Readers of my column in P&T know that I have a penchant for evaluating reports from the business literature, especially those relevant to P&T committee members. An article published by PriceWaterhouseCoopers Healthcare Research Institute (PWC–HRI)1 attracted my attention. PWC has more than 130,000 people in 148 countries across its network. The company analyzes trends that affect all health-related industries, including governments, health care professionals, drugs, health and life sciences, and insurance firms. The Institute helps executive decision-makers and stakeholders navigate change through research and collaborative exchange drawing on a network of more than 3,000 professionals with ongoing experience in the health industries.

PWC–HRI conducted more than 30 in-depth interviews with thought leaders and executives representing hospitals, government organizations, and business communities in more than 10 countries and commissioned a global survey of more than 200 health care executives from 20 countries. PWC–HRI also attempted to capture the collective intelligence of its entire global practice to create this report.

Not surprisingly, the report’s authors noted that incentives were not aligned, thereby unfortunately affecting the quality and quantity of the health care provided. Almost two-thirds of health care leaders responded that the performance of their country’s health system was good or very good; however, fewer than 40% graded the payment system as good or better. The report noted that this was “analogous to owning a high-performing vehicle that costs too much to operate” and asked “how sustainable can that be?”

In my view, the report implies that high-performing health systems require high-performing payment systems. Patients and payers want good-quality health care at an efficient price, whereas health care professionals want incentives to provide this level of care. However, the old adage that “what gets paid for gets accomplished” is true in every business—and health care is no exception. Health leaders from around the world, as shown in the interviews, are trying to develop incentives that improve health care and enhance the coordination of care. These leaders see the payment system as one of the best tools to achieve these objectives.

Other key findings of the survey:

- Caring for an increasingly aging population is the most difficult challenge facing health systems.
- Payment systems are not structured to support future models of health care delivery.
- Controlling costs is the most important factor in developing payment systems in the future—more important than quality, efficiency, or demand.
- Cost control has already influenced a shift to hospital payment systems that encourage efficiency.
- Case-based prospective payment has been adopted by 70% of member countries of the Organization for Economic Cooperation and Development.
- Most countries have few, if any, financial incentives in public hospital systems for rewarding quality. The most promising incentive is the English pay-for-performance system for general practitioners.
- Having better-informed patients is the best way to manage the demand for health care.
- Quality data are emerging in many countries; however, patients and gatekeepers do not always act on those data. Payers are reluctant to base reimbursement on quality of data alone.
- Executives in health care want financial incentives to encourage more coordination of care. Bonuses for coordinating health care that are paid to physicians and hospitals were among the top five methods needed to improve cost control and health care quality and efficiency.

I’m not surprised by any of the results. We’ve certainly covered many of these topics in this column. I’m even more ambivalent about the whole system; we seem to face insurmountable problems, but everyone is in the same boat!

Are there any transferable lessons for the future? Here are my conclusions:

1. As more health care is delivered in outpatient settings, capital planning and financing must follow with payment methods that encourage flexibility and innovation.

2. Models that integrate payments for both hospitals and physicians create mutually agreed-upon incentives.

3. In countries where payers are increasing, there is more potential for confusion about improvement and incentives.

4. Patients are paying more out-of-pocket expenses for care and are shopping for care at nontraditional venues.

5. As more data from insurance claims, diagnostic test results, patient surveys, and electronic medical records become available, health care professionals and payers need to use these results to evaluate their reimbursement systems.

Whatever changes may occur in our own health care system, we would be well advised to embrace the message from the PWC–HRI report. Other countries have tackled many of the same challenges we currently face. If nothing else, the report should give us pause and help us recognize that sometimes we need to look beyond our own borders for answers to domestic questions.

As always, I’d like to hear your views. You can reach me at my e-mail address, david.nash@jefferson.edu. My blog is http://nashhealthpolicy.blogspot.com.

REFERENCE