WITH Johan Hjertqvist, President, Health Consumer Powerhouse, Brussels

Johan Hjertqvist is the founder and president of the Health Consumer Powerhouse in Brussels, the European think tank dedicated to improving health care with consumer information and knowledge. Before the Powerhouse, Hjertqvist was the manager of the Timbro Health Policy Unit, a division of the Timbro Policy Group in Stockholm, Sweden, with a background in healthcare policy and entrepreneurial activities in social welfare. Beginning in 1999, he led a four-year project to analyze the transformation of health care in the Stockholm region, which resulted in three comprehensive reports. His paper, *The Stockholm Health Care Revolution,* published in 2000, is an internationally well-known inspiration to reform. During the 1990's, Hjertqvist played an active role in the transition of internal market ideas to a number of countries, incuding the United Kingdom, Norway and Canada. He has also acted as an advisor to the Greater Stockholm Council on the creation of market infrastructures where purchasers and providers can meet to strengthen the impact of market pluralism. He holds a Master of Laws degree from the University of Stockholm and is a member of international health care networks and institutions such as the Stockholm Network in London and the Centre for the New Europe in Brussels. He is also on the Frontier's Board of Advisors. He did this interview on November 14, 2005 after a Centre seminar.

Frontier Centre: The EuroHealth Consumer Index has some ambitious goals. Can you summarize them?

Johan Hjertqvist: The Index will empower consumers to take their own actions, by making far better judgements regarding waiting times, what are reasonable and what are not, regarding what kind of providers and treatments they would like to access, and what kind of pharmaceuticals they would like to include in their treatments. In total, you might say it enables them to manoeuvre the healthcare system to get the best outcomes and set their own contexts with health care.

FC: You started the project in Sweden, and you mentioned that some healthcare providers have already changed their behaviour because of the benchmarking they received on the Index.

JH: That is right. We are noticing that many of the 21 county councils in Sweden, the level of government responsible for health care, are taking action following publicity for the Index we have been presenting now for two years.

FC: What were the effects in Sweden of your Index? What happened after you published it?

JH: It prompted a new discussion about the inequalities in health care. Why do you have better access to certain treatments or shorter waiting lists in one county council or another? There was also a quite interesting, powerful discussion within the political parties and between governments and minorities or the opposition in the regional parliaments about the position of their ranking in the index. Finally, yet importantly, many patient organizations took action based on this index and used it as a tool for advocacy in relation to the governments and medical profession. We noticed that regional governments are taking action now to improve the information they provide. Starting November 1, 2005—so it is quite new—we have guaranteed national access, saying that you should not have to wait more than 12 weeks for any kind of treatment. We will look into this, and see to what extent the county councils really can deliver here. That will be interesting not in the least because we have general elections next year, when we will present the outcomes of our index. It will be well-timed for the election campaign. That is not the aim of our Index, but it will be well-timed.

FC: On your website, you describe the media impact of the index as "very strong." Was that surprising to you?

JH: No. One of the reasons we gave it this kind of design is that we know that the media and people in general like to compare things, the best car, or the worst restaurant, and so on. It is quite a popular forum for presenting material that otherwise might be a bit difficult to access or understand. I expected the media in Sweden and around Europe to be interested, but they were even more positive and alert than I expected.

FC: Did the first two Indexes in Sweden generate attacks on you as the messenger?

JH: The first year we noticed some criticism of that sort, but it quickly turned into much more of a positive experience and a surprisingly quick acceptance of what we are doing. We have met surprisingly little criticism.

FC: You perceive an increasing consumer demand for information on all fronts. Why is that?

JH: People around the world, or in at least the developed countries, evidently count on much more personal involvement in their health care than they have today. We would like to change the poorly informed patient into the articulate, well-informed, strong patient. Our research is finding that people put an equal amount of emphasis between having better information about an illness and better outcomes. People in general interpret improved knowledge about health care as maybe not a guarantee that they will receive good treatments but at least something that makes it more likely.

FC: It seems almost a tautology that transparency is a vital public value, yet the public sector resists it quite consistently. What do governments have to gain by embracing transparency?

JH: They immediately fear, of course, that increased patient awareness will cost more money. But I would say that the informed patient will likely save money for an insurance company or for a public healthcare system. It will no doubt make consumers more satisfied, by feeling that they have influence, or listened to. From a taxpayer's point of view, as well as from a consumer's, it is reasonable to support this movement towards increased consumer knowledge.

FC: So ultimately better outcomes would be realized.

JH: Absolutely. And again, better outcomes save money and lower not just costs but especially suffering. More patient knowledge and involvement will save lives and will more quickly bring sick people back to full levels of activity.

FC: Do governments have anything to lose with more transparency?

JH: On the policy level, there is a general feeling among politicians that they must be in control, and you may hear the quotation marks when I say "control." Typically, those ways are often futile. You may believe you are in control if you can change the figures in a budget, but after many discussions you generally focus mainly on inputs and far too little on outputs. In reality you become a much more powerful player as a politician if you listen to this kind of information, but of course many still have the feeling of being threatened by the empowered consumer.

FC: For thousands of goods and services in our society, those traditionally delivered within a competitive market, consumer associations have ranked quality against price for years. Why did important public goods like health care and education escape such scrutiny?

JH: It is a good question. One answer is that some kinds of public goods are not looked upon as commercial services or goods. But now you notice in the world a number of initiatives that really do exactly that for education and health care. These are two areas of primary importance to people. In five or ten years time, I believe that it will be a given that you can compare the quality of basic education. You can already do it in many countries regarding universities. In health care, I think people will not be satisfied until they have far more transparency.

FC: Let's go through the most important indicators in the Index for a short explanation of each one. First, patient rights.

JH: Is there a legal framework for patient rights in the country, or not? It gives a fairly good view of the ambition of the system or the government to support the patient. It is not the only way to reflect that, but to us it is important.

FC: The information on waiting times is a pretty obvious indicator, but how do you amass that information? Do you gather information from people who are actual patients?

JH: We have been using a number of resources. We have been building on public figures and statistics when they are available. In Europe you can generally have access to public figures for waiting list, but not everywhere. In those cases, we have to find our own resources—interviews, or polls and surveys of patients, patient organizations, authorities and agencies. We also have to validate our findings and we have done that with different kinds of interviews.

FC: The next element in the index is outcomes, and you have selected some particular diseases to reflect them. What was your selection process for deciding which outcomes should be included?

JH: It was a combination of broad illness or diagnostic groups and the availability of information on them. In reality, that is a limitation. We would have liked to look much more into diabetes, for example. But around Europe we have poor public statistics on it so in this first round we had to exclude diabetes for that reason. We will try to find ways to display it accurately in the coming years.

FC: The last one is pharmaceuticals, which are becoming increasingly more important as the least expensive yet most effective healthcare tool. Is drug access getting better or worse?

JH: Both. There is a trend in Europe for governments, through different kind of mechanisms, to replace patented drugs with generic ones and to introduce different guidelines that often force doctors to prescribe cheaper drugs. That tends to reduce access to the most modern or most sophisticated medication. Another method they use is to try and delay the introduction of new drugs into the reimbursement system. These two factors threaten access to the best medication. On the positive side, there a number of governments who let new drugs into the reimbursement system without delay. It is a bit of a mixed picture.

FC: Your index makes no distinction between public and private health care, it simply measures performance. Yet don't your results indicate that private providers are more responsive? The totally private system in Switzerland ranked very high.

JH: It was second, the Netherlands scored the highest. We see it as important to introduce ranking tools regardless of the system, whether it is privately funded, publicly funded or a mixed one. I would say the most successful systems have mixed funding. Often you find that private providers are more responsive regarding drugs and the introduction of new methods. They are also more service-oriented.

FC: Aren't the introduction of internal markets in Sweden and more recently in England attempts to replicate the dynamics of a private, competitive system?

JH: Yes, you might say so. We know from developments in the United Kingdom, where they tried to reform the National Health Service, and ten or fifteen years ago when we tried to reform parts of the healthcare system in Sweden, that competition among private and public providers is the key to success. The private providers inject a lot of new ideas and a lot of efficiency into the system.

FC: Advocates for public heath care claim that such systems are more efficient than private ones because they have lower administrative costs. Is that true, or the costs simply masked?

JH: It is always difficult to define what you really mean by "administrative." You can find terrible examples of administrative costs, for example in the American system, where legal costs and all that are driving prices. It's quite evident that's something you would like to avoid. I would say that a reasonable mix between public and private and a reasonable share for private providers within the umbrella of public funding are speeding up efficiency and the awareness of consumer attitudes and expectations.

FC: In Canada, we found that reducing administrative costs to a minimum meant a loss of information that made efficiency difficult, if not impossible. How can that be reconciled?

JH: It is tricky to be a purchaser in an internal market system, as well. It is often the case that these purchasers lack ingenuity and the willingness to take risks. You have to offer providers an opportunity to design a contract in a different way. There are much higher costs, I would say, in the publicly funded sector. In Canada, you don't use or exploit the capacity of creative public/private partnerships. You don't notice these kinds of costs

in the ordinary sense, but you lack efficiency and productivity because you don't use the full capacity of the system. That is probably a much higher cost than if you just add up some administrative costs.

FC: In Canada our public authorities have been very reluctant to provide benchmarking information of any kind. The most rigorous, from the Fraser Institute, has been gathered by surveys of doctors. Are you getting more assistance from governments in Europe?

JH: We haven't actually looked for that much assistance. We have been building relations with a number of governments, but we're in the early stage and we wouldn't like to rely on public funding for this. But we have a good relationship with a number of governments. Some of them are quite enthusiastic and some rather questioning or even hostile to this kind of approach. It's about what you'd expect.

FC: How much difference have you discovered in your Index between countries that organize health care on a welfare model, like Sweden or Britain, and countries like Germany or Belgium that organize it on insurance principles? Do the lower waiting lists in the ones based on insurance indicate that it is a superior system?

JH: I would refer to every system in Europe or at least Western Europe as a welfare system. The general idea is that everybody should have access to good healthcare. You are right, you have mainly two models, the first more Scandinavian and the other type more common on the continent. Our index indicates that you have the best overall conditions if you have mixed funding and mixed provision. It's more likely that a system like that, as in Germany, will provide good healthcare.

FC: So all those thousands of little health clubs are a smart way to go?

JH: You have a number of purchasers who work for money in the system, and you also have competition, a cultural competition you might say, on the provision side. It is more likely that you have good outcomes with that than in a monopoly system.

FC: Another transparency issue in healthcare is an understanding of costs, which are masked in our system because they are funded out of general taxation. Shouldn't citizens also be made aware of the costs of each service provided and how much is being paid on their behalf for it?

JH: Yes, I think that would be relevant. If you look some years ahead, when the consumer can control the funding in a far better way than today by a voucher or an account system, this awareness will be essential. You will be able to make your own deals in a different way and of course you would like to know what is the value for money or what different providers offer. The economic information will be essential.

FC: Conventional wisdom says that regular economic principles don't apply in health care because providers have more information than consumers because of their medical training. To what degree down the road can the Index level that playing field and counter that imbalance?

JH: The main idea is that in the initial stages you would like to put search lights on the information that consumers need to assure timely access. In a couple of years time, I hope the Index will be able to move down in the system and look more for illness groups, diagnoses, and how you can find the best treatments. It really becomes really a guide system for the individual. But the basic idea isn't to make everybody a doctor. Doctor have a special position in the system, as do specialists. The idea is to give the consumer enough information and knowledge to be able to become much more influential in healthcare choices.

FC: Will you eventually integrate information on rates of iatrogenic illness in different facilities?

JH: Absolutely. Our consumer-based rating system will include many other factors. Our system is still in the development stage. It hasn't found its ideal or final form yet.

FC: Who funds your Index and why do they do it?

JH: We have a number of funding partners. Among them are stakeholders in healthcare, insurance companies, service and treatment providers and pharmaceutical companies. They support and take part in access to the system's information and knowledge, the elements we develop around our Index. They do it because they find it essential that we move in this direction. They see a future for the power of the consumer and that's why we join ranks.