



Blind Faith and Choice

It's February. Politicians, back from climbing mountains or whatever else they do during their summer vacations from boarding school and current affairs programmes are looking for easy road kill. Already a few health managers (unproductive bean counters and bureaucrats is a common sobriquet) have been caught in the glare of searchlights looking for a headline. As the debate on access to Herceptin went through its headline cycle here I looked in vain for mention of the English High Court turning down a suit by a woman seeking to have the NHS supply her.

A lot has been happening within the NHS. Despite the unsustainable billions thrown at it, the NHS is in deep financial trouble and services are being cut back as Trusts frantically try to balance their books. Yet still new innovations are being rolled out in attempt to provide more choice and faster service. Before going on in this issue to outline some of those innovations, a British health economist, comparing her first experience navigating the American health care system with a visit to the local Baskin-Robbins ice cream parlour—famous home of the '31 flavours'—asks, "Can we treat health care like ice cream? Does more choice raise collective society benefit or well-being?"

During a year spent in Seattle as a Commonwealth Fund Harkness Fellow in Health Care Policy, Rhiannon Tudor Edwards was "overwhelmed" by the choices offered among coffee, TV channels, and health care options. But, as she recounts in her essay, *Blind Faith and Choice* (*Health Affairs*, Nov./Dec. 2005), when Edwards developed a serious sinus infection, she had trouble tracking down a provider that would both agree to accept her "comprehensive" health insurance and schedule a timely appointment. Edwards, a senior research fellow in health economics at the University of Wales, noted that in the U.K. waiting a day or two for an appointment with a general practitioner is routine, Yet ironically, "in the U.S. there was more choice of providers unable to offer me an immediate appointment." (As Commonwealth Five Nations surveys show, access to a primary care provider is one area in which New Zealand excels).

Edwards, who has retinitis pigmentosa, has been visually impaired since birth, and legally blind for the past ten years, eventually visited a health clinic that accepted walk-ins—not so much as a result of informed choice as one of immediate need. Her experience was quite illuminating.

"The waitingroom was extremely basic, and the bedside manner with which we were greeted was far less friendly than at the vet's office where my guide dog was treated. It went through my mind that this visit was not the outcome of an informed choice. The first question put to me was whether I would be billing an insurance company for the appointment. I then had to surrender my insurance card and wait whilst it was checked. The primary concern of the clinic was not "What is the problem?" or "Have you been here before?" just "How will you be paying?" After handing over my Blue Cross insurance card, I was presented with five pages of forms to complete. The forms asked for background information, Social Security number, insurance details (again), and then there was a health questionnaire. Of course, for a blind or visually impaired person, forms are difficult or impossible, so this became a job for my husband.

After waiting about half an hour, I was asked for my \$5 co-payment. Another half-hour later, I was shown into a small examining room. Fifteen minutes after that, a nurse practitioner came in, confirmed that I had a sinus infection, and wrote a prescription for Augmentin. On

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the way out, the receptionist—who wanted to photocopy the prescription I had been given—chased us across the road. All of the records, I learned, were paper and kept for only one year. At the Safeway pharmacy I was asked for more insurance details and proof of identity. The pharmacist wanted to see my driver's license, which, as a blind person, I was not able to produce. By now I was feeling really rough. Two signatures and a further \$5 co-payment later, I had the antibiotics in my sweaty little hand and retreated to bed.

Edwards was surprised when American friends later quizzed her about the brand of antibiotics she had been prescribed; as a Briton, she would not have thought that she had a choice in the matter.

Proponents of the individual health

insurance market and health savings accounts promise they can provide consumers choice among health plans, providers, and even treatments. Such policies are grounded in economic theory positing that the "invisible hand" of the competitive market can efficiently balance supply and demand. This can work when consumers are fully informed, goods or services are homogeneous, and there is free entry into and out of the market. But, Edwards argues, none of these conditions exists in the U.S. health care system.

Rather than freely choosing among providers, patients typically depend on their doctors to act in their best interest. Edwards cites a 2002 Harris Interactive survey of U.S. adults that found only 1 percent of respondents had made a decision to change health plans, doctors, or hospitals on the basis of performance evidence.

What's more, choice has yet to produce outstanding health status or equitable access to needed care in U.S., especially when compared with other modern health systems. Patients without insurance have few or no choices about their care. In fact, policies such as health savings accounts can actually isolate patients, Edwards finds, forcing them to take on greater financial responsibility and risk.

"Ultimately, choice comes at a price. As consumers, we are expected to pay for the privilege of choice, and if we cannot pay, we do not get to choose and, more than likely, do not get at all," concludes Edwards. "I left the U.S. convinced that having less choice in health care is a price well worth paying for universal coverage." #

Spiralling cash crisis has NHS Hospitals on critical list

THE full scale of the crisis facing the NHS was revealed in January when ministers admitted that up to 50 trusts had lost control of their finances.

Patricia Hewitt, the Health Secretary, "named and shamed" 18 NHS trusts who have plunged into substantial deficit and will now have outside accountants imposed on them to find millions of pounds of savings. A further 32 organisations will be given additional "advice and management support", while another 19 needed "drive and focus" to meet their financial targets

Her comments came as a survey of hospital managers found that more than three quarters of NHS trusts currently in deficit have cut staff, 52 per cent have closed wards while 48 per cent are delaying work, and another 38 per cent have cancelled services or restricted eligibility for services.

Ms Hewitt admitted that it was a "difficult and anxious time" for NHS staff as years of huge financial generosity ended with the health service last year recording its first financial deficit since 1999-2000. At £76.4 billion, the NHS budget is now larger than the gross domestic product of 155 members of the United Nations, she said. "It is one of the largest and most com-

plex organisations in the world, and three quarters of trusts have delivered improvements within their budget."

The NHS Confederation, which represents managers, gave warning that the financial problems were undermining public confidence. "It is wrong of the Government to simply blame NHS managers" said Gill Morgan, the confederation's chief executive.

"The causes of the current problems are deep-rooted and long-term." They would never be resolved until politicians allowed NHS managers to "make some painful decisions" — such as closing hospitals or reducing the number of beds. "A fixation with buildings is preventing the development of new and imaginative services," she said.

Andrew Lansley, the Shadow Health Secretary, said: "There are clearly systematic problems because at the same time as resources to the NHS are increasing dramatically, costs have ballooned. "Instead of the Department of Health blaming trusts, Patricia Hewitt should come to Parliament and make a full statement on the financial prospects for the NHS, for this year and the coming financial year".

Asked to explain how in the midst of plenty the NHS was running out of

money, she said that there were a variety of reasons. Last year she said that halfway through the financial year the NHS was forecasting a total deficit of £620 million, against last year's £250 million.

She refused to say where the projected deficit now stood, saying that the situation was being closely monitored. Publishing a "rulebook" for the NHS for 2006/07, she said that financial good health would be among the priorities for all NHS organisations. But she emphasised that she was not putting money before medicine.

"For the next financial year we actually want to move the NHS towards a surplus and we want every part of the NHS to start thinking about how it can build reserves. "Every organisation ought to be operating on the basis of small reserves" she said.

Many of the deficits have arisen in more affluent areas. One reason is that they tend to have more GPs, and therefore more patients tend to be referred for hospital treatment. In poorer areas, there were fewer referrals but more emergency admissions, the result of health problems not being treated sooner. #

Squeezing a surgery in next to the delicatessen

Here, we are all set to accept pharmacies in The Warehouse, where we hope customers will get a bargain. In England they have taken choice and convenience one step further.

J SAINSBURY is poised to become the first supermarket group to house NHS surgeries in its stores, after talks between Justin King, the retailer's chief executive, and Caroline Flint, the Under Secretary for Public Health.

Sainsbury's believes that a move into healthcare would be a natural fit for its brand, and is keen to install GP surgeries in those of its stores that already contain pharmacies.

Further meetings are scheduled for next week between Sainsbury's and Department of Health representatives. The department has also held discussions with Boots, the high street chemist, about the issue.

The move comes after the Government last month published a White Paper in which Patricia Hewitt, the Health Secretary, promised to bring "healthcare to the doorstep".

The Government wants Primary Healthcare Trusts to commission extra surgeries through open tendering and is changing the rules so that patients can register at practices near their work or in other convenient locations, rather than near their homes.

Sainsbury's told *Retail Week*, the trade journal, that it saw an opportunity for having GP surgeries in the 161 of its stores that already house pharmacies. The supermarket chain plans to open a further 50 pharmacies over the next 12 months. However, industry experts said that the supermarket was unlikely to be able to open GP surgeries in all its stores because of lack of space.

Sainsbury's and Boots are already assessing suitable locations for trial surgeries and it is thought that the first practices could open by the end of the year.

The Government is keen to encourage the opening of new surgeries in deprived areas where, traditionally, GPs who are self-employed have been less likely to work. Stores in those loca-

tions are likely to be the first to get surgeries.

A spokesman for Boots said: "We can see the demand in our stores to put healthcare on the high street. It makes a lot of sense and we want to work with the Government to provide those services."

Boots wants to gain a bigger share of the £1.76 billion annual government fund paid out to pharmacies that offer health services such as medicine reviews.

Boots already offers at its stores clinics for people trying to give up smoking or to lose weight and has trialled testing for chlamydia in London stores.

However, having doctors in stores would present a new problem because most GPs are self-employed. Retailers are unlikely to want to have GPs on their payrolls and so will want to agree an arrangement whereby, for example, a third-party provider of health professionals would employ GPs for stores.

City analysts said that Boots's brand could clearly be easily translated into health services, but that its past moves into chiropody and dentistry had proved commercially disastrous.

The White Paper plans to allow private companies to run super-surgeries that serve inner-city or deprived areas. The new plans aim to make GP services more accessible and easier to use.

Patients will be able to register with practices near where they work, some in supermarkets. Unlike traditional practices, they will not have catchment areas.

The White Paper aims to encourage primary care trusts to commission extra surgeries, through open tendering, in a series of nationally co-ordinated waves. Voluntary organisations and doctors' out-of-hours co-operatives will also be encour-



aged to become involved in providing the new practices.

These new clinics seem to be an advancement on the 60+ NHS Walk-in Centres sited near railway stations and other high pedestrian count locations. The centres offer fast and convenient access to local NHS services, information and treatment without needing an appointment. There are some variations between services offered by Walk-in Centres but commonly they provide:

- * Treatment for minor illnesses and injuries
- * Assessment by an experienced NHS nurse
- * Advice on how to stay healthy
- * Information on out-of-hours GP and dental services
- * Information on local pharmacy services
- * Information on other local health services #



The concept is not confined to Britain. A Doctor's surgery in an Omaha, Nebraska supermarket

Health Alert: Infectious Ideas

The closing of hospitals and/or bed reductions are never popular with the local community directly affected. In a response to proposed NHS hospital closures, communities in the stockbroker belt are fighting back with a radical idea (popular in New Zealand) - funding their own hospital. Libby Purves filed this account in *The Times*.

"The websites of NHS primary care trusts are bright and jolly. They feature babies smiling at grandparents, and phrases like "Changing for the Better - Next Steps" and "More care closer to home". They reduce the font size to mutter hastily about "modified care pathways" and "strategic closures", but all the same, those who script this stuff are plainly feeling good. Their cyber-world is a far cry from the timeless aches and staggerings of humanity: like Keats's nightingale, they live apart from the weariness, the fever and the fret of this sad world where palsy shakes a few sad, last grey hairs and men must sit and hear each other groan.

Nor do they reflect the grim visage of the Health Secretary, who this week ruled that "excellence in financial management" comes ahead of mere clinical objectives. From PCT websites you would never guess at the depth, breadth and despair of the NHS recession. Twenty-two years ago, here in rural Suffolk, we had a cottage hospital, GPs who came out by night, an NHS dentist within cycling distance and a maternity home and mental hospital ten miles away. Now those two are shut and sold, out-of-hours illness condemns you to the evasions of NHS Direct ("a nurse will ring in the next hour or two") and eventually to a tired, cross locum. We have had no dentist for two years, though we are offered a place on a six-month waiting list 40 miles away.

Now the primary care trust is axing the last cottage hospitals. I am glad my children are grown up, and very glad we have two cars. Plenty do not. Cities have their problems — observe the London hospital betrayals — but for every 125p spent in urban deprived areas, we receive 80 or 90p. The Amicus union found one Suffolk health visitor had 500 patients under her care. Yet we have an large aged population and many unnoticed rural poor. Local practitioners are excellent and ener-

getic, but the glossy PCT websites look more and more like skeins of stardust thrown over real anxiety and pain.

Yet there is ingenuity and hope at the grassroots, if only government would let it flourish. Communities keep coming up with cracking good ideas, at minimal public cost, to provide what is needed. Two examples stand out. In the small town of Saxmundham, local doctors welcomed the NHS plan of 2000 and after involving everyone from police and firefighters to charities, proposed a one-stop shop for social and NHS services — including a nursery to serve a local pocket of child deprivation — all under one roof. In the *NHS Magazine*, John Hutton, then a Health Minister, said it should be progressed as soon as possible.

The primary care trust said it couldn't afford the rent (whereon the Department of Health hastily removed the article about it from its website) so the community worked out a way to get private money from a commercial provider to cover the rent. But the PCT panicked and said, according to Dr John Havard, the incredulous local GP, that a new building might "raise expectations" and cause "unmet need". So much for patient choice: they're afraid that people will selfishly choose to be ill, therefore services must be kept awkward and unavailable.

The next proposal was even more daring. In a round of hasty cuts to meet a £40 million deficit, several small hospitals are due to be closed (as are 80 others nationwide) and the heavily used Aldeburgh Cottage Hospital to be reduced by a third. The intention is to abolish "step-down" beds for patients recovering after treatment in the big distant hospitals. These are an immensely valuable service for the elderly, and free up acute beds in the main hospital. The PCT, however, airily says that it is "better" for people to receive care at home — which, when you live alone in a cottage up a track, with a five-hundredth share of a health visitor and no bell to ring if you can't breathe at 3am, is not convincing.

But here come saviours! The community wants the little hospital; the PCT's own consultation overwhelmingly proved that, though they staunchly ignored it.

So the community - which has already raised hundreds of thousands to support it - proposes to buy the hospital outright. They would issue shares - untradeable, more like a loan note against the property value. A charitable trust would run it, reserving the right to buy the shares back gradually.

It would have a contract with the PCT to provide the beds it still wants; the remaining ones would be used for new services such as dialysis, hospice care and outreach chemotherapy, which would attract income under the new NHS principle of practice-based commissioning by GPs. A decent little hospital would be saved, in a very new Labour spirit of diversity and public-private co-operation, with the more affluent gladly supporting the rest by ethical investment. Which, after all, is how the great Victorian hospitals began.

This daring piece of people-power was mooted at the end of last year and drew some attention. Shareholders stepped up to make an investment without thought of profit. One, a retired director of *Crédit Suisse*, said: "I consider my capital safe in the bricks and mortar of the hospital . . . more importantly, we can indirectly contribute to the good of the extended community."

So far, so good. But no official has yet said "yes", let alone "yes please!". Watch carefully now: see whether the PCT bureaucrats impede this daring plan because it undermines their desire to show that such hospitals are not necessary, and might raise questions as to why they couldn't run it properly themselves.

See whether the Health Secretary backs it as an example of local responsibility, or whether she pretends not to notice, afraid that a successful small hospital might rock the boat nationally. See whether - if the buyout happens - the new trust gets spitefully loaded with expensive mad regulation on purpose to scupper it. Watch closely. It's not just about Suffolk #

Primary Care and Health System Performance: Adults' Experiences in Five Countries

An effective, accessible primary care system is instrumental in improving health outcomes, keeping health costs down, and helping people lead healthy, productive lives. But according to a 2004 Commonwealth Fund/Harris Interactive survey of patients in five industrialized nations, a serious shortfall in the delivery of safe, effective, timely, or patient-centered primary care is an international problem.

In assessing adults' primary care experiences in the last three years in Australia, Canada, New Zealand, the United Kingdom, and the United States, the researchers found widespread concerns about gaining prompt access to a doctor when sick, delays in receiving lab test results and test errors, and physicians' failure to engage patients or promote health, as reported in "[Primary Care and Health System Performance: Adults' Experiences in Five Countries](#)" (*Health Affairs* Oct., 2004). Americans reported cost-related difficulties accessing care at especially high rates. Lack of same-day appointment availability, long waits to see a doctor when sick, and reliance on the emergency room for routine care were also big problems in both Canada and the U.S.

The authors note that all five countries could do better. The survey findings, they say, underscore "the importance of examining international strategies that could be adapted and instituted at home."

Access to Care

Access to care is related to costs, and particularly to a nation's insurance system. Given often high uninsured rates and cost-sharing in the U.S., Americans were the most likely to report not seeing a doctor when sick, not getting recommended tests or follow-up care, or going without prescription medications because of high costs. The U.K., in contrast, showed negligible cost-related access problems, while the other countries stood in between the extremes. Timeliness of access was also a greater problem in North America than elsewhere. While the majority of adults in New Zealand and Australia said they received appointments on the same day when

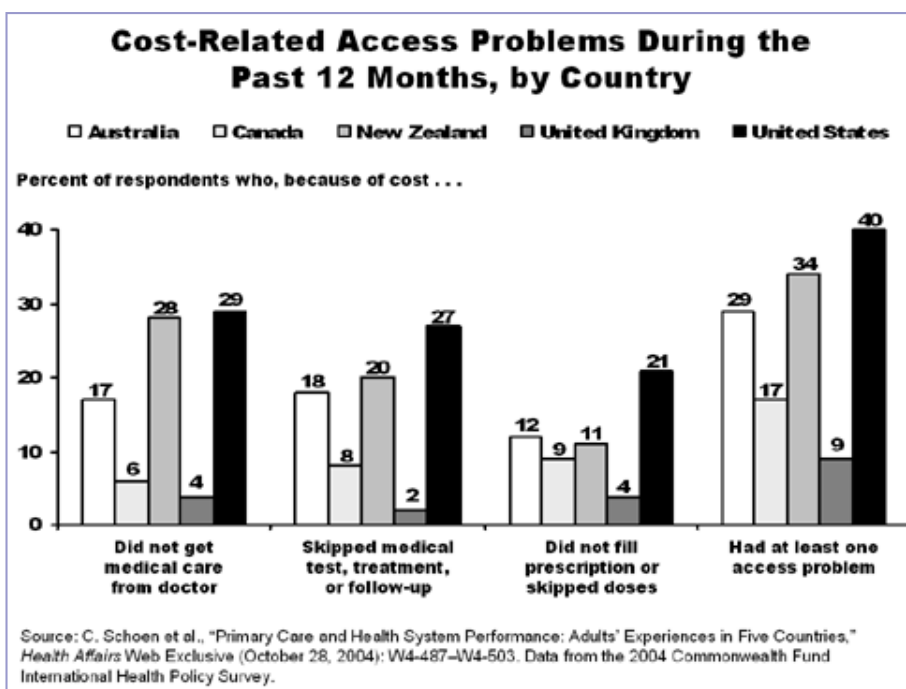
they were last sick and needed medical attention, only one-third or less of Canadian or U.S. adults reported such rapid entry.

Reliance on Emergency Rooms

Emergency rooms are a key access point for patients in crisis, but their use is also an indicator of how well a nation's care system is responding to patients' needs. ERs function as safety nets when timely access to primary care is not available. Though the survey found that adults in all five countries substituted ER visits for regular doctor care, Canadian and U.S. adults

physicians to review medications were frequent, and high proportions of these respondents also said that their doctor had not explained drug side effects.

The survey revealed doctors' missed opportunities to identify patient preferences or concerns, to communicate well, or to engage patients in care decisions. For example, one of five U.K. and U.S. adults said their doctors only sometimes, rarely, or never made treatment goals clear. Similarly, failure to engage patients in treatment plans was frequent in all countries, though highest in the U.K. and U.S.



were more likely to have gone to the ER for care that regular sources could have provided, if available.

Coordination and Communication

The survey found coordination and continuity concerns in all five countries. Among adults with recent doctor visits, more than one of four reported that test results or medical records were not available at the time of a scheduled appointment, that they received duplicate tests or procedures, or that they received conflicting information. For each of these three measures, U.S. rates were higher than rates for three of the other four countries. Among patients taking prescription drugs on a regular basis, failures by

Preventive Care

Preventive care was one area where the U.S. tended to lead or rank highly. The U.S. stands out for having the best rates of preventive care, such as Pap tests for women ages 25–64 and mammograms for women 50–64. However, shortfalls—such as in directing patients toward flu shots—were found in all five countries. At least half of respondents in each country said their doctor does not send reminders, has not recently provided advice or counseling on weight or exercise, or does not ask if emotional issues are affecting their health.

Conclusions

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Respondents in the surveyed countries called for major reforms in their nations' primary care systems, with only a minority of adults saying they were "very confident" that they will get quality, safe medical care when needed. U.S. respondents, however, stood out as the most negative in their overall health system views. U.K. respondents had the most positive perspectives on their country's health system.

The report cites a variety of promising policy initiatives under way in each country that are aimed at addressing some of the noted deficiencies. Such

efforts—ranging from incentive-based contracting with general practitioners in the U.K. to ER learning collaboratives in Australia—warrant tracking over time, the authors say, adding that all five nations should examine these and other international strategies for possible adaptation at home.

Facts and Figures

- One of five adults surveyed in the U.S. and Canada had to wait at least six days to get an appointment when sick.
- Eight to 15 percent of patients in all five countries said they were given incorrect test results or ex-

perienced delays in being notified about abnormal results.

- Only 37 percent of U.S. survey respondents reported that they had been going to their doctor or usual place of care for five years or more. By contrast, 50 to 63 percent of respondents in the other four countries reported the same.

Between one-half and three-quarters of patients in the five nations said they had not received advice or counseling on weight, nutrition, or exercise—from 48 percent in the U.S. to 72 percent in the U.K. #

Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries

A new international survey supported by The Commonwealth Fund finds that one-third of U.S. patients with health problems reported experiencing medical mistakes, medication errors, or inaccurate or delayed lab results—the highest rate of any of the six nations surveyed. While sicker patients in all countries reported safety risks, poor care coordination, and inadequate chronic care treatment, with no country deemed best or worst overall, the United States stood out for high error rates, inefficient coordination of care, and high out-of-pocket costs resulting in forgone care.

Results and analysis from the survey—the eighth in a series of Fund-supported cross-national surveys—are discussed in [Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries](#) (*Health Affairs*, November, 2005).

For the first time, the survey includes Germany, in addition to Australia, Canada, New Zealand, the United Kingdom, and the United States. The 2005 study examines issues of safety, health care coordination, chronic disease care, and access to care. Adults who had recently been hospitalized, had surgery, or had health problems were interviewed by telephone between March and June 2005.

Medical, Medication, and Lab Errors

One-third (34%) of U.S. respondents

reported at least one of four types of errors: they believed they experienced a medical mistake in treatment or care, were given the wrong medication or dose, were given incorrect test results, or experienced delays in receiving abnormal test results. Three of 10 (30%) Canadian respondents reported at least one of these errors, as did one-fifth or more of patients in Australia (27%), New Zealand (25%), Germany (23%), and the U.K. (22%). While patient safety efforts have focused chiefly on hospital settings, most patients (60% or more) said these errors occurred outside the hospital—a signal that safety initiatives should also focus on ambulatory care, said Cathy Schoen, the study's lead author and a senior vice president at The Commonwealth Fund.

Patients receiving complex care may be at even higher risk of medical errors: the incidence of patient-reported errors rose sharply with the number of physicians seen. Despite studies showing patients value discussion about mistakes or errors, most patients (61% to 83%) in each country said the health care providers involved did not tell them about the mistakes.

Communication and Care Coordination

Communication issues also adversely affect patients' experiences during hospital stays. At least one-fifth of patients (19% to 26%) in the six countries reported communication gaps between

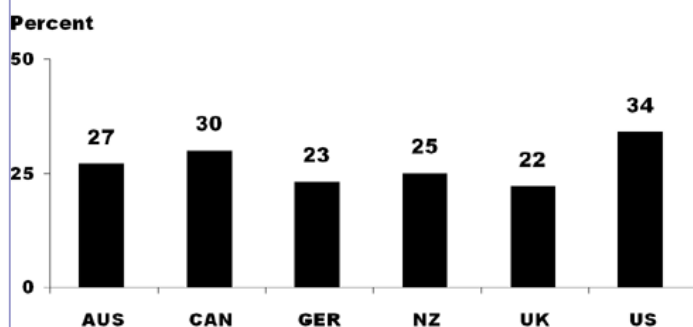
themselves and hospital staff, and one-sixth said they would have liked greater involvement in decisions made about their care.

Good transitional care—helping patients transfer from hospital to home—also relies on clear communication and coordination. In all six countries, however, at least one-third of patients said they did not receive instructions about symptoms to watch for, did not know whom to contact with questions, or were left without follow-up care arrangements. German patients had the highest rate of coordination deficiencies when discharged from the hospital, with 60 percent reporting failures to coordinate care. According to the authors, poor transitional care can result in complications and increase the likelihood of hospital readmission, raising concerns about costs as well as quality.

While the U.S. performed better than most countries on the hospital transition measure, it had the highest rate of patients reporting coordination problems during doctor visits. One-third (33%) of U.S. respondents said that either test results or records were not available at the time of appointments or that doctors duplicated tests. These delays and duplications are a clear sign of inefficient care, the authors said, and waste both physicians' and patients' time and resources. Rates of care coordination problems in the other sur-

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Any Error: Medical Mistake, Medication Error or Test Error in Past 2 Years



Source: C. Schoen et al., "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005): W5-509–W5-525. Data from the 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults.

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vey countries were significantly lower, ranging from one-fifth to one-quarter of patients reporting such problems.

Access Issues, Financial Burdens, and Forgone Care

As was found in past surveys, the U.S. is an outlier in terms of financial burdens placed on patients. One-half of adults with health problems in the U.S. said they did not see a doctor when sick, did not get recommended treatment, or did not fill a prescription because of cost. Despite these high rates of forgone care, one-third of U.S. patients spent more than \$1,000 out-of-pocket in the past year. In contrast, just 13 percent of U.K. adults reported not getting needed care because of costs, and two-thirds had no out-of-pocket costs.

more likely to wait six days or longer for an appointment.

Overall Performance

The authors say that no country emerges as a clear winner or loser. All survey countries experience high rates of safety risks, failure to coordinate care during transitions, inadequate communication, and a lack of support for chronically ill patients. These areas of shared concern, they conclude, will likely require policy innovations that transcend current payment and delivery systems.

At the same time, majorities of patients in New Zealand (58%) and Germany (56%), and nearly half in Australia (49%) and the U.K. (45%), were able to get same-day appointments. Waiting times for elective surgery or specialists were shortest in Germany and the U.S., with the majority of patients in both countries reporting rapid access.

Facts and Figures:

- More than one of four patients in each country (28% to 32%) said risks were not completely explained during their hospital stay.
- In all countries, sizable majorities of patients said physicians had not always reviewed all their medications during the past year, and one-third or more reported infrequent reviews.
- Across countries, one-sixth to one-fourth of patients said physicians only sometimes, rarely, or never make goals of care and treatment clear or give them clear instructions.

Relative to the U.S. and Canada, the four countries reporting comparatively rapid access to physicians—Australia, Germany, New Zealand, and the U.K.—also had significantly lower rates of emergency room use. #

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by electronically
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or e-mail the Editor for more information at admin@nzihm.org.nz

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Inform Editor Bruce Parkes

Seminar Programme

March 28th

@ Red Cross Offices, 2
Woodbine Ave, Green Lane
5:30p.m. for 6p.m.

Leadership Myths

Shawn Bishop

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US Health Spending to 20% of GDP by 2015

The relatively stable trends expected through to 2015 are likely to obscure dramatic changes to the U.S. health care system during the next decade, say Christine Berger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal, and M. Kent Clemens, in their paper *Health Spending Projections Through 2015: Changes On The Horizon*, published in Health Affairs 22 February 2006.

The growth in national health spending is projected to slow in 2005 to 7.4 percent, from a peak of 9.1 percent in 2002. Private health insurance premiums are projected to slow to 6.6 percent in 2005, with a rebound expected in 2007. The introduction of Medicare Part D drug coverage in 2006 produces a dramatic shift in spending across payers but has little net effect on aggregate spending growth. Yet health spending is expected to consistently outpace gross domestic product (GDP) over the coming decade, accounting for 20 percent of GDP by 2015.

With the advent of the prescription drug benefit in 2006 and the oldest baby boomers enrolling during the next decade, Medicare is expanding quickly. The continued growth of Medicaid spending makes this source of health care funding an increasingly important issue for both the states and the federal government. Employers, meanwhile, are facing key decisions about the level and types of benefits to offer their employees and retirees, given rising health care costs and premiums. Private insurers continue to create new cost-sharing measures while also offering high-deductible health plans, both of which could change the dynamic of who pays for health care. With the continuing advancements in medical technology and treatments, the costs of and demand for health care are expected to increase.

Given this confluence of changes for both public and private payers and the authors' projection that health care spending growth will outpace the growth of the economy, they anticipate that society will again need to confront the underlying questions about the supply of and demand for health care services, as they anticipate that one in every five dollars will be devoted to this sector by 2015. #

Shawn Bishop, our March seminar presenter, held senior management positions with large national NZ organisations for many years. She was disappointed when training programmes these companies brought in failed to create lasting results. "When the workshops were over the manuals went onto the bookshelves - and nothing changed."

Does this ring bells with you? It was the catalyst for Shawn to create her own leadership development programme, which insisted on practical application after the initial training. Incorporating adult learning concepts, a modular format and participant project work; combined with an accountability for the learners to produce results, her leadership programme has filled a much needed niche in the training market.

Shawn is an international facilitator, having conducted training in countries as diverse as China, Japan, Taiwan, North and South America, Europe, United Kingdom, India, Singapore and the Middle East. She guest lectures for certain specialist modules such as Employment Law and Stress Management..

Shawn completed a Master of Science Degree in Education in The United States. After moving to New Zealand in 1985 she completed her post-graduate work in Personnel Management and Industrial Relations at the University of Auckland.

