

## THE EXPERIENCE OF OECD COUNTRIES IN COPING WITH RISING HEALTH COSTS

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Chairman Bennett, Representative Stark, distinguished committee members, I am John Martin, Director for Employment, Labour and Social Affairs of the Organization for Economic Cooperation and Development. I am pleased to be here with you today to discuss the experience of OECD member countries in coping with rising health costs.

The Medicare program faces economic challenges that are common to many publicly financed health insurance programs across industrialized countries. In my testimony today, I will describe those challenges, the general approaches that have been used to deal with them, and the extent to which those efforts have been successful. My testimony is based on a recent OECD study of the health system reform experience across OECD countries and on a comparative evaluation of the US health system that was published in last year's OECD Economic Survey of the United States. It also draws upon recent OECD work to assess the impact of population aging on future health spending.

## 1. HEALTH SPENDING TRENDS IN OECD COUNTRIES

***OECD countries face rising health costs, with the United States the biggest spender.***

Health care represents a growing share of OECD countries' economies (Table 1). In 2000, health expenditure represented an average of 8.4 percent of GDP, up from 7.7 percent in 1990 and 7.1 percent in 1980.<sup>1,2</sup> The United States, spending 13.0 percent of GDP on health in 2000, devotes a greater share of resources to health than any other OECD country.<sup>3</sup> The next highest-spending nations, Switzerland and Germany, came in at 10.7 and 10.6 percent, respectively, in that year.

***Health spending growth reflects rising incomes.***

Growth in health spending that outpaces overall economic growth is attributed to several factors. Importantly, per capita health spending is linked to per capita growth in GDP. The effect of income on health spending appears to reflect income's impact on both volume and price of services, in that both the amount of health care consumption and the relatively labor-intensive prices of health services tend to increase with growth in national income. In general, OECD countries with higher per capita GDP tend to spend more per capita on health (Figure 1). However, there is significant variation across countries, which may partly reflect policy decisions regarding appropriate spending levels and the perceived value of additional spending on health relative to other goods and services.

***Advances in medical technology are a major driver.***

Advances in the capability of medicine to treat and prevent health conditions are widely agreed to be the greatest underlying factor driving health cost growth. Recent developments in imaging, biotechnology, and pharmacology suggest that this trend is likely to continue.

***Population aging will also drive health spending higher...***

Population aging is also expected to play an important role in driving future growth in health spending. Health-care costs tend to increase sharply with age beginning at about age 45, tending to fall back at age 80 or 85. Assuming current age-related cost patterns hold over time and that spending is unaffected by other factors, the OECD projects that total health-care spending will increase by an average of nearly 2 percent of GDP over the period 2000 -- 2050 as a direct result of population aging.<sup>4</sup>

### Public Sector Spending on Health

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<sup>1</sup> *OECD Health Data*, a compilation of internationally comparable statistics on health spending, health, and health systems, is issued annually as a CD ROM. Analyses based on the data, including tables, charts, and supporting explanations, are published by the OECD in *Health at a Glance*.

<sup>2</sup> Reflecting the availability of comparable data across years, these averages refer to 19 of the 30 OECD countries.

<sup>3</sup> 2000 is the latest year for which internationally comparable data on health spending are currently available.

<sup>4</sup> These projections are based on data from 18 OECD countries, not including the United States.

*... putting further pressure on public budgets.*

In most OECD countries, concern about health cost growth reflects the pressure such growth places on public budgets. Given the predominance of publicly financed health insurance coverage or direct public financing of care in most OECD countries, the public sector accounts for the greatest part of health spending in all countries except Korea, Mexico, and the United States (Figure 2). Nevertheless, the United States' public sector spends as much per capita on health as the average OECD country spends in total (public and private), even though only about one-quarter of Americans are publicly insured.<sup>5</sup>

## **2. APPROACHES TO HEALTH COST-CONTAINMENT IN OECD COUNTRIES**

*Several approaches have been used to rein in spending.*

Faced with a rising trend in their health spending, most OECD countries have sought to rein in this growth over the past two decades. Typically, the approaches used to slow the growth in public-sector spending have relied on three types of policies: (1) regulation of prices, input resources, and (to a lesser extent) health care service volumes; (2) caps on health spending, either overall or by sector; and (3) shifts of costs onto the private sector.

### **Administered pricing and controls on health care production inputs**

*Price and wage controls are common.*

Most countries regulate health-sector prices and/or service volumes in some fashion. Wage controls are prevalent in systems where most of the health care workers are public-sector employees, as they are in the Nordic countries, Greece, Italy, and Portugal. In other systems, prices for medical services, supplies, and institutional care are usually set administratively, as in the US Medicare program, or governments provide oversight on prices agreed between health-care purchasers and providers. Most countries take steps to influence service volumes, ranging from controls over medical school admissions and other workforce policies to more direct efforts to control hospital sector capacity.

*Such tools can be effective, although they have limits.*

While such tools can curb spending growth, the impact of price controls on health expenditure can be limited by provider responses, as experience has shown that health care providers respond to the economic incentives established in payment systems. For example, to compensate for price limits, practitioners may increase the volume of services provided or change the mix of services to include more of those paid at a higher rate. Sometimes services are shifted into sectors or systems where there are no price controls, something that has occurred in some countries where public and private programs operate side-by-side, as in Greece and Ireland.<sup>6</sup> And patients may be up-coded to higher level payment classifications, where such differentiation is built into payment systems. Thus, the success of price controls as a cost-containment tool depends on the extent to which payment systems can be gamed, the

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<sup>5</sup> Those covered by public insurance in the United States include elderly and disabled persons, who are relatively high users of health care.

<sup>6</sup> In Eastern Europe, where over-supply of health care resources is a legacy from the communist era, prices and wages in the health sector remain low and under-the-table gratuity payments to providers are common.

administrative costs associated with their use, and whether prices are set at levels that correspond to the costs of health care delivery by an efficient provider. A more important limitation over the longer term is that long periods of wage or price restraint can seriously limit the ability of the health-care sector to attract qualified personnel and maintain health care capacity

### **Budget caps**

*Budget caps are also widely used.*

Budgetary caps or controls have been widely used as an instrument for containing expenditure. Initially, these were directed at the hospital sector, the most costly element of the system. They were subsequently extended to other providers and suppliers so as to improve ability to control overall expenditure, particularly given the potential for substitution across sectors. Spending controls now often include global budgets spanning all components of public spending on health and supplementary spending caps on ambulatory care and pharmaceuticals.

*They also can be effective, although they risk undesired side-effects.*

In general, use of budgetary caps to control spending appears to have been most successful in countries where health care delivery is a public-sector responsibility -- as in Denmark, Ireland, and New Zealand -- and in single-payer countries, like Canada. Where budget limits are firm and enforceable, they can serve as a powerful tool to limit spending. However, top-down spending constraints in the form of budget caps can also have undesirable incentive effects in that they can provide little incentive for providers to make efficiency gains or increase productivity. For example, fixed budget ceilings encourage providers and suppliers to spend up to the ceiling. Setting budgets based on historical costs may favor inefficient providers and penalize efficient ones. As a consequence, OECD countries have been moving increasingly to combine budget caps with measures that take account of levels of output and relative efficiency across hospitals.

### **Cost shifting to patients**

Although the degree varies across countries, an increase in cost-sharing for medical care has been a common feature over the 1980s and, particularly, the 1990s. Greater cost-sharing has mainly affected pharmaceuticals, while patient payments for inpatient and doctor visits have been less widespread.<sup>7</sup> The number of drugs not reimbursed has increased, mainly for “comfort” drugs or those without proven therapeutic value. The degree of cost-sharing has been increased for many others. In a number of cases, flat-rate payments per prescription have been established. Reference price systems have also been introduced in a number of countries. These arrangements increase cost-sharing for individuals using branded or higher cost products while assuring access to less costly generic drugs.

*... and the public share of total spending fell slightly.*

Cost-sharing measures appear to have had an impact on the share of public spending in total spending (Table 2). Following large increases relating to the expansion of public health insurance programs in the 1970s, the increase in the public share of total health spending slowed markedly in the 1980s. Between 1990 and 2000, the average share of total health spending represented by the public sector declined slightly from 72.5 percent to 71.5 percent.<sup>8</sup>

### **3. THE EFFECTS OF COST-CONTROL INITIATIVES**

*Spending growth has slowed.*

Cost-containment efforts such as those described above coincided with a decline in the rate of spending growth across many OECD countries. On average, there has been a fall in the rate of growth in health expenditures across OECD countries over the past three decades: the average annual growth rate dropped from 6 percent in the 1970s to 3.2 percent in the 1980s and to 3 percent in the 1990s. Nonetheless, while spending growth has slowed considerably over the past two decades, health spending continues to grow at rates exceeding overall economic growth in many OECD countries.<sup>9</sup>

*Judging the appropriateness of spending levels is challenging.*

Such growth is not necessarily problematic from a policy perspective. Indeed, an emerging dilemma facing governments after this period of restraint is judging the “appropriate” level of health spending. On the one hand, social welfare may well be improved by increased government spending, particularly if demand for health-care services tends to rise more rapidly than income and if the cost of technological change is more than compensated by improvements in the quality of care and resulting outcomes. On the other hand, the economics of the health sector, typically characterized by market failures and heavy

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<sup>7</sup> Such policies presumably reflect the higher price elasticity for pharmaceutical drugs than for ambulatory and, particularly, for hospital care.

<sup>8</sup> The average dropped over the decade in 18 of 27 countries for which data are available and remained constant in one country. Those countries where the public share increased tended to be those, like the United States, Mexico, Portugal, and Turkey, in which the public share was lower than the OECD average in 1990. Hence, the tendency has been toward a reduction in the extent of variation across countries.

<sup>9</sup> In many countries, including the United States, growth rates picked up at the end of the 1990s and this trend appears to have continued in the early part of this decade. In a few cases, this growth coincided with deliberate policies to increase spending.

public intervention, suggest a risk of excess or misallocated spending, with equivalent health outcomes possibly attainable at lower cost.

#### **4. NEW DIRECTIONS FOR REFORM: THE MOVE TO COST-EFFICIENCY ORIENTED REFORMS**

***Large differences in inputs, practice patterns and outcomes exist across OECD countries.***

Although the efficiency of health-care systems (*i.e.*, achievement of maximum outputs for a given level of spending or achievement of comparable outputs at lower cost) is hard to measure, evidence suggests that there are large differences across OECD countries -- and even within countries -- in what is produced, in the way that it is produced, and in the resulting impacts on health outcomes. The level of capital and human resources employed in the health sector shows wide variation across countries.<sup>10</sup> In addition, there are as many different combinations of spending on ambulatory and inpatient care as there are countries and there are also very different levels of specialist care and use of pharmaceuticals. For any given health condition, wide differences also exist in the treatment and in the intensity of care (practice patterns), both within and between countries.<sup>11</sup>

***Hence, improved efficiency is a major focus of current health reforms.***

Improvements in the efficiency of health systems have been an important focus of reforms in OECD countries, particularly over the past decade or so and these efforts are continuing today. Improved efficiency is desired both to offset the budgetary impact of increased demand for health care and to improve the return on health spending. Reforms to-date have focused on modifying payment arrangements so as to better align the incentives of health-care providers -- and, in some cases, patients -- with efficient production and use of health services. There has also been increased interest -- although less experimentation -- in introducing to the health sector more of the elements found in normal economic markets, such as competition among health care providers or insurance funds, and greater use of price signals.

***Better purchasing arrangements and experiments to enhance competition have been tried.***

In countries with health systems in which the financing and delivery of health care is an integrated, public-sector function, efficiency-related reforms have included:

- making a greater separation between the health-care purchasing and providing functions with the introduction of clearer contractual relations and better indicators of what and how much is to be supplied;
- better aligning payment incentives with objectives for provider performance;
- decentralizing decision-making in efforts to better match local supply

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<sup>10</sup> For instance, the number of practicing physicians per 1 000 population in 2000 averaged 3.0 across the OECD, with a standard deviation of 1.0. The United States, at 2.8, stood at slightly below the OECD average. However, this rate does not take into account differences in productivity and how resources are deployed.

<sup>11</sup> Recent OECD work evaluated differences across countries in practice patterns, resources, and outcomes for ischaemic heart disease, breast cancer, and stroke. Proceedings from the project's concluding workshop will be published by the OECD later this month as *A Disease-Based Comparison of Health Systems: What is Best and at What Cost?*

and demand; and

- introducing greater competition among providers.

***Policies to create a purchaser – provider split have been sustained, but efforts to foster competition among providers have been less successful.***

While the potential impact of such policies on efficiency has most often been dampened by tight spending limits and supply constraints, policies aimed at creating a purchaser-provider split and decentralization reforms have usually been sustained. However, experiments designed to foster competition among providers, which have also been undertaken in multiple-payer systems, have been less successful and reforms have been reversed in those countries (e.g., New Zealand, Sweden, and the United Kingdom) where they were introduced. Failures partly reflected tight supply conditions and monopoly positions of providers in local health care markets, strong information asymmetries, and lack of sufficiently skilled purchasers. Positive results from competition probably require establishing market conditions conducive to competition, better purchasing capacity, and the information base needed to appropriately set and monitor contracts.

***New provider payment systems can improve efficiency.***

One seemingly successful area of efficiency-oriented reforms has been in the area of provider payments. New payment systems can enhance productivity if introduced carefully. For example, output-related prospective payment systems --- notably hospital payment systems that assign a payment rate based primarily on diagnosis, rather than length of stay --- encourage providers to minimize costs. They can avoid adverse effects on patient care if associated prices are set correctly and there is appropriate control of quality and of strategic provider behavior.

***But efforts to increase competition among insurers have yielded mixed results.***

Experience with efforts to increase competition among insurers, the most salient feature of reforms in multiple-payer systems, is mixed. In the few countries where such reforms have been introduced -- Belgium, the Czech Republic, the Netherlands, and Germany -- there is some evidence that increased insurance market competition may have had some positive effects by narrowing the premia across insurers, encouraging better service and instituting incentives for administrative cost reduction.<sup>12</sup> However, as in the United States, market segmentation by risk can be problematic where insurers can benefit from enrolling better risks because of inadequate payment adjustment methods. In addition, price negotiation and selective contracting among providers by competing insurers appears to have been successful in slowing cost growth under some circumstances.

***While managed care has had some success in the U.S, other countries are wary of it.***

Experience from the United States suggests that managed-care arrangements, under which patients accept some limitations on choice of providers and services, may be particularly adept at increasing efficiency by containing costs without harming health outcomes. However, managed care continues to be viewed warily by policy makers in many OECD countries and many countries therefore limit insurers' ability to contract selectively. In line with the recent trend in the United States, the overall OECD trend has been to increase, rather than decrease, patient choice of provider and treatment. At the same time, a number of countries are introducing patient-oriented economic incentives -- such as reference pricing systems for prescription drugs -- that give patients incentives to make economical choices among alternative services.

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<sup>12</sup> Switzerland also has private health insurance markets and allows consumer switching. However, in Switzerland, there appears to be considerable consumer loyalty to individual funds and, despite very large differences in premiums, consumer flows from high to low-cost funds have been limited.

## 5. LOOKING AHEAD

***There are no universal solutions.*** Experience has shown that there is no one-size fits all solution to problems with escalating health-care costs and health-system inefficiencies. Trade-offs across policy goals -- between containing costs and improving health system responsiveness, for example -- may be inherent in some policy decisions. In many cases, decisions about which path to pursue in undertaking reforms depend largely on decisions about the relative weights to apply to policy goals such as promoting adequate and equitable access to services, ensuring delivery of safe and effective care, and containing the rate of growth in spending.

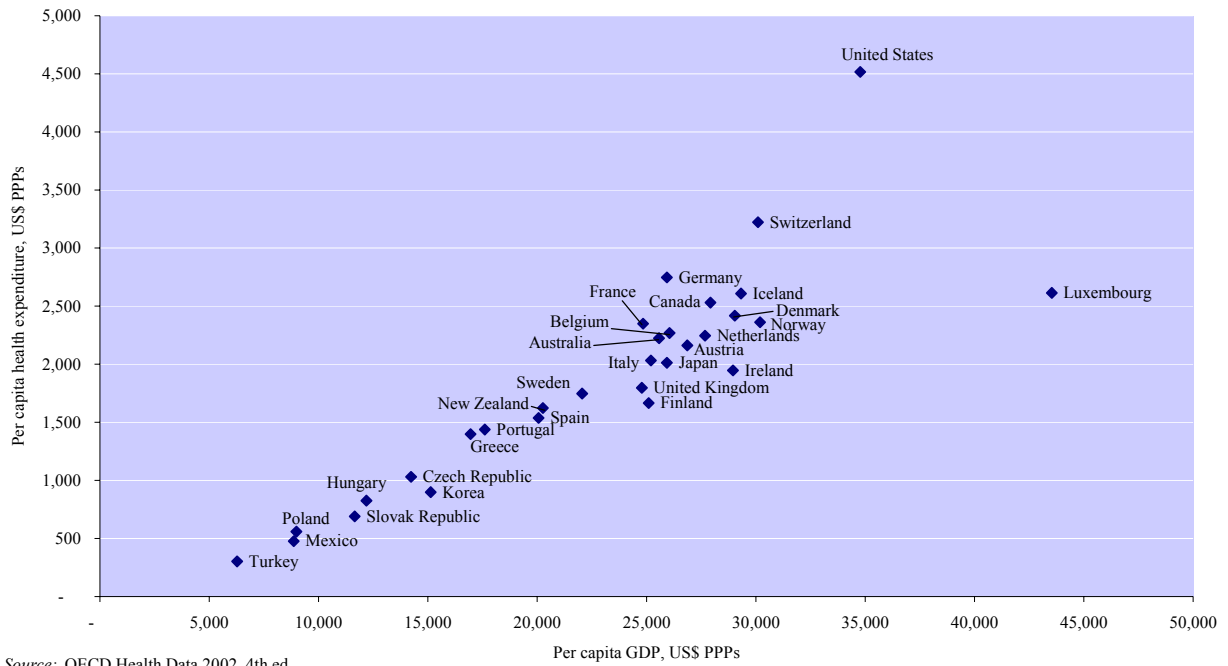
***Further health spending growth is expected.*** As OECD countries look to the future, they increasingly recognize that further growth in health costs is likely, reflecting rising incomes and demand for care, aging populations, and continued improvements in the capacity of medicine to allay disability and disease. Policy makers will therefore need to ensure that health financing systems are prepared to meet the growing burden with the minimum impact on economic growth, taking into account horizontal and vertical equity considerations.

***Investments geared toward efficiency gains are under way.*** OECD countries are increasingly recognizing that efforts to improve the value of health spending may require additional investments in the short term. We have seen increased attention to building better health information systems, developing improved measures of health system performance, improving payment systems so as to better align economic incentives with desired outputs, and investigating the factors explaining differences in health system performance.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions you or other committee members may have at this time.

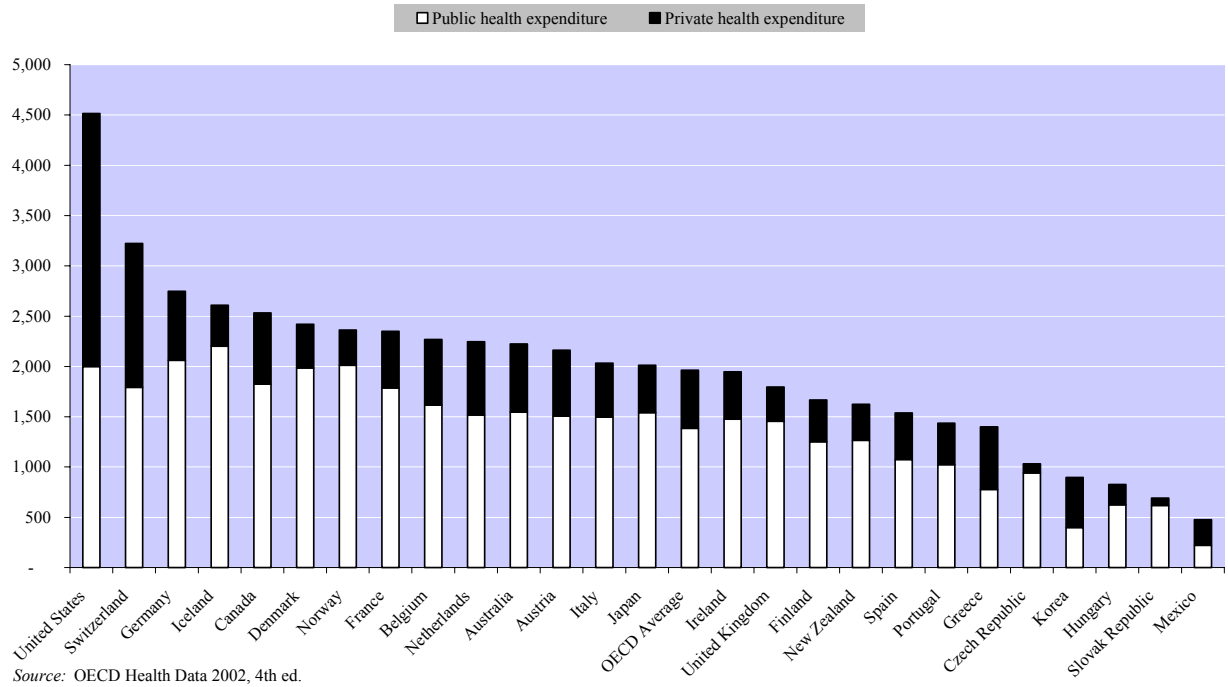


Figure 1. Per capita GDP and per capita health expenditure, 2000



Source: OECD Health Data 2002, 4th ed.

Figure 2. Per capita expenditure on health, 2000, in US\$ PPPs



Source: OECD Health Data 2002, 4th ed.

Note: Luxembourg, Poland, Sweden and Turkey are not included in the average.

Table 1: Total health expenditure as a percentage of GDP, 1970 - 2000

	1970 <sup>a)</sup>	1980	1990 <sup>b)</sup>	2000 <sup>c)</sup>	Change		
					1970-1980	1980-1990	1990-2000 <sup>d)</sup>
Australia	5.6	7.0	7.8	8.3	1.4	0.8	0.5
Austria	5.3	7.6	7.1	8.0	2.3	-0.5	0.9
Belgium	4.0	6.4	7.4	8.7	2.4	1.0	1.3
Canada	7.0	7.1	9.0	9.1	0.1	1.9	0.1
Czech Republic	..	..	5.0	7.2	..	..	2.2
Denmark	8.0	9.1	8.5	8.3	1.1	-0.6	-0.2
Finland	5.6	6.4	7.9	6.6	0.8	1.5	-1.3
France	..	..	8.6	9.5	..	..	0.9
Germany	6.3	8.8	8.7	10.6	2.5	-0.1	0.7
Greece	6.1	6.6	7.5	8.3	0.5	0.9	0.8
Hungary	..	..	7.1	6.8	..	..	-0.3
Iceland	4.9	6.1	7.9	8.9	1.2	1.8	1.0
Ireland	5.1	8.4	6.6	6.7	3.3	-1.8	0.1
Italy	..	..	8.0	8.1	..	..	0.1
Japan	4.5	6.4	5.9	7.8	1.9	-0.5	1.9
Korea	..	..	4.8	5.9	..	..	1.1
Luxembourg	3.6	5.9	6.1	6.0	2.3	0.2	-0.1
Mexico	..	..	4.4	5.4	..	..	1.0
Netherlands	6.9	7.5	8.0	8.1	0.6	0.5	0.1
New Zealand	5.1	5.9	6.9	8.0	0.8	1.0	1.1
Norway	4.4	7.0	7.8	7.8	2.6	0.8	0.0
Poland	..	..	5.3	6.2	..	..	0.9
Portugal	2.6	5.6	6.2	8.2	3.0	0.6	2.0
Slovak Republic	..	..	..	5.9	..	..	..
Spain	3.6	5.4	6.6	7.7	1.8	1.2	1.1
Sweden	6.9	9.1	8.5	7.9	2.2	-0.6	-0.6
Switzerland	5.6	7.6	8.6	10.7	2.0	1.0	2.1
Turkey	2.4	3.3	3.6	4.8	0.9	0.3	1.2
United Kingdom	4.5	5.6	6.0	7.3	1.1	0.4	1.3
<b>United States</b>	<b>6.9</b>	<b>8.7</b>	<b>11.9</b>	<b>13.0</b>	<b>1.8</b>	<b>3.2</b>	<b>1.1</b>
Total OECD <sup>e)</sup>			7.2	7.9			
OECD 19 Country Average <sup>f)</sup>	5.4	7.1	7.7	8.4	1.7	0.6	0.6

.. Data not available.

a) Data refer to 1971 for Austria and Denmark and to 1972 for the Netherlands.

b) Data refer to 1991 for Hungary.

c) Data refer to 1999 for Luxembourg and Poland and to 1998 for Sweden and Turkey.

d) German figures are for 1992-2000.

e) Unweighted average for 29 countries. Figures exclude the Slovak Republic.

f) Unweighted average. Figures exclude Belgium, Czech Republic, France, Greece, Hungary, Italy, Korea, Mexico, Poland, the Slovak Republic and Turkey.

Source: OECD Health Data 2002, 4th ed.

Table 2. Public share of total health expenditure: 1970-2000

	Percent of total spending				Change in percentage points		
	1970 <sup>a)</sup>	1980	1990 <sup>b)</sup>	2000 <sup>c)</sup>	1970 <sup>a)</sup> -1980	1980-1990 <sup>b)</sup>	1990 <sup>b)</sup> -2000 <sup>c)</sup>
Australia	62.7	63.0	67.1	72.4	0.3	4.1	5.3
Austria	63.0	68.8	73.5	69.7	5.9	4.7	-3.8
Belgium	..	..	..	71.2	..	..	..
Canada	69.9	75.6	74.6	72.0	5.7	-1.0	-2.5
Czech Republic	96.6	96.8	96.2	91.4	0.2	-0.7	-4.8
Denmark	83.7	87.8	82.7	82.1	4.1	-5.0	-0.7
Finland	73.8	79.0	80.9	75.1	5.2	1.9	-5.9
France	..	..	76.6	76.0	..	..	-0.6
Germany	72.8	78.7	76.2	75.1	5.9	-2.5	-1.1
Greece	43.3	55.7	62.7	55.5	12.4	7.0	-7.2
Hungary	..	..	89.1	75.7	..	..	-13.5
Iceland	82.6	88.2	86.6	84.4	5.6	-1.6	-2.2
Ireland	81.6	81.5	73.1	75.8	-0.1	-8.4	2.7
Italy	..	..	79.3	73.7	..	..	-5.6
Japan	69.8	71.3	77.6	76.7	1.5	6.3	-0.9
Korea	..	..	36.6	44.4	..	..	7.8
Luxembourg	89.3	92.9	93.1	92.9	3.6	0.2	-0.2
Mexico	..	..	40.8	46.4	..	..	5.6
Netherlands	60.7	69.4	67.1	67.5	8.6	-2.3	0.5
New Zealand	80.3	88.0	82.4	78.0	7.7	-5.6	-4.4
Norway	91.6	85.1	82.8	82.8	-6.5	-2.3	0.0
Poland	..	..	91.7	71.1	..	..	-20.5
Portugal	57.1	64.5	65.5	71.2	7.3	1.0	5.6
Slovak Republic	..	..	..	89.6	..	..	..
Spain	65.4	79.9	78.7	69.9	14.5	-1.2	-8.8
Sweden	86.0	92.5	89.9	83.8	6.5	-2.7	-6.1
Switzerland	..	..	..	55.6	..	..	..
Turkey	37.3	27.3	61.0	71.9	-10.0	33.7	11.0
United Kingdom	87.0	89.4	83.6	81.0	2.4	-5.8	-2.5
<b>United States</b>	<b>36.4</b>	<b>41.5</b>	<b>39.6</b>	<b>44.3</b>	<b>5.1</b>	<b>-1.9</b>	<b>4.7</b>
OECD comparable average <sup>d)</sup>	67.8	71.7	72.5	71.5	3.9	0.8	-1.0
Standard deviation of comparable average	17.3	17.5	12.7	10.9	5.5	8.5	4.8

.. Data not available.

a) Data refer to 1971 for Australia and Denmark; 1972 for Netherlands.

b) Data refer to 1991 for Hungary.

c) Data refer to 1998 for Sweden and Turkey; 1999 for Luxembourg and Poland.

d) Unweighted average of 21 countries. Figures exclude Belgium, France, Hungary, Italy, Korea, Mexico, Poland, Slovak Republic and Switzerland.

Source: OECD HEALTH DATA 2002 4th ed.