

REPORT 1 OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT (I-09)
The Experience of International Medical Associations with Universal Coverage

EXECUTIVE SUMMARY

In light of current proposals to reform the US health system, the Council on Long Range Planning and Development (CLRPD) sought to explore the experiences of a sample of national medical associations in countries that have implemented universal coverage in order to provide information that might be useful to our American Medical Association (AMA) as a key player in health system reform. This informational report describes the experiences of seven national medical associations.

CLRPD selected the medical associations of Canada, France, Singapore, Thailand, the United Kingdom, Taiwan, and Australia because these countries implemented universal coverage at different points since World War II. Telephone interviews were conducted with one or more spokespersons for each medical association to explore four major topics of interest:

1. The role of the medical society in the design and ongoing functioning of the system of universal coverage;
2. The impact of universal coverage on patient demand for services;
3. The impact of universal coverage on the day-to-day practice of medicine; and
4. What advice would they give to the AMA as the US considers implementing universal coverage.

The interviews revealed that the general feeling of physicians toward their country's forms of universal coverage was more positive than initially expected. According to the association spokespersons, physicians seemed to adapt fairly well following the implementation of health system reform and increasingly accepted it while pointing out components that could be improved. Association representatives generally cited the positive aspects of health system reform, including increased patient access to care, improved national health indicators, and better predictability for reimbursement for their services. Their common recommendations were that, where possible, medical associations should be involved in the planning and implementation of reform and be advocates for their patients.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-09

Subject: The Experience of International Medical Associations with Universal Coverage

Presented by: Neil Brooks, MD, Chair

1 INTRODUCTION

2
3 The current US health care system is perceived by many to be unsustainable, and pressure has been
4 mounting for the US to adopt reforms. While there is significant information about the health
5 delivery systems and the history of reform in other countries, there is very little information about
6 the role of national medical associations in the health system reforms that have taken place in their
7 countries. Accordingly, the Council on Long Range Planning and Development (CLRPD) has
8 prepared this informational report to share the experiences of a sample of national medical
9 associations in countries that have implemented universal coverage for their citizens.

10 11 METHODOLOGY

12
13 In March, 2008, CLRPD identified several nations and sought to assess the experience of their
14 national medical associations before, during and post adoption of universal coverage. The Council
15 selected seven countries which had adopted health system reform at different times from immediate
16 post-World War II to relatively recent times. These included Canada, France, Singapore, Thailand,
17 the United Kingdom, Taiwan, and Australia. Interviews were conducted with association
18 leadership between March, 2008 and June, 2009. The American Medical Association (AMA) pre-
19 arranged international telephone connections and undertook single, one-hour interviews with up to
20 five individuals from each association.

21
22 This study focuses on the role of the seven national medical associations in the evolution of
23 universal health care in their countries and the impact of reform on patient care. Hopefully, the
24 information derived from these interviews will provide perspectives that our AMA can utilize as
25 our association plays a key role in the current US health system reform debate.

26
27 In preparation for the interviews, the Council reviewed published and online resources related to
28 each country's medical association, the nation's health issues, and its health care system. This
29 research provided background and context for the discussions and helped frame relevant and
30 individualized questions pertaining to four major topics which were covered in all seven
31 interviews:

- 32
- 33 1. The role of the medical society in the design and ongoing functioning of the system of
 - 34 universal coverage;
 - 35 2. The impact of universal coverage on patient demand for services;
 - 36 3. The impact of universal coverage on the day-to-day practice of medicine; and
 - 37 4. What advice would they give to the AMA as the US considers implementing universal
 - 38 coverage.

1 In examining the experiences of national medical associations, interviews focused on the activities
2 of the national medical associations and impacts on physicians' everyday practices rather than
3 components of the plans that were developed per se. While it would have been desirable, for
4 example, to inquire about the public's expectations of the new health care system pre- and post-
5 reform and to delve into the mechanisms used by the health systems of these countries to manage
6 health resources within budgetary limits, including price controls, those matters were not the aim of
7 the Council's study. Given the brevity of the interviews and differences in the experiences of the
8 various association representatives, variations existed in the extent to which each key area was
9 covered in the interviews.

10
11 This informational report is based entirely on responses provided by spokespersons to questions
12 related to these four key areas of interest. However, it is important to note that comments made by
13 interviewees were their perspectives and may not reflect official policies of their associations.

14 15 OVERVIEW OF EACH COUNTRY'S EXPERIENCE

16 17 *Canada*

18
19 Prior to the final adoption of universal coverage at the national level in 1966, individual provinces
20 initiated reform between 1948 and 1962, starting with hospital coverage and in some cases
21 incorporating physicians' services. In anticipation of a surge in demand, Canada doubled its
22 hospital capacity and expanded medical education to increase physician supply. To further avoid
23 abrupt changes, Canada intentionally controlled residency training slots, resulting in a 51/49 split
24 between primary care and specialists.

25
26 Consequently, the demand for care, especially physicians' services, did not increase sharply
27 following the nationwide implementation of the Canadian Universal Coverage system in 1966. In
28 fact, the surge in demand did not materialize as expected in part because of the provincial systems
29 that had been developing over the years. Over-preparation for the expected surge in demand led to
30 the unintended consequence of creating a surplus of physicians. According the spokesperson for
31 the Canadian Medical Association (CMA), this resulted in a supplier-induced increase in the
32 number of services.

33
34 The CMA, which currently has an 85% membership market share, was not originally a key player
35 as the various provinces adopted universal coverage reforms. However, 1986 proved to be a
36 turning point as CMA mounted a constitutional challenge to the 1984 Canada Health Act which
37 banned balance billing. Even though four years later the challenge was dropped, CMA's
38 spokesperson believes it became the basis for CMA being viewed by physician members as a real
39 leader in advocacy.

40
41 Since that time, the CMA has been credited with increases in physician income and addressing
42 issues important to physicians. The provincial medical associations, which are divisions of CMA,
43 have substantial autonomy as well as influence within CMA and serve as the formal bargaining
44 agents for physicians.

45
46 Implementation of universal coverage presented many benefits including a substantial increase in
47 physicians' incomes due to the virtual disappearance of bad debts. Incomes leveled off in the
48 1990s as government funding for the overall system was reduced in response to rising costs.
49 Starting in 2000, funding began to increase again, with some positive impact on physicians'
50 incomes.

1 Even though the payer is a public entity (primarily provincial), about two-thirds of Canadian
2 physicians are reimbursed on a fee for service basis. The provincial associations negotiate the fee
3 schedules on behalf of the physicians. Provinces with physician workforce shortages try to pay
4 higher fees as an incentive to attract physicians from other provinces.

5
6 Waiting lists for some procedures remain a problem in Canada and are high priority for
7 government and the Canadian Medical Association. While the wait for some procedures has been
8 reduced, it has been offset by an increase in wait time for others.

9
10 *France*

11
12 Universal coverage was initially implemented in 1947, shortly after World War II, as a social
13 service. In 1974, the health system was adapted to provide universal coverage for all salaried
14 employees. Employee salaries were used to finance the system with employers assuming some
15 financial responsibility for providing such coverage.

16
17 In France the medical association exists alongside several physician unions. While membership in
18 the medical association is mandatory, membership in a union is not. Though separate, the medical
19 association, physician unions, and government work collaboratively. For example, the
20 development of a system similar to CPT has been identified as a key necessity and is an issue that
21 the medical association, unions, and government are working on together.

22
23 The medical association focuses mainly on working conditions, education, and professional issues,
24 but has become somewhat involved in recent years in financial issues as well. Since the universal
25 coverage system is state run, the medical association is not directly involved in its management.
26 The unions focus mainly on financial issues, including negotiations for physician payment which
27 are conducted every five years.

28
29 The demand for physicians' services gradually increased as universal coverage was implemented.
30 However, because the increase was not immediate, it did not unduly burden physicians.

31
32 At the time of implementation of universal coverage, there was a predominance of general
33 practitioners over specialists. Subsequently, the mix has changed and now is approximately equal.

34
35 The big change for physicians that came with universal coverage was an "equalization" of
36 payment. Physicians were assured of the same payment regardless of the patient, compared to
37 before when some paid in cash and on a timely basis, while others paid "in kind" and/or when they
38 could afford to pay.

39
40 *Singapore*

41
42 Due to Singapore's small population and the existence of an already developed medical system, the
43 implementation of universal coverage in 1983 did not have a major impact on private, community-
44 based practice. However, a maldistribution of work developed which left physicians in the
45 government "polyclinics" more burdened than private, community-based physicians. Further, there
46 was a shortage of physicians in some specialty areas.

47
48 Physicians in Singapore are considered upper middle to upper class and medicine is a well
49 respected profession. Physicians in Singapore are either in private practice or work for the
50 government. Among specialists, about half work in government hospitals and half in community-
51 based private practice. Private practice specialists earn 30-50% more than government hospital-

1 based specialists. Among physicians in private practice, specialists earn about twice what primary
2 care physicians earn.

3
4 Seventy percent (70%) of physicians in Singapore are members of the Singapore Medical
5 Association (SMA) which focuses on assisting physicians with regulatory matters, including
6 representation with managed care and various workforce issues.

7 The medical society is working to address maldistribution and shortages by outsourcing certain
8 services to other countries. It is also working toward making Singapore an international hub for
9 medical care in the region by importing medical professionals. The SMA has played a role in the
10 expansion of health services to attract more patients and ensuring that quality assurance measures
11 are in place.

12
13 In addition, the SMA has been active in health care financing. For many years, the SMA had a set
14 of “fee guidelines” but recently discontinued the guidelines in response to new government
15 regulations similar to US antitrust laws that are designed to promote more vigorous competition.
16 The representatives from the SMA expressed concern over what will happen in the market as a
17 result.

18
19 One aspect of the system in Singapore that could have an impact in the future is its “medical
20 savings account” system, which is used only to pay for hospital care. Unlike the HSAs or MSAs in
21 the US, participation in the medical savings account system is mandatory, and may serve more as a
22 tax than a savings mechanism. The Singapore MSA program has proven to be quite successful and
23 has generated a very substantial balance of funds. However, there is continuing pressure to ease
24 restrictions so that the money can be used for other services, not just hospital care. Should this
25 restriction be lifted, the result could be a sudden movement of funds to pay for physician services
26 and a subsequent increase in supplier-induced demand.

27 28 *Thailand*

29
30 The Thai representatives noted that there was a distinct increase in demand for physician services
31 even though universal coverage was phased in between 1990 and 2006 for different segments of
32 the population. Outpatient visits increased from 103 million in 2002 to 116.5 million in 2007.
33 Outpatient care constituted 96% of total medical visits in 2007. For in-patient care, Thailand
34 transitioned from a capitation to a DRG system between 2003 and 2007. In hospitals, demand
35 increased approximately 10% annually during the first two years and the hospitals had inadequate
36 budgets for hiring more physicians and nurses. To compensate, they used capital funds to hire
37 medical professionals instead of investing in equipment and supplies. Overall, inadequate funding
38 at the implementation of the system along with an increase in covered people compounded the
39 problem of being able to add capacity to the system.

40
41 The Thailand Medical Association (TMA) has about 2000 members out of a total population of
42 about 12,000 (16.7%). Physicians are also a part of other medical organizations, especially rural
43 physicians’ organizations and patients’ organizations. Because many of the rural physicians
44 indicated that they wanted a stronger voice and more involvement, the TMA has had more success
45 in working with organizations representing rural physicians and patients in recent years.

46
47 The TMA was not consulted on the design of the universal coverage system, which association
48 representatives believe may have stemmed from its disjointed relationship with the other medical
49 organizations and its low membership market share. This disjointed relationship contributed to a
50 missed opportunity where the medical association could have helped anticipate and address issues,
51 especially those related to the initial inadequacy of overall funding of the system.

1 Physicians are seeking more support from the medical association to expand primary care, so that
2 fewer people go to the hospitals for routine care. More primary care in rural areas is especially
3 needed. There was a shift from public clinics to private physicians' offices, and in some areas,
4 especially rural areas, there were not enough physicians and some did not have the supplies they
5 needed. Adding to the problem, language barriers deter physicians from moving to Thailand to
6 supplement capacity.

7
8 When first implemented, the Thai system was inadequately funded. Physicians lost income (some
9 substantially – up to 50%), but adjustments have been made in the funding base and physicians'
10 incomes are improving along with increased resources for other components of the medical system.

11 *Great Britain*

12
13
14 When the British government implemented universal coverage in 1948, there was pent up demand
15 in the system which led to a considerable surge in the patient flow to physicians' offices. Primary
16 care physicians constituted about 60% of the physicians but grew to a high of 80% around 2000
17 and are now at about 70%. Moreover, in the 1940s, there was not a nursing shortage and medicine
18 did not utilize technology to the extent that it is used now.

19
20 Demand for health services increased due to universal access and freedom of choice and resulted in
21 an increase in the number of patients treated. The surge in demand was expected, but what was not
22 anticipated was that it did not subside. It continued to grow as medical technology, increased
23 public expectations, and post-war economic growth continued to feed it.

24
25 To accommodate this increase, a wait list initiative was implemented. The British Medical
26 Association (BMA) spokesperson stated that the UK has largely resolved the waiting list problems
27 in recent years due to excess hospital and physician capacity, with the wait times now down to less
28 than six weeks. Currently, the only major area of backlog is for services related to reproductive
29 endocrinology. Since the issue of waiting lists is politically sensitive, if a backlog of services were
30 to begin to build again, the system is now authorized to pay for care in other countries.

31
32 The BMA spokesperson characterizes the association as a very participatory organization.
33 Approximately 2000 members serve on various committees, some of which are very active and
34 meet monthly. Physicians' expectations of BMA today are to achieve change to improve the
35 system. The BMA spokesperson indicated that the association is focusing on what it considers
36 "sensible" change. Most general practitioners are not government employees but contract with the
37 government to provide services. There is some effort to localize negotiations by districts, but
38 physicians are reluctant about this since they have more confidence in collective negotiations at the
39 national level.

40
41 The BMA has played the role of a negotiating agent for collective pay and working conditions for
42 physicians. The spokesperson for the BMA indicated that over the years, the association's
43 negotiations have been fairly successful on behalf of physicians. This role in negotiations allowed
44 the BMA to play a significant role in the initial functioning of the universal coverage system. This
45 role was formalized in 1971 to meet regulatory requirements.

46
47 The BMA has been presented with another opportunity to negotiate on behalf of UK physicians. In
48 2004, the government proposed a very substantial payment increase for physicians (60% for GPs
49 and 25% for specialists). On the other hand, the BMA proposed more moderate increases for
50 physician salaries while ensuring that there would be adequate funding for the provision of health
51 services. However, the government proposal was approved. Currently, reform measures are being

1 proposed by the government in response to cost increases associated with providing various health
2 services.

3
4 Some physician income is from private insurance, which has been a stable 9-12% of the health
5 economy for many years. The amount of income from private insurance varies by physician.
6 Physicians in the UK are considered upper middle class to upper class and consistently rate very
7 high in public satisfaction surveys. However, the spokesperson for the BMA commented that
8 physicians themselves are not comfortable with their place in society as a result of media attacks on
9 professionalism over the past decades. There is a sense that the government and media are trying
10 to “de-professionalize” medicine, especially the general practitioners, in order to promote
11 delegation of responsibilities to non-physician groups.

12 *Taiwan*

13
14
15 A system of universal coverage was adopted in 1995 during a time when popular demand,
16 economic conditions, and the agenda of the government administration favored a move towards
17 universal coverage. The short lead time prior to the implementation of universal coverage and
18 other factors precluded participation in the planning process by the Taiwan Medical Association.

19
20 The Taiwan Medical Association (TMA) obliges all physicians to be members. The Association
21 has jurisdiction over specialty societies. After registering with the TMA, a physician may join a
22 specialty society, which supports credentialing and various academic interests.

23
24 According to TMA spokespersons, the government is receptive to recommendations from
25 organized medicine only on a limited basis. Physician influence is not expected to increase since
26 the government considers the small and more conservative physician community less important
27 politically than the general public. The Department of Health is staffed with practicing physicians
28 (virtually all of whom were trained in the US) who also serve as consultants. These physicians
29 typically help develop the majority of health directives, e.g., experiments with pay-for-performance
30 and quality measures, before the TMA is even consulted.

31
32 Overall, Taiwan has seen some surge in demand as patients now have total freedom to access,
33 sometimes excessively, any physician (primary or specialist) or hospital with their “smart-cards.”
34 However, because of this generous government policy of open unfettered access, physicians are
35 frustrated about their lack of ability to coordinate patient care.

36
37 According to the spokespersons for the TMA, physicians are pleased that patients have access to
38 care and that there are both declines in overall mortality and improved management of chronic
39 diseases. However, these physicians expressed concern that the system does not include some sort
40 of a gate-keeper provision to address patients who tend to over use access to care and abuse the
41 freedom of choice of providers. Physicians are not able to appropriately monitor and improve
42 quality of care but hope to be able to influence public policy on this issue.

43
44 The TMA representatives also expressed that they believe physicians are generally pleased with
45 professional fees they receive. Their incomes have increased due to expanded coverage for
46 patients seen after the implementation of universal coverage. Physicians receive their revenues
47 from fee-for-service payments through the Bureau of National Health Insurance (BNHI) and direct
48 payment by patients in the form of user fees and co-payments. The TMA representatives
49 acknowledged that the BNHI has been very efficient in keeping its administrative costs at less than
50 2% and Taiwan spends approximately 6.23% of its GDP on health care, but noted that funding is
51 not always available to cover services offered.

1 The health system is financed through a global budget, which entails universal coverage for dental,
2 traditional Chinese medicine, clinic, and hospital budget systems. The TMA had limited input into
3 the negotiated fee schedules under the global budget.

4
5 *Australia*

6
7 In the 1970s and 1980s, the Australian Medical Association actively opposed government reforms
8 and feared a British-style National Health Service (NHS) system which might dictate terms of
9 practice and salary. The Australian Medical Association spokesperson indicated that in response,
10 the government totally closed the association out of negotiations about the implementation of
11 reform.

12
13 However, once universal coverage was implemented, the association became its greatest supporter.
14 Physicians saw a marked reduction in bad debt and those in private practice gained added security.
15 The new mixed private/public system also yielded benefits for patients in the form of a government
16 subsidy for fees along with improved quality and access to care.

17
18 Approximately 50% of physicians in Australia are in primary care and half of all Australian doctors
19 belong to the Australian Medical Association. However, association membership fluctuates
20 depending on how urgently physicians perceive challenges and the ability of the association to
21 address them.

22
23 With the first wave of health system reform, the demand for services did not increase due to the
24 dual system of government and private health insurance being equally accessible to patients,
25 regardless of age or health status. Over 45% have private insurance, which frees up an estimated
26 three billion dollars for public care and the waiting period for services in the public sector. The
27 Australian Medical Association spokesperson indicated that over utilization is not a major issue
28 with regulatory oversight of practice guidelines and potential penalties for physicians.

29
30 The spokesperson for the Australian Medical Association indicated that the new association
31 leadership is more supportive of collaboration with the government. The association sees this as
32 essential in order to resolve key issues, such as scope of practice, health information technology,
33 practice management, public health, mental health services, and increasing the number of medical
34 schools. However, residual effects of negative interactions with the government during the first
35 round of health system reform still impact relations between the association and the government.

36
37 **SUMMARY OF FINDINGS AND ADVICE FROM OTHER INTERNATIONAL MEDICAL**
38 **ASSOCIATIONS**

39
40 The interviews revealed that the general view of physicians toward their countries' form of
41 universal coverage was more positive than initially expected. According to the associations'
42 representatives, physicians seemed to adapt fairly well following implementation of reforms and
43 increasingly accepted those changes even though they pointed out certain components that could be
44 improved. Spokespersons for the associations generally cited the positive aspects of health system
45 reform, including increased patient access to care, improved national health indicators, and better
46 predictability for reimbursement for their services. Their common recommendation is that, where
47 possible, medical associations should be involved in the planning and implementation of reform
48 and be advocates for patients. Responses pertaining to the four key interview topics are
49 summarized in this section.

1 *Role of Medical Society in Design and Implementation of Universal Coverage*

2
3 Medical associations perform a range of functions, from general advocacy to formalized
4 negotiating agents. Even where there are formal negotiating roles, the importance of keeping
5 professional considerations in the forefront of discussions seems to be high. Many of association
6 representatives said that ensuring that the interests of patients (i.e. access to and quality of care) are
7 a priority that all the medical associations share.

8
9 In countries where there are formal negotiations separate from the medical association, there is
10 some working relationship between the medical society and the negotiating organizations. Medical
11 society involvement in the design of universal coverage is considered necessary and important.

12
13 *Summary of the Impact of Universal Coverage on Demand for Service*

14
15 There was a considerable range of experiences related to the demand for physicians' services
16 across the various countries. Some saw substantial and sustained increases in demand while others
17 saw increases that subsequently subsided, and still others did not experience problematic surges in
18 demand.

19
20 The extent of a surge in demand for physicians' practices depended in part on how recently and
21 how suddenly or incrementally universal coverage was implemented. In general, developed
22 countries that implemented universal coverage more recently and more incrementally saw less of a
23 surge in demand, whereas less developed countries and countries that implemented universal
24 coverage longer ago saw relatively more impact on demand. The gradual introduction of
25 employer-based insurance in developed countries in the post-WWII era made adoption of universal
26 coverage a less dramatic change.

27
28 Another issue on demand is the relative distribution of services across the country. Areas of
29 substantial deprivation will likely see a more dramatic impact as universal coverage is
30 implemented. Moreover, the proportion of primary care to specialists and whether primary care
31 has a gatekeeper role also predict the impact on the initial demand for physician services.

32
33 *Summary of the Impact of Universal Coverage in the Day-to-Day Practice of Medicine*

34
35 When spokespersons discussed the impact of reform on practice, they responded with comments on
36 the impact on physicians and reimbursement. In the countries studied, physicians remain among
37 the upper middle to upper class, as measured by income, and are consistently considered to be
38 among the most respected professions. It is important to note that when formal negotiation of
39 physicians' fees and/or salaries occurs, there have been periodic substantial increases in income.
40 The UK in 2004 is a notable recent example. Conversely, in countries where medical association
41 involvement was missing or very limited, financing of the system (and thus physicians' incomes)
42 was lower and in some cases inadequate. Thailand is an example of this.

43
44 In countries where some form of coverage existed prior to the implementation of universal
45 coverage, physicians' incomes were more likely to remain stable and predictable. In addition,
46 physicians were able to benefit from reduced collection issues as well as lowered administrative
47 costs and burden.

1 *Advice to the AMA as the US Considers Health System Reform*

2
3 In response to a question about what general advice each interviewee had for the AMA and the US
4 as our nation negotiates universal coverage, some interesting observations were made. The
5 responses were categorized into key areas:

6
7 Approach to universal coverage:

- 8 • Focus first on the most common clinical conditions and where there is the most need.
9 (Singapore)
- 10 • Incremental change is better than the “big bang” approach. This may be best achieved through
11 local demonstration projects to see what really works. (Canada)
- 12 • Keep in mind three key areas: insurance, private pay, and delivery. All three are important.
13 Experiment to get the right mix. (Canada)
- 14 • Keep the medical association and negotiating organization separate so the medical association
15 does not lose focus on professional matters. (France)
- 16 • Universal coverage is not that difficult to achieve, but no plan will please everyone.
17 (Singapore)
- 18 • Make sure the medical society is involved in the design phase or there will be important
19 aspects that are overlooked and will have to be corrected later. (Thailand and Taiwan)
- 20 • “Be the agent of change rather than the object of change” meaning that active involvement in
21 the reform process more likely assures that the association can influence change. Otherwise,
22 decisions may be made that are not advantageous to the profession, the association, or patients.
23 (Canada)
- 24 • Make sure everyone is aware of the difference between health and health care, and make sure
25 the system addresses each according to its specific nature and needs. (United Kingdom)
- 26 • The AMA should continue to be at the table with reasonable positions and to stand for the
27 interests of patients. Be part of the debate and don’t be afraid of the debate. (Australia)

28
29 Finance:

- 30 • The system may lose money and miss some people initially so make sure there is a good safety
31 net. (France)
- 32 • Adequate quality of care requires adequate funding of the system. (Singapore)
- 33 • Design the system so that each generation pays for its own health care. Do not create inter-
34 generational subsidies. (Singapore)
- 35 • Promote the development of a mechanism for community rating that will make universal
36 coverage affordable for all patients. (Taiwan)
- 37 • In developing universal coverage, Taiwan modeled their system after our Medicare system and
38 applied it to their entire population. In turn, the TMA representatives encourage the
39 development of a global budget system, which may entail a private health delivery or partial
40 single payer system. Further, they urged the US to develop a mechanism for community rating
41 that will make universal coverage affordable for all patients. (Taiwan)

42
43 **CONSIDERATIONS FOR THE US**

44
45 Experience from other countries suggests that major reform that covers all and effectively restrains
46 costs will have to embrace price restraints, set spending targets and aggressively address the
47 administrative costs of insurance and regulation. However, many of the association representatives
48 noted that after implementation of universal coverage in their countries, overall health care
49 spending was low while improvements in national health indicators were realized. Moreover, even
50 though the design and outcome of reforms were not always perfect, physicians were generally

1 pleased that their patients benefited. Significantly, too, in the countries in our report, physician
2 social status remained high. Incomes have been good and generally became more stable and
3 predictable.

4
5 All seven associations interviewed indicated that medical association involvement in the reform
6 process was desirable even though it was not often achieved. Spokespersons indicated that the
7 design and implementation of system reform without physician input is less than ideal and runs the
8 risk of not working well for either patients or physicians. In addition, the representatives expressed
9 the opinion that it is important for the medical association to have a distinct role in protecting the
10 professional dimensions of medical practice and being an active patient advocate. A key lesson
11 from this report is that as the debate continues for reform in the US, it is important for our AMA to
12 be involved in the planning and implementation of reform and to be the advocate for patients.