuing to learn about different country experiences, we will analyze health system constructions and the cost-control mechanisms so we can understand the rich and varied character of their experiences. With this in mind, we will suggest what might be learned from international experience, and we will suggest one way in which this knowledge might be applied to an academic health center in the United States. Finally, we shall consider health reform as a global trend and examine the value of international conferences.

## BARRIERS TO CROSS-NATIONAL LEARNING

A variety of myths can prevent one from learning important lessons from other countries' experiences in the financing and delivery of health care. The most important is a misconception that can be termed the myth of infantile yearning. All too often we search for a perfect world in the field of health policy. However, no system of health care financing is either free of problems or easily administered. We cannot avoid the gap between wishes and facts. The relevant inquiry is whether the problems associated with a particular health system are more serious than those linked to another.

For example, as the last industrial democracy without universal health insurance, the United States at least has the advantage of being potentially able to learn from nearly a century of experience with national health insurance elsewhere in the industrialized world. Canada's path to, and experience with, universal health insurance is a useful object of inquiry.

The United States shares with Canada a common language and political roots, a comparably diverse population with a similar distribution of living standards, and increasingly integrated economies. We also share a tradition of fractious but constitutionally based Federalism, a phenomenon that makes most North American political disputes similar (although not identical). Moreover, until Canada consolidated its national health insurance in 1971, North American patterns and styles of health care were nearly identical. (This similarity of care had been the case for so long that, until well after World War II, Canadian regulators used the U.S. Joint Commission on Hospital Accreditation to judge the credibility of their hospitals and medical schools.)

If public financing of health care has worked reasonably well in Canada, one might think it should work in the United States as well. This, at least, was the plausible premise of most of the favorable U.S. commentary about Canada's national health insurance program during the past health reform debate. Let us reiterate, however, that learning from the experience of others does not mean that one simply can import another country's institutional form of universal health insurance. The most enlightening comparisons seldom indicate that a foreign program, whatever its virtues, can simply be transplanted from one country to another with identical results. Nonetheless, the U.S. debate has been characterized not by cross-national learning but by myth-making, largely inferred from anecdotes told by critics of national health insurance about the Canadian experience.

The average person in the United States may not believe that dying Canadians are wading across the Niagara River to obtain access to life-saving health care; however, our public discourse is rife with overblown anecdotes about Canada's shortages, waiting periods, and long queues. What often is not reported in such accounts is the possibility that these drawbacks may serve as effective rationing mechanisms for elective and often unnecessary procedures, such as high-resolution imaging. Indeed, they may prove to serve as a more effective rationing mechanism than the U.S. micromanagement of doctor-patient relations.

Another myth may be called the left-pocket myth that misleads people into thinking that public health expenditures are more economically dam-


Learning About and Learning From Others' Experiences

aging than private health expenditures. Consider the significance of managing health care under public auspices and through public budgets: A few Canadians believe that all would be well if only there were private arrangements to augment the overburdened public system. However, the productivity and growth of the Canadian economy does not depend on how much health care financing flows through the public sector (the "left-hand pocket"). Nor does the growth of the American economy depend upon how much finance flows through the private sector (our "right-hand pocket"). The fact is that health care services represent current consumption. As such, they drain resources from investment, research, and productivity; they do so no matter whose budget they flow through or from which pocket they are drawn.

It is worth remembering that the OECD nations share a number of economic troubles. These nations have been rightly concerned about lagging productivity and, from a worldwide standpoint, modest levels of economic growth. Future economic competitiveness will depend upon investment in human as well as physical capital. Therefore, current consumption must be restrained if noninflationary investment is to have a future.

The current U.S. savings rate is anemic by any standard. The Canadian rate is not impressive either, except in comparison to that of the United States. The future economic health of any country will rely heavily upon its ability to cope with the pressure of increasing health care costs. To cope with the costs by painting mythical pictures of foreign experience is downright dangerous. To avoid that danger, we must take care to interpret the selective and sometimes seductive glances that are cast across national borders.

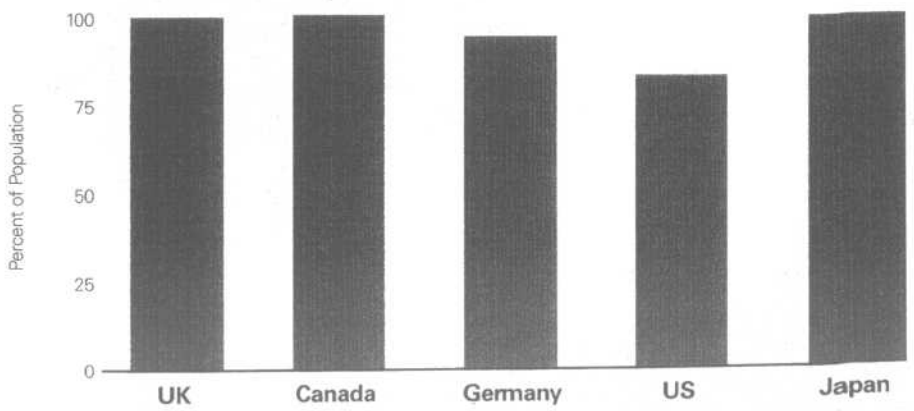
## INTERNATIONAL HEALTH SYSTEM DESIGN AND PERFORMANCE

Any effort at comparative analysis must begin with the selection of the comparison set. To do this in health care, it is helpful to note the enormous disparity in health spending between developed and developing nations: Eighty-nine percent of worldwide health spending occurs in countries with 16 percent of the world's population (Scheiber and Maeda, 1999). To learn from comparative health policy analysis, U.S. observers first need to select those countries about which we hope to learn. The choice should be made from the variety of high-income nations in both the West and Far East.

By doing this, we in no way mean to trivialize the wide disparity of cultures and health care policies around the world. Ignoring the health problems of the developing world is arguably immoral and certainly foolish in a world in which a morning case of West Nile Fever can be transported to New York City on the afternoon flight. However, for the purpose of helping academic health centers learn relevant policy lessons from international experience, we must choose a comparator set of countries whose economic and social conditions are broadly similar to those in the United States. Based upon these criteria, we believe that Canada, the United Kingdom, Japan, and Germany are the ones most similar to the United States. The question then is: What do we know about their health systems in relation to the health system in the United States?

The United States stands alone among developed nations in its reluctance to guarantee health insurance for necessary health care services to all of its citizens (figure 1). (Germany makes its program optional.) This is not to say that uninsured Americans cannot gain access to the system. However, financial considerations do weigh heavily upon the 44 million uninsured U.S. residents, as well as upon their caregivers.

**Figure 1. Health Insurance Coverage in Five Industrialized Nations, 1998**




Source: OECD Health Data 1968.

The use of terms such as "socialized medicine" in political debates only clouds the real issues by creating more fear than understanding. Among the cited countries providing universal health insurance coverage, each has developed its own, distinctive system based upon a variety of factors, including sources of financing and sector of health care delivery, that is, public, private, or a blend of the two (figure 2). Many other dimensions also are involved, such as the type of private financing (personal premiums or employer mandates), type of public financing (national, state, or mixed), method of payment (fee for service, capitation, or salary), cost control method (global budget, capital expenditure controls, or provider competition), and degree of provider autonomy. By considering all of these elements, we can see that Japan, Germany, Canada, and the United Kingdom have developed coverage policies that meet their own, unique needs. There are many ways in which the United States could insure all citizens for necessary health care.

Spending in developed nations has been growing over the last four decades, consuming ever-larger shares of real income. In this regard, the United States stands out, spending 30 to 50 percent more than other nations (figure 3). If we were buying improved health with our augmented spending, this would make good sense. But do we?

Health outcomes can be difficult to measure, and even more difficult to interpret. Because outcomes are difficult to determine, we are left with

**Figure 2. Financing Mechanisms in Four Industrialized Nations**

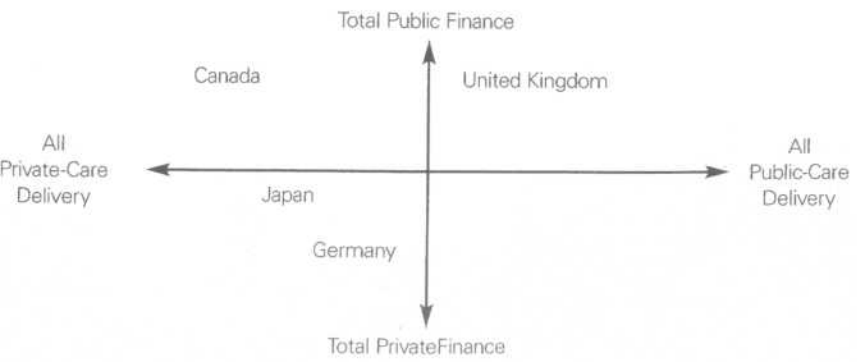
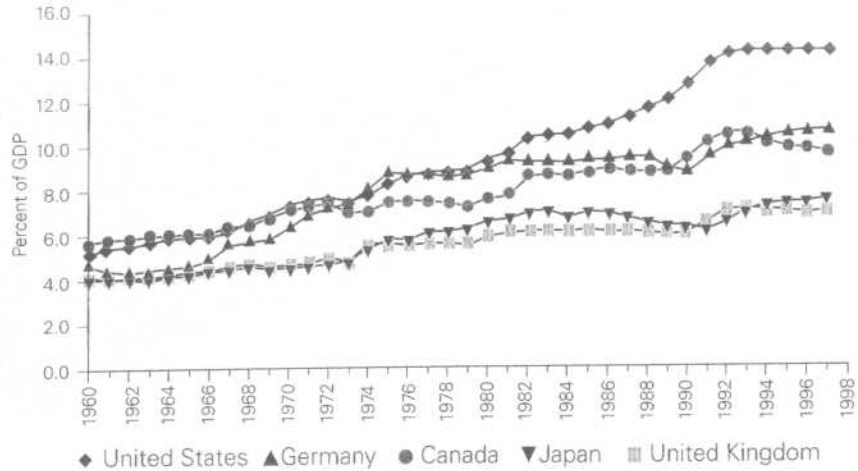





**Figure 3. Health Spending in Five Industrialized Nations, 1960–1998**




Source: OECD Health Data 1998.

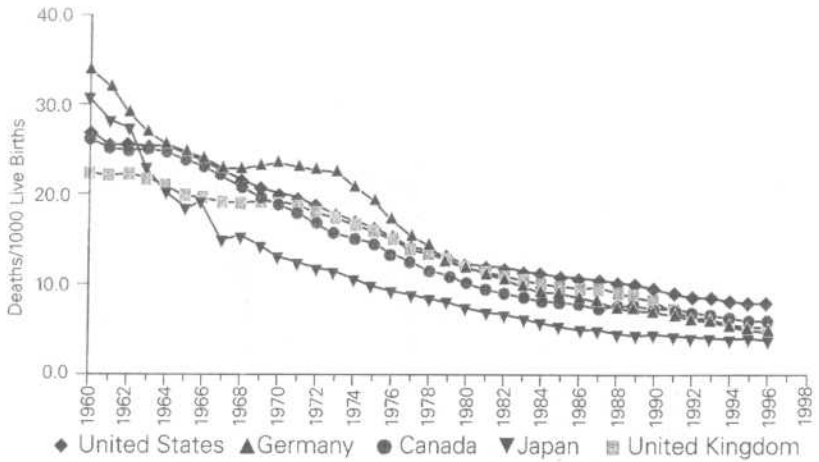
the bluntest of measures, and because they are difficult to interpret, we risk confusing correlation with causality.

Many variables affect health in addition to the provision of health care: air and water quality, diet, smoking, exercise, speed limits, availability of firearms, etc. Nonetheless, with such large sums being invested in health care, we must examine the rough measures that do exist and infer cautiously about health system effectiveness.

Basic to any examination of health outcomes is a consideration of life expectancy. Over the past three decades, life expectancy has been increasing at similar rates in Japan, Canada, Germany, the United Kingdom, and the United States. This increase has been seen in both men and women, although women live approximately 5 years longer than men in each nation. It should be noted, however, that the United States lags slightly behind the other nations in terms of life expectancy.

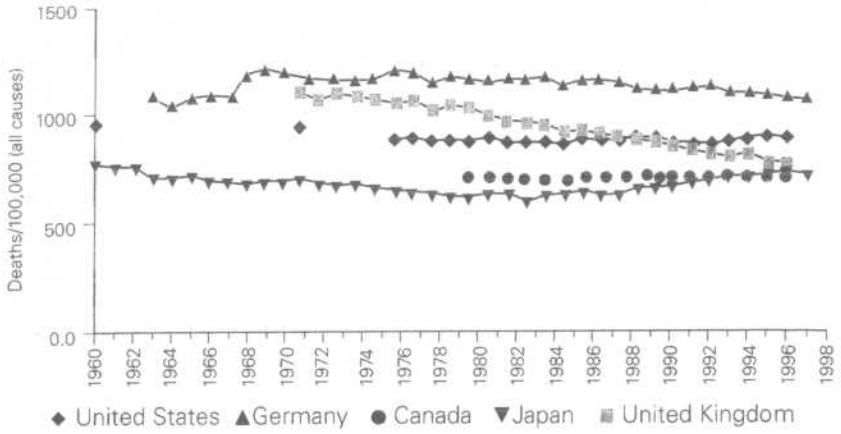
Over the same period, infant mortality has declined, steeply at first and then more gradually. Again, the United States fares somewhat worse than the comparator nations. General population mortality performance is mixed, but falls within a fairly tight range (figure 4). Approximately two-thirds of all deaths in each nation arise from the top two major causes: heart

**Figure 4. Infant Mortality in Five Industrialized Nations, 1960–1998**




Source: OECD Health Data 1998

**Figure 5. Mortality in Five Industrialized Nations, 1960–1998**




Source: OECD Health Data 1998

disease and cancer (figure 5).

On balance, what is striking about the health outcomes of the systems in these five countries is their similarity. Health, as it can be measured, has been improving. Spending, too, has been increasing. Also, although people are living longer, they are dying of similar causes and at similar rates.

Why are health care costs so much higher in the United States than in other developed nations? There are many possible reasons. Perhaps it is because, per capita, the United States provides more care (as measured by the number or duration of doctor visits, hospital stays, or prescriptions). In addition, the United States may be providing higher-cost care at similar rates per capita. We also may be delivering health care less efficiently (i.e., with high administrative or overhead costs). Another explanation may be that the costs of other health systems are being "externalized," that is, expenses are taking the form of long patient-waiting times and unnecessary suffering.

Analysis of existing data suggests that higher U.S. health care expenditures are driven by higher per-unit cost of care. Hospital expenses are the largest component of health care spending, about 40 percent of the total. U.S. hospitals have fewer beds and shorter lengths of stay, but employ more staff and technology to accomplish the job.

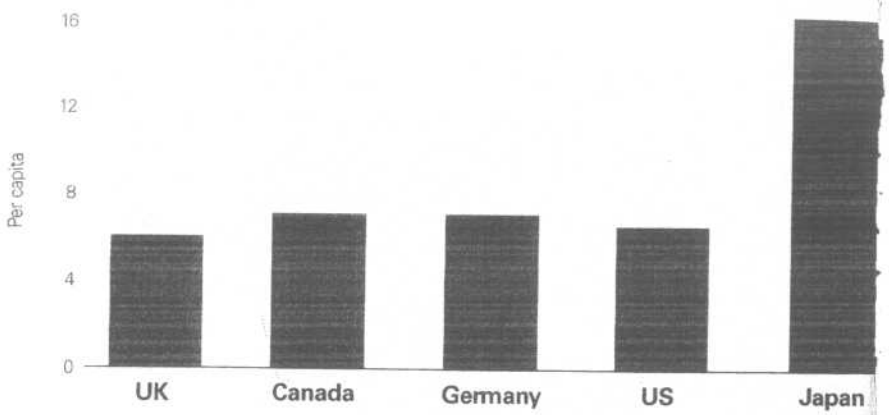
Physician services make up the second biggest health system expense, comprising approximately 20 percent of the total. The United States has a high number of physicians, and they are among the highest paid. Nevertheless, they see their patients no more frequently than do their international colleagues (figure 6).

How do other nations control the cost per unit of service? The details vary by country, but the broad answer is that powerful associations of payers (national or state government, insurance companies, or sickness funds) bargain with providers over fee schedules or institutional budgets. With most care covered within this framework, little opportunity exists for the cost to shift backward to payers, forward to patients, or sideways to other payers. In such budgetary systems, controls are often mandated (or adopted by administrators) to prevent the proliferation of expensive technology or growth in physician supply.

## ACADEMIC HEALTH CENTER LESSONS: A CASE STUDY IN WASTED RESOURCES

One might argue that, short of a major national reform of health care, aca-

**Figure 6. Average Physician Visits in Five Industrialized Nations, 1998**




Source: OECD Health Data 1998

demic health centers in the United States can do little to learn from the international experience. This view, however, is mistaken. Indeed, the authors' experience within a large academic health center also proves otherwise.

As previously noted, many nations (other than Japan) keep costs down in part by maintaining tight controls on capital equipment expenditures (i.e., outlays for long-term assets that are expensed over many years). At times and in certain countries, difficult choices made to constrain such spending have produced waiting lists for nonemergency procedures or a preference for lower-cost, lower-resolution imaging.

The United States, on the other hand, may have the opposite problem: an oversupply of sophisticated technology. Some might argue that this is the unavoidable result of hospital competition, or what is often called the "medical arms race." Although true during the Cold War years, the basis for competition in health care (and, coincidentally, between the United States and Russia) has changed drastically in the last decade.

Technological competition is still a factor for academic health centers, but it is only one of many explanations for the oversupply of sophisticated medical technology. Consider the following typical anecdote that any external health care consultant (such as the coauthors) can relate.



An analysis of Radiology Department data at a large institution recently indicated that, of 150 different imaging machines, 60 were being used once per day or less. When queried, organizational managers and radiologists reacted defensively, suggesting that these results could be explained by inappropriate data entry (a poor use of expensive information technology), special research and teaching needs, and the failure to retire old and fully depreciated resources. These justifications indeed were true to some extent. Nonetheless, it was also true that the department capital was not being managed efficiently. Many seldom-used resources took up rooms full of expensive (and highly needed) space, and all the machinery required maintenance or service contracts as well as a spare-parts inventory. Erroneously assuming that all resources were being used at full capacity, administrators were continuing to replace equipment.

We discovered, as might be expected, that the process by which hospital capital expenditures were approved was political. The powerful won the day. This statement is less pejorative than realistic. The world is political. Once we face this fact, we can seriously consider the character of political processes. Does the political process weed out the truly bad ideas despite the power of their advocates? Does it allow the good ideas to bubble up, even from weak advocates?

At this particular academic health center, department managers and clinical chiefs, armed with cost-benefit reports, argued with the hospital's top officers in favor of their department's priorities. Anyone familiar with such constructions knows that, in such situations, people tend to project great future benefits (often with help from the vendors) while understating the costs. Surprisingly, the Finance Department's role at this institution was to support these analyses, not question them.

What this institution was missing was an organizational force that questions the assumptions of such reports and holds the managers accountable for the benefits promised once the money is spent. In this case, by the time the funds were spent, the original analyses had found the dustbin. Promised benefits, which often had necessitated painful labor cuts or procedural changes, typically failed to materialize. This pattern is by no means unique to the particular academic health center used as an example. Every institution should develop such an organizational force to control costs.

Those charged with the responsibility of controlling costs must have access to the data used to make cost-and-benefit projections. The members of this force also need the analytical skills to make sense of the data, as well as an appreciation for the clinical processes to be funded. In addition, it would be wise to give the force members tenure or some other form of job security, so that frustrated project advocates cannot undermine their careers.

Tighter management of capital expenditures will become increasingly important as the health care industry invests more heavily in information technology (IT). Other industries, better known for their management expertise, have been frustrated with their returns on such investments. Other nations have strong IT cost controls in place. The wise academic health center executive will learn from these other countries and carefully examine the organization's capacity to choose and manage these large investments. This is a case of the aforementioned form of lesson-drawing that is rare but powerful: a policy generalization that holds true in many divergent cases, across all countries.

## HEALTH POLICY, NATIONAL SCHEMES, AND GLOBAL FORCES

Why is health reform a global trend today? Health care policy came to the forefront of public agendas during the late 1980s and early 1990s for one or more of the following reasons.

First, all around the world, the financing of personal health care had become a major financial component of the budgets for mature welfare states. When fiscal strain arises, as it did during the prolonged recession of recent years, the predictable result is policy scrutiny, not simply incremental budgeting.

Second, under almost all circumstances, mature welfare states have less capacity for bold fiscal expansion in new areas (O'Higgins and Klein, 1988). This means that the management of existing programs (in new ways perhaps, but under changing economic circumstances) necessarily occupies a larger share of the public agenda. We also are now seeing what might be termed the "wearing out" (or perhaps the "wearing down") of the postwar consensus about the welfare state—namely, we are at last outgrowing the



effects of more than two decades of fretfulness about the affordability, desirability, and governability of the welfare state (Murray, 1995; Herrnstein, Murray, 1996).

The critics of welfare became outspoken during the 1973-74 oil crisis when they were sustained by stagflation and bolstered by the advance of parties opposed to welfare state expansion. For the first time, the mass public witnessed programs being challenged that for decades had seemed sacrosanct (Marmor et al., 1990). From Mulroney to Thatcher, and from New Zealand to the Netherlands, reformers were calling for a "necessary change."

At such times, when economic strain reappears, the inner rim of programmatic protection weakens, that is, not because the commitment of particular interest groups grows more faint but because their social faith dwindles. The incentives for exploring transformative, but fiscally practical options, grow stronger. Such developments help to explain the clear international pattern of welfare state review, including health policy, over the past decade. It is a process of review that intensified in 1990 as recession moved across national borders.

## CONCLUSION

Even if we accept this contention, however, the question still remains: Why have these reviews focused so much attention on other national experiences? Times of policy change sharply increase the demand for new ideas, or at least for new means to old ends. Just as many U.S. analysts have turned to Canada's example, so too have Canadian, German, Dutch, and other analysts turned their attention internationally. This is readily seen at international meetings where conference participants eagerly cite accounts from other countries' experiences.

As illustration, let us consider the topics in which attendees expressed interest at one recent international conference. Participants sought to obtain better policy answers to the problems conferees face at home, such as how to find a balance between solidarity and subsidiarity; how to maintain a high-quality health system in times of economic stress; and (an optimistic query) what are the optimum relations between patients, insurers, providers, and the government.

If viewed as simple expressions of curiosity, these topics are comparatively unremarkable. However, if the topics are understood to be an outgrowth of a diligent pursuit of the best health care model (albeit excluding further exploration of the political, social, and economic context required for implementation), they reveal an overall intent to initiate change, even if the intention constitutes little more than wishful thinking. This is a crucial distinction because all too often conferees see international meetings as an opportunity to exchange information merely so they can stretch themselves intellectually. In such a case, people may embark upon quests to exchange policy information of various sorts without intending to make a commitment to policy importation. In other words, there is a substantial difference between simply exchanging views with kindred spirits and explicitly seeking to stimulate new ideas about specific initiatives.

What may be said about drawing policy lessons from such international conferences? What are the rules of defensible conduct at these meetings, and are they followed? The truth is that, whatever the appearances, most policy debates in most countries are, and will remain, parochial affairs. They address national problems and emphasize historical and contemporary national developments within a particular domain (pensions, medical finance, transportation, etc.). In general, they embody conflicting visions of which policies each particular country should adopt. Only rarely do participants seriously consider the experiences of other nations and the lessons they can teach.

Unfortunately, when cross-national comparisons are employed in such parochial struggles, their use is typically limited to policy warfare and not to policy understanding and careful lesson-drawing. Furthermore, at home there are typically few knowledgeable critics of ideas about solutions abroad. In the world of the U.S. health care debate, the misuse of the British and Canadian experience surely illustrates this point. From the late 1940s to the late 1970s, the U.K. National Health Service was viewed by many U.S. observers as the specter of what government medicine and rationing could mean. In recent years, mythmaking about Canada has dominated the distortion league tables in North America (Marmor, 1994). It is clear that the parochialism of national debates remains dominant.

The reasons are almost too obvious to cite. Policy makers and managers are busy with day-to-day pressures. If they take the time for comparative inquiry at all, practical concerns incline them to pay more attention to what appears to work. They cannot take the time to examine academic reasons for what is and is not transferable, and why.

Policy debaters, whether they are politicians, policy analysts, or representatives of particular interest groups, are more engaged in struggles than in seminars. Like trial lawyers, they seek victory, not illumination. For this purpose, compelling stories, whether well-substantiated or not, seem to be more useful than careful conclusions. Interest groups, as their label suggests, have material and symbolic stakes in policy outcomes and neither have nor feel the need to protect a reputation for intellectual precision.

These considerations are not new, nor are they surprising. However, there has been an increased flow of cross-national claims in health policy in recent years. This trend, if nothing else, will generate new reasons to reconsider the meaning of cross-national policy learning.

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