

AARP EUROPEAN LEADERSHIP STUDY:

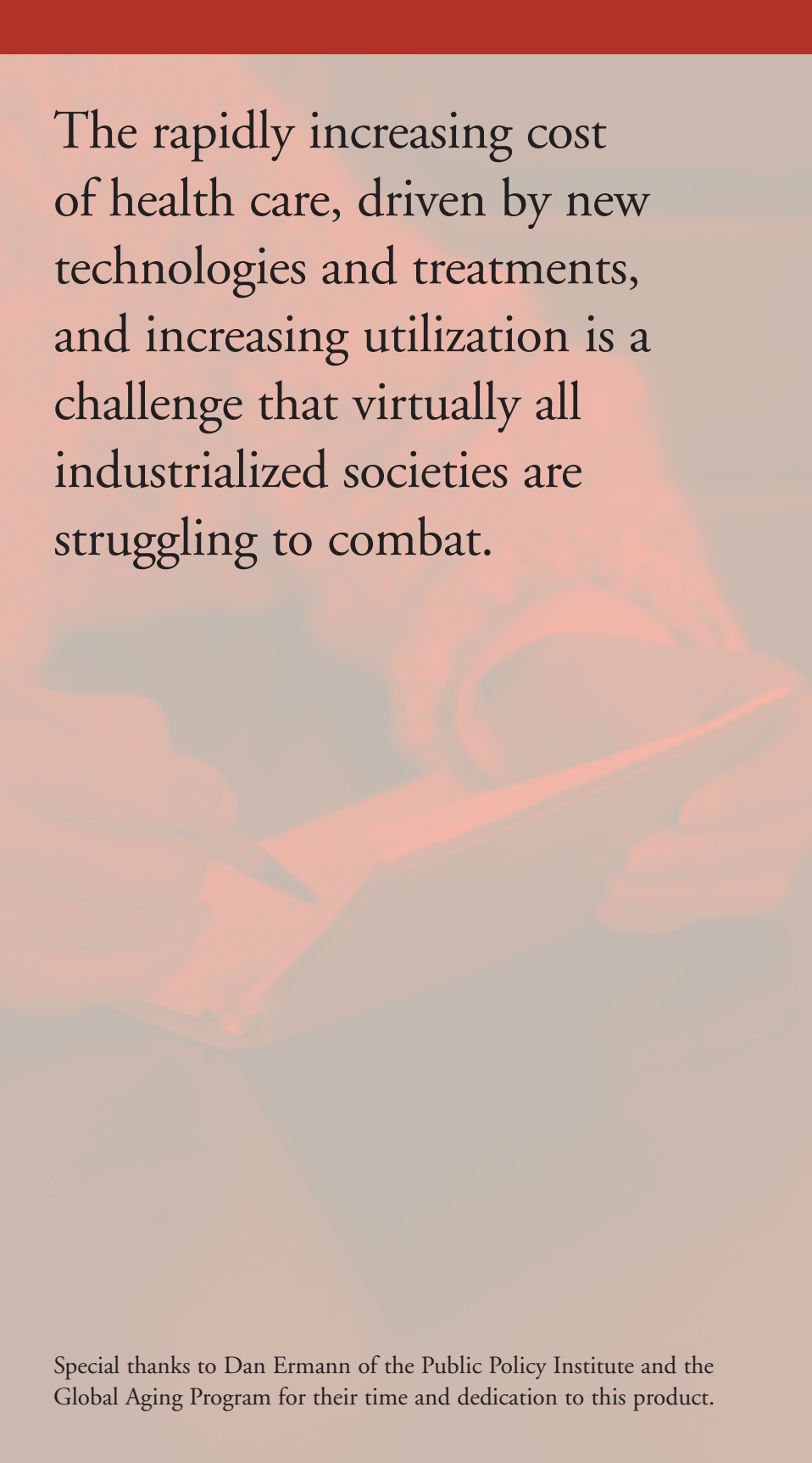
# European Experiences with Health Care Cost Containment

France, the Netherlands,  
Norway, and the United Kingdom

October 2006

The AARP logo is positioned in the bottom left corner of the cover. It features the word "AARP" in a white, serif font, with a registered trademark symbol (®) to its upper right. Below the text is a white, stylized graphic element consisting of two curved lines that suggest a ribbon or a wave.

AARP®



The rapidly increasing cost of health care, driven by new technologies and treatments, and increasing utilization is a challenge that virtually all industrialized societies are struggling to combat.

Special thanks to Dan Ermann of the Public Policy Institute and the Global Aging Program for their time and dedication to this product.

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# Preface

With health care costs rising at unsustainable rates and the Baby Boom Generation nearing retirement, the United States faces essential and imminent debates on the reform of our health care and long-term care systems. As the leading organization in America for positive social change, AARP is poised to lead the discussion on how to achieve better and more affordable health care in the United States and provide long-term care for older Americans. To further inform the discussion, AARP's Board of Directors and senior management traveled to Europe in June 2006 on a fact-finding mission to examine the experiences, trends, and best practices in global aging.

The European Leadership Study (The Study) concentrated on AARP's priority issues of health care and long-term care and examined how certain European countries are addressing challenges similar to those faced in the United States. In particular, The Study provided a deeper understanding of the European experience on pharmaceutical pricing, health information technology, financing and delivery of long-term care services and health care cost containment.

During The Study, the AARP delegation visited France, Norway, the United Kingdom and the Netherlands. The Study provided an opportunity for direct conversations with government officials, representatives from key nongovernmental organizations, consumers, and business leaders. The Study participants held discussions with national health ministers, health care consumers and practitioners, including sessions with the Chief Executive of the United Kingdom's National

Institute for Clinical Excellence (NICE), representatives from Sanofi-Aventis, France's leading pharmaceutical company, and political party officials in the Norwegian Parliament from the Standing Committee on Health and Care Services. The Study also included site visits to hospitals and long-term care facilities that provided invaluable first-hand observation of care as it is practiced abroad.

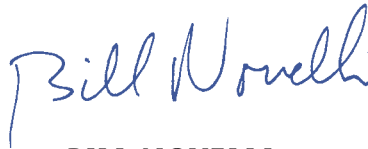
With the publication of four Issue Papers prepared by the AARP Public Policy Institute, AARP is presenting the background materials prepared in advance of The Study and the lessons learned that were compiled afterwards. The four Issue Papers address: long-term care; health information technology; pharmaceutical pricing; and health care cost containment. The Issue Papers rely on published materials, readily available data sources (such as reports and studies from the Organization for Economic Cooperation and Development and the European Commission, among others) and include, when possible, knowledge from first-hand, in-country experiences.

Due to the nature of available information sources, it was difficult to systematically draw direct comparisons among the four countries visited. Nevertheless, the papers offer important lessons for the United States and teach us that, while we are progressing in some areas of health and long-term care, there is much we can learn from European countries as we address these critical issues.

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ERIK OLSEN  
*President*



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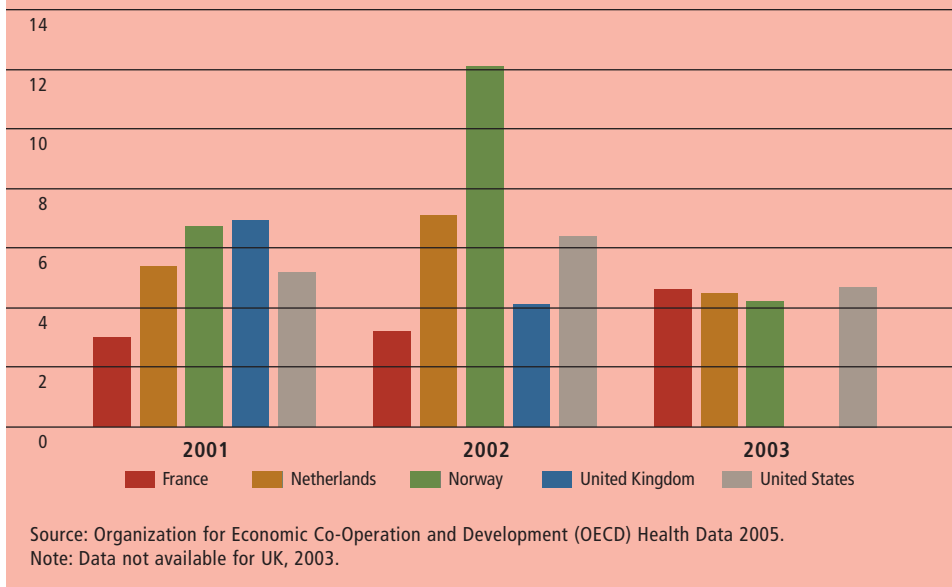
# Key Issues In Cost Containment

The rapidly increasing cost of health care, driven by new technologies and treatments, and increasing utilization is a challenge that virtually all industrialized societies are struggling to combat. This report describes key trends, cost containment issues and approaches being used, and policies that influence health care spending and system sustainability in the U.S. and four European countries—France, the Netherlands, Norway, and the United Kingdom (which includes England, Northern Ireland, Scotland, and Wales). The report also identifies some lessons learned from the experiences of these countries in attempting to contain health care costs.

As shown in Figure 1, the European study countries have seen substantial real percentage increases in national health spending, after adjusting for economy-wide inflation. Organization for Economic Co-operation and Development (OECD) countries are attempting to control health care expenditures—both public and private—through a myriad of approaches.

At the same time, countries are attempting to address problems and balance goals that can be very specific to their systems. For example, The United Kingdom's (UK's) National Health Service, widely considered underfunded, has had a policy since 2000 to increase funding in order to address problems of staff shortages, waiting lists, and limited access. Critics of the French health system say the national health insurance program is plagued by chronic operating deficits (excessive cost), numbing complexity, and inefficiency. However, the French believe their system

**FIGURE 1: Annual Growth Rate of Total per Capita Health Spending, 2001–2003**



strikes a realistic balance between the U.S.’s overly competitive model, which still fails to insure 1 in 7 residents, and Britain’s nationalized system that limits care and choice. In the case of Norway, successful economic policies have made it possible for the government to fund social-welfare programs consistent with other advanced Western societies. Even though Norway’s retirement and other programs do not face serious economic shortfalls in the short-term, recent reports cite growing concern about future funding deficits. The Netherlands implemented significant changes in the beginning of 2006, which they hope will foster competition and bring high quality care to all individuals while containing cost increases.

The U.S. health care system is no exception in terms of the cost challenges it faces. Long considered one of the world’s best systems by many citizens, the U.S. spent over 15 percent of GDP on health care in 2004 and much more per person than other countries in recent years (see Table 1). More recently, it has been characterized as underachieving because its performance is worse than in lower cost countries and is uneven, with large segments of the population unable to get needed care (U. Reinhardt 2004). Of the 30 OECD member countries, in 2004 Korea spent the smallest percentage of GDP on health care while the U.S. spent the largest. In addition, the U.S. spent \$6,102 per capita, which was \$1,013 more than second-ranked Luxemburg and \$3,552 more than the OECD average (OECD Health Data 2006, June 2006).

**TABLE 1: Comparison of Health Spending Among Study Countries**

	Total health spending per capita (\$PPP), 2004*	Total health spending as percent of GDP, 2004*	Admin. costs (2000)**
U.S.	\$6102	15.3%	6.9%
France	\$3159	10.5%	1.9%
Netherlands	\$3041	9.2%	4.4%
Norway	\$3966	9.7%	NA
UK	\$2546	8.3%	3.3%
OECD Mean	\$2550	8.9%	

\* OECD Health Data 2006, June 2006

\*\* "Other Countries, Other Worlds: US Health Spending in an International Context," E. Docteur, OECD, My Health Is Your Business: Emerging Issues Forum, Raleigh, NC, February 2005, 2000 data

NOTES: \$PPP is purchasing power parity. GDP is gross domestic product.

Some of the factors that are driving costs higher in the U.S. than in other industrialized countries include: (1) high gross domestic product (GDP) per capita; that is, increased ability to pay; (2) fragmented purchasing power through multiple payers resulting in greater market power in the supply side; (3) limited supply-side growth; that is, number of doctors and nurses per capita, in recent years providing the supply side with increased “bargaining power”; (4) administrative complexity and costs; and (5) unwillingness to ration health care explicitly (U. Reinhardt 2004).

# Country Approaches

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## FRANCE

France's per capita health care spending is above the OECD median, due to a high volume of services provided (i.e., comprehensive coverage) and high reimbursement levels (Health Care Systems in Transitions: France 2004). Other factors contributing to this situation include alleged waste within the system, unfettered choice, patients "shopping" for doctors until they receive the diagnosis they want, and high use of prescription drugs (National Coalition on Health Care 2004). Although expensive, the French health care system has been identified as one of the best in the world. In 2000, the World Health Organization (WHO) ranked the French system number one among 191 member countries (World Health Organization 2000). The French believe their national health insurance system strikes a balance between the U.S.'s competitive model on the one hand and Britain's nationalized system on the other (OECD Observer 2000).

Roughly 75 percent of all health spending is publicly funded, 10 percent is paid for by supplementary insurance, and patients pay the remainder. Lower income individuals are entitled to free care (1.8% of the population). Before 1988, the national insurance system was funded by employee and employer contributions based on wages. Since then, France has broadened the financial base of the health insurance system by taxing both earned and non-earned income (e.g., pensions), but this has been designed so that the actual amount of revenue collected has not increased (Health Care Systems in Transition: France 2004).

Health coverage is provided based on residence in France, so that nearly all residents have coverage for basic health care through the national system of sickness insurance funds. The National Health Insurance Fund for Salaried Workers or “general fund” is the dominant sickness insurance fund in France’s extensive system. Other sickness funds provide coverage for special groups; for example, farmers and other agricultural workers, railway and subway workers, and the self-employed. Over 90 percent of the covered population has private supplemental insurance providing additional benefits and covering cost sharing imposed by the national system (Health Care Systems in Transitions: France 2004).

About 50 percent of supplemental insurance policies are provided by employer-based plans. Two general types of organizations provide this insurance. *Mutuelles*, which are nonprofit and emphasize “mutual aid and solidarity,” represent about 60 percent of the market typically represent occupational categories (e.g., teachers). Their premiums are not based on the individual’s health status. Private insurance companies, which may be either for-profit or nonprofit, provide the remainder of supplemental insurance and they are more likely to adjust their premiums for health status (but less so than in the U.S.). Since January 2003, France has had to conform to the European Union directive requiring all insurance companies to meet uniform regulatory requirements (e.g., all are now subject to the same tax rules). This is hypothesized to result in increased competition because all insurance companies would have to meet similar requirements in the supplemental insurance market in the future, thus eliminating the tax benefits *mutuelles* previously held (Buchmueller 2004).

Doctors, dental surgeons and pharmacists self-regulate their profession by developing and monitoring professional ethics and the right to practice. The Ministry of Health establishes norms for hospital care, with compliance monitored by doctors and the health insurance funds. The government regulates the supply of health personnel and materials and is responsible for training health professionals. Unlike other European countries, France has never embraced market competition as a strategy for providing health coverage and controlling costs. However, recent changes in the supplemental insurance market (mentioned above) may bring about more competition (Health Care Systems in Transitions: France 2004).

**Patient Cost-sharing.** Under the national insurance system, there is cost sharing for physician, hospital and clinic services, and drugs; further, hospitals and doctors can balance the bill. The level of cost-sharing depends on whether the provider is “participating” and the specific treatment received or type of drug purchased. However, because the majority of people have private supplemental health coverage, the effects of the national insurance system’s cost sharing on demand suppression are thought to be minimal. A copayment of one euro (approximately \$1.25) was implemented in August 2004 (Buchmueller 2004).

A number of studies have shown that greater insurance coverage results in increased demand for services that may or may not be necessary. A 1998 study found that, when controlling for the effects of age and sex, but not controlling for health conditions, individuals in France with supplemental insurance were 10 percent more likely than those without supplemental insurance to have purchased any prescription drug during a one-month period. Another study found that French dental patients without supplemental coverage were over three times more likely than their covered counterparts to report having gone without care (Buchmueller 2004). After the 2000 reform activities, which provides publicly financed supplemental coverage to low-income people, inequities in access have declined.

**Spending Limits.** Since 1996, the Parliament has voted on an annual ceiling for health insurance expenditures. Once the overall ceiling is set, the budget is divided into four subgroups: public hospitals (divided by region), private for-profit hospitals, private physician practice, and social care. Public hospitals are paid prospectively through global budgets. Physicians practicing in public hospitals receive a salary but are allowed to have a private practice outside the hospital. Private hospitals are paid a diagnosis-related group (DRG)-type fixed rate for all costs other than physician costs, including the cost of care provided by specialists. This approach includes payment for meeting quality and safety standards; however, this is still in its early developmental stage. Self-employed physicians, who are paid on a fee-for-service basis, provide most outpatient and private hospital services. Patients pay the doctor's fees directly and then are partly reimbursed by the statutory health insurance system.

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Ninety-seven percent of doctors and hospitals accept the government-set price for covered services. However, health professionals responded to controls on prices by increasing the volume of services, or activities, in order to maintain a particular income level, and many physicians balance-bill patients. Because physicians have been able to change their behavior in order to thwart the goals of the price controls, cost control efforts seem to have been more effective in hospitals. Still, the country has faced difficulties in recent years in assuring that spending does not exceed the predetermined budget. A reform currently underway aims to equalize payments to the public and private sectors and to introduce an activity-linked reimbursement system that rewards physicians when their productivity exceeds expectations (further details are unavailable). This approach replaced the budget target system, under which the government was unable to control costs because there was no mechanism to correct for overspending (Health Care Systems in Transition: France 2004).

**Pharmaceutical Costs.** Because the cost of pharmaceuticals has risen dramatically from 15 percent of total health expenditures in 1980 to 22 percent in 1999, there has been a concerted effort to contain this sector. The French national insurance system recently began reimbursing pharmacists the same amount for brand name and generic drugs based on the cost of the lower priced drug. The patient is required to pay the difference if the more expensive brand name equivalent is chosen.

The Agence Nationale Pour le Developpement de l'Evaluation Medicale (ANDEM) was established in 1990 to develop coverage and payment recommendations to policymakers based on research findings and to identify needed additional research. ANDEM produced regulatory practice guidelines, which were introduced in 1993 to: foster appropriate use of resources, avoid dangerous practices, and control the cost of ambulatory prescriptions. In 1996, Parliament replaced ANDEM with the National Agency for Accreditation and Evaluation of Health Care (ANAES) to increase the level of knowledge on diagnostic and therapeutic procedures and improve the quality and safety of inpatient and outpatient clinical care, and implement an accreditation process for all hospitals. Between 1983 and 1998, physicians could be fined for not following the guidelines, an approach that was considered effective in modifying drug prescribing patterns. However, sanctions were eliminated in 1999, as the guidelines have been perceived by physicians as a means to control costs, not to promote quality, and thus most physicians were against them. In addition to producing clinical guidelines, now voluntary in nature, the ANDEM makes recommendations to financing agencies concerning reimbursement for specific products and services (Health Care Systems in Transition 2004).

*(See separate AARP paper on prescription drugs for information on other French public policies intended to control these expenditures.)*

**Physician Gatekeeping.** In 2004, a form of “soft gatekeeping” was introduced, which requires consumers to select a primary care physician as their “medical home.” This change encourages, but does not require, patients to see a primary care physician first before obtaining specialty treatment. Therefore, patients still have free choice of doctors; and previous attempts to change this approach have been unsuccessful. According to the European Observatory on Health Systems and Policies, “In the past 25 years, a succession of cost containment policies (both on the demand and supply sides) has attempted to balance the accounts of the health insurance system. However, it has not been easy to implement cost control policies in a system characterized by fee-for-service payment of doctors, retrospective reimbursement, and unrestricted freedom of choice for patients” (Health Care Systems in Transition 2004).

The public appears to be happy with their health care (there are no waiting lists for private or public providers), despite a 2000 OECD report that working households were spending, on average, 20 percent of their gross income on health care (Health Care Systems in Transition 2004). French officials, however, are optimistic that the gatekeeping mechanism will begin to control patient utilization as financial incentives to physicians and patients are increased in the near future.

More recently, in May 2004, the government proposed raising revenue and reducing government expenditures through reforms that shifted the financial burden from the state to the individual and their private supplemental insurance. These include: charging nominal co-pays for physician visits; charging higher co-pays to those with higher incomes; raising health care taxes on firms; reducing waste and

over-consumption of expensive drugs by reducing reimbursements to individuals; preventing national health insurance card fraud; establishing a computerized, personal medical record accessible to all providers; and continuing to try to encourage gatekeeping.

## THE NETHERLANDS

As of January 1, 2006, the Netherlands instituted a new insurance system requiring all residents to purchase private health insurance that covers basic medical services, pharmaceuticals, dental care for children and some specialty dental services for adults, ambulance and transportation costs, and some rehabilitation services. Because of the regulation of the insurance market, the Dutch tendency to insure, and the coverage of low-income and at-risk populations, coverage is nearly universal. Individuals may purchase supplementary private insurance to cover medical expenses not covered by the national health insurance plan (standard benefit package), or cost sharing requirements. The primary goal of the new insurance system is to ensure that all residents get the care they need in an efficient and responsive manner. Prior to this, the Netherlands had a fragmented system of health insurance with some population groups not covered (Hewitt 2005).

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Private insurers must accept all applicants in their geographic area and charge the same “nominal premium” for the same policy (i.e., a \$1,400 to \$1,700 range for 2006), regardless of age or health status. However, the premium for a given policy may differ between insurers. In addition, insurers may offer policies with differing deductibles or benefits in addition to the required package and, therefore, charge different premiums. Insurers may also offer plans that cover services provided either through a contracted network similar to a preferred provider organization (PPO) with little or no cost sharing, or with the patient choosing their provider, paying the bill, and getting reimbursed by the insurer. The latter approach entails higher cost-sharing. Individuals who choose the first option may obtain services from a non-network provider but may face higher copays. People making no, or minimal, claims under their policies are entitled to a refund up to about \$330 annually (Hewitt 2005).

Everyone older than 18 years of age pays a premium for health insurance. People can apply for a health care allowance or additional subsidy if the nominal premium is excessive compared with their income. Over 60 percent of the population qualifies for a health care allowance, which is paid by the Inland Revenue Service. The income of a person’s partner is taken into consideration when determining eligibility for a full or partial allowance. Families with children under age 18 do not pay a premium for those children.

In addition to the premium, people also pay an income-related “statutory solidarity supplement” to the government if the person has an income (e.g., job, social allowance, etc.). Employers and the social security agency reimburse individuals for these payments. These “contributions” are used to pay insurers to account for risk

differences in their covered population. That is, there is cross-subsidization between those paying premiums (younger and healthier) to those socially insured with no premiums (older and less healthy). Employers must contribute to this fund for their employees.

**Regulated Competition.** This coverage for a defined minimum package of benefits offered at a set premium regardless of age or health status and with the option of benefit enhancements is believed to encourage competition among insurers. In addition to introducing universal health care coverage, the program is intended to create a more equitable and cost-efficient health care market with the benefits package based on demonstrated efficacy, while preserving individuals' freedom of choice. Higher cost insurers with higher premiums are expected to have fewer people applying for policies. No information is available on how the Dutch will introduce cost efficiency or determine efficacy.

The Dutch consider their new system to be “regulated competition,” whereby:

- Once a year, everyone can switch insurers.
- Insurers compete with each other based on a package of benefits, deductibles, premiums and provider networks, while not varying premiums by age or health status for a given insurance policy.
- Insurers buy health care from providers for their insured population.
- Providers compete with each other and sell health care services to insurers.
- The vast majority of hospitals and other providers of care are private (Tapay 2004).

**Patient Cost-Sharing.** Insurance companies are termed “care insurers” because the government wants them to act as effective, customer-driven organizers for their insured. As described above, they must offer either “in-kind” services (where the insurer contracts with providers and controls accessibility, quality, and costs) or reimbursement for care (where the individual chooses a provider, pays the bill and gets reimbursed). Individuals pay more if they enroll in a reimbursement arrangement but have increased freedom of choice. Insurers can offer policies with both contract care and reimbursable care, thereby providing the consumer with added flexibility. The recent reforms have increased cost-sharing in order to make the consumer more cost conscious (den Exter 2004).

**Spending Limits.** Since 2000, hospital payments have been “performance-based, the first step towards changing to a DRG-type system.” Hospitals receive additional budgets for major capital expenditures. The government targeted higher fee-for-service reimbursement in order to encourage preventive services such as vaccination and screening (den Exter 2004).

**Pharmaceutical Costs.** The maximum reimbursement for drugs is based on the average price of groups of medicines that are therapeutically interchangeable. Individuals are responsible for any difference in price between the maximum reimbursement and higher costs. There is no reimbursement limit for covered drugs for which a substitute is not available. In addition, the government has considered limiting dispensing to one week's supply of drugs at a time so as to curtail waste of pharmaceuticals. The government has calculated that 3 percent of drugs are discarded without use (den Exter 2004).

**Physician Gatekeeping.** General practitioners act as gatekeepers for specialist and inpatient care.

## NORWAY

The Norwegian health care system is based on the principles of universal access to health care services, political decentralization to local governments and regional health authorities, and free choice of provider. The government finances 85 percent of health care through general taxation. All residents are publicly insured for health care through a national system financed by taxes and contributions from employees, employers, and the self-employed. Local government health spending is mostly financed through national government grants. Both contribution rates and grants are determined by the Parliament (Health Care Systems in Transition: Norway 2004).

Coverage is quite complete, except for dental care. Insured people receive free inpatient hospital care with no co-pays. There are co-pays for laboratory tests, x-rays, some outpatient drugs, and physician services. Laws passed in 1999 and 2001 reinstated equity principles; for example, equal access to health care services regardless of income, age, education, gender, ethnic background, or place of residence. Norway is one of the most sparsely populated (i.e., rural) countries in Europe, with a much lower population/square mile than the U.S., making the last criterion for equity difficult to satisfy.

**Cost Issues.** Health care spending, especially public spending, in Norway continues to rise, resulting in per capita expenditures that are among the highest in OECD countries, and the percentage of GDP spent on health is the third highest in the OECD. The activities of several former centers were recently consolidated in the Norwegian Knowledge Centre for Health Services, which assesses the cost effectiveness of new treatments and technologies and monitors existing treatments and patients' satisfaction. In principle, the cost-effectiveness analysis of the Centre—which also reviews ethical considerations—is to be taken into account by the authorities when deciding on the reimbursement of treatments (Norwegian Knowledge Centre for Health Services 2006).

The use of general practitioners as gatekeepers of hospital and specialty care and drugs has not had much effect on utilization of services. Primary care physicians are paid through a system that incorporates both fee-for-service (70% of earnings) and capitation (30% of earnings) payments. Some general practitioners who have fewer patients on their panel than the stated desirable number are providing an increased number of services, thus increasing their total income. Capitation payments to these providers are often increased later in the year after spending exceeds the budgeted amount, lessening the effectiveness of budgeting (Bibbee 2006).

Although Norway introduced a DRG-type payment system in order to foster efficiency in hospital operations, there has been DRG-creep; that is, “up-coding” or coding of admissions with diagnoses that receive higher payment. It has been argued that DRG procedures are over-paid in some areas, leading to increases in supply-driven interventions by physicians. For example, cherry-picking of profitable patients is evident with surgeries for better paid procedures such as “snoring” doubling from 1999 to 2003 (Health Care Systems in Transition: Norway 2004).

It is proving difficult to increase competition in the drug market. Although in principle, new drugs are only covered by the national insurance program if cost benefit analysis indicates that such coverage is worthwhile, in practice some expensive drugs that did not meet the cost benefit test have been included at the request of Parliament, following voter pressure. Patient co-pays for drugs are low and, therefore, Norway relies on price regulation of patented drugs to contain spending increases in this sector. (See separate paper on prescription drugs for information on other Norwegian public policies intended to control these expenditures.)

**Access Issues.** While some attention has been given to controlling the growing cost of health care, Norway’s abundant petroleum reserves have staved off major pressure to control expenditures. The focus of many reform activities has, therefore, been on increasing access to health care. Geographic variability in the quantity and quality of services is of concern because of the relative lack of medical resources in certain areas. In some cases, the volume of some services is lower than expected and lower payments may have resulted in too few providers of certain services (e.g., psychiatry). Reforms begun in the late 1990s have attempted to use market mechanisms to eliminate provider shortages and raise patient satisfaction as well as to improve efficiency. As a result, the supply of hospitals and physicians has increased, especially in more populated areas; waiting times have been reduced for primary and specialty care; more pharmacies are available in urban areas; and the population seems more satisfied. However, trade-offs between access and cost are difficult to avoid. Activity-based reimbursement (i.e., DRGs) is providing incentives to increase utilization but at a higher than expected cost (Health Care Systems in Transition: Norway 2004).

## UNITED KINGDOM

The National Health Service (NHS), established in 1948, provides comprehensive coverage to all legal residents of the United Kingdom (UK), residents of the European Economic Community, and citizens of other countries with which the UK has reciprocal agreements. Total health expenditures have remained low, with public sources accounting for about 83 percent of the total. Health care funding is from central government taxes (direct taxes, value added tax, and employees' contribution). This is considered to be a "mildly" progressive financing system, where people with higher incomes pay a somewhat greater share of their income. Out-of-pocket expenses for health care services remain relatively low. Only 11.5 percent of the population had supplemental private insurance in 2001 (European Observatory on Health Systems and Policies 2004).

Health care responsibility in the UK is delegated to its four constituent countries: England, Northern Ireland, Scotland, and Wales. Although the UK has the NHS, it is not uniformly administered by the four countries. For example, the Welsh Assembly Government set targets to increase the number of doctors, nurses, and dentists in order to reduce waiting times. In addition, Scotland funds personal and nursing care for people in long-term care separately, while the other three countries have integrated health and social care services (European Observatory on Health Systems and Policies 2004).

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**Health Spending Budgets.** Health care budgets are set every three years. The NHS delegates most patient care delivery and purchasing to Primary Care Trusts, which are locally based and own their own assets. The trusts receive a per capita-based payment from the NHS to provide specified services to between 50,000 and 250,000 people (European Observatory on Health Systems and Policies 2004).

Hospitals are public; only 5 percent of hospital beds are in private institutions. Doctors who are employed at NHS hospitals are paid a fixed salary but may treat private patients after hours in order to increase their income. The number of physicians has also been restricted, so that the UK has had the lowest number ratio of physicians per unit of health care expenditure with a relatively low productivity (Koen 2000).

Currently, the NHS believes that they have an undersupply of physicians, nurses, and dentists. The tight budgets and manpower supply constraints have led to long waits for surgery and other elective procedures. As a result, the main goals of recent reforms have been to improve supply, access and quality of care, as well as to ensure cost-effectiveness of service delivery. Recently, the government increased spending to: (1) augment the number of providers; (2) give patients a wider choice of hospitals and reduce waits by developing agreements with private hospitals; and (3) send some patients to other neighboring countries for care. In 2003, NHS began paying hospitals on an activity-basis, that is, they receive a set sum for each treatment they

carry out, adjusted for case-mix, in order to increase services provided and reduce long waiting times. Prior to 2003, hospital payments were based on historic costs (OECD Economic Survey of The UK: 2004, 2004).

**Payments to Physicians.** GPs are predominantly self-employed and have panels of about 1,800 members, whose visits to specialists require a GP referral. In 1990, the NHS implemented a voluntary payment system for GPs. Instead of receiving the national contract amount, the 30 percent of GPs who opted for this system were allocated a budget with which to buy hospital and specialty care for their patients and were given financial incentives to provide immunizations, health promotion, and cancer screening. GPs were encouraged to become active purchasers of referral care while continuing to provide most primary care. However, they were able to use savings from patients' care accounts to extend the range of services offered to patients in their primary care clinics. It appears that this resulted in some preferential hospital treatment for patients of fundholders who admitted a significant number of patients. However this was not the case for patients in inner cities or areas disproportionately populated by patients of lower socio-economic status. Thus it increased socio-economic differences in access to hospital care but resulted in little progress in moving care out of the hospital. This activity had a high cost to the government and was terminated by the Blair government (OECD Economic Survey of The UK: 2004, 2004).

Beginning in 2004, the UK began implementing a new payment system for GPs. Each general practice is scored on 146 quality of care performance measures and payments are made according to the accumulated score. GPs can earn about one-third more by improving the quality of their practice as measured on an evidence-based scorecard (Smith 2004).

**Pharmaceutical Costs.** The system provides coverage for prescription drugs up to a fixed monetary amount, irrespective of whether the drug is a brand name or generic, providing a financial incentive for patients to purchase less expensive generic drugs. (See separate paper on prescription drugs for information on other UK public policies intended to control these expenditures.)

**Clinical Guidelines.** The National Institute for Clinical Excellence (NICE) is an independent organization that was set up in 1999 to provide national guidance on the "promotion of good health and the prevention and treatment of ill health." Its name was changed to the National Institute for Health and Clinical Excellence in 2004, although it is still referred to as NICE. It develops guidance to the government about whether a particular medical service, product, technology, or practice is both efficacious and cost-effective and should be covered by the NHS for all or part of the population. For example, NICE guidelines state that, for services with an incremental cost-effectiveness ratio greater than 30,000 pounds (about \$52,000)/quality-adjusted life year (QALY), "the case for supporting the service has to be increasingly strong" for the Appraisal Committee to recommend its use. Although NHS generally does not prescribe coverage, since 1999 it is mandatory

that local authorities accept the guidance provided by NICE. However, adherence is considered variable both at the country and local levels. Individuals with sufficient personal resources or supplemental private insurance may obtain services or treatments not covered by the NHS (A Guide to NICE 2005).

**Reducing Medical Errors.** The National Patient Safety Agency was established in 2001 to manage the mandatory national reporting system for adverse events and near misses. Effective April 2005, the agency's work was expanded to include safety aspects of hospital design, cleanliness and food, and the conduct of research. It also now supports local organizations by addressing their concerns about the performance of individual doctors and dentists, a function formerly conducted by the National Clinical Assessment Authority (The National Patient Safety Agency 2006).

# Lessons for the United States

As demonstrated above, countries are attempting to control health care expenditures using a variety of approaches. Very few cost containment approaches have been empirically studied and reported in the literature; therefore, there is a paucity of evidence regarding the effectiveness of many approaches in the countries where they were implemented. In addition, it appears that new approaches are frequently started and stopped—perhaps due to public or political pressure—before any examination of their effect on cost, quality or access to care.

Nevertheless, European experience with cost containment strategies reveals the following experiences:

- **Patient cost sharing**, which is used in all study countries, is for the most part low and generally used to encourage cost-effective behavior rather than to suppress demand. If the cost sharing is high enough, it can change behavior by suppressing demand, which affects lower-income individuals more than others. This does not appear to be a goal in these countries. While increased cost sharing may lead to less use of unnecessary care, it may also reduce access to needed services. Supplemental insurance coverage reduces the demand suppression effects of cost sharing.
- **Restricting funding for certain types of services or treatments** does not necessarily prevent use of those services but, rather, may increase the cost sharing. Thus, demand for these services or treatments will depend on the cost to patients and their ability and willingness to pay. If a service or specific drug is not cov-

ered, it effectively increases the cost sharing to 100 percent. If the payment is limited (e.g., paying for the generic equivalent drug), then the individual has strong financial incentives to use the lower priced drug.

- **Budget-setting** seems to be one mechanism that results in lower expenditures; however, it may result in other negative effects on consumers. Budget-setting systems can include both negative incentives (i.e., penalties) for overspending and positive incentives (i.e., rewards) for underspending. The UK has been able to control cost growth; however, patients have been faced with long waits for some services. An OECD report found that countries are less likely to have waiting time problems if they rely mainly on activity-based funding for hospitals rather than fixed budgets and if they pay hospital physicians on a fee-for-service basis rather than a salary. However, these approaches may also encourage provision of unnecessary and costly care.
- **Rate setting** is routinely used in all countries as part of the reimbursement process. The process used to determine rates, and the level and growth in rates, will effect the number of providers, access to care, waiting times and other measures of quality and consumer satisfaction.
- **Controls on the way providers supply health care** may either contain costs or result in cost shifting to other forms of treatment. For example, when access to specific drugs is limited, patients may use other drugs in greater volume or shift from a drug to an alternative treatment modality.
- **Competition** between insurers or providers is based on conventional economic theory. However, because there is imperfect information in health care, consumers are not always able to make informed decisions. Sometimes, because of the perception of a positive relationship between price and quality, they will “purchase” a service that is more expensive. There appears to be little competition fostered in European countries to date. However, experience with recent reforms in the Netherlands should provide useful information on this issue in the next few years.
- **Evidence-based policies and coverage** are being researched and implemented in many countries, including the U.S., and show great promise. The European Observatory on Health Systems and Policies, the OECD, and other agencies in European countries support and promote evidence-based health policy through comprehensive and rigorous analysis of the dynamics of health care systems in Europe. In recent years, evidence-based research has also been emphasized in the U.S.; for example, development of practice guidelines for selected conditions. More attention to this approach is required, and methods to disseminate information to consumers and providers are needed. It is still unclear if voluntary or mandatory compliance with practice guidelines by providers is preferable.

As we consider what can be learned from other countries, it is important to view European cost containment approaches and results in the context of the entire health care delivery system, the local culture, and the national economy. For example, the U.S. has a long history of freedom of choice, which has hampered acceptance of managed care and could further hinder implementation of another country's system features. Some European countries also place a high value on choice, including France. Furthermore, the fragmented delivery and financing of U.S. health care, coupled with lower ratios of doctors and hospital beds per capita than in many other countries, creates a different purchasing dynamic than in countries with a single public plan that dominates the market.

Despite these differences, the U.S. has and continues to employ some of the techniques described above, or similar ones, in an effort to better control health care spending and increase the value of health care spending. Major approaches include identifying and reducing fraud and abuse, introducing prospective payment systems, setting provider payment rates, limiting payment increases, implementing or increasing cost sharing to make patients more sensitive to the implications of using services, introducing management techniques to improve the appropriate use of services, shifting service use to lower-cost settings, and supporting the development of evidence-based medicine. In the end, however, the success of the U.S. in moderating spending is likely to lie in making trade-offs within the system.

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