DataWatch

Health Reform Lessons Learned From Physicians In Three Nations

by Robert J. Blendon, Karen Donelan, Robert Leitman, Arnold Epstein, Joel C. Cantor, Alan B. Cohen, Ian Morrison, Thomas Moloney, and Christian Koeck

Abstract: To explore the concerns of practicing physicians as a way to inform the health reform debate, the authors conducted a survey of physicians in the United States, Canada, and Germany. Survey results indicate that U.S. physicians are most likely to view affordability as the greatest barrier to access to care for their patients. However, unavailability of services and long waiting times were cited most often by Canadian physicians. German physicians did not cite access problems as frequently as Canadian physicians did; other measures of satisfaction were closer to U.S. levels, suggesting fewer trade-offs if the United States were to adopt aspects of the German health care system.

Many experts and political figures contend that the Clinton administration's proposed health care reform plan could be vastly improved if it resembled more closely the national health plans found in Canada and Germany.[1] Unlike parts of the administration's health proposal, which are largely untried in practice, the systems in these two countries have been in place for many years. Studies have shown that both nations provide universal coverage to their citizens at a lower cost per person than is true in the United States, with more public satisfaction.[2]

However, the question remains whether either the Canadian or the German systems, which include global budgets, price controls, and government health planning, would satisfy Americans' demands for high-quality and readily available health care. To address these issues, we developed a survey designed to determine the types of concerns the American public and its practicing physicians might have about alternative health systems and their desirability as models for U.S. health reform. These questions

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were designed to be asked of practicing physicians in all three countries, since we assumed that practicing physicians would have first-hand, in-depth knowledge about many of these crucial issues.

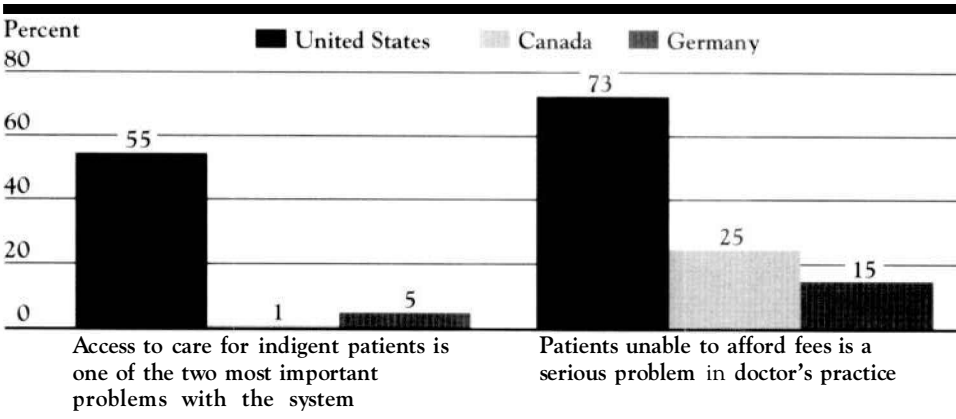
The first paper we developed from this three-nation physician survey reported that of physicians in all three countries, U.S. physicians were the least satisfied with their health system and German physicians the most satisfied.[3] In addition, U.S. physicians noted serious problems of access to care for low-income or uninsured persons-problems that were largely nonexistent in either Canada or Germany. However, in Canada physicians perceived problems with access to an adequate supply of health care facilities, a problem not seen widely in the other two countries. Similarly, German physicians reported much greater concern about the quality of certain types of inpatient hospital services than did their counterparts in either the United States or Canada.[4]

Methods. In this DataWatch we address questions that are of general policy interest, not targeted specifically at an audience of physicians. The data are taken from a survey of 602 physicians in the United States, 507 physicians in Canada, and 519 physicians in Germany, conducted in the period February-May 1991. Detailed information about the survey methods is presented elsewhere.[5] Respondents were selected at random from lists of practicing physicians in each country. All surveys were conducted by telephone by Louis Harris and Associates in the United States and its subcontractors, Consumer Contacts in Toronto, Ontario, and EMNID in Ebenhausen, Germany. Response rates were 44 percent in the United States, 49 percent in Canada, and 41 percent in Germany. Samples of 500 to 600 respondents are associated with sampling errors of approximately ±4 percent. Sources of nonsampling error include potential nonresponse bias, question wording and ordering effects, and cross-cultural differences in question interpretation.

Results

Do patients have problems obtaining the health services they need? Physicians responding to a number of different questions in our survey noted that barriers to needed care exist in all three countries, but the types of constraints are very different. Physicians in the United States were far more likely to see access to care for indigent patients as one of the two most important problems with their health care system (Exhibit 1). The data suggest that the Canadian and German systems do not insure all needed health services, but problems created by patients' inability to pay for care are relatively insignificant issues in these countries. On the other hand, our research has indicated that nonfinancial barriers to needed care, such as

Exhibit 1
Percentage Of Physicians In The United States, Canada, And Germany Who Identify Financial Barriers To Care As A Problem, 1991



Source: Three-Nation Physician Survey, 1991.

queuing for or unavailability of certain services, are more common in these countries than in the United States, particularly in Canada.[6]

In an effort to assess the impact of the three different health systems on the patients who rely on them for care, we asked physicians about their ability to meet patients' needs. Specifically, we wished to determine whether in the year prior to the survey, physicians were ever unable to provide or secure, within a reasonable time period, a series of particular clinical services. If they answered affirmatively, they were then asked how many times this had occurred. Exhibit 2 reports responses to these items; the results indicate some major differences between the countries in physicians' ability to provide needed care to their patients.

Exhibit 2
Percentage Of Physicians In The United States, Canada, And Germany Who Were Unable To Secure A Needed Service For A Patient Three Or More Times, 1991

Service	United States	Canada	Germany
Routine surgical procedures, such as cholecystectomy or hernia repair	5%	15%	4%
Complex surgical procedures, such as coronary artery bypass	5	17	12
Hospitalization	17	36	7
Complex diagnostic tests, such as CT scan or MRI	16	37	7
Long-term care and rehabilitative services	34	48	34

Source: Three-Nation Physician Survey, 1991.
Note: CT is computed tomography scan; MRI is magnetic resonance imaging.

Important differences exist between the United States and Canada in the proportion reporting difficulties in obtaining all five of the categories of patient care services listed. Canadian physicians reported problems of securing needed care for their patients with greater frequency than did U.S. physicians. Canadian physicians especially noted the difficulty of gaining access to hospital beds for routine admissions and of obtaining high-technology diagnostic tests; they reported fewer problems getting surgical care for their patients.

On the other hand, German physicians closely parallel the experience of U.S. physicians, reporting relatively few incidents where needed care could not be obtained for their patients. The only area where German physicians reported more frequent difficulties was that of providing complex surgical procedures, but the difficulties were noted by a smaller proportion of this group than of the Canadian physicians surveyed. The availability of adequate long-term care and rehabilitative services for patients was reported as a frequent problem by physicians in all three countries.

As a follow-up to this series of questions, we asked physicians to assess the main reason why they were unable to provide services their patients required. In the United States the two most frequently reported reasons were that health insurance would not cover payment (37 percent) and that providing the service would cause a financial problem for the patient (25 percent). Canadian physicians cited long waiting times required to obtain care (39 percent) and the lack of availability of hospital beds and services (each 27 percent). German physicians' responses were similar to those found in Canada in that the barriers were noneconomic–long waiting times (3 7 percent) or unavailable services (20 percent).

Do patients in Canada and Germany wait longer for care than in the United States? Critics of these systems often suggest that government-sponsored cost containment efforts inevitably lead to long queues for patient care services.[7] We queried physicians in all three countries about waiting times for five types of specific health care services (Exhibit 3).

For many types of services, waiting times are longer in Canada than in either the United States or Germany. For example, the survey found that in Canada the average reported waiting time for obtaining nonemergency surgery is six weeks, compared with two weeks in the United States and three weeks in Germany. Similarly, we asked how long a patient would have to wait for a breast biopsy after identification of a suspicious lesion by mammography. Thirty-two percent of Canadian physicians surveyed said that the patient would have to wait longer than a week to see a surgeon, while only 11 percent in the United States and 7 percent in Germany said that patients would have to wait that long.

How equitable are these waiting times within each country? Physicians

Exhibit 3
Physician Estimates Of Waiting Times By Patients In The United States, Canada, And Germany For Various Types Of Health Care Services, 1991

Item	United States	Canada	Germany
Mean wait for new nonemergency patient (days)	8	14	8
Mean wait in doctor's office (minutes)	20	18	32
Mean wait for specialist appointment (days)	8	27	9
Mean wait for nonemergency surgery (weeks)	2	6	3
Percent of patients waiting for more than a week for breast biopsy after identification of possibly malienant lesion	11%	32%	7%

Source: Three-Nation Physician Survey, 1991

were asked whether more affluent or influential patients were able to shorten waiting times for needed services. In Canada only 12 percent of physicians reported this as a frequent occurrence; in the United States the figure was 23 percent, and in Germany, 20 percent. These results suggest that Canadians wait longer for care, but the process of waiting is more equitable than is the case in either the United States or Germany.

Are medical services provided at an appropriate level to patients? Policy analysts have noted that providing universal access to health insurance could lead to excessive use of certain services.[8] On the other hand, we also have seen that limiting certain services could lead to underuse of important types of medical care. We asked physicians whether they believed certain types of care were underused, overused, or used in the right amount by other physicians in their specialty (Exhibit 4).

Physicians in Canada were more likely to indicate that consultations and referrals, diagnostic tests and procedures, and medications were underused than were doctors in the United States or Germany, although they did not differ in their assessment of the use of therapeutic surgical procedures. U.S. and German physicians gave similar reports of the overuse of consultations,

Exhibit 4
Physicians' Perceptions About Level Of Use Of Medical Services In Their Specialty, United States, Canada, And Germany, 1991

	United States			Canada			Germany		
	Over-used	Right amount	Under-used	Over-used	Right amount	Under-used	Over-used	Right amount	Under-used
Cmsultatiom/refenals	17%	66%	14%	10%	56%	30%	23%	61%	12%
Diagnostic tests] procedures	44	49	5	7	43	48	39	50	10
Therapeutic surgical procedures	11	77	2	3	75	7	12	77	3
Medications	38	55	2	4	43	47	69	27	1

Source: Three-Nation Physician Survey, 1991.

tests, and surgical procedures, although a substantially higher proportion of German physicians expressed concern about the overuse of medications. Substantial majorities of physicians in all three countries reported appropriate use of consultations and surgery.

Does the threat of malpractice influence physicians' treatment of patients in Canada and Germany? U.S. physicians have often pointed to the necessary practice of "defensive medicine" as contributing to overuse of certain health services in this country.[9] We asked doctors in all three countries how frequently they did more than they thought was clinically appropriate because of the threat of being sued for malpractice (Exhibit 5). The results indicate that U.S. physicians perceive the threat of malpractice as being a stronger influence on their decision making than do Canadian or German physicians. A majority (61 percent) of U.S. doctors said they often or sometimes do more than is necessary, compared with 39 percent in Canada and 44 percent in Germany. However, the data suggest that concerns over malpractice play a greater role in clinical decision making in these other countries than had been recognized previously.

How aggressively are terminally ill patients treated? The appropriate level of treatment for terminally ill patients has become a pressing issue in the United States from the standpoint of both quality of life and cost.[10] We used two types of questions to assess the differences in perspective on this issue among physicians practicing in the three different health systems. The first was a vignette prepared by a general internist to describe an elderly person who would need intensive care to provide him a very small likelihood of survival {Exhibit 6).[11] The majority of U.S. physicians (53 percent) said that this patient was very likely to be treated aggressively, compared with only 27 percent in Canada and 22 percent in Germany.

Responses to a more general question about the appropriateness of the level of services provided to terminally ill patients is shown in Exhibit 7. Although slight majorities of physicians in all three countries said that the

Exhibit 5
Frequency With Which Physicians Report That They Do More For Patients Than Is Clinically Appropriate Because Of Threat Of Being Sued For Malpractice, United States, Canada, And Germany, 1991

	United States	Canada	Germany
Often	32%	16%	20%
Sometimes	29	23	24
Occasionally	28	39	25
Never	10	19	24
Not applicable	1	3	6
Not sure	-	1	2

Source: Three-Nation Physician Survey, 1991

Exhibit 6
Vignette Describing Appropriate Level Of Treatment For Elderly Patients

Consider an eighty-five-year-old male with a fifty-year history of cigarette smoking and chronic pulmonary disease who has a baseline dyspnea on climbing four or five stairs or on 100 yards of ambulation. Seven days ago he was admitted to the hospital with pneumococcal pneumonia. Since then, despite antibiotics, he has continued to worsen with a persistent cough and progressive hypercapnia. His doctors now believe that he will die without aggressive care including intubation for a period of approximately three weeks. Even if this approach is attempted, his likelihood of survival is only 10 percent. In the hospital in which you currently work or in which most of your patients are hospitalized, are such patients very likely, somewhat likely, somewhat unlikely, or very unlikely to receive the type of aggressive care described?

Physician response	United States	Canada	Germany
Very likely	53%	27%	22%
Somewhat likely	26	23	32
Somewhat unlikely	9	15	19
Very unlikely	3	17	5
Not applicable	4	15	8
Not sure	4	4	14

Source: Three-Nation Physician Survey, 1991.

care provided is "the right amount," U.S. physicians were substantially more likely than Canadian doctors to say that too many services are provided. Medical specialists in Canada were more likely to see this as a problem than were primary care physicians in Canada.

These findings underscore the fact that there may be important cultural differences among these countries not only in the intensity of services provided at the end of life, but also in perceptions of whether that level of care is appropriate.

Exhibit 7
Physicians' Opinions About The Level Of Services Provided In Their Community And Specialty To Terminally Ill Patients In Their Final Stages Of Illness, United States, Canada, And Germany, 1991

	United States			Canada			Germany		
	Primary care	Specialists	All physicians	Primary care	Specialists	All physicians	Primary care	Specialists	All physicians
Too many services	31%	38%	35%	7%	21%	14%	29%	30%	29%
Right amount of services	58	49	52	69	43	57	57	49	54
Too few services	9	6	7	18	12	15	9	8	8
Not applicable	1	3	3	1	18	10	1	7	4
Not sure	1	4	3	3	6	4	3	7	5

Source: Three-Nation Physician Survey, 1991.

Policy Implications

The data from this international survey of physicians emerge in the midst of a debate about whether the United States should develop a uniquely American national health plan relying on aspects of managed competition, or whether we should adopt key aspects of the health systems of countries with a long-established universal health insurance program such as Canada or Germany. One important issue in this decision is how the American public would look at the success of these other systems. Repeated surveys of the American public show that the majority continues to support the enactment of a national health plan financed at least in part by some form of taxes. However, these surveys show that many Americans are not as likely to support such a program if it results in longer waiting times for medical care or rationing of needed care.[12]

The study findings reported here confirm anecdotal reports that in Canada there are longer waiting times for and less availability of certain specialized medical services than in the United States. U.S. physicians simply do not report this type of problem with any frequency. These findings are likely to lead some U.S. citizens to reject proposals to develop a Canadian-like system in the United States. On the other hand, this study cannot measure whether longer waiting times or less availability of services have any clinical impact on the health of patients. We know from recent surveys that these problems are not reflected in the high levels of satisfaction of Canadians with their medical care; in fact, Canadians' satisfaction has increased in recent years.[13]

In thinking about the Canadian health system, both physicians and the public in the United States should be aware of what they are trading for the privilege of shorter lines for medical care. Canadian physicians report that problems of not being able to provide needed care to uninsured or indigent patients hardly exist. In fact, these data show that Canada's system provides more equity because physicians are able to treat patients similarly despite differences in personal wealth or influence. In addition, Canada's use of budget mechanisms to control health care cost increases leads to less interference with physicians' decisions about patient care than is reported by U.S. physicians.

The study findings in Germany do not suggest the substantial trade-offs that Americans likely would have to make in adopting a Canadian-type health system. As in Canada, German physicians do not face problems of caring for uninsured patients who cannot pay for their health care. Unlike their Canadian counterparts, German physicians did not report pressures of shortages of facilities or queues for care. Moreover, there are no apparent differences between the United States and Germany in waiting times,

ability to procure needed services, or appropriate use of services (except perhaps in use of prescription drugs).

In summary, the results of this survey published here and elsewhere indicate that the Canadian system appears to include constraints on some aspects of health care that are highly valued by Americans. The German approach, however, has fewer apparent problems, even when concerns about quality of hospital care reported previously are taken into account. In our opinion, a particular strength of the German system is that its success in containing costs has been achieved through a process of negotiation of budgets and fees among health providers and other interested parties. These negotiations take place in a manner that is similar to private-sector business/labor negotiations in the United States and involve lower levels of direct government decision making. Such structured negotiations are largely absent in the Canadian system, where the locus of decision making about resource allocation is in the government agencies. This factor could contribute to the greater satisfaction German physicians express with their health care system and likely would enhance the desirability of adopting such a system in the United States. Likewise, it could be very important for making health care reform work in a country such as the United States, where both citizens and physicians remain highly cynical about government agencies' doing what is appropriate most of the time.[14]

The authors owe a debt of gratitude to Samuel Levitt of the Harvard School of Public Health and to Humphrey Taylor, president of Louis Harris and Associates, for their many contributions to this research. The authors also acknowledge the assistance of Michael Arnold, Cathy Charles, Gregory Curfman Robert Ebert, John Iglehart, and Andrea Kabcenell in reviewing earlier drafts of The survey questionnaire. This work was jointly supported by The Robert Wood Johnson Foundation, The Commonwealth Fund, and The Pew Charitable Trusts. The views expressed in this paper are solely those of the authors, and no official endorsement by any of the sponsors is intended or should be inferred.

NOTES

1. At the time of the survey, Germany had recently reunified. We sampled only physicians from former West Germany, and all references to German physicians reflect only the responses of those who lived and practiced in the West before reunification.
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3. R.J. Blendon et al., "Physicians' Perspective on Caring for Patients in the United States, Canada, and West Germany," *The New England Journal of Medicine 328* (1993): 1011-1016.
4. Ibid.
5. Ibid.
6. Ibid.
7. P.M. Danzon, "Hidden Overhead Costs: Is Canada's System Less Expensive?" *Health Affairs* (Spring 1992): 21-43.
8. J.F. Sheils G.J. Young, and R.J. Rubin, "O Canada: Do We Expect Too Much from Its Health System?" *Health Affairs* (Spring 1992): 7-20.
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10. H.A. Tenekin-Greener et al., "The Use and Cost of Health Services Prior to Death: A Comparison of the Medicare-Only and the Medicare-Medicaid Elderly Populations," *The Milbank Quarterly* 70, no. 4 (1992): 679-701; and R.J. Blendon, U.S. Szalay, and R.A. Knox, "Should Physicians Aid Their Patients in Dying? The Public Perspective," *Journal of the American Medical Association* 267, no. 19 (1992): 2658-2662.
11. The clinical case vignette was developed by Arnold Epstein, associate professor of medical and health care policy, Harvard School of Medicine, 1991.
12. R.J. Blendon, T.S. Hyams, and J.M.. Benson, "Bridging the Gap between Expectations and Public Views on Health Care Reform," *Journal of The American Medical Association* 269, no. 19 (1993): 2573-2577.
13. Gallup-Canada, "Canadians Satisfied with Health Care Services," *The Gallup Report* (12 June 1992).
14. Data are from the University of Michigan Center for Political Studies, as reported in "America the Cynical," *Time* 142, no. 3 (1993): 17.