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Perspective

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Envy — A Strategy for Reform

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Aristotle saw envy as "the pain caused by the good fortune of others." Medieval theologians considered it a deadly sin, and in Dante's purgatory, the envious had their eyes sewn shut. Nevertheless, we believe that envy has an appropriate place in health policy, if in this case it means health systems struggling to address specific weaknesses by identifying strengths in other systems that they could emulate.

Strategic envy could be particularly useful in the United Kingdom and the United States, where critics cite the weakest aspects of the other country's system — poor coverage in the United States and waiting times in the United Kingdom — to rationalize stasis in their own. But if we instead focus on the most positive aspects of each system, the characteristics that should inspire envy, we may find solutions to each country's challenges just an ocean away.

For starters, the United States should envy the United Kingdom's commitment to universal access to health care, not because it suggests moral superiority but because it confers a strategic advantage. Only when societies commit to covering all their citizens with their limited resources do they take on the difficult work of improving the value of care. Thus, virtually every major study shows that systems that cover all citizens achieve better outcomes at lower cost.[1]

Universal coverage creates challenges — notably, the rationing that results from competition for scarce funds. But without commitment to universal coverage, it's too easy to "solve" financial problems by not insuring or underinsuring people. Universal coverage forces discipline. It also shapes social solidarity, community responsibility, and even audacious aspirations. In U.S. institutions, for example, "stroke teams" think about giving great care to people who've had strokes. In the English National Health Service (NHS, which is administered separately in England, Northern Ireland, Scotland, and Wales) stroke teams do the same but also think about how to reduce strokes in a given population.

The English, for their part, should envy Americans for their choices and the competition that drives health care organizations to respond to their needs and wants. U.S. reliance on market principles has created an enormous laboratory, with the best organizations defining what's possible and "disruptive innovators" shaking up the marketplace.

The evidence favoring competition is increasingly inescapable

even in England. Last year, the London-based Office of Health Economics concluded that competition can improve the quality of health care and that the entry of new providers "can be an important source of innovation."[2] England needs that innovation because the NHS lags in responsiveness to patients.[3] Patients in England get what they are given: if their local hospital happens to be Stafford, where a recent investigation confirmed that the care was "appalling," or they can't get a general-practitioner appointment for a fortnight, that's just bad luck.

The best U.S. providers gain a large market share because they earn patient loyalty through great outcomes and service. We see no reason why universal access should conflict with choice and competition. More choice and competition would not undermine the commitment to coverage in the NHS, but it might improve access and quality.

The overall U.S. system is weak but allows strong organizations to thrive; the English system is strong but weakens the organizations within it. In other words, the U.S. system is too "bottom-up," and the English system too "top-down." The U.S. system encourages providers to think outside the box, whereas the English system encourages providers to regard themselves as part of a broadly defined community, but one in which change is harder to imagine.

Both approaches provide causes for envy and motivate a search for a middle ground. The English top-down approach has enabled the London Strategic Health Authority (a government planning body) to reduce the number of hospitals that receive patients with acute strokes from 32 to 8. Concentrating stroke care in high-volume centers has dramatically reduced 30-day mortality, which is now 28% lower in London than in the rest of England.[4]

Although the United States struggles with wholesale realignment, it benefits from an evolving, pluralistic set of change mechanisms. The absence of extra-organizational frameworks frees creative systems from constraints that stifle innovation. Organizations such as Geisinger Health System have taken advantage of that freedom to experiment and integrate payer–provider functions in innovations such as its "warranty" for cardiac surgery, through which costs of care for complications are included in the basic price.[5] More bottom-up flexibility for England and some top-down regional strategy for the United States would represent progress.

In both systems, patients fall between the cracks. The holy grail is integrated care, which means getting hospital doctors, general practitioners, nurses, and community care workers to collaborate much more effectively and flexibly. The U.S. system is fragmented, but acknowledging this reality has enabled some organizations to become sophisticated integrated delivery systems with a sense of shared accountability and responsibility for patients, regardless of where they are in the system. (For example, at Kaiser Permanente, office staff identify patients who need screening colonoscopies and other preventive care whenever they have contact with the organization and can schedule the needed tests on the spot.)

The NHS is less fragmented but also less integrated than it acknowledges. Ignoring that reality has been a barrier to progress. No one steps forward to take on divisions between inpatient and outpatient care, doctors and nurses, and clinicians and administrators — which are actually wider in the tradition-bound NHS than in the U.S. system.

The English should envy integrated care organizations because they don't have anything like them. Such organizations have been much studied in the NHS, but political intent has yet to be translated into delivery. Policy measures should be directed at encouraging new entrants in the health care market to change business models so that services are shaped around patients' needs.

Finally, character traits may be hard to change, but the English could do with a bit of American optimism, whereas the Americans would benefit from a bit of English stoicism.

The English are willing to endure austerity — such as 5 years of flat spending on the NHS. When the NHS was created, its founder, Aneurin Bevan, predicted that "we shall never have all we need," and for nearly seven decades the English have been willing to queue, wait, and suffer so long as everyone else has to do so as well, believing that, as Prime Minister David Cameron's slogan has it, "We're all in this together."

Americans are unwilling to accept such constraints. The downside of this characteristic is that coordinated systemic change is mistrusted and rare. The upside is that U.S. leaders believe in what John Locke called "robust individuals" and the power of organizations to deliver change, an attitude that's reinforced by market pressures and rewards. U.S. leaders are

prepared to promise that "things can and will get better" — something the English say only in jest.

With some of this energy and optimism, the English could stop waiting for government directions and go ahead and make the changes they want. With a bit of English stoicism, Americans might find that as a nation, they can make difficult choices and get better care at lower cost.

Each country has strengths to be proud of and weaknesses that demand humility. Translating the best of each system need not mean transplanting the worst as well: a synthesis of the two systems could conceivably cover everyone, offer choice and competition, blend bottom-up creativity with top-down strategy, and integrate services so that patients get the right care in the right places. In the future, English and U.S. health care organizations could compete for patients on the basis of the integration of delivered care.

We're not being utopian; we're being strategic. Converting the sin of envy into a virtue can strengthen both health care systems and make our countries' special relationship that much more special.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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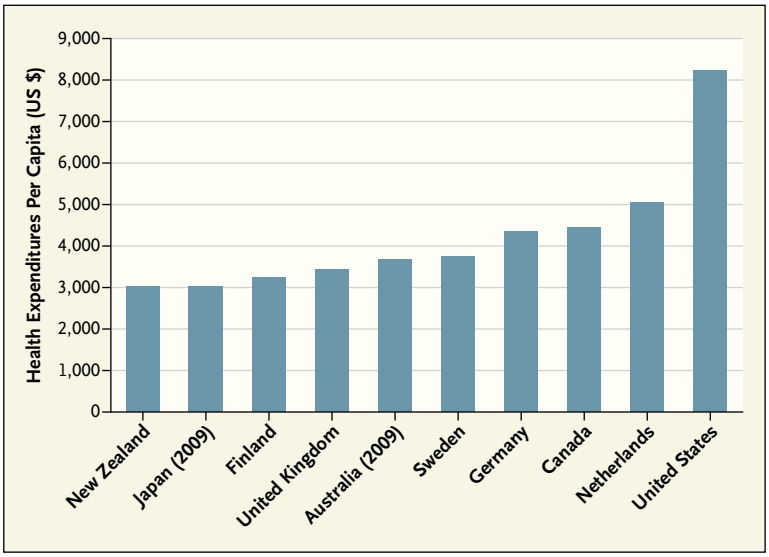
Reevaluating "Made in America"— Two Cost-Containment Ideas from Abroad

Gerard F. Anderson, Ph.D., Amber Willink, M.I.P.H., and Robin Osborn, M.B.A.

Per capita spending on health care in the United States is more than double that in most other high-income, highly industrialized countries (see graph), yet performance on indicators of health status is often worse. The Institute of Medicine recently reported that there is a "strikingly persistent and pervasive pattern of higher mortality and inferior health" in the United States than in other high-income countries.[1] We believe that this poor correlation between spending and outcomes should prompt a reevaluation of current cost-containment efforts.

Unlike the United States, which tends to have a "Made in America" orientation, many other countries routinely incorporate and adopt policies developed elsewhere in efforts to improve their own health care systems. This U.S. mindset runs counter to the global transfer of ideas that has become second nature in biomedical research and many other industries. The uniqueness of the



Per Capita Health Expenditures of 10 Selected Countries in the Organization for Economic Cooperation and Development (OECD), 2010.
Data are from the OECD.