



Common Concerns: International Issues in Health Care System Reform



President's Message
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On the cover:

At the 1998 International Symposium on Health Care Policy in Washington, D.C., participants from five industrialized nations discussed common issues affecting their health care systems. From left are the Honorable Bill English, M.P., Minister of Health, New Zealand; the Right Honorable Frank Dobson, M.P., Secretary of State for Health, United Kingdom; the Honorable Donna E. Shalala, Secretary, U.S. Department of Health and Human Services; and John K. Iglehart, founding editor, *Health Affairs*.

Photo: Bill Gallery

President's Message

Common Concerns: International Issues in Health Care System Reform

Karen Davis

Most industrialized nations want similar things from their health care systems: effective services that improve the health and quality of life of their citizens, equitable access to those services, and efficient use of resources. In pursuing those goals, however, different countries have historically taken very different paths. The United States has relied heavily on market forces to shape the provision of health care services, while countries such as Canada and the United Kingdom have given government a much stronger role.

To a great extent, these choices have formed the systems we know today. The American health system has the advantages of flexibility and innovation, providing technologically advanced health care to the majority of Americans with good health insurance coverage. By contrast, Canada, the United Kingdom, and many other countries have done a better job of controlling total health spending, assuring access to basic health care for all citizens, and reducing preventable mortality and morbidity.

In the last decade, efforts to control health care costs—a major priority in many industrialized countries—have produced some interesting shifts

in strategy. The United States, for example, has relied increasingly on managed care plans. These organizations have assumed many of the functions typically carried out by governments: rationing care, setting hospital and physician payment rates, and controlling costs. Other countries have instituted even tighter controls, while at the same time experimenting with limited market-oriented reforms. In the United Kingdom, for example, some public hospitals have been converted to quasi-independent “trusts,” with greater autonomy in internal management but stricter accountability to public purchasing authorities. The United Kingdom has also moved to give primary care physicians more control over their patients’ access to specialty and hospital care—along with a share of the financial risk.

Both types of reform have encountered serious public backlash, as citizens express their concern about the future of their own health care and the capacity of their national health care systems. In the United States, the “private regulation” of health care through managed care plans has raised alarms about issues such as access to specialty care and the length of hospital stays. In the United Kingdom, the new government retained many elements of a recently implemented payment system but reshaped it to address criticisms of its fairness. Around the world, public opinion is an increasingly important factor in the ability of governments to regulate and reform their health care systems.

This year, The Commonwealth Fund launched its new International Program in Health Policy. Predicated on the belief that industrialized nations are grappling with many similar problems in the area of health, the program is designed to open new opportunities to learn from common experiences. In addition to Harkness Fellowships, now refocused on health care issues, the program includes an annual international symposium, research and analysis on international health care topics, and an annual multinational survey. The Commonwealth Fund 1998 International Health Policy Survey—an inaugural study that provides a fascinating

snapshot of current public opinions and experiences—indicates intense public interest in health in Australia, Canada, New Zealand, and the United Kingdom, as well as the United States.

In the current climate of experimentation, international comparisons can be especially helpful in assessing the effectiveness of national efforts and suggesting approaches that might improve performance. The concerns and failures of others can help the United States put its own problems into perspective and raise cautions about potential challenges and pitfalls. These lessons are directly relevant to the most important areas of current national health care policy, including health care spending, the roles of hospitals and primary care, the cost of prescription drugs, measuring and maintaining health care quality, and equity in the provision of care.

Controlling Health Care Spending

Health care is an expensive service in any industrialized nation. Over the past two decades, most countries have struggled to find a balance between providing high-quality, accessible care on the one hand and maintaining a reasonable level of health care expenditures on the other. In the 1980s and early 1990s, macro-efficiency—slowing the growth of total health care spending—was a predominant concern. Driven in part by international competition, slower real economic growth, and the perception that health care was consuming too large a share of total economic resources, the issue was also fueled in most countries by governmental budgetary pressures and a desire to reduce or control the growth of tax burdens. Although government pays a smaller share of health care costs in the United States—47 percent—that share is higher than commonly perceived because public programs cover many of the sickest patients. High health care costs in the United States, therefore, are of keen concern both to employers and to government.

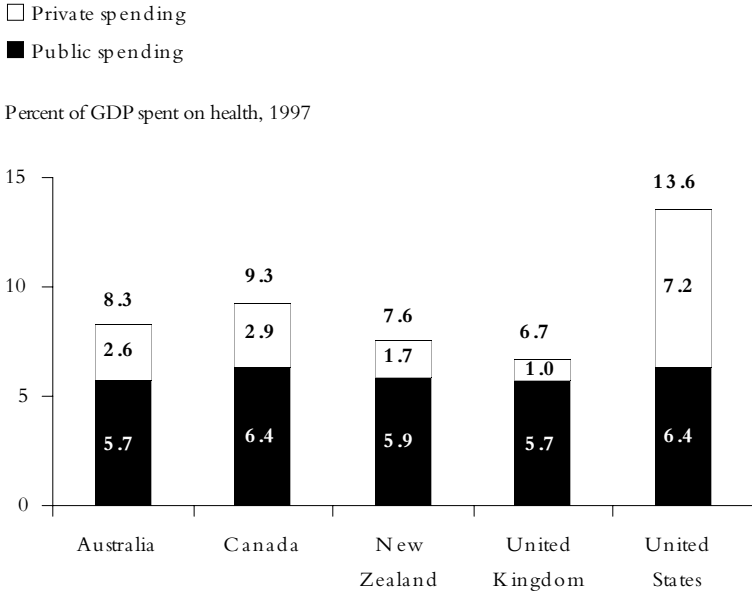
Although total spending remains a potent issue, concern has recently shifted in several countries to micro-efficiency—increasing productivity and changing delivery systems to provide care at lower cost. Since hospital care is the most costly segment of the health sector, new policies have attempted to shorten hospital stays, replace inpatient care with ambulatory services, and stress the role of primary care. At the same time, quality of care is attracting new attention as officials attempt to respond to public discontent with cost-saving measures, such as restrictions on the use of services, and other perceived threats.

The United States has the highest health spending of any country, whether measured as a percent of the gross domestic product (GDP) or on a per capita basis. In 1997, 13.6 percent of American GDP was spent on health care, compared with 6.7 percent in the United Kingdom, 7.6 percent in New Zealand, 8.3 percent in Australia, and 9.3 percent in Canada. Given its relatively higher income, this level of expenditure may be appropriate for the United States. Countries and individuals with more income tend to be willing to pay more for the benefits of health care, even if those benefits are costly. Yet the gap seems too large to be explained by this reason alone.

This pattern of national expenditures is not new, nor is there yet any evidence that the United States is slowing its spending relative to other countries. Despite considerable change in the health sector in the 1990s, American per capita health spending grew at about the median rate for industrialized nations. In Canada, health spending as a percent of GDP actually declined in the 1990s as a result of stiff governmental budgetary measures.

For the United States, these comparisons spell good news and bad news. On the positive side, they suggest that measures to control health spending—whether legislative changes to the Medicare and Medicaid programs or market-driven approaches such as employers' shift to managed care—have not been excessive but, rather, are roughly in line with changes

The mix of public and private financing for health care varies markedly across major industrialized countries. In general, health care consumes a lower share of gross domestic product in countries where public spending predominates.



Source: Organization for Economic Cooperation and Development, 1998.

in other countries. On the negative side, they provide no evidence that domestic strategies are working better than methods used by other countries.

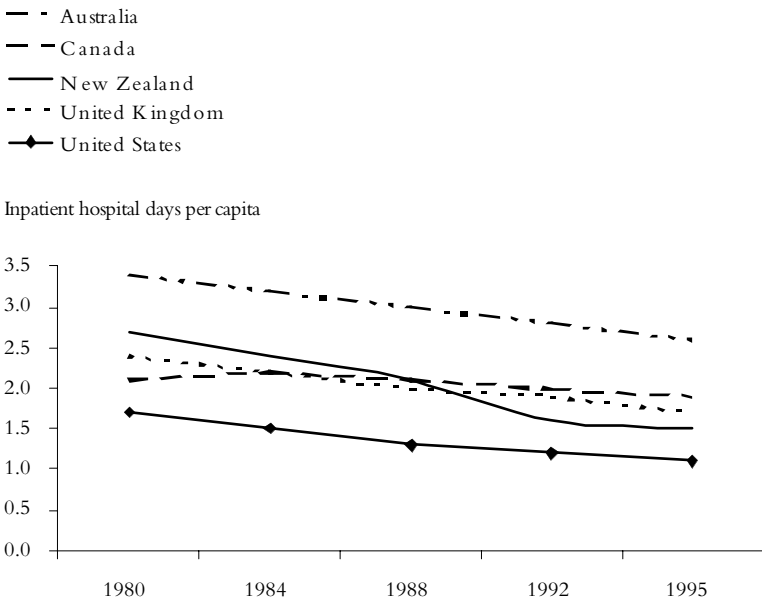
Managing the Use of Hospital Care

Despite disparate patterns of hospital ownership and methods for financing and delivering care, nearly every industrialized country has sought to contain health care costs by curtailing spending in the hospital sector and shifting the locus of care to ambulatory services. United States has accomplished this through two strategies: the adoption of capitated managed care and, in 1983, a change to per-patient hospital payments under Medicare. The first strategy has given health plans a strong

incentive to reduce hospitalizations and shorten stays, while the second encourages hospitals to discharge patients more quickly. These changes, along with technological advances, have also resulted in a major shift to outpatient or day surgery, where patients are not kept in the hospital overnight. Almost half of all surgeries in the United States are now done on an outpatient basis, but so are nearly 70 percent in Canada.

Certainly, there is evidence that these policies have worked to reduce hospital utilization. The average length of a hospital stay has declined, as have hospital admissions. The rate of inpatient hospital use (1.1 hospital days per capita) is low in the United States—well below the median for industrialized countries and the national rates for Australia (2.6), Canada (1.9), or the United Kingdom (1.7). Even so, hospital utilization was low

The number of hospital days per capita is dropping in many industrialized countries, as inpatient hospital care is used less frequently and for shorter periods.



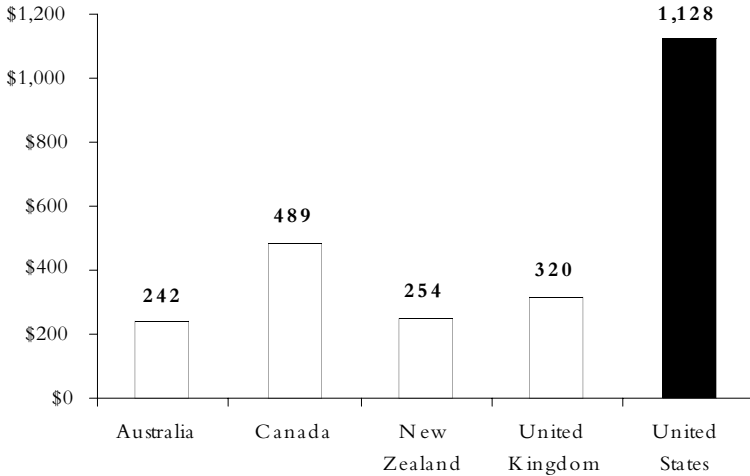
Source: Organization for Economic Cooperation and Development, 1998.

in the United States before the onset of cost-cutting reforms. Also, an international comparison shows comparable drops in inpatient hospital days in other countries.

Where the United States appears high is in average hospital costs per day. The American system is clearly more technology-intensive and specialized, featuring more magnetic resonance imaging machines (MRIs), more computerized tomography (CT) scanners, and more bypass operations, cataract surgeries, and joint replacements per capita than other countries. This care undoubtedly improves the quality of life of many American patients and may reduce mortality for some conditions.

Although Americans spend relatively few days per capita in the hospital, spending per day of care is exceptionally high. Technology and specialized procedures account for some of the difference.

Hospital costs per day, 1996

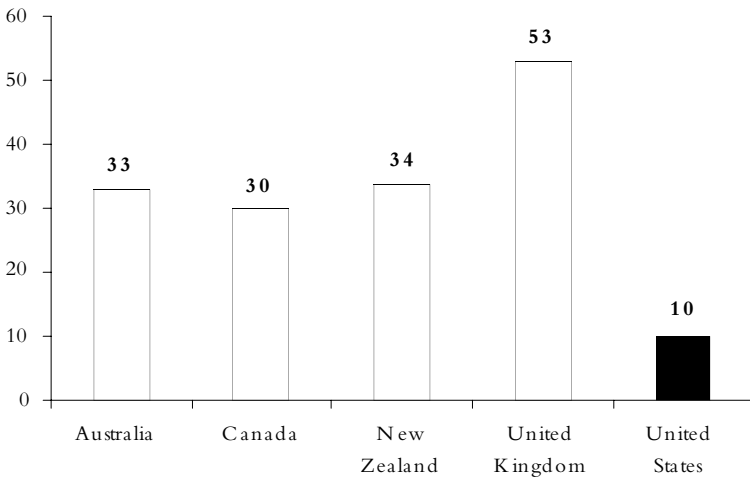


Source: Gerard Anderson, *Multinational Comparisons of Health Care: Expenditures, Coverage, and Outcomes*, 1998.

Other countries avoid high costs per day and excessive use of expensive technology through direct measures. Hospitals are typically subject to tightly constrained global budgets, and capital outlays for major equipment or facilities must be approved by government authorities. In some countries, the numbers of surgeons and other specialist physicians are directly controlled. Although effective, these strategies have their shortcomings. Waiting lists for surgery grow long in some systems, and hospitals short of funds at the end of a fiscal year may have to postpone the admission of elective patients. The Commonwealth Fund 1998 International Health Policy Survey found, for example, that 53 percent of patients in the United Kingdom wait longer than one month for non-emergency surgery, compared with 10 percent of patients in the United States.

About a third of patients report waiting for more than a month for non-emergency surgery in Australia, Canada, and New Zealand. The percentage is much higher in the United Kingdom and lower in the United States.

Percent of patients waiting longer than one month



Source: The Commonwealth Fund 1998 International Health Policy Survey.

Countries have tried a variety of strategies to increase the productivity of their hospital sectors, shorten waiting lists, and encourage hospitals to be more responsive to patient concerns. In the United Kingdom and New Zealand, public hospitals have become quasi-independent “trusts,” able to enter into contracts with health financing authorities to deliver specified hospital “outputs” in exchange for negotiated budgets. In some parts of Australia, global budgeting has been replaced by per case payments. Local planning groups in Canada have identified excess capacity and closed a significant portion of hospitals. Yet most of these innovations have been controversial and have yielded only mixed success.

Reliance on private market forces in the United States has sometimes turned out to be equally controversial. With a national hospital bed occupancy rate of only 62 percent, many American hospitals have accepted sharply discounted payments from managed care plans—a practice that could result in the financial failure of key institutions. Some nonprofit hospitals have converted to for-profit status, but this has provoked criticism and may affect the availability of specialized or charity care. Mergers may help some hospitals achieve economies of scale and increase their bargaining position with managed care plans, but the effectiveness of the strategy is still unclear.

What is clear is that sharing information within and across countries can highlight effective practices. In the United States, for example, where surgery rates vary as much from state to state as they do among major countries, much needs to be learned about the consequences of specific policies for the cost, quality, and timeliness of care. When are shorter hospital stays too short, leading to patient discomfort or anxiety, burdens on families, medical complications, or hospital readmission? Is consolidation of the hospital industry desirable—yielding better patient outcomes through the use of high volume surgical centers of excellence, for example—or will it reduce flexibility and innovation, increase market power, and ultimately

raise costs? The international experience does not answer these questions definitively, but it does offer a rich database for exploring important issues.

Emphasizing Primary Care

Most patients make their first contact with the health care system through a primary care or generalist physician. Countries differ markedly in their supply of primary care physicians, the role of those providers, and their financial incentives, yet the average number of physician visits a year is remarkably similar across the major English-speaking countries. Per capita, however, the United States has far more specialists and far fewer primary care physicians than other industrialized countries.

Primary care physicians serve as “gatekeepers” to specialty care in some but not all countries. Under this arrangement, patients have a regular, primary care doctor in charge of their care—typically one they are able to choose—and see a specialist (such as a dermatologist, ophthalmologist, or cardiologist) only upon referral from their primary care physician. The United States formerly had a tradition of direct access to specialists, but health maintenance organizations—the most tightly organized form of managed care—require all care to be authorized by a primary care physician. This gatekeeping function changes important dynamics of care and enhances the role of the primary care physician in influencing the cost and quality of the total care a patient receives.

Mechanisms for paying primary care physicians also differ across countries. In the United Kingdom, the dominant mode is a fixed rate per patient registered in the practice, a capitated system. In Canada and Australia, physicians receive a fee for each service rendered. Denmark is unusual in its blended payment system for primary care, with capitated per-patient payments accounting for approximately one-third of generalist physician compensation and fee-for-service payments accounting for approximately two-thirds. The United States has a long tradition of fee-

for-service payment, but the evolution of managed care has increased the share of physicians receiving salaries or capitated payments.

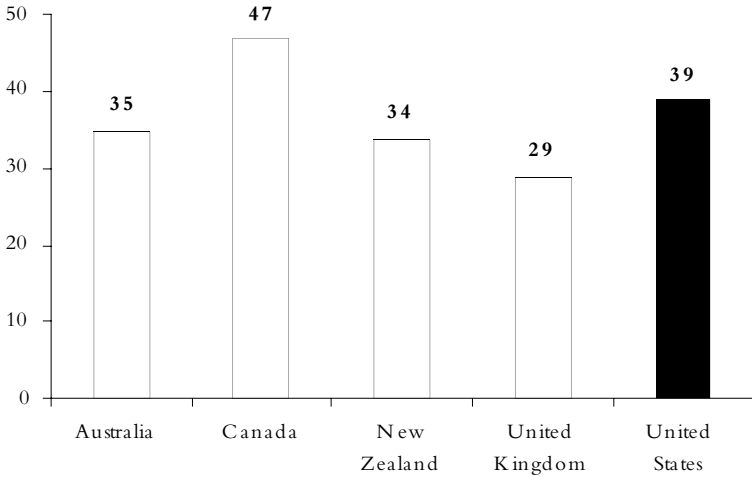
The method of payment can influence the quantity and quality of care provided. In general, fee-for-service systems have the disadvantage of encouraging overprovision of services: doing too many tests, for example, including some that may be of only marginal value. At the other extreme, salary or capitated payment systems can encourage physicians to work fewer hours, see fewer patients, or refer patients to specialists for treatment of routine problems.

When patients are unable to receive care they believe they need, the problem can become a major source of dissatisfaction with the health system. The Commonwealth Fund 1998 International Health Policy Survey found that Americans are more likely than patients in other countries to indicate that they find it difficult to get care when they need it. Other studies have documented that the main sources of this problem are lack of health insurance coverage and not having a regular doctor.

Difficulty seeing a specialist is an even more common complaint, in the United States and other countries alike. Almost half of Canadians say they have a hard time seeing a specialist, as do 39 percent of Americans; by contrast, less than one-third of British respondents reported this problem. A 1991 survey of physicians in the United States, Canada, and Germany, cofunded by The Commonwealth Fund, the Robert Wood Johnson Foundation, and the Pew Charitable Trusts, also reported barriers to obtaining needed services for patients, including specialist referrals and consultations, surgical procedures, diagnostic tests, and rehabilitative services. The 1995 Commonwealth Fund Survey of Physician Experiences with Managed Care found that access to specialty care in the United States is hampered increasingly by the requirement of approval from managed care plans.

Many patients find it difficult to see a specialist when they need to, no matter where they live. In most systems, patients get access to specialists only through referrals by their primary care physicians.

Percent of patients reporting that it is extremely, very, or somewhat difficult to see a specialist when needed



Source: The Commonwealth Fund 1998 International Health Policy Survey.

Some interesting recent innovations include giving primary care physicians a financial incentive to manage the total care of patients more economically. Reforms in the United Kingdom under Prime Minister Margaret Thatcher included “GP fundholding,” through which general practice physicians received capitated payments to cover not only their own services but additional services (such as surgery) “purchased” for their patients. Under Prime Minister Tony Blair, GP fundholding is being phased out and replaced by “primary care groups.” At their most advanced level of development, primary care groups of approximately 50 physicians will receive the entire allocation for their patients’ health care and purchase all services, including hospital care, through the group. New Zealand has

been moving in a similar direction: under a system called “budget holding,” groups of physicians will assume the financial risk for providing a broad array of services.

These trends have direct relevance to the United States, where physicians have formed associations to negotiate managed care contracts, often entering into capitated payment agreements. Primary care physicians may receive capitated payments for their own services, plus a bonus if funds set aside for specialty care are not exhausted. Medicare now permits managed care plans established by physicians and hospitals—provider-sponsored organizations (PSOs)—to participate. Medicaid agencies are beginning to consider direct contracting with provider groups, especially as for-profit managed care plans pull out of the program. Sharing experiences across countries may clarify the administrative, financial, and quality implications of these new arrangements.

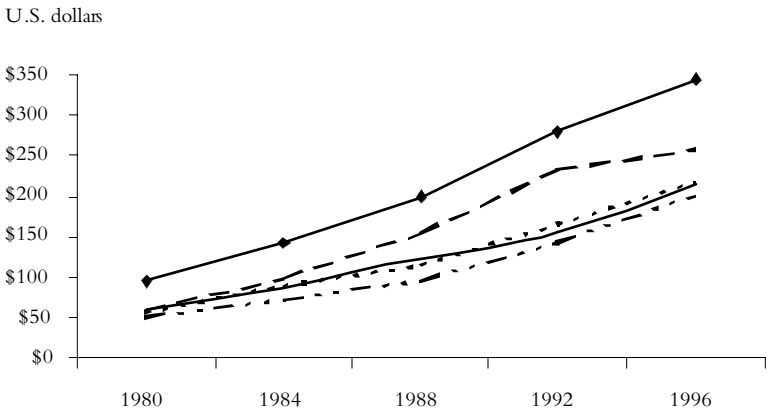
Containing the Cost of Medications

Another recent trend common to most industrialized nations is the rapid growth in expenditures for prescription drugs. This upward climb has been particularly strong in the 1990s: between 1992 and 1996, per capita expenditures for pharmaceuticals rose by 41 percent in Australia, 31 percent in the United Kingdom, and 23 percent in the United States.

This change is partly attributable to the movement of patient care out of the hospital sector. A patient hospitalized for four days typically receives a variety of medications during that time, which are counted as part of hospital expenditures. If the same patient receives outpatient surgery, the medication costs are counted as pharmaceutical expenditures. The implications touch on more than accounting: although hospital expenses are usually fully covered by insurance, patients often pay for prescription drugs themselves.

Spending on prescription drugs has risen sharply over the past 15 years. National distinctions have broadened, as well, with the United States and Canada now spending far more on pharmaceuticals per patient than the United Kingdom, New Zealand, or Australia.

- - Australia
- - Canada
- New Zealand
- - - United Kingdom
- ◆ United States



Source: Organization for Economic Cooperation and Development, 1998.

New drugs for conditions ranging from HIV to heart disease have also pushed up costs. Yet these new, more effective pharmaceuticals often extend life expectancy, prevent hospitalizations, and avert the need for surgical interventions. Managed care plans in the United States tend to encourage the use of such pharmaceuticals as part of sound disease management.

Government in both the United States and Canada has been noticeably reluctant to cover prescription drugs despite the financial burden on patients with chronic health conditions. Medicare does not routinely cover prescription drugs, although the 1997 Kaiser/Commonwealth Survey of Medicare Beneficiaries found that more than three-fourths of

beneficiaries have ongoing medication requirements. In Canada, prescription drugs are not routinely covered as part of basic benefits, but provinces typically offer subsidies for the elderly and poor. Ironically, the segments of the American population most in need of prescription drug coverage—the elderly and disabled—do not receive it, although the healthier working population often gets drug coverage through employer-sponsored health plans.

Australia has instituted a number of innovations to hold down rising pharmaceutical costs, including patient cost-sharing, incentives to use generic drugs, and negotiating prices with suppliers. As a result of this last tactic, drug prices in Australia are only about 50–60 percent of world prices.

Ensuring the Quality of Care

The preoccupation with containing rising health care expenditures has led to some public backlash and a growing fear that the quality of care is being compromised. These concerns are felt most keenly in countries that have recently instituted very stringent measures to curtail expenditures, such as Canada and New Zealand. Growing waiting lists for surgery and other specialized procedures in the United Kingdom are a particular source of public debate. In the United States, restrictions by managed care plans have prompted worries about getting access to specialist care and receiving care in an emergency.

Fund-supported surveys of patient-centered care in the United States, Canada, and the United Kingdom in the early 1990s found clear differences in responsiveness to patients' concerns on several particular aspects of care. American hospitals scored best on physician-patient communication, while Canadian hospitals got high marks for having a particular doctor in charge of a patient's care and British hospitals were praised for nursing care and for providing extra help when a patient returned home. On the other hand, almost a third of patients in the United States complained

that hospital nurses were too busy to take care of them; a third of patients in the United Kingdom felt they suffered pain that could have been eliminated by prompt attention from hospital staff; and two-fifths of Canadian patients were not told of danger signals to watch for after they got home.

Most countries have responded—through either government or private efforts—by developing methods to measure and monitor the quality of care. The United States has led the way in defining both patient-centered measures, derived from patient surveys, and clinical measures. The Health Employer Data Information Set (HEDIS), collected and published by the National Committee for Quality Assurance with partial support from the Fund, now functions as a yardstick for the quality of care provided by managed care plans. The Medicare program requires participating managed care plans to provide HEDIS information, and samples of Medicare beneficiaries in all participating plans are surveyed to obtain patient-centered care information.

The United Kingdom has recently contracted with Picker Europe—a joint venture of the Picker Institute (established with partial support from the Fund) and the Swedish corporation Bure Managed Care—to conduct patient-centered care surveys in British hospitals. The United Kingdom has also established the Institute on Clinical Effectiveness. Britain, Canada, and other countries have put increasing emphasis on “evidence-based medicine” and other efforts to promote improved clinical quality, while New Zealand has worked with physicians to develop clinical guidelines and identify best practices.

Consumer rights legislation is another widely used response. In the United Kingdom, the Patient Charter sets forth the rights of patients and establishes guidelines on certain key issues, such as waiting time for surgery. The Code of Patient Rights in New Zealand permits any recipient of health and disability services to make complaints to the health and

disability commissioner. Denmark's Patient Charter includes a system for making written complaints regarding clinical care or patient service to the national Department of Health; although the sanctions are modest, most Danish hospitals and physicians are acutely aware of the number of complaints filed against them in the previous year. Various proposals to establish a bill of rights for patients in managed care plans have received attention from the United States Congress and state legislatures. Cross-national studies could reveal important lessons regarding the administrative costs and effectiveness of such efforts in improving the quality and responsiveness of care.

Reducing Inequities in Access and Services

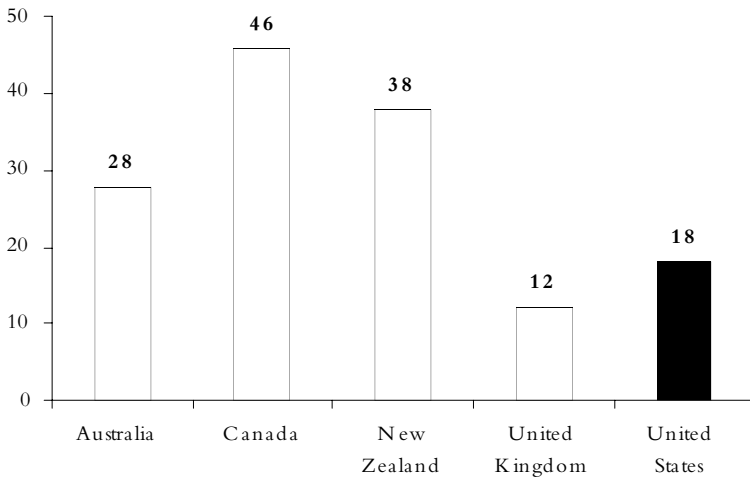
In recent years, equity issues have largely been eclipsed by public concern with health care costs and quality. Yet certain strategies to slow health care spending are likely to widen differentials in access to care across population groups. In the United Kingdom, for example, GP fundholding was criticized because many of the physicians who participated served relatively high income patients; those patients were subsequently advantaged in access to specialists and waiting times. In response, the new plan for primary care groups is mandatory for all United Kingdom physicians.

The creation of the European Community raises the possibility of establishing minimum standards for all health systems. A study commissioned by the European Community's COMAC-Health Services Research Committee examined health care financing and delivery of care across income groups in ten nations, including the United States. The study found that, although the probability of seeking care did not differ by income in most countries, the amount of care received was higher for high income patients in both the United States and Britain. With its heavy reliance on patient premiums and out-of-pocket costs, the United States was found to have the most regressive methods for financing health care. Tax-financed systems like the United Kingdom's tend to

distribute the burden of health care financing in proportion to income or disproportionately to high income individuals.

The Fund's new international survey suggests that many people believe that recent changes will harm the quality of health care. These fears could have profound implications for government's ability to enact further reforms.

Percent saying recent changes in the health care system will harm the quality of care



Source: The Commonwealth Fund 1998 International Health Policy Survey.

Health outcomes—particularly differentials in health status across socioeconomic or racial/ethnic population groups—have received some attention as important indicators of the overall quality of a nation's health care system. The United States lags behind other major industrialized nations in measures such as infant mortality and disability-free life expectancy at birth. Progress may be achieved in these and other areas under a new national initiative aimed at eliminating racial and ethnic differentials in six health conditions by the year 2010. In the United

Kingdom, a recent green paper on public health calls for a comprehensive strategy to improve health outcomes and reduce socioeconomic discrepancies.

In the United States, the growing number of Americans without health insurance is the dominant concern in discussions of health care access. The Kaiser/Commonwealth 1997 National Survey of Health Insurance found that insurance status was systematically related to access problems, including difficulty in obtaining needed care, postponing care, and not receiving high-quality care. Although most other industrialized nations offer universal health insurance coverage, the growth of patient cost-sharing in those systems—especially for services such as prescription drugs—may cause new or wider gaps in access to care.

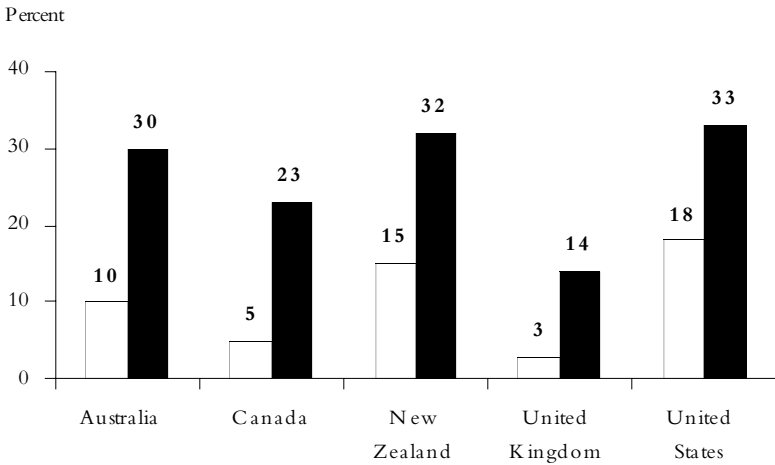
Popular Opinion and Health Care Reform

Health care is central to individual health and well-being; therefore, when people become dissatisfied with their health care system, government must take notice. Issues that prompt widespread public dissatisfaction include high out-of-pocket patient costs, difficulties in getting access to care, and the perception that care is poor or inadequate.

The Commonwealth Fund 1998 International Health Policy Survey found high levels of discontent in both the United States and New Zealand: almost a third of patients in each country say they would favor a complete rebuilding of the health care system. Their dissatisfaction seems to be linked directly to high medical bills—an acute problem for the 15 percent of Americans with no health insurance and for the many working families whose coverage is inadequate to their needs. In New Zealand, very unpopular user charges for hospital inpatient and outpatient services were imposed in 1993 but subsequently withdrawn. By contrast, only 14 percent of Britons believe their health care system needs extensive reform. The celebration of the fiftieth anniversary of the British National Health Service this year reflects a long-standing history of public support.

Persistent, serious problems that have a direct impact on patients—such as difficulty in paying medical bills—can cause people to lose confidence in their health care system as a whole. Nearly a third of Americans and New Zealanders now believe that their health care systems need to be rebuilt completely.

- Those saying they had problems paying medical bills in the past year
- Those saying the health care system needs to be rebuilt completely



Source: The Commonwealth Fund 1998 International Health Policy Survey.

Achieving popular reform is often elusive. After failing to reach consensus on an approach to universal health insurance coverage in 1994, the United States has turned instead to more modest incremental reforms. Responsibility for health care costs is a constant source of tension between the national and state or provincial governments in Canada and Australia. Conflict between the medical profession and public officials over reforms in the United Kingdom and New Zealand in the early 1990s has yielded to more collaborative and conciliatory approaches in recent years.

One of the obstacles to change is division over fundamental strategies. Some advocates favor a market-oriented approach, tempered with financial incentives to use health care resources more economically. Others endorse

equity and social solidarity as guiding principles, emphasizing the public provision of care along with decentralized decision-making and accountability mechanisms. Yet the concerns being debated and the choices being considered are similar in many ways, even in radically different health care systems. This rich foundation of common goals and diverse experiences could open new opportunities for each system to develop better, more efficient services.

The International Program in Health Policy builds on the Fund's 80-year tradition of scientific inquiry and commitment to social progress and draws on the time-tested tactics of fostering partnerships, mobilizing talented people, and communicating effectively. Through the new program, the Fund endeavors to wed its interests nationally and internationally, while establishing a framework for the systematic examination of common concerns.

The Commonwealth Fund is a philanthropic foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund carries out this mandate through its efforts to help Americans live healthy and productive lives and to assist specific groups with serious and neglected problems. In 1986, the Fund was given the assets of the James Picker Foundation, in support of Picker programs to advance the Fund's mission.

The Fund's current four national program areas are improving health care services, bettering the health of minority Americans, advancing the well-being of elderly people, and developing the capacities of children and young people. In all its national programs, the Fund emphasizes prevention and promoting healthy behavior. The Fund's international program in health policy seeks to build a network of policy-oriented health care researchers whose multinational experience and outlook stimulate innovative policies and practices in the United States and other industrialized countries. In its own community, the Fund makes grants to improve health care services and to make the most of public spaces and services.



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