S. Hrg. 102-597

CUTTING HEALTH CARE COSTS: EXPERIENCES IN FRANCE, GERMANY, AND JAPAN

JOINT HEARING

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

AND THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

NOVEMBER 19, 1991

Serial No. 102-15

Printed for the use of the Committee on Governmental Affairs

U.S. GOVERNMENT PRINTING OFFICE

54-832 ≒ WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-038576-8

COMMITTEE ON GOVERNMENTAL AFFAIRS

JOHN GLENN, Ohio, *Chairman*

SAM NUNN, Georgia
CARL LEVIN, Michigan
JIM SASSER, Tennessee
DAVID PRYOR, Arkansas
HERBERT KOHL, Wisconsin
JOSEPH I. LIEBERMAN, Connecticut
DANIEL K. AKAKA, Hawaii

WILLIAM V. ROTH, Jr., Delaware
TED STEVENS, Alaska
WILLIAM S. COHEN, Maine
WARREN B. RUDMAN, New Hampshire
JOHN SEYMOUR, California

Leonard Weiss, *Staff Director*
Jane J. McFarland, Professional Staff
Franklin G. Polk, *Minority Staff Director and Chief Counsel*
Michal Sue Prosser, *Chief Clerk*

SPECIAL COMMITTEE ON AGING

DAVID PRYOR, Arkansas, *Chairman*

JOHN GLENN, Ohio
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota
J. BENNETT JOHNSTON, Louisiana
JOHN B. BREAUX, Louisiana
RICHARD SHELBY, Alabama
HARRY REID, Nevada
BOB GRAHAM, Florida
HERBERT KOHL, Wisconsin
TERRY SANFORD, North Carolina

WILLIAM S. COHEN, Maine
LARRY PRESSLER, South Dakota
CHARLES E. GRASSLEY, Iowa
ALAN K. SIMPSON, Wyoming
JAMES M. JEFFORDS, Vermont
JOHN McCAIN, Arizona
DAVE DURENBERGER, Minnesota
LARRY CRAIG, Idaho
CONRAD BURNS, Montana
ARLEN SPECTER, Pennsylvania

Portia Porter Mittelman, *Staff Director*
Christopher C. Jennings, *Deputy Staff Director*
Mary Berry Gerwin, *Minority Staff Director/Chief Counsel*

CONTENTS

WITNESSES

TUESDAY, NOVEMBER 19, 1991

ALPHABETICAL LIST OF WITNESSES

APPENDIX

CUTTING HEALTH CARE COSTS: EXPERIENCES IN FRANCE, GERMANY, AND JAPAN

TUESDAY, NOVEMBER 19, 1991

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS AND
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committees met, pursuant to notice, at 9:36 a.m., in room SD-342, Dirksen Senate Office Building, Hon. John Glenn, Chairman of the Committee on Governmental Affairs, presiding.

Present: Senators Glenn, Pryor, Levin, Sasser, Kohl, Graham, Roth, Cohen, Grassley, McCain, Specter, and Burns.

Chairman GLENN. The hearing will be in order. I am very pleased that we can have this joint hearing this morning. This hearing grows out of not only our interest, but also the interest of Senator Heinz, the late Senator John Heinz, who had asked for a study by the GAO, "Cutting Health Care Costs: The Experience of France, Germany, and Japan," which have some similarities to our system and can give us perhaps some guidance.

After his untimely death, the request to continue this study was made by Senator Cohen, Senator Pryor, and myself that this be continued, and so this is a joint hearing this morning between the Governmental Affairs Committee and the Senate Special Committee on Aging.

I will keep my opening statement until last and ask for Senator Pryor, who is chairing the Senate Special Committee on Aging, for his statement this morning, and others.

OPENING STATEMENT OF SENATOR PRYOR

Senator PRYOR. Mr. Chairman, thank you very much, and I want to thank Senator Cohen of Maine and others who have made this joint hearing of the Aging Committee and the Governmental Affairs Committee possible. We think this hearing is a very constructive way to approach this issue. I don't think there is an issue that is going to be any more on the front burner over the next several months than health care. So this joint venture this morning gives us a rare opportunity to look at various ways that other countries are attempting to contain the costs of health care, and in some instances actually succeeding.

I don't think there is a community out there in my State—I don't know about the States of Ohio, Maine, Arizona, and Montana, but I can tell you there is not a community in Arkansas today that feels that their health care system is good or that the access is

plentiful. We find today a growing number of communities and people in our country who are absolutely petrified of what is going to happen to them if and when they get sick.

We also know that in our country we are spending today $2,500 per person, per capita, on health care for every man, woman and child. In about 9 years, we are going to be spending about $6,000 per person. If we can't afford $2,500 a year, and we can't, then I want to know how we are going to afford $6,000 per person.

It is types of questions like this that we are going to ask to our distinguished witnesses this morning. I think there are some good results in the GAO study that we are releasing today. I want to congratulate the GAO for this.

I will conclude by saying, Mr. Chairman—I do have a longer statement for the record—I don't think that there is any country in the world today that has a worse record in containing health care costs than we do. I also think that there is not a country in the world today that has a better or a higher quality of health care. The challenge before us is to maintain our quality while finding ways to contain the costs of this care. We should and we must make some dramatic improvements to our health care system.

That said, Mr. Chairman, I thank you once again for making this joint hearing possible. I look forward to the hearing this morning and hearing from our witnesses.

PREPARED STATEMENT OF SENATOR PRYOR

Good morning. It is my pleasure to co-chair today's hearing with Senator Glenn and to join Senator Cohen and Senator Glenn in releasing the General Accounting Office's report, "Health Care Spending Control: The Experiences of France, Germany and Japan."

I often say we need to go outside the beltway for new ideas. Normally, I am talking about seeking suggestions from towns and cities from around this country. When it comes to the health care crisis we face, though, there is no community in this nation that is even remotely satisfied with its health care system. We could not help but benefit from the lessons learned around the world. It is my belief that it is long past time that we started.

No one disputes the fact that our health care system is chronically, if not terminally, ill. No nation comes close to spending as much on health care as we do. We frequently cite GNP figures to illustrate this problem, but I prefer to use per American citizen numbers. Today, on a per capita basis, we spend over $2,500 on health care for every man, woman and child in this country. Should we not find a way to contain these costs, we will be spending $6,000 for every American citizen by the turn of the century. If we cannot afford $2,500, how in the world will we find a way to pay for more than twice that figure in just nine years?

While our unprecedented investment in dollars provides us with arguably the highest quality and most technologically advanced health care in the world, the only people who have access to this care are those who can afford insurance to pay for it. Already, over 33 million Americans, and 430,000 Arkansans—20 percent of my home state's population, live without insurance.

If costs keep soaring as they have been, spending on health care will increase from $662 billion in 1990 to an almost unbelievable $1.6 TRILLION by the turn of the century. As a result, we have every reason to believe and fear that fewer and fewer people will be able to afford the health care and insurance protection they need.

There can no longer be any question that the key to solving the access to insurance problem for our citizens is finding a way to contain the costs of health care. Without achieving this goal, many of those people who are fortunate enough to have private and/or public insurance will find themselves in the same boat as those who do not. That is one reason why this hearing is so important to the Aging Committee.

The other reason why this hearing is significant is because it provides a forum for the release of a GAO report that provides extremely useful information about the

relatively successful physician and hospital cost containment strategies employed by France, Germany and Japan. I congratulate GAO on its fine work and look forward to its future report responses to Aging Committee's requests to analyze international approaches to containing the costs of prescription drugs and long-term care.

As long as there is a health care provider who says he or she has a cure or a treatment for a loved one, there is probably no way we will ever have a complete handle on health care costs. It is therefore not surprising that there is no nation in the world that believes it has solved the health care cost problem. It is very possible that no one ever will. Having said that, there is no nation in the world that has a worse record in this regard than the United States. If we do not start addressing the health care cost problem in deeds, as well as words, our constituents will fairly judge us to be at least as much of the problem.

Our citizens, our businesses, our unions, our consumer advocates, and our state and local governments are understandably demanding changes to our health care system. It is past time we started learning how we can effectively respond to their calls. I believe this morning's hearing will be a good start down that road and I look forward to hearing and reviewing the testimony from our distinguished witnesses.

Chairman GLENN. Senator Cohen.

OPENING STATEMENT OF SENATOR COHEN

Senator COHEN. Thank you very much, Mr. Chairman, and let me also pay tribute to Senator Heinz, and to Senator Pryor for his continuation of Senator Heinz' efforts in this regard in seeking to compare our costs with that of France, Germany, and Japan. Undoubtedly we will talk about Canada as well either directly or parenthetically.

We have a situation in which our health care costs are going skyward. And while the costs are going up, the coverage is going down. We have this paradox that while we are recognized as having perhaps the most innovative system in the world today, we have also one of the highest infant mortality rates when compared to other industrialized countries.

We are also finding out that more is not always more, that is, we find ourselves in the situation where a person writes out a check to his favorite charity and thinks that he has made his contribution to society, without bothering to check to see how that charity is spending the money or indeed how much money the charity itself is spending.

We are in a situation in which we are buying first-class tickets for an airline, but fewer and fewer people are flying first-class. In fact, they may be on standby, and maybe they are not even flying at all. So this is the problem that you touched upon, Mr. Chairman, in terms of the ever escalating costs that our citizens are confronted with.

It touches all income groups. It is not only the poor or those who are uninsured. Young people are concerned about how they are going to care for their parents. Parents are concerned how they can cover their children. It cuts across every segment of our society.

Daily, I might point out, the constituents in Maine are telling me how difficult it is to make ends meet. They tell me that prescription drugs cost too much, and I know that is something that Chairman Pryor is concerned about. They can't afford nursing home care. They can't afford to buy health insurance for their employees.

Recently, a woman from Brewer, Maine, contacted me to let me know that she has cancer that is in remission, but she can't get in-

surance even if she had the money. She is single, has no children, and doesn't qualify for Medicaid. And so even though my own State has a high-risk insurance pool, the premiums are still too high for her to afford. So for this person and millions like her everywhere, it is no solace to say that our country has the best medical technology available or that we spend more on health care per capita and as a percentage of GNP than any other nation. All she knows is that the health care system is not helping her, and we have to do something to fix it.

Mr. Chairman, I have a longer statement that I would like to submit for the record, but I think that we should be careful as we pursue these other options. There is no such thing as a silver bullet. We cannot simply look to another country and say that is the system that belongs in the United States, be it in Japan or Germany or France or Canada. There is no single cure-all for our system. What we have to do is examine those countries' systems to find out what is working there and whether we can, in fact, transplant it or engraft it, or even replace facets of our own system with those others.

So I look forward to hearing from our witnesses today to see what it is about these other countries that we can adapt to our own.

PREPARED STATEMENT OF SENATOR COHEN

Mr. Chairman, thank you for convening the hearing this morning to examine the health care systems of three countries—France, Germany and Japan. Each of these countries spends less on health care than we do in the United States. At the same time, each provides universal coverage and access to quality care for every citizen, a feat which we, in this country, have sadly been unable to manage.

The United States spends more than any other nation in the world on health care both as a percentage of GNP and on a per capita basis. Today we will hear in testimony, for example, that the U.S. spends over 12 percent of its total production on health care. By the turn of the century, our health care spending will soar to over $1 trillion and will consume one out of every six dollars of our total production.

Ironically, at a time when American health care expenditures are skyrocketing, more and more Americans are going without needed care. As many as 37 million people—almost a third of them children—have no health insurance at all, and many more have inadequate coverage.

Further, while our health care system is the most innovative and most technologically advanced in the world, as we will hear in testimony, the United States lags far behind when it comes to such health care indicators as infant mortality and life expectancy.

Even though health care is costing big dollars, the size of the check we write each year should not lull us into believing that we are doing enough to solve the problem. The situation we are facing is somewhat like the person who writes a big check to charity and then believes that he or she has done enough to help their fellow man.

The problem is not only that our nation's health care bill is too high, it is that we are not getting an adequate return on our investment. While, as a country, we are paying for a first class health care ticket, far too many Americans are flying standby or not flying at all because they simply can't afford to buy insurance.

The growing discontent with our nation's health care system goes far beyond concerns about the poor and the uninsured. Deep, heart-felt concerns about health care cut across generations and affect every segment of our society. Young parents worry about providing adequate care for their children and grown-up children worry about providing care for their aging parents. Residents of rural areas are plagued by shortages of health care providers. Senior citizens fear the devastating financial and emotional costs of serious illness, and many businesses simply can no longer afford to provide health care coverage for their employees.

Daily, my Maine constituents tell me how difficult it is to meet health care costs. They tell me that prescription drugs cost too much, that they cannot afford nursing

home care, or that they cannot afford to buy health insurance for their employees. A woman from Brewer, Maine, recently contacted my office to let me know that because she has cancer in remission she "cannot get insurance even if she had the money." She is single with no children, and can't qualify for Medicaid. Even though my State has a high-risk insurance pool, premiums are still too high for her to afford.

For this person and millions like her nationwide, it is no solace to tell her that our country has the best medical technology available, or that we spend more on health care than any other nation. All she knows is that our health care system is not helping her, and we must do something to fix it. These problems have reached critical proportions, and the need for comprehensive reform is not just clear, it is compelling.

Mounting concerns about our current system have pushed health care reform to the top of Congress' agenda. I have introduced my own comprehensive health care reform plan to expand access to affordable care and control costs. I have also joined with Senator Chafee and Senator Bentsen in attempts to reach a bipartisan consensus on health care.

As we explore the various options for financing and delivering care, we should look to other countries' experiences for ways to help us increase the return on our own health care investment.

Not that another country's system will be a cure-all for our nation's health care problems. There is no "silver bullet." But there is much to be learned from studying the ways other countries finance and deliver care, and there certainly are elements of those systems which might be adapted for use in our own.

As we seek to change our system, we will be faced with many decisions and questions about what Americans can, and should, expect from their health care system. Are we, for example, prepared to adopt spending caps for health care? Are Americans prepared to accept a larger government role and less freedom of choice in their health care and treatment? Are medical provider groups ready to negotiate with the government on payment issues? In order to ensure greater access for all, are we willing to give up some of the high technology that is so readily available to those who can afford the care?

I look forward to hearing from our experts today on the tradeoffs we may have to make if we borrow elements of other countries' health care systems.

To date, the Canadian system has been the focus of most of the discussions comparing health care in the United States with other countries. However, additional alternatives do exist. The countries we will be looking at this morning—France, Germany and Japan—are prime examples, and I look forward to the upcoming testimony.

Chairman GLENN. Thank you. Without objection, all statements will be included in the record.

PREPARED STATEMENT OF SENATOR KOHL

This is a very important issue we will be discussing today.

We've all been pushed and pulled on the Canadian health care system. The administrative savings are attractive. So is the concept of expenditure targets.

But before I endorse a Canadian style plan, I have several questions I need answered.

First, I believe there is an unassessed value of providing health benefits through the work place, as do Germany and Japan. In the next 20 years the U.S. needs to regain its competitiveness, increase productivity and support in their retirement, the largest aging population in our history. To do that, we will need every able-bodied person in the work place. Employer-provided health benefits are one incentive to work. Some researchers even suggest that socializing these types of benefits is correlated with decreased productivity in the work place. It warrants some careful consideration.

A second concern I have with this whole debate is the notion that we can just go to a single-payor system, and it won't cost any money. Now there's an attractive sales pitch, is it true? What do we do with the jobs and money derived from the private insurance industry? How would that effect our economy?

Third, if we are to provide and establish a compulsory health benefit package, how generous should it be? Some of my colleagues were here in 1979 when a similar debate took place. Honest differences over whether those benefits should be catastrophic or comprehensive helped to defeat national health insurance just over a

decade ago. What are the benefits provided by these other nations and have they remained constant or are they fluid?

And finally, the "t" word. How much can we afford and how are we going to pay for it? The models we will be talking about today use employer-employee taxes, similar to those we use for Social Security and Medicare. How much ARE taxes going to be increased to pay for this? A recent poll found that the majority of Americans thought we should spend more on health care, but they were unwilling to pay more individually to get it. As the chairman of the House Ways and Means Committee stated, "Nice work if you can get it." What WOULD happen if we couldn't find the savings or raise the revenues needed to finance a national health care program? Would we streamline the benefits covered? Would we cut provider payments? Is there a potential impact on the quality to which most Americans have become accustomed?

Mr. Chairman, I do believe that we need health care reform to address the spiraling costs and increased problems with access. But I'm having a hard time trying to figure out how to give everyone more than they have now without asking someone to pay more.

Perhaps the witnesses today can enlighten us concerning how these problems have been addressed, and to what degree of satisfaction, in other nations.

Prepared Statement of Senator Grassley

I am pleased to be here today and I commend the Chairmen of both committees for holding this joint hearing as part of our continuing efforts to grapple with solutions to our nation's health care problems. I know that our late friend Senator Heinz would be pleased with today's hearing as we continue to pursue his interest in looking far and wide for lessons learned which might ease the burden of America's health care cost and access dilemma.

I think that it is no simple task to examine the components of foreign based systems to determine whether health care experiences in Germany, France and Japan would be applicable in the U.S., given our political, cultural and geographical differences. However, given the alarming growth rate in per capita spending on health care in the U.S. and such a large uninsured population, we would be remiss in stopping at the border in our search for solutions. Especially when these other countries have experienced better cost control than the U.S.

As I mentioned earlier, I am curious about the effects that national health insurance would have, if adopted in America, because of our differences and because of the levels of service, technology, quality and efficiency and care on demand which we have grown so accustomed to.

Nevertheless, I promise to keep an open mind on the subject and am most anxious to hear from our distinguished witnesses today.

I'm finished for now Mr. Chairman but will have some questions for the witnesses a little later. Again thank you for scheduling this hearing today.

Prepared Statement of Senator Pressler

Mr. Chairman: I wish to thank the Chairman for conducting the hearing this afternoon. Health care and health insurance costs are touching every socioeconomic segment of our society. The poor, the middle class, the young and old are all struggling to secure affordable health care.

In my home state of South Dakota there are an estimated 56,000 uninsured individuals. Most of whom are under the age of 24. There are 108,000 senior citizens dependent upon Medicare to pay their medical bills. These two groups equal nearly one-fourth of South Dakota's population. Many farm families are being forced to cancel health insurance due to skyrocketing premiums. Many middle class families have had to increase medical deductibles to $3,000, $4,000 and $5,000. Some young parents don't obtain basic health care for their children because the cost is too prohibitive. No one is able to escape this problem.

We each have participated in hearings dealing with health care costs. When returning to our home states we have listened to people discuss health care in the work place, at the local coffee shop and at public meetings. The concerns are not new.

While we have struggled with this issue in recent months the cost of health care has continued to escalate. While we have studied the reasons why health care is becoming increasingly expensive many individuals have been forced to reject needed health care.

I have concluded that there is no easy answer to solving our health care crisis. We need to address the issues of cost containment, insurance reform, malpractice reform and the availability of health care in rural areas. Any solution would involve sacrifice. This may be on the part of the individual, their employer or the Federal Government. The key is that we need to proceed in a cost-effective manner.

The General Accounting Office (GAO) report we are looking at today points out one thing. Other industrialized nations have found more cost effective methods of delivery health care.

All agree that the quality of care and the advanced medical technology of the United States is the best in the world. We need to congratulate our medical community for its great technology. However, we need to improve the delivery of health care.

I am here today to learn about other health care systems. I hope to take the best attributes of their systems and apply them to our system.

PREPARED STATEMENT OF SENATOR SIMPSON

It's good to be here this morning. I thank both of our fine chairmen, Senator Pryor and Senator Glenn, as well as Senator Cohen, for their good efforts in bringing our committees together for this important and unique hearing.

Health care spending is a major concern in this nation and it will continue to be so for many years to come. We all recognize the critical importance and urgency of bringing this spending under control. That fact is so clearly evidenced by the multitude of proposals for health care reform that have been introduced in this Congress. As we work to reach a consensus on which solution—or combination of solutions to adopt—I think it is quite proper and fitting to study the health care systems of other industrialized nations.

I must confess to having very serious reservations about the wisdom of completely "imitating" the health care system of any one other nation. So I am pleased that the General Accounting Office has approached this issue in an objective fashion by acknowledging not only the strong points, but also the shortcomings of the French, German, and Japanese systems. We can learn a great deal by studying the successes and failures of our friends, as they have surely learned from us.

As I review the testimony of the GAO, I find it particularly interesting that these nations have used standardized payment rates that are not imposed by the government, but are negotiated by insurers, providers, and the government. To the extent that these rates are portrayed as being satisfactory to the various parties, I think that is a rather impressive accomplishment.

Our own experiences with the Medicare and Medicaid programs have been somewhat less successful in terms of satisfying health care providers. In Wyoming, we have a collection of very able and caring physicians who do a remarkable job of calling my attention to the various inadequacies of these programs. So I am intimately familiar with the concerns of our nation's health care providers and I would be very interested to hear what the providers of France, Germany, and Japan might say about their own systems. Any comprehensive examination of these systems would certainly have to include this very vital factor.

I am also intrigued by the "budget controls" that are so successful in holding down costs in these countries. The statistics show that France, Germany, and Japan are only spending between 7 and 9 percent of their national income on health care, while we are spending 12 percent. We express a pang of envy at these numbers, yet we also wonder what sacrifices or tradeoffs may be associated with such low costs. I look forward to hearing more on that subject as well.

In closing, I would repeat that I think there is much we can learn by observing the merits and flaws of health care systems in other countries. As we attempt to do that, we should pay particular attention to the manner in which these systems have evolved. I think we will discover that these countries are similar to the United States in the sense that political realities have a significant impact on this process.

In the United States, an important political reality is that 85 percent of all Americans are relatively well taken care of under our current health care system. Our challenge of taking care of the other 15 percent is complicated by this vivid reality. The great puzzle is how do we care for everyone without disrupting those who already "have theirs?" I trust we may learn something today about how other nations have coped with this problem.

Chairman GLENN. Senator McCain.

OPENING STATEMENT OF SENATOR McCAIN

Senator McCAIN. Mr. Chairman, I want to thank you and Senator Pryor and Senator Cohen for making this hearing possible, and I think it is particularly important for us to recognize not only what we are going to receive today from the General Accounting Office, which is very important information, but some information that was in this week's Economist Magazine that I would like to just make reference to concerning the problems that other countries are having today which affect us as policymakers.

In France, the administration has upset voters by increasing social security contributions. It has angered doctors and nurses by imposing new controls on medical expenditure. Pharmacists and doctors are now staging strikes and demonstrations throughout the country. A march by 3,000 nurses on the Elysses Palace was met by the police with water cannons and tear gas grenades. A mass demonstration of health professionals is planned for November 17.

In Australia, the Government introduced an up-front fee of $3.50, which is $2.75 for all consultation. The Labor Party denounced its Government for betraying the principle of free health care. The resulting row threatened to undermine the authority of the Prime Minister, Bob Hawke. With the charge reduced to $2.50, the Hawke line prevailed.

The Italian Government aroused noisy opposition when it announced plans to prune health spending. The real problem in Italy is a lack of resources. It says, the joke about Italy is ill Italians have to take an aspirin or an airplane.

In Spain, in July, a parliamentary commission recommended privatizing much of Spain's health care management, and it suggested that pensioners should pay 40 percent of the cost of their medicines, which at present are free. Trade unionists and medical lobbyists joined with pensioners in opposition to politicians to rubbish them. In September, the Government, which faces election in 1993, decided that more value for money is not worth the price of political oblivion, and shelved the whole package.

My point here, Mr. Chairman, is that as we look at the costs that other countries bear and how they handle the health care issue, I think it is also important for us to recognize that every Western industrialized nation in the world is grappling with this problem, some with singular lack of success, as I just recited.

It seems to me that the lesson here is that we have got to build consensus in this nation as to what action we must take, and without that consensus, which we do not have at this time, I think almost any one of our efforts will be deemed futile.

So I appreciate the opportunity particularly to hear the report this morning, recognizing that every other Western industrialized nation is grappling with the same problem that we are in varying degrees. At least we have not had to repel with tear gas and grenades and water cannons demonstrations yet, although we may if we don't get a handle on this issue. And, again, the urgency of this issue is clearly articulated by the front page of our magazines.

By the way, we might want to read this; this cures the problem. But there is no doubt that this issue is of the utmost criticality to

the American people, and I appreciate the opportunity for us to get this additional information.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR MCCAIN

Mr. Chairmen, I want to thank both of you for convening this important hearing today. While the subject of today's hearing, cost containment, is of critical importance to all Americans, it is especially important to older Americans most of whom are trying to make ends meet on a fixed income.

The American health care system is very much like an extremely ill patient, infecting us all.

In looking at our nation's health care system, we find the following serious symptoms: over 32 million uninsured; business and government health expenditures rising rapidly; rural areas facing health care provider shortages, and hospitals struggling to keep their doors open. Nearly 25 percent of every dollar spent on health care is consumed by defensive medicine; young mothers lack adequate prenatal care; there is unequal access to medical services; and the costs of long-term care are prohibitive.

Pure and simple, the health care system is suffering from financial hypertension, with explosive cost pressure pushing every part of the system to the breaking point.

Health care costs are the fastest rising segment of our economy. From 1981 to 1989, they grew some 93.5 percent—while general inflation rose only 44.8 percent. This year, we will spend 750 billion. In 1960, health care consumed 5.3 percent of our GNP, a figure which will rise to 13 percent by the end of this year, affecting our competitiveness with other countries.

So difficult has the burden of health care become that this year has witnessed an unprecedented movement aimed at nationalizing at least some part of the health care system. And, there are at least two attractive features to most nationalized systems—everyone is guaranteed access to at least the most basic of care, and administrative costs are generally lower than our system.

But, while reform of our health care system is essential and we cannot waste time, we need to proceed judiciously. There are, after all, some good aspects of our current system.

For example, approximately 85 percent of all Americans do have health coverage, and enjoy state of the art health care. Most patients have choice. For those who are covered, there are usually no lines for care. We spend billions of dollars a year providing services for the poor. Nowhere in the world is the art and science of medicine so advanced, or advancing so quickly as in the United States. But that advancement certainly comes at a very high price.

Mr. Chairmen, in laying the road map for reform, I believe it is critical to determine how the good in our system can be protected and what alternatives exist to help us deal with the problems.

I believe this hearing is very important. It is critical that we examine the health care systems of other countries both in terms of what seems to work and what does not. Today's hearing will examine the cost containment efforts of three countries: France, Germany and Japan. As we look at the experience these three countries have had in this area, and take into account the differences of culture, expectations of health care, advancement of technology and practice and their medical liability systems, perhaps we will begin to identify some strategies that might work in our own country.

In looking at other countries, however, Mr. Chairmen, I don't believe we will find the single solution. We might, however, find a piece of the puzzle.

I firmly believe the answer to our nation's health care crisis does not exist in the form of a "magic bullet". Rather, the answer is going to be found in a series of reforms.

For the last two years, I have been meeting with health care providers, consumers and other Senators. We have been examining what's good and bad about our system, and searching for possible remedies. As a result of this process, many have come to the view that reform is essential, and believe there are some sensible options for reform.

These options build on the strengths of our present system by focusing on the coverage needs of small businesses and their employees, addressing the needs of the poor and underserved, expanding access to care for children, increasing access to preventive care, and providing long-term care coverage for the elderly. These proposals will expand access to health care, and begin to control costs. Some of them I

have introduced myself, and others are bills I have introduced with Senators Durenberger, Pryor, Chafee and Bentsen.

I am convinced, though, Mr. Chairmen, that not all of the pieces to the puzzle are out there yet. Certainly, one of the most critical and difficult of all is the subject of this hearing: effective cost containment. While many proposals have begun to address this issue, there is no doubt more to be learned about what works and what doesn't. I have been looking forward to this hearing and the release of the GAO's report, "Health Care Spending Control: The Experiences of France, Germany and Japan." Perhaps we will discover a piece to the puzzle through the examination of the cost containment strategies of these three countries.

Mr. Chairmen, I would again like to applaud you for calling today's hearing. The issue of cost containment is, and clearly must be, one of the critical elements of the health reform debate. This debate, which needs to take the form of a national dialogue, must also include an examination of what we as Americans can, should and do expect of our health care system. Only as we look to these factors and the questions that surround them will we be able to fashion a comprehensive national strategy for health reform. It is time that we set our health care system on the road to recovery, and hearings such as this will help lay the foundation to make this possible.

Chairman GLENN. Senator Burns.

OPENING STATEMENT OF SENATOR BURNS

Senator BURNS. Thank you, Mr. Chairman, and I want to thank you and the Chairman of our Committee on Aging, how you have pursued this in this report. I want to also thank Senator Cohen, of Maine, who has sort of taken up the cause, because we know how important this study was to Senator Heinz before he left us.

We do need to review it, and it is important that we search out some answers that are confronting us as far as health care. I think all members of this Committee have stated their case very clearly. The United States is unique in its politics, in its demographics, in its makeup of its society, and particularly in its health care system.

As terrific as some of the systems in other countries may seem, I doubt it would be feasible to adopt an entire system from any other country and make it apply here in the United States. That would become very difficult, and I am not real sure that we need to, but we may be able to take parts of what other countries have used, the most successful parts of those health care delivery systems, and solve some of our own problems here.

I think the American people, in their quest for not only access to health care but affordable health care, have also got to take into account the quality of health care. Will we accept a lower quality of health care just for the sake of establishing a national health care system?

There are some areas—and we live in Montana very close to the Canadian border. You would be surprised at the number of Canadians who come across the border and visit doctors and dentists in the United States, which tells me that their system is not perfect either in the country of Canada.

But one thing that I am curious about, and perhaps Mr. Thompson will be able to answer this, is how will countries deal with rural areas, those folks who live 150 miles away from any kind of a health care facility—that is a concern to rural health—what kind of facilities we will have in those rural areas in order to deliver the quality health care that those people are entitled to just like people who live closer to the urban areas where health care facilities are more abundant.

Also, I would hope that the report would talk about the underlying costs of medical care. How do other countries deal with malpractice insurance, insurance premiums? How do their courts operate? How do we deal with that and the underlying costs that are intangible, it seems like, when we start talking about the delivering of health care, and a little bit of tort reform when it comes to delivering a quality product at an affordable price?

So, Mr. Chairman, I appreciate these hearings and this report because I think it is very important, and it may set some parameters on how we deal with policy as far as this important issue for our country. So I thank you very much.

PREPARED STATEMENT OF SENATOR BURNS

Mr. Chairman, I want to thank Senator Cohen for taking the leadership to pursue this report in Senator Heinz' place. Not only is it important to honor Senator Heinz' work prior to leaving us, but this is a study we need to review, one that is important in our search for the answers to our health care problems.

The United States is unique—in its politics, its demographics, the makeup of its society, and particularly its health care system. As terrific as some of the systems in other countries may seem, I doubt it would be feasible to adopt an entire system. And I'm not sure we need to! However, we may be able to take parts from here and there to strengthen what we have and fix those areas that need to be fixed, and I hope in this GAO study we might find which parts of these systems would be workable.

The one thing I am curious about, and perhaps Mr. Thompson will be able to answer this, is how these countries deal with very rural areas. How do rural areas attract health care providers or how do residents who live 150 miles or more from a health care facility obtain quality care?

I think one of the primary reasons for the increasing cost of health care here in the U.S. is the increasing premiums of malpractice insurance. I'd be interested in knowing how France, Germany and Japan handle malpractice, court and lawyers fees.

I appreciate having such a distinguished list of witnesses and thank you all for coming here to brief us on the finding of this study. This is not the first study of foreign health care systems and I'm sure it will not be the last. But the more we can learn the better our solution will be.

Thank you, Mr. Chairman.

OPENING STATEMENT OF SENATOR GLENN

Chairman GLENN. Thank you all.

Just a couple of remarks before we get to our witnesses this morning. As has been indicated, I think there are few issues that so galvanize the whole American public as the current state of our health care system. It affects everyone's pocketbook. It is the third biggest personal consumption item in the country, surpassed only by personal expenditures on housing and on food.

The bad news is, as is well known, that some 37 million Americans are without health insurance coverage of any kind, and 80 percent of these people are working Americans and their dependents. Many more Americans are under-insured. One major illness for an uninsured or under-insured person can render them destitute. This is unacceptable. The only industrialized nation in the world with this kind of record is South Africa, and I think we can do better than that.

Now, that is the bad news, that we have those 37 million Americans. I guess the flip side is that we have 230 million Americans that do have health insurance. However, what I am running into,

and I am sure every other Senator here is running into, is the fact that even those with health insurance are not confident that the insurance they have will be able to pay the bills; that they could get into a health situation where they have a major catastrophic illness or something and they still could be rendered destitute. So, where they used to be very confident, they now have less confidence, and I think that that is one of the reasons why we have such a tremendous interest in health care these days.

We need new direction, and yet there is little consensus about exactly what direction to take. Proposals to move toward universal access and cost containment are the subjects of very, very heated debate. We have the crisis in access because of dramatically rising health care costs in an otherwise very slow economy.

In the past decade, health care expenditures have increased at twice the rate of inflation. This has made health care services the fastest growing industry in the country. Our current delivery system has generated 16 percent of the net new jobs between 1980 and 1990, just the last decade.

Now, we can look to the experiences of other industrialized nations in trying to guarantee access to health care services, and at the same time contain costs, and they may offer us some useful insights.

Let me say that the picking of Germany, Japan and France was not accidental. This is not something that has come up as a recent issue in those countries and been something that just came to the fore and we are looking at how they are dealing with it. I don't think most people in this country realize that Germany, for instance, has a century of experience in this field. They put in their universal health care system back in the late 1880's, and so they have had a century of experience in adapting this to their industrialized society as things changed.

Japan put their system in in 1920, and France in 1928. So we are looking at nations that, while not exactly comparable with the United States, are certainly major industrialized nations that we can look to, we hope, for some guidance as we address the GAO report, titled "Health Care Spending Control: The Experience of France, Germany, and Japan." So we look forward to their testimony today.

PREPARED STATEMENT OF SENATOR GLENN

Good morning. I am pleased that the Governmental Affairs Committee and the Senate Special Committee on Aging are holding this joint hearing today entitled "Cutting Health Care Costs: The Experiences of France, Germany, and Japan". I appreciate the cooperation between the Members and staff on this very important issue.

Few issues so galvanize the American public as the current state of our health care system. It's on everyone's mind these days and affects everyone's pocketbook. It's the third biggest personal consumption item in this country—surpassed only by personal expenditures on housing and food.

We have a crisis in our current health care system. It is estimated that up to 37 million Americans are without health insurance coverage of any kind and 80 percent of these people are working Americans and their dependents. Many more Americans are underinsured. One major illness for an uninsured or underinsured person can render them destitute. This is unacceptable. The only other industrialized nation in the world with this kind of record is South Africa and we can do better.

While some 230 million Americans do have health insurance, many of them have fears. As costs escalate, some fear that their employer will cut back on health coverage or eliminate it altogether. Other Americans feel locked into a particular job for fear of losing their insurance. Many others fear that their health insurance will not cover the cost of a major catastrophic illness or accident.

We need new direction. Yet, there's little consensus about exactly what direction to take, and proposals to move toward universal access and cost containment are the subjects of heated debate.

We have this crisis in access because of dramatically rising health care costs and an otherwise slow economy. In the past decade, health care expenditures have increased at twice the rate of inflation. This has made health care services the fastest growing industry in the country. Our current delivery system has generated 16 percent of the net new jobs between 1980 and 1990.

The experiences of other industrialized nations—in trying to guarantee access to health care services and at the same time containing costs—may offer us some useful insights as we try to address our own problems. We are pleased to release a new report today from the General Accounting Office entitled "Health Care Spending Control: The Experiences of France, Germany and Japan." I look forward to today's testimony.

Chairman GLENN. Our first witness is Lawrence Thompson, Assistant Comptroller General, Human Resources Division, General Accounting Office, accompanied by Jonathan Ratner, Assistant Director of the Human Resources Division; and David Gross, Senior Economist, Human Resources Division. We welcome you all to our hearing today. We look forward to your testimony and your work on this.

Mr. Gross, the last time I saw you, I believe you didn't look this way. What happened to your eye this morning? [Laughter.]

Mr. GROSS. It is a small injury.

Chairman GLENN. I hope the other fellow looks—— [Laughter.]

Senator MCCAIN. I hope you are going to sue.

Chairman GLENN. Are you satisfied with our health care system this morning?

Mr. GROSS. I have had excellent health care, yes, sir.

Senator PRYOR. Some of those people that John McCain was talking about got hold of you, I guess. [Laughter.]

Chairman GLENN. But what happened?

Mr. GROSS. I just scratched a cornea with a contact lens.

Chairman GLENN. Are you all right?

Mr. GROSS. Yes. They say tomorrow I won't need the patch.

Chairman GLENN. All right, good. Well, we hope you are getting good care in our health care system. Thank you all very much.

Mr. Thompson, if you would go ahead, we would appreciate it.

TESTIMONY OF LAWRENCE H. THOMPSON,[1] ASSISTANT COMPTROLLER GENERAL, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY JONATHAN RATNER, ASSISTANT DIRECTOR, HUMAN RESOURCES DIVISION; AND DAVID J. GROSS, SENIOR ECONOMIST, HUMAN RESOURCES DIVISION

Mr. THOMPSON. Thank you, Mr. Chairman—both Mr. Chairmen. We are pleased to be here today at the joint hearing of these two Senate Committees to discuss the health systems in France, Germany, and Japan, and the results of the report that we are releasing today.

As you know and as many of you have alluded to, there is a major debate now occurring about how to address the twin problems that afflict the health care system in the United States—escalating spending and narrowing access to health insurance. In this context, the late Senator John Heinz asked us to report on the lessons that the United States might be able to draw from other industrialized countries.

We are not advocating any one system or feature in these countries. We don't think that their systems can be transplanted wholesale from where they are to the United States, but we do think that there may be valuable lessons to be learned by examining how they achieve the results they achieve.

For several reasons, we focused on France, Germany, and Japan. First, these countries include those which are emerging as our leading international competitors. In addition, each of these countries provides universal access to health insurance while spending proportionately less of their national income on health care.

Finally, these countries have systems which resemble the system in the United States in a number of ways. First, they provide health insurance using multiple insurers, in contrast, say, to Canada. Second, people typically get health insurance for themselves and their dependents through their place of employment. The third similarity is that people in these countries have a free choice of physicians and that the physicians charge on a fee-for-service basis. And, finally, these countries have both private and public hospitals which deliver care.

I don't want to overstate the similarities, however, because there are several major differences between the U.S. and the French, German and Japanese systems. In particular, these differences involve the degree of regulation in these other countries. For one thing, almost all residents are guaranteed access to health insurance, as I said, but this is achieved by having the Government stipulate which insurers will cover which population groups. The Government also mandates a minimum package of health care benefits, compulsory enrollment, and payroll contributions, from both employers and employees, for that subset of the population where insurance is obtained at the workplace.

I might also add parenthetically that in each of these countries, employees must pay a rather considerable fraction of the cost of their health insurance—half of the premium in Germany, a third

[1] The prepared statement of Mr. Thompson appears on page 141.

of it in France, and up to half in Japan, so that health insurance is not an employee fringe benefit that the employees do not realize the expense of.

A second difference involves the way that the insurers and the physicians and the hospitals are regulated to establish standardized rates. All three countries use price controls that place ceilings on physicians' fees and on daily hospital charges, and insurers are required to reimburse the hospitals and the physicians according to those set rates. This means that a given service gets reimbursed at the same rate regardless of the insurer.

Now, these rates are not set unilaterally. Instead, insurers, doctors, hospitals and other providers help develop the rates through a process of formal or informal negotiations. Each country is a little bit different in this respect, but each does use some sort of a negotiation process.

A final difference is that in each country there is a nationwide policy that sets goals for overall health spending increases. France and Germany set goals for overall spending and impose budgets on inpatient hospital care, and Germany also has imposed budgets and caps on the total spending for outpatient physician services.

Let me now turn briefly to the four main lessons that we think might bear on the cost and access problems of the U.S. The first lesson is that these countries have been able to achieve universal health care coverage using a system that relied on many insurers. To provide this coverage, these countries mandate that a minimum broad package of health benefits be offered by all insurers. In addition, the Government designates an insurer for those people not covered through the insurance offered at the workplace. So they have been able to achieve universal coverage by using multiple and basically, in most cases, private sector insurers.

Secondly, these countries standardize rates for reimbursing providers without necessarily having the Government set those rates unilaterally. Although there are exceptions, insurers' reimbursements to providers are usually made at these uniform rates, which, as I said, are set through the participation of the payers and providers. It is an arrangement that differs greatly from that in the United States, where physician fees are largely determined in a market with the interaction of a number of players—physicians, insurers, and consumers.

Because reimbursement rates in these countries are standardized, providers have little reason to shift costs of care from less generous payers to more generous ones. In addition, when prices are uniform, providers have less incentive to withdraw their services from people whose payer might otherwise reimburse less generously. In the United States, Medicaid is such a payer. Medicaid beneficiaries in some parts of the country encounter difficulty finding physicians willing to accept Medicaid's relatively low reimbursement rates.

The policy of placing a ceiling on reimbursement rates for providers is not universally popular, as Senator McCain has just alluded to. Physicians in France and Germany, for example, have sought to undo or soften the effects of this policy on their incomes.

Third, these countries can moderate increases in health spending by putting entire sectors of health care on a budget. Our report de-

tails how these budget controls worked in France and Germany. We estimate that by 1987, German physician spending was 17 percent lower than it otherwise would have been as a result of the budget controls used in Germany. We also estimate that the French budget controls, by 1987, had reduced spending on hospital services by 9 percent compared to what it would have been otherwise.

Our analysis also found that those budget controls that have teeth are more effective than those that were simply guidelines. Perhaps this is not surprising, but at least we were able to document it. Germany first introduced a target for physician spending that did not have an enforcement mechanism and later shifted to a cap that did. Because the cap had an enforcement mechanism, it was more effective than the earlier target.

Targets for hospitals have not been very effective in reducing expenditure growth in Germany, but they were in France. And, again, I think the difference is that the targets in Germany didn't have effective enforcement mechanisms, whereas those in France did.

Our fourth and final insight is that the experience of these countries shows that the budget controls can be effective in controlling spending, but they are not a panacea. They do not relieve many of the pressures on spending, they do not assure efficient provision of health services, and they do not assure quality.

France and Germany's health expenditures continue to rise. For one thing, some sectors are not subject to budget controls. For another, social pressures on spending, such as the aging of the population and the spread of AIDS, are beyond the reach of budget controls.

In addition, budget controls in France and Germany offer little incentive for physicians or hospitals to deliver health care efficiently. The fixed budgets for the hospitals do not reward administrators or physicians for making cost-saving innovations. Likewise, fixed budgets can keep inefficient hospitals open that might otherwise suffer losses and have to shut down.

People we talked to in both France and Germany recognized these limitations, and in both countries officials are exploring policy proposals and reforms, including reforms such as those adopted in the United States, such as diagnosis-based hospital reimbursement system, to see whether those would fit in their own systems.

In summary, Mr. Chairman, consensus on how to address the problem of cost and access in the U.S. health system has been elusive and Americans have begun to look elsewhere for insights. Given the complexity of the U.S. health care system and the diversity of the United States, no foreign model can be imported wholesale. Nonetheless, the debate over divergent approaches to health financing reform will benefit from assessing the merits and the flaws of the health care systems in our more advanced competitor nations.

This concludes my statement, and I would be happy now to answer any questions that you may have.

Chairman GLENN. Thank you very much. This is a joint hearing, and Senator Pryor, who is Chairman of the Aging Committee, will lead off.

Senator PRYOR. Thank you, Mr. Chairman. I will try to be very brief because we have a lot of Senators here this morning and I know they have questions.

Do these countries that you studied in the General Accounting Office—do they have a system similar to ours where it is an employer-employee-based relationship, or is everyone guaranteed access?

Mr. THOMPSON. Well, the answer is yes to both parts of your question. The foundations of the system are insurance based on your employer, but each country has figured out a way to make sure that virtually everyone has access to health insurance even if they don't get it in the first instance through an employer.

Senator PRYOR. We have talked about the pay-or-play system in this country. In fact, I think that this was developed, or a large part of this philosophy was discussed and ultimately developed in the Pepper Commission, chaired by Senator Rockefeller, and I was a member of this. That system, of course, requires an employer to provide for insurance for their employees, or at least a portion thereof, and then if they don't, to pay into a fund whereby those who are not covered participate in a general fund. Is there anything like this in those countries you observed?

Mr. THOMPSON. Yes. There is a rough approximation to that system in at least two of these countries. First of all, I should point out that in each of these countries, insurance is financed by contributions that are related to payroll wages. The contribution looks like a Social Security payroll tax. It is not a premium that is a fixed amount per employee, such as is common in this country. All three countries all use the payroll tax contribution approach.

In Japan and in Germany, companies can form their own insurance funds if they are large companies, in essence, offering their own insurance, the way a large corporation does in this country. More or less, these companies self-insure. They also have the option of just paying into an alternative insurance fund—in Japan, one that is run by the National Government for all of the smaller businesses, and in Germany a series of funds which are specialized by each region. So, in that sense, there is kind of a pay-or-play approach for the larger corporations.

Senator PRYOR. How do these countries prevent the problem of over-utilization, let us say, by a worker, by a patient, by someone going for too many tests and over-utilizing the system?

Mr. THOMPSON. I would have to say that some of the people we talked to in these countries would not agree that they had prevented that problem. I think some of the people with whom we spoke in Germany and in France think that there is over-utilization, and that is a problem that they have not successfully addressed.

Senator PRYOR. The insurance companies you discuss—you said that there are many. Are they profit-oriented companies? Is this a competitive industry there in the three countries?

Mr. THOMPSON. There is very muted competition. I want to emphasize that these companies are highly regulated, that there are minimum benefit packages that must be offered and they are fairly

comprehensive. Most of the insurers are non-profit, to answer that question. There is a small segment of for-profit insurance companies in Germany, but they also are highly regulated with respect to what kind of a package they must offer. There is also a small for-profit insurance industry in France. But most insurers are non-profit and within each country offer essentially the same package, with only minor exceptions. Then their competition is even further constrained in that there are few insurers to choose from. The employer could set up his own fund or use one of the local funds, as in Germany, or a white collar worker in Germany can pick between maybe two or three insurers, but there is not the kind of competition you see in the Federal employee health benefit program where there might be 20 different options.

Senator PRYOR. Mr. Thompson, thank you. Mr. Chairman, I have used my five minutes. Thank you. I yield back.

Chairman GLENN. We are on five minutes here so everyone will have a chance to get their questions in here. I will go second.

Do you think that the systems that they have in these countries could be applicable in this country directly? We have a different lifestyle. We are a bigger country geographically. Perhaps they are more homogenous in their population demographics than we are. From your look at this, do you think these systems can be applied in this country?

Mr. THOMPSON. I wouldn't advocate picking one of these systems up and trying to remake it in the United States wholesale. I think that that could not be done. Each one of these countries has its own unique structures and features and history. Indeed, each one of them has features that you probably wouldn't want to emulate.

But I think that from looking at what they do, you do gain insights as to how you can get universal coverage in a system which does not have a Government insurance company, but relies on non-Government or quasi-Government insurance companies and has multiple insurers. You can do that.

The way that they structure their insurance system, though, implies a great deal more regulation than we are used to in this country. So you need to understand that you can get universal coverage with multiple insurers, and you can create mechanisms that seem to keep the lid on costs, but you do pay a price in terms of having to have a more regulated environment.

And I think you see also the greater role in these other societies played by negotiation. You see quite a difference between the United States and these foreign countries—in how rate schedules are derived through negotiation among the interested parties, as opposed to being promulgated by the Department of Health and Human Services.

Chairman GLENN. This is a fee for service that they all have, I guess. Are there any deductibles under this; in other words, the first $100, the customer pays, the sick person pays, as opposed to full coverage of everything?

Mr. THOMPSON. Now, that varies. In Germany, insurance is pretty much first-dollar coverage. I think you pay about $6 a day if you are in a hospital, but pretty much first-dollar, full coverage for physicians and virtually all hospital costs.

In France and Japan, there are more co-pays. They don't have deductibles the way we have them in this country. In the United States often the first $200 or $250 or $300 is just totally out of your pocket, and then, like in Medicare Part B, it is a 20-percent co-pay that the patient pays. In France, it is a 25-percent co-pay that the patient pays, and in Japan it varies from 10 to 30 percent. So, they do have those kinds of co-pays.

Chairman GLENN. We tend to think of health care, calling on the doctor, going to the doctor's office, fee-for-service, and so on, as being the major costs. Yet, in our overall medical expenses in this country, that is only, I believe, around 20 or 22 percent of our total health care costs, something like that. The major costs in the past, at least, have been in hospitals.

How do they address this, and is their system similar? In other words, do they have private, religiously-sponsored hospitals, private hospitals, to the same extent that we do here? How do they work that? How do they handle their hospital cost containment, which is bigger than the physicians, really?

Mr. THOMPSON. The structures differ in those countries. Germany has a system that is probably closer to ours than in the other two, where it has some public hospitals, and some hospitals that are set up by religious or charitable organizations. The French rely much more heavily on Government-run hospitals. They tend to be run by the municipal governments. And the Japanese are dominated by hospitals that are owned by physicians.

Chairman GLENN. You are talking about municipal governments, not state governments, then?

Mr. THOMPSON. Municipal governments, yes. The French have developed a system that is very similar to the Canadian system, in which there is a negotiation that ends with a fixed budget that each hospital is going to get for delivering care that year. That fixed budget works very much the way an appropriation to a Federal agency works. That is, the budget represents the money you are going to get for that year and you have to live with it.

The German system for hospital payment is less rigid. Germany has been negotiating budgets with its hospitals but after negotiations are completed, they actually compensate the hospitals on a per diem basis, and it turns out there really aren't any teeth in that. The budget becomes sort of a target, but there isn't any way of enforcing the budget, so that it hasn't been as effective as France's controls.

Chairman GLENN. How do they take care of long-term health care or catastrophic health care, where a person is disabled for life? We have a growing segment of the population that is 80 and up, and we spend a great deal of our health care dollar in the last few years of life in this country. How do they deal with that in a system like this? Do they just keep them in the hospital, or how do they arrange that?

Mr. THOMPSON. On the issue of catastrophic care, all three countries have limits to how much you can pay and then a catastrophic cut-off kicks in, so that you are not exposed for your entire wealth.

Long-term care is a problem in all of these societies, and I wouldn't say that any of them has done much better than us at solving the problem. In fact, I think in some cases they are behind

us. The average length of stay in hospitals is much longer than in the United States. There are several reasons for that, but one of them appears to be that there are people in those hospitals that we would say don't need to be in a hospital, but there are not sufficient alternative institutions for them.

Japan is just now trying to organize a network of nursing homes and long-term care facilities. Germany and France do not pay for institutionalized long-term care as part of their mandated health insurance systems. All of those countries do have some home health care coverage, but long-term care is a problem, and I know it is a problem that they are struggling with in Germany and in Japan. I am sure they are struggling with it in France, too, but I didn't talk to anybody about that.

Chairman GLENN. Yes. I think in this country, I believe the figures are they estimate that about 80 percent of our long-term health care or care for the elderly is still family-given, family-administered, in our homes.

My time is up. Senator Cohen.

Senator COHEN. Mr. Chairman, Senator McCain would probably verify that the issue of catastrophic coverage produced a firestorm of some proportions a year or so ago, and I suggest that the issue of long-term care in this country will prove that to have been a brush fire by comparison. Senator Pryor and I are going to be requesting that the GAO do a comparative analysis of the long-term care systems in those countries.

Mr. Thompson, you indicated initially that all of these systems involve some degree of regulation, but it is quite extensive. As we listened to your answers each time the question was posed, it seems more extensive than simply "some degree" of regulation.

Let me ask, for example, when the budgets are exceeded—there is a global budgetary cap, is there not, on physicians' fees?

Mr. THOMPSON. In Germany, yes.

Senator COHEN. In Germany. What happens when the billings exceed the cap?

Mr. THOMPSON. The mechanism is the following. There is a fee schedule, but it is defined in terms of points, not in terms of deutschemarks, so that when a procedure is performed, or office visit, whatever, the physician bills points.

Senator COHEN. But his fees are reduced, are they not?

Mr. THOMPSON. Yes, because at the end of the year you then figure out how much money you have to spend and the value of a point is determined by how much you can pay for each service and still live within the budget.

Senator COHEN. So what happens to the physicians? Do they then decrease the volume of patients they start seeing?

Mr. THOMPSON. No. They tend to increase the volume of patients that they tend to see.

Senator COHEN. In order to compensate for the reduction?

Mr. THOMPSON. That is right.

Senator COHEN. Is that true in Italy?

Mr. THOMPSON. Well, now, I haven't studied Italy. I can't comment on Italy.

Senator COHEN. Is it true that France and Germany are now looking to the United States to see how we are handling our prospective payment systems?

Mr. THOMPSON. Yes. I think that that is not the only thing they are looking to us for, but the prospective payment system, the way that we compensate our hospitals, I think, is viewed by these people as a very promising reform that might be incorporated into their system of setting global budgets. They are also interested in our managed care approaches here. Managed care is another feature that you don't find in these other systems.

Senator COHEN. Just to put this in perspective, as many of us are calling for an examination of other systems to see if we can't find some type of repair for our own, it is also true that other countries are looking to the United States to see where we have had our successes as well.

Mr. THOMPSON. Absolutely.

Senator COHEN. What about price controls on drugs? Are any of the drugs controlled in Japan, Germany or France?

Mr. THOMPSON. They are all controlled. The Germans are the most recent ones to put controls on and theirs aren't as tight yet, but France and Japan, it is totally controlled.

Senator COHEN. Are all of their drugs manufactured locally or by the State, or where do they get their drugs?

Mr. THOMPSON. Well, the same pharmaceutical companies operate throughout the world. Japan, I think, runs a slight trade deficit and imports drugs from the United States.

Senator COHEN. They are importing from the United States. What about Germany and France?

Mr. THOMPSON. Well, Germany has its own large pharmaceutical industry, but a lot of those pharmaceuticals are international concerns. They operate in all these countries. Some of the big ones in the United States are subsidiaries of German and Swiss companies.

Senator COHEN. So the Germans now have decided to put price controls on drugs?

Mr. THOMPSON. Yes. They are phasing in a very complicated system in which they are trying to classify drugs as to whether they are close substitutes or not close substitutes, and then for drugs where there is a category that has got a number of drugs—some of which are kind of generic—they will say that they will only pay so much for all the drugs in that class.

Senator COHEN. Do you know whether or not those countries have had the same kind of experience on the part of their drug companies where they have had to invest substantial amounts of money for research and development for innovative or new, exotic types of drugs?

Mr. THOMPSON. Well, you have got to understand that these international companies operate in all the countries, and the same company might be doing research in the United States, Japan and Germany.

Senator COHEN. Mr. Thompson, I have a question about rural areas and the distribution of physicians. Did you find that the standardization of payments contributed to a more equitable distribution of providers? For example, did you find that because everyone is essentially paid the same for the same type of service that

physicians might tend to locate in rural areas as well, or in equal proportion to urban areas, or is there something else at work; namely, quality of life factors?

Some physicians, even though they are paid the same, might decide an urban area is more desirable. There might be more teaching facilities. They like the support of their colleagues, which they might not have in a rural area. What are these other countries doing in their own health care systems to see to it that there are incentives provided to, not force, but at least give a nudge to those to get out to those rural, underserved areas?

Mr. THOMPSON. I didn't look in detail at that issue. I can give you some general observations, but I can't give you as good an answer as I would like to, I am afraid. First of all, I don't think there really are rural areas in Germany. Almost everyone in Germany lives close to a medium-sized city. I didn't get into a conversation about this with the French.

Japan has a fee schedule that is uniform throughout the country, and you do hear concerns that it has become impossible for people to set up practice in Tokyo, given the fees that are being paid uniformly across the country. But I think there are also some problems in Japan with remote rural areas being underserved, so I would say that that uniform fee schedule has got problems both in Tokyo and in the rural areas.

In France, there is a uniform fee schedule across the country, but I didn't discuss it with French officials. We get into it a little bit in the report here. There are what are called Sector II physicians, and those are ones who basically balance bill, in the words we use in this country. They charge more than the fee schedule, and when they do that, they have to give up certain privileges or financial assistance that they would ordinarily get, but they make that decision. These doctors are mostly in Paris and Lyon, so that the ones in the rest of France apparently are still pretty much on the fee schedule.

I think that we should recognize that assuring universal coverage under an insurance scheme in and of itself does not guarantee access to providers, and I think the rural areas and some of our inner cities are both examples of places where, just because everyone had insurance, wouldn't mean that we had solved all of the problems of health access. So I wouldn't want to sell any of these things as being the cure-all for our health access problems.

Senator COHEN. Thank you, Mr. Chairman.

Chairman GLENN. Senator McCain, under our early-bird rule.

Senator MCCAIN. Thank you, Mr. Chairman. Mr. Thompson, as you know, we are not only concerned about the cost of health care in this country, but the escalation and inflation associated with those costs. How do these countries that you looked at track as far as the rate of increase of the cost of health care?

Mr. THOMPSON. Well, they have generally been lower. Now, Mr. Schieber is going to follow me, and he has really studied this at great length. It is hard to answer that question because a country like Japan, for instance, has had rapid increases in spending over some periods in the last 20 years, but their economy is growing so fast that they could have real spending grow at 5 percent per year and the fraction of their national income that goes to health re-

mains constant. Whereas if real spending grew at 5 percent per year in this country—well, it has grown that fast and it has been shooting up as a fraction of our national income.

So the United States tends to be at the top, at or near the top, in terms of how fast spending has been growing, and these countries tend to be lower; I think the Germans and the French are more consistently lower. The Japanese have been up with us for some periods and a little bit lower for others.

Senator MCCAIN. Thank you. As you know, in this country it is maintained that about 25 percent of a physician's practice is in so-called defensive medicine. Do you find a significant difference in the medical liability system in these countries than in the United States?

Mr. THOMPSON. Sir, I think there is a difference in the medical liability system, and we are now doing a study to look in more detail at malpractice systems in these countries.

Senator MCCAIN. You could draw a preliminary conclusion—that is, that there are fewer cases—though, couldn't you, just by comparing the number of lawyers per capita?

Mr. THOMPSON. You do not get the same level of concern about medical malpractice when you talk to people in these other countries.

Senator MCCAIN. That brings me to the next question. Are the expectations in the United States—this is a purely subjective—I am asking you for your subjective view. Is the level of expectation of quality and type of health care higher or different in the United States than in these other three countries?

Mr. THOMPSON. Well, first of all, I think there is a difference. There are significant differences between the United States and the European countries, on the one hand, and Japan on the other in what people's expectations are and in how they relate to the health care system. I don't want to say more or less; clearly, it is different.

As regards France and Germany versus the United States, I think it is fair to say, and I think it was Senator Pryor who observed, that we probably have the highest quality of medical care for the really cutting-edge things.

For something that we have been doing for two or three years, and now it is not exactly the absolute cutting edge, but it is still very sophisticated medicine, my impression that that stuff is equally available in Germany and in France, and that the expectations are probably fairly similar about how people will be treated when they go to their physician.

It is clear that physicians in the United States are more prone toward invasive procedures. In Japan, they love to do diagnostic imaging; there are lots of CT scans in Japan. But the United States is more prone to invasive procedures than these other countries are, and I assume that part of that is the expectations of both the physician and the patient.

Senator MCCAIN. But it is also safe to assume that the United States is the country that leads in almost all of these high-tech advances in medicine?

Mr. THOMPSON. I don't know that I would want to push that. I think some of these imaging things have really come out of Germa-

ny. The MRIs, I believe, and the CT scans were developed abroad. You know, there is high-quality medicine in Germany and France.

Senator MCCAIN. I wasn't questioning the high-quality care. I was just thinking where most of the advances in medical technology have come from, and I said most, not——

Mr. THOMPSON. Yes. I suppose that if you lined it up, the United States would rank above Germany and France, but we don't have an exclusive franchise on that sort of——

Senator MCCAIN. On the issue of drugs, is there any significance concerning the patent law link on the issue of generic drugs between the United States and these countries you studied?

Mr. THOMPSON. I am sorry. We didn't get into that, and I just can't answer that question. We are doing a study right now on international price comparisons in drugs, and we may get into that as part of that study, but as part of this study, we did not.

Senator MCCAIN. All of these countries obviously are experiencing the budgetary problems that we are. Have they looked at a managed care system, such as a large HMO kind of a thing? Has that been something they have contemplated?

Mr. THOMPSON. Yes. As I was saying to Senator Cohen, I think there is interest in Europe in how we have developed our managed care—there is also interest in Canada—and how HMOs operate, and so forth. We have had people visit us from these countries, asking about how these things work.

Managed care will be a difficult thing to fit into a German system, and that is another insight that perhaps I should have listed. Once you have set up a system with first-dollar coverage and you have given everyone free choice of provider, it becomes difficult to figure out a way to restrict them, as managed care in this country does, to gatekeepers or to HMOs.

So it seems to me if the French wanted to move in that direction, they have got more room to do so because their system does not automatically give first-dollar coverage to everybody.

Senator MCCAIN. Finally, as compared with our system, could you say that there is at least some sort of rationing of health care in these countries——

Mr. THOMPSON. I don't think——

Senator MCCAIN. —certain age groups or certain access to certain kinds of treatments, except for long-term care, obviously?

Mr. THOMPSON. I don't think in these three countries there is any rationing at all. We bumped into no rationing at all. You hear about rationing and queues in other countries—in Canada and in the United Kingdom and in the Netherlands, which is not part of this study. But not in Germany or France or Japan.

We asked three or four different physician associations in Germany about whether they felt they had adequate facilities, adequate capital; could they provide all the services that were needed to give high-quality care to the German people, and we always got yeses. We never got any indication of any shortages or any need to queue or anything like that.

Senator MCCAIN. Thank you. Thank you, Mr. Chairman.

Chairman GLENN. Senator Burns.

Senator BURNS. Thank you, Mr. Chairman. To pick up on a couple of points that were made both by Senator Cohen and Sena-

tor McCain on these fee schedules and controls on drugs, the R&D—who pays for the research and development of a new product to get it on the market? We look in this country where we buy drugs here in this country and we can buy the same drug in Canada for almost half price.

Are the companies, the multinationals, are they taking their money out of the United States where they can do it on a free-market basis and where they have to operate with controls in other countries—are we paying for other countries' drugs?

Mr. THOMPSON. I have to warn you that that was not part of our study, so I didn't really get into that. We are doing another study now looking at these pricing questions. I think that there are a number of these companies which are multinational companies. They do research in different countries, they sell all over the world, they manufacture all over the world.

You have to assume that if we are paying higher prices than the French are, then we are probably ponying up a little higher percentage of the R&D costs than the people in some of the other countries are. Now, it is also true that although our prices are higher, we don't necessarily spend more on pharmaceuticals than these other countries do. It turns out that the French and the Germans and the Japanese are all big consumers of pharmaceuticals. So the French have low prices, but they have a hell of a volume that they are able to consume of pharmaceuticals.

Senator BURNS. Also, in the area of the price controls and rates as far as the services of hospitals and doctors, you say that all three of three countries—and correct me if I am wrong, if I misunderstood you—that they negotiate those rates. Is that done on a yearly basis?

Mr. THOMPSON. Yes, I think so.

Senator BURNS. Now, are there any violations of those? Once a rate for a service has been established through negotiations, are there violations of somebody overcharging or undercharging?

Mr. THOMPSON. I don't know of violations, but let me explain that each——

Senator BURNS. "Violations" is probably a poor word choice.

Mr. THOMPSON. I don't know that there are any, but I want to point out that there are features in both Japan and France in which it may be that what you pay the physician is more than what the negotiated rate is. These rates are not ceilings, necessarily, in France or in Japan. In France, physicians have to decide whether they want to, using our words, accept assignment or not, and if they don't, they can bill more than the fee schedule. The patient has to pay the difference out of his or her pocket.

The incentive for a physician has to do with the way their pensions are calculated, and so forth. The Government tries to encourage them to accept the fee schedule as payment in full, but it doesn't mandate that. So, that is kind of a safety valve, if you will, that is built into the French system.

In the Japanese system, the fee schedule is mandated and uniform across Japan, and the physicians simply submit vouchers to the insurance company to get reimbursed when somebody comes for a visit. But it is also freely discussed that in Japan, for a major procedure, it is socially acceptable to give gifts, and these gifts may

be envelopes with money in them. No one has got a real good feel on how significant that is, but it seems to be admitted by everybody that it goes on and is a fairly widespread practice. So, that is over and above the fee schedule.

Senator SASSER. Where is this, in Japan, did you say?

Mr. THOMPSON. In Japan, yes. And even in Germany, there is a special position for a physician who is the chief of a department in a hospital, and that physician has a special status and is able to see outpatients and do inpatient work and bill at higher rates than are negotiated by those sickness funds that we talked about earlier.

So in each of these countries, there is a safety valve of sorts, in which people who want to pay more can find a physician who is free to accept over and above what the fee schedule provides. They have worked out a system in which most people have access to health care through a system that has sort of a uniform fee schedule, but they have also got a safety valve some place for people who want a particular physician and are willing to pay a lot more.

Senator BURNS. One more question, Mr. Chairman. What I am hearing here is that these rates that were negotiated are a floor rather than a cap.

Mr. THOMPSON. In France and Japan, that is a fair statement. In Germany, the negotiated fee is the fee for 90 percent of the population, but there is 9 percent of the population that has private insurance and they have a higher compensation rate, up to 2.3 times that fee. But in Germany, there is no supplement.

Senator BURNS. Thank you, Mr. Chairman.

Senator COHEN. Mr. Chairman, could I just follow up on that question, if my colleagues would yield? Senator McCain asked whether or not there was rationing in any of these countries, and the answer was no. But, in fact, if you have some of the wealthier people who can afford to pay more money, whether you call it, in the Iranian context, baksheesh, or gifts or whatever else it could be called, it is nonetheless a different kind of a system for those who have money and those who don't. So I don't think we should just say they don't have any rationing. They may have a different form, a more subtle form of rationing.

Chairman GLENN. Senator Levin.

Senator LEVIN. Thank you, Mr. Chairman.

Could you compare the minimum package, say, in Germany to a typical package in a company here in America in terms of the benefits? Are they about the same?

Mr. THOMPSON. The German package is a very comprehensive package. Do you know offhand anything that they wouldn't have that the big corporation would have here?

Mr. GROSS. The only thing they might not have is certain types of dental surgery and some types of optical care. Generally, insurance pays for preventive care, most any kind of laboratory tests, prescription drugs, and basic inpatient and outpatient care.

Senator LEVIN. Would you say that basically they are comparable, these packages, better, or not as good?

Mr. THOMPSON. They are probably as good as or, if anything, better than the average package in the United States in terms of what is covered.

Senator LEVIN. All right. Now, are there also supplemental coverages that some people buy to those packages?

Mr. THOMPSON. Yes.

Senator LEVIN. Not the 9 percent that use private insurance, but the 90 percent that use the packages in Germany?

Mr. THOMPSON. In Germany?

Senator LEVIN. Yes.

Mr. GROSS. Yes, there is some purchase of supplemental insurance to pay for this dental surgery and things like that.

Senator LEVIN. And what percentage of the people buy supplemental insurance in Germany?

Mr. THOMPSON. I don't think we know that. It is not very important in Germany. It is important in France.

Senator LEVIN. All right. How about in France? Is the minimum package in France comparable to our typical package?

Mr. THOMPSON. Yes. All three of these countries are going to have packages which are very comprehensive. They are a little different here and there, but they are very comprehensive, and I would say that I would give you the same answer for each of those three countries.

Senator LEVIN. Now, can you compare the cost of that comparable package on an apples-and-apples comparison? How much does that package cost here, how much does it cost there? Is there any way of comparing that?

Mr. THOMPSON. That would be tough. I don't know to what extent it is possible, to compare the costs. It is not just that the fees are different. You know, you can figure out what the charge is to go to a hospital, what the charge is for an office visit or an MRI, or something like that, and you can price that out. But the practice of medicine is just enough different that exactly what the pattern is of usage will be different in these different countries.

Senator LEVIN. Well, I am not talking about the pattern of usage. I am talking about the cost of that package.

Mr. THOMPSON. But in order to cost a package, if I offer you coverage for physician services, then an actuary is going to sit down and figure out what does it cost each time you go and how many times will you go.

Senator LEVIN. No. I am talking about the cost, if we could, to the employer. There is a percentage. You have a pay-or-play system in one of these countries, and you could compare that to the cost of a comparable package here to a company. Would you try to do that for the record, where you are able to do it?

Mr. THOMPSON. Sure.

RESPONSE TO SENATOR LEVIN'S QUESTION

In Germany, the average insurance contribution is about 13 percent of payroll; this contribution is split evenly between the employer and the employee, so the average employer's health insurance bill is about 6.5 percent of payroll. In the United States, the analogous figure for the average employer in 1989 was 9.7 percent of payroll. In addition, U.S. employers pay a fraction of payroll that is earmarked to the Medicare program; employers' share of general revenues also is used to help finance Medicare and Medicaid.

This is not to say that the average employer in the U.S. would pay only 6.5 percent of payroll if the United States adopted a German-type insurance system here. The payroll contribution rate required for such a system would reflect the higher

U.S. ratio of health spending to national income. In addition, U.S. utilization patterns might change. No estimates are available of whether the U.S. adoption of features of German health insurance—for example, enhanced coverage for preventive care, prescription drugs, and medical services—would increase (or perhaps decrease) U.S. utilization relative to German utilization. Lacking an estimate of the change in U.S. utilization that a German-style reform would cause, we cannot estimate the impact of such a system on U.S. employers' costs.

Senator LEVIN. Now, you said there is a large percentage of people in France who have supplemental packages. What percentage would that be, about?

Mr. THOMPSON. Oh, it is about 80 percent that have supplemental insurance. In France, you have large co-pays, so it is like our Medicare program where, you know, 20 percent is paid by the patient. In France, 25 percent of providers' fees are paid by the patient, and so it is very common that they have what amounts to a medi-gap policy.

Senator LEVIN. I see, OK, but that is the major purpose of the policy. It is not to cover additional services; it is to cover the co-pay part?

Mr. THOMPSON. That is right.

Senator LEVIN. Can you compare administrative costs?

Mr. THOMPSON. We are looking at that right now in yet another report, and we have not compared that.

Senator LEVIN. So you have no preliminary assessment or hunch on that issue?

Mr. THOMPSON. My hunch is that—if we are able to do the study—we will find that the administrative costs in Germany are more than in Canada and less than in the United States.

Senator LEVIN. Physician income—can you compare physician income in the three countries to U.S. physician income?

Mr. THOMPSON. Yes. Well, I can do it for Germany. Relative to the average incomes in each country, physician income in Germany not too long ago was higher than it was in the United States. For instance, in 1975, in Germany, physicians, on average, earned 5.6 times the average wage, whereas in the United States, 4.96 times the average.

Senator LEVIN. Is that the most current one you have, 1975?

Mr. THOMPSON. The point I wanted to make is that since 1975, German physician income has come down relative to the average wage in Germany.

Senator LEVIN. Could you give us that roughly now?

Mr. THOMPSON. The most recent number I have got on this table is 4.29 times the average wage in 1986.

Senator LEVIN. Compared to what in the U.S.?

Mr. THOMPSON. 5.12. So they had been above us and now they are below us.

Senator LEVIN. And how about Japan and France?

Mr. GROSS. We don't really have anything for Japan.

Mr. THOMPSON. Do we have France?

Senator LEVIN. Can you give us that for the record?

Mr. THOMPSON. I will give you what I have got for Japan, but I have to explain to you that I am not sure that the numbers are all-inclusive. The numbers show Japan at about 2 times the average wage, but I don't think they include all the sources of income.

Mr. GROSS. Physicians in France receive about 2.5 to 3 times the average wage, according to the numbers we have here.

Senator LEVIN. And do we think those are apples-and-apples comparisons? You mentioned, for instance, that physicians get pensions in one of those countries.

Mr. THOMPSON. In France.

Senator LEVIN. In France. Now, would that 2.3 in France include what apparently sounds like is a different pension for physicians than other people get?

Mr. THOMPSON. We could check that out. I think that the German and probably the French is close to the United States conceptually. These things across countries are never apples-and-apples, but sometimes they are sort of Washington apples versus Virginia apples.

Senator LEVIN. Or Michigan apples.

Mr. THOMPSON. Yes, whatever. [Laughter.]

Senator LEVIN. But there is no comparison anyway. Thank you, thank you. My time is up.

Chairman GLENN. Senator Kohl.

Senator KOHL. Thank you very much. What do we know are givens in setting up a system of national health care compared to what you see around the world? What things are likely to be givens, like global budgeting? I am trying to get some sense of where we are in terms of what we already know or think we know and try and get some clearance from the fog. What are the things that we know will probably have to occur in this country?

Mr. THOMPSON. Well, let me answer by saying that everything has got a trade-off, and it is your job as policymakers here ultimately to vote on those. But what we think we see that we can help you with—the insights that we have gleaned here—are that you don't have to have one payer. You can have a multiple-payer system, but as I said, the experience of these countries suggests you will have a very regulated multiple-payer system.

Secondly, you can contain costs in that multi-payer system, but it will require something like standardized rates and global budgets. They are effective. They do not stop all cost pressures. In and of themselves, they don't necessarily guarantee the most efficient provision of services, and they don't necessarily guarantee quality. They will constrain spending.

There are other tools which we have developed in this country which may be more effective at encouraging efficiency. In other words, you can have both global budgets and then a prospective payment, so you have got a global budget like France and prospective like the U.S., and you may be able to have a better system than either one now has in terms of both cost and efficiency.

So those are some of the things that we gleaned. We also see in these countries much more of a role for negotiation between the doctors and hospitals, on the one hand, and the insurers or the people who are paying the bills on the other hand—much more of a formal negotiating process in trying to derive what those budgets should be, what the rates should be. In some cases, such as in Germany, this is a process in which the Government really plays little direct role. In fact, I would say that the German health care system operates basically with very, very little interference from

the National Government. The number of people who are employed by the National Government in Bonn to manage the health insurance system is fewer than the number of Federal employees in this room right now.

Senator KOHL. Who sets the overall budgets?

Mr. THOMPSON. Well, they actually start with a process called Concerted Action, in which they have representatives of all of the insurers and doctors and dentists and hospitals—meeting nationally once every six months to discuss the overall state of the economy, the trends in health care, where it hurts, what needs to be paid attention to, and to develop guidelines about how much we think physician rates can be increased this year.

Those negotiations to actually effectuate a rate increase are conducted at the equivalent of the State level between associations of insurers and the physicians associations. In Bonn, the minister is there going on TV every so often reminding folks that the stated policy is that the average contribution rate, the payroll tax rate, if you will, that supports this system, shouldn't rise, so that we should try to make sure that our spending goes up only as fast as wages go up so that we can keep the same contribution rate. And then if it starts to drift up, the Government is going to have a reform bill of some sort that is going to make changes in the rules, and maybe some of the participants in the system aren't going to like the new rules, so they will have an incentive to try to make the system work under the old rules.

Senator KOHL. Would you say that the picture that is beginning to emerge here is that it will turn out to be not nearly as foggy as the way it appears right now to so many people in this country? With all the various ideas and the various proposals, and everybody seems to have a different idea, some things are fairly uniform, like the things you are mentioned. The biggest things appear to be fairly uniform across the world today.

Mr. THOMPSON. Well, in these countries—now, for this study, we looked at countries that have multiple payers. In contrast, Canada has a single payer and provides universal insurance that is not necessarily work-based, and there is yet a third model in the United Kingdom in which the Government has much more of a role in actually providing services.

I would say that there is a fundamental decision to be made about whether this country wants multiple payers or wants to go to a single payer. But if the decision is to go with multiple payers, then there are patterns that emerge. There is no cookbook, but there are insights that you get into how you can do this and still have high quality and keep costs under control.

Senator KOHL. One final question. If we are going to keep costs under control, do you think we will have to price-control drugs like these other countries are?

Mr. THOMPSON. I suspect sooner or later you are going to have to address that issue, yes.

Senator KOHL. Thank you, Mr. Chairman.

Chairman GLENN. Under our early-bird rule, Senators Roth, Sasser, Grassley and Graham is the line-up here.

Senator Roth.

Senator ROTH. Thank you, Mr. Chairman. Mr. Thompson, I regret I have not had the opportunity to fully study your report at this time. It obviously is a very important document in helping us better understand the comparative costs and treatment of health care in these countries.

I understand from the Congressional Budget Office that during 1980 to 1987, the United States experienced an increase in per capita cost of health care of 39 percent; Japan, 31 percent; West Germany, 13 percent. And in comparing long-term studies from 1967 to 1987, the U.S. experienced an increase in per capita health costs of 176 percent; West Germany, 167 percent; and Japan, 339 percent. None of these statistics if correct, have shown that these countries have found a solution for the problem.

As you pointed out earlier, in the case of Japan, the large increases are attributable to the growth of the economy, therefore the percentage would be less if growth had been less. As I say, if this is correct none of these figures are very comforting. Is that a correct interpretation?

Mr. THOMPSON. I would say the first and correct interpretation is that cost pressures are universal, and that none of these systems is going to deal with some of the underlying drivers of aging populations, of things like AIDS, and of new technologies which are universal.

I think you will see from your statistics, if you look at the German situation, you will see that they had a cost explosion in the 1970's and a very slow growth of costs in the 1980's. And, in fact, it was because of the cost explosion in the 1970's that they adopted some of the structural reforms that we talk about in this report. The Germans recognized that they had started something that was unsustainable.

Those reforms have slowed down the rate of spending increase in Germany quite dramatically. In fact, the Germans' fraction of their national income devoted to health care has actually drifted down in the last few years. Now, my understanding is that this relative slowdown in health spending is also creating a lot of counter-pressures among physicians. So I wouldn't want to leave you thinking that everyone is just entirely happy with everything that is going on in Germany.

Senator ROTH. The figures here support what you are saying—West Germany, 13 percent, compared to Japan, 31, and ours, 39 from 1980 to 1987. Yet, a few minutes ago, you said that the Federal Government intervened very little.

Mr. THOMPSON. The German system is not run by the Federal Government. It is run by these sickness funds. The closest analogy in the United States would be Blue Cross-Blue Shield plans. The funds are governed by boards which are elected by workers and appointed by employers, and they negotiate with physician associations. They run the system.

The Government in Bonn articulates policies about what it believes ought to be the trend in total health care spending, but then through these other mechanisms such as this Concerted Action that I alluded to—the institution that allows the various interest groups to get together and spend a couple of days kind of working through how to take the budget that is available and make recom-

mendations about how it can be divided—it is through that nongovernmental mechanism that those Government policies get translated into what actually happens in the insurance system.

Senator ROTH. Then there is a very significant difference between our two systems.

Mr. THOMPSON. Yes; at the moment, yes.

Senator ROTH. Let me return to your statement on rationing. In considering this, I guess you have to look at the "expectations" of people. These expectations differ in each country. For example, I have been told that in the case of Japan, the expectation of the kind of treatment a patient will receive for a terminal illness is quite different, than what we would receive here.

Is it true that 20 percent of our health care costs in the Medicare program can be attributed to the final two weeks of a patient's life?

Mr. THOMPSON. I can't confirm that number, but it is a large number in the last year or the last six months, or whatever.

Senator ROTH. And is that a significant difference between the United States and other countries?

Mr. THOMPSON. We really didn't get into that in depth in the study here, so I can't give you a well-informed answer to that. My sense would be that the difference in expectations would be the greatest between the United States and Japan, and that it is a different system in Japan.

The expectations are also different between here and in Europe, although the difference isn't as great. But they go to the doctor much more often than we do in all of these countries. They go twice as many times, on average, per year. They go into hospitals——

Senator ROTH. Is that more preventive health, would you say?

Mr. THOMPSON. Well, we are more apt to wait and see if whatever ailment we have got takes care of itself, and they are more apt to go and get taken care of, and there are probably arguments on both sides of that. As I said, they spend much more on pharmaceuticals in these three countries than we do. That is probably connected to going to the doctor quite frequently.

They go into the hospital more frequently. The average patient in the hospital isn't as sick in those countries as in this country. In this country, when you go into the hospital, you are surrounded by people and high-tech equipment, and so it is a very intensive experience, which is really different from what the experience is in these other countries. If you go into a German hospital or a Japanese hospital, you do not have the sense of the same intensity of activity that you have in the large hospitals in this country.

Senator ROTH. One final question. Returning to the subject of doctors and compensation, is it true that in these other countries doctors are educated at the expense of the State? How does it compare to our system? One of the problems here is that so many young doctors are burdened with very heavy debts as a result of the cost to become medically trained.

Mr. THOMPSON. Yes. The higher education system in Germany, Japan and France is basically free, and I don't think that is unique to physicians, but it is a more general proposition, so that physicians coming out of medical school in these countries don't have debt. In fact, I think in Germany they may even be paid a stipend

while they are in school. I know in Germany, and I think also in Japan, as an intern or a resident you have a pretty good-paying job in a hospital, so that it is much easier for them financially.

They have a tremendous over-supply in both Germany and France. They have physicians driving taxicabs in Germany, and they have had a real problem. They are trying to cut back the supply in both places because they are concerned.

Senator ROTH. In the past, there have been times in this country where there have been those who thought we have too many doctors, and the consequence of that was too many procedures are performed. Is there any truth to that kind of a charge?

Mr. THOMPSON. There are a lot of people who would agree with that charge. I don't know how you prove it one way or the other, but there is a correlation between the number of physicians in a given area and the number of procedures and operations, and so forth. Japan has a few private medical schools which charge tuitions that are as high as the ones in the United States, but they also have Government ones that are much cheaper.

Senator ROTH. Thank you, Mr. Chairman.

Chairman GLENN. Senator Sasser.

Senator SASSER. Thank you very much, Mr. Chairman. Mr. Thompson, I want to congratulate and commend you and your colleagues at the General Accounting Office for this very useful study that you have produced. I haven't had an opportunity yet to read all 70 pages, but I will in due course. It is an excellent study, and you do us a good service here, as you did with your previous study with the U.S., I think, and Canadian health systems.

Mr. THOMPSON. Thank you, sir.

Senator SASSER. Let me just ask you this question. What percentage—if you can answer this question, what percentage of the health care dollar in Germany, France and Japan goes to administrative costs as opposed to what percentage of the health care dollar in the United States goes to administrative costs?

First, what percentage of our health care dollar goes to administrative costs here in the States? Do you have that figure? I have seen figures as high as 40 cents out of every dollar spent.

Mr. THOMPSON. Well, it is probably not that high. I don't have it handy. I am sorry. Unfortunately, we don't know the administrative overhead in the three countries, so we can't answer your question yet. We are doing a study trying to see if we can get a good fix on what the German system costs to administer, with its over 1,000 different sickness funds, and how that would compare to a Canadian-style system, and how that compares to the U.S. system.

As you know, as part of our report on the Canadian system, we did take a stab at estimating how much less the United States would pay if it administered its health insurance the way the Canadians do. I expect that we will find that the German system is more expensive than the Canadian system, but less expensive than the American system, but I don't know where it will be in that range.

Senator SASSER. Is it your tentative conclusion at this time—and I emphasize tentative—that the administrative costs of the American health care system are higher than the other systems, and if so, are our administrative costs significantly higher?

Mr. THOMPSON. Our costs, I would suspect, are higher than those of the other developed countries, the comparable countries, the ones we are talking about here, because our payment system is so uncoordinated. These countries all have uniform payment mechanisms where you essentially have the same system.

In Germany, when you go to the physician, you have got a little voucher that you got from your sickness fund, and it is the same voucher no matter which sickness fund you are a part of. You take that to the physician and he writes down on the back of it what he did to you. At the end of the calendar quarter, he sends that voucher in to a central place. Now, he doesn't have to have three billing clerks to figure out what is covered under this plan versus what is covered under that plan.

I mean, the last time I was in my doctor's office, they had a whole bookcase full of forms and you had to get the right form for the right insurance company to send it in for compensation. You don't have that in these other systems. They are much more coordinated, and it is clear that they are going to be able to process the claims much more efficiently than we can in this country.

Senator SASSER. Now, there have been some questions here earlier, I think, about the cost of drugs or pharmaceuticals, and at the risk of repeating some of those—I came in a little late—I have long had a concern about the cost of pharmaceuticals in the United States. This concern has been shared by Senator Pryor, who has authored some legislation which I think he is going to introduce shortly, which I intend to cosponsor.

But I have seen studies that indicate that we pay as much as 60 or 70 percent more here in the United States for an identical pharmaceutical or drug than is paid in Europe, in France, Germany, et cetera. I think you have indicated that price controls are set on pharmaceuticals in the European countries that you studied. In all three of them?

Mr. THOMPSON. Yes.

Senator SASSER. Well, how do these price controls work, and what impact has it had on the development of new drugs, if any?

Mr. THOMPSON. I sound like a broken record. We are doing a study on that, Senator.

Senator SASSER. All right. Well, it is a very important and complex subject.

Mr. THOMPSON. Yes, and we are not far enough along that I have much to say in response to that. We didn't do that as part of this study and I don't really know how they set the prices, in particular, in, say, France or in Japan. I know that in Japan, when we were there in April talking to the managers of the health care system, they were going through a negotiation process, which they do periodically, and they were coming up with alternative ways of setting drug prices. They have a very complicated mechanism.

One of the things that was—what should I say—a wake-up call was that the Japanese were consciously redoing their reimbursement mechanism in an effort, among other things, to make their pharmaceutical industry world-class competitors. They believe that they are not now world-class competitors, so they were going to change the way they compensate under the health insurance system. But they planned to do this not through taking the regula-

tions off, but rather by fine-tuning the relationship between what you paid for a brand new drug and what you paid for one that was generically very similar to another one.

Senator SASSER. One final question. I know you are hesitant to draw conclusions from the comparisons that you make in your report, but I would be interested in knowing, taking into consideration all of the positive and negative aspects of the foreign programs that you studied, what you feel is the most valuable lesson that we in the United States can learn from our foreign neighbors with regard to health care and the efficient and effective delivery of health care to our citizens.

Mr. THOMPSON. We started off worried about cost containment, and I think one of the things that we stumbled into that we didn't expect to find or we weren't looking for was the critical role that universal coverage plays in trying to contain costs. To contain costs, you probably need to construct a system in which you are going to coordinate the payments, but to make it work everybody has to have access to health insurance and be part of that system.

Now, as I said earlier, each one of these countries has got a little safety valve arrangement, so that there are a few people who can opt out of the system and perhaps get slightly higher quality care. That safety valve is kept relatively modest in size, though, so that the system for the vast majority, 90 percent of the population or more, remains one that basically everyone is in, and therefore everyone gets access to the kind of quality care that I probably have access to—pretty good care.

We learned, then, that it is critical to have universal access, critical to have some sort of a coordinated payment mechanism, and probably critical to have some sort of targets or budget caps to keep costs under control.

Now, there are lots of things that are not done. As I emphasized, each of these countries has a strategy that keeps expenditures under control, but you need other tools to make sure that hospitals have the incentive to be efficient. You need other tools to make sure that there is room for managed care and for all the benefits that you get from managed care.

So we learned some things from the foreigners. There are things that we have done that they can learn from us, I think.

Senator SASSER. Thank you, Mr. Thompson. Thank you, Mr. Chairman.

Chairman GLENN. Senator Grassley.

Senator GRASSLEY. Mr. Thompson, probably you know that one of the things that the Secretary of HHS, Dr. Sullivan, has concentrated on that contributed to excess costs are the social problems that we have, social health problems—drugs, alcohol, smoking, et cetera.

To what extent do the levels of these problems in the U.S. compare to the levels in Japan, Germany, and France regarding their impact on health costs?

Mr. THOMPSON. We probably don't smoke as much as the rest of the people do, so on that front we are better off, or we soon will be as the down-the-road effects of our having reduced our smoking occur. With regard to the other items you mentioned, I suspect that those are situations where we have costs that they do not have; in

particular, gunshot wounds and other sorts of street violence. You just don't have those in the other countries, so you don't incur the costs in the trauma centers associated with that kind of violence. You have spectacular motor accidents on the autobahns in Germany that result in trauma costs, but you don't have the kind of violence-related costs that we have.

Senator GRASSLEY. Well, would the cost control mechanisms in these various countries that you have studied be effective in controlling related to adverse social behavior, or would these costs still continue to rise?

Mr. THOMPSON. Well, I think you shouldn't assume that if you adopted the Japanese system or the German system you could reduce spending to the level at which the Japanese or the Germans now spend. I don't think you could do that in this country, and so although the institutions could be imported here and adapted, and if they were effective we could hope that they would slow the rate of increase in our spending, the costs of these kinds of social problems would still be there and would still have to be borne.

But I want to go on to say something about preventive care. In each of these countries, I was impressed especially in the area of prenatal care, by how effective those systems have been at getting women access to prenatal care and getting their children access to well-baby care, and it is pretty easy to show that prenatal care is cost-effective. So there are costs in our system which we bear but that they avoid through their social organization and through the fact that they have universal coverage.

You know, we have in this country a remarkable ability to take a two-pound infant and help it survive, but we have more two-pound infants than any other country in the world, proportionately speaking.

Senator GRASSLEY. In regard to these problems, do we know enough about their costs, the long-term ramifications for health care costs, or do we still have more work we have to do in that area.

Mr. THOMPSON. Well, I am not sure how to answer that question. I think the message I would like to leave you with is that these countries have developed institutions that seem to be effective at controlling costs. But these institutions are not panaceas. They don't stop the pressures that lead to cost increases, and they probably cannot be picked up lock, stock and barrel and transported to the United States, because each of our societies has its own traditions and its own social institutions. But they do offer us sign posts. They offer us ideas of directions that we could move in or things that we could think about as we struggle with the cost and access issues in our own system.

Senator GRASSLEY. Thank you, Mr. Chairman.

Chairman GLENN. Thank you.

Senator Graham.

Senator GRAHAM. Thank you very much, Mr. Chairman. I have an opening statement which I would like to put into the record.

Chairman GLENN. Without objection, the statements of anyone will be included in the record if they wanted to submit one.

PREPARED STATEMENT OF SENATOR GRAHAM

Mr. Chairman. Thank you for convening a joint hearing with the Government Affairs Committee on the significant issue of cost containment. Cost control will be a crucial element of any comprehensive health care reform our nation undertakes. It is important to consider existing cost containment models and to learn from their successes.

During my visits to Florida, it is apparent that health care reform is the dominant economic and social issue of this decade. Our system can't keep up with rising costs. For example, according to a November 11 Orlando Sun Sentinel article on a recent statewide survey, the cost of health insurance has jumped 13 percent so far this year for employers in Florida, a gain that far exceeds the inflation rate.

We are all affected by rising health care costs through system wide cost shifting, family members with pre-existing conditions, and the large number of Americans who work for small businesses which can not afford insurance costs. Americans are increasingly experiencing job lock; stagnation due to fear of losing health insurance when they switch jobs. Additionally, rising costs and decreasing access hurts the ability of our nation to compete.

In considering the GAO report to be released today, I find Germany, Japan, and France's cost containment efforts worthy of note. Each nation has managed to contain their cost to at least 8.7 percent of the gross domestic product through mechanisms such as rate setting and expenditure targets. All three nations, however, operate a workplace based health care system similar to the United States.

Mr. Chairman, I hope that any cost containment efforts our nation adopts include outcomes research for prevention and health promotion procedures to cut costs in the future through treatment guidelines administered by the Federal Government.

I look forward to a productive discussion on a very important issue.

Senator GRAHAM. I wish to express my appreciation to you and to Chairman Pryor for convening this joint hearing on a very important subject.

I would like to pick up on the question that Senator Grassley just alluded to and your comments on prevention. You mentioned the significance of early childhood and maternal preventive care. What do these three systems do in other areas of prevention, early diagnosis of illness, provision of medication to arrest conditions, other techniques that can prevent, reduce or ameliorate potentially critical health circumstances?

Mr. THOMPSON. We are doing a study on that very topic, in which we are studying the Medicaid program—early prevention, screening and diagnostic program—trying to understand why that has not apparently been successful, whereas the European countries have appeared to be more successful at it. I am afraid that there isn't a magic bullet. I am not sure that there is an easy answer that will guarantee success if adopted in the U.S.

Now, in the area of maternal and child health, they tend to have some sort of a system in which pregnant women will register and they will get some sort of prenatal care. In Japan, there is really a passport, and the French have a similar thing. It tells you what it is that you ought to do, how often you ought to go and have check-ups before your delivery, and then what good well-baby care is and when you should have immunizations, and so forth. In Japan, you keep this and you record not only your child's progress—it is kind of a baby book, too. You can stick a picture of the infant in and record how much they weigh and how they grow. They will have in there chits to take to the physician to make sure that you have got access to the care.

In Japan, the local municipalities will have one day every two weeks in which they have a clinic in a school building or in some municipal building, and there is a pediatrician there and everyone

brings in their two-month-old or their three-month-old or their six-month-old, whatever the right spacing is, and has them checked up. So there is a lot of that that goes on.

If you tried to put your finger on what is the key difference—and this is just my impression now, I want you to understand that—I think it is a difference of attitude, and I have likened it to the fact that Americans—when they are five years old, they know that at the age of five you go to the public school, and that the school is there and you are expected to show up and you do show up and the school is available there for you.

In France and Japan, women know that when you are pregnant, you go to the doctor, and so they do. So when you go to these other countries and you ask health officials, what do you do to encourage women to have prenatal care, they give you a blank stare and they say, well, why wouldn't they have prenatal care? You say, well, how do you encourage it? Well, it is something that they don't think about in a conscious way the way we do. They have just been able to organize their society in such a way that it comes naturally, apparently.

I don't know that there are so much organized attempts, then, to have structured screening, as there is an acceptance on the part of everybody that this is something that you ought to do. In addition, there is the knowledge that they are covered and that the services are available, and they therefore do it.

Senator GRAHAM. Will your study of prevention cover middle-age and older persons as well as youth?

Mr. THOMPSON. No. The one we are doing is basically young children, I believe. A table in here—in our report on "Health Care Spending Control"—shows what is covered, and can give you some sense of the preventive services that are covered. Each one of these countries' minimum benefit packages will have a schedule, let us say, of how often mammographies are covered and will specify routine physicals every five years for people of a certain age group, and things like that. So they are all specified in the health care packages, and in that regard probably they are covering things that our health insurers don't cover.

Senator GRAHAM. I see the yellow light is on. I am going to slip two questions into one. I was struck in your remarks at some of the potential wedges within our current health care system to adopt items that you identified as being important in these three countries' systems. One of those was the use of Government standards for minimum insurance coverage.

I would like your comment as to how those countries are using that opportunity vis-a-vis how we are doing it, for instance, in determining what insurance funds will qualify for tax deductibility.

And then, second, in the issue of negotiation for payment, while you mention that Government is not a unilateral negotiator, I would assume that since Government is one of the sets of payers that Government sits at the table with insurance companies and the private sector. What would be the opportunities for the Government in the United States to sit at the table and be a force for more uniformity in reimbursement schedules?

Mr. THOMPSON. OK. On the insurance package, I think the first thing we have to realize is that we start with a mandate; everyone

must offer insurance. We are not talking about if you offer insurance, it must have the following features. We are saying you must offer insurance and it will have the following features, and to get it, you will go to this particular or that particular non-profit organization that has been set up. So they have fairly comprehensive packages.

As you can well imagine, they argue about whether some features should be covered or not, and the Germans have been famous for their coverage of visits to spas. They cut back on that recently. They decided that was more than they needed to be paying. But, you know, that is the way that process works.

The packages are pretty uniform, and it is only that a few large corporations might have add-ons. Where perhaps they are required to cover at least 80 percent of the costs of something, they might cover 90 percent and add on that way.

In terms of the bargaining and the role of the Government, the role of the Government varies in the three countries we studied. I would say that the German Government has more of a hands-off approach than the other two. It sort of sets the tone, but it does not consider itself to be a payer. It considers that the sickness funds are private sector institutions and they are financed by what are mandatory contributions, but the Government does not consider itself to be a payer, except for its own employees. So it is not a direct participant in these negotiations. If they don't come out right, the Government may do something about it next year or the year after, but it does not involve itself directly in the negotiations on a day-to-day basis.

At the other extreme, in Japan, the Government technically promulgates the rates, just like our Secretary of HHS promulgates the hospital prospective payment rates, but the process is one in which, prior to that promulgation, a group that has representatives of all of the various interest groups meets, forms a consensus of what the new rate schedule should look like, and then advises the minister. And if you know anything about Japan, these consensuses get formed and once the minister is advised, he doesn't deviate from the consensus. He was probably part of forming it.

So I think that there is clearly a role for the U.S. Government, if we evolved in this direction, to encourage negotiations and to be a participant either directly or indirectly, and through that sort of a mechanism Government policies about how much we want to spend on health care can actually be implemented.

We don't have those institutions here today, so you have to create institutions for negotiation before the Government can involve itself. We don't have those institutions, and because we don't have those institutions, even if you people, the Congress and the Executive, wanted to agree on how much we were going to spend next year on health care, there is no way to effectuate that agreement. That would just be a statement of desire in this country, whereas in these other countries they have developed institutions that allow them to actually carry it out.

Senator GRAHAM. Thank you, Mr. Chairman.

Chairman GLENN. Senator Specter.

Senator SPECTER. Thank you, Mr. Chairman. Mr. Thompson, I noticed that the language of the report says that there is a guaran-

tee of virtually all residents and near universal coverage. To what extent are some not covered?

Mr. THOMPSON. In Germany, if your income is above a certain level, you may opt out of the mandatory system, and about one-third of the people who are eligible to opt out do opt out. As I understand it, technically they are not required to buy health insurance, and most of them do, but about 1 percent of the population does not.

Senator SPECTER. So in excluding those who are extremely wealthy, there is not a problem about ability to pay or access to medical care on their own?

Mr. THOMPSON. No. I think——

Senator SPECTER. So that aside from that factor, it really amounts to universal coverage?

Mr. THOMPSON. Pretty much. In France, I think you can find people who never had an attachment to the workforce, and they have a small program that is kind of a welfare-type program that buys coverage for these people. But we are talking one percent or less of the population in each of the societies.

Senator SPECTER. The report puts some emphasis on the budget controls and notes that the policies in France and Germany, with teeth, have achieved compliance. What experience could we apply in the United States on our continuing effort to hold down costs?

Mr. THOMPSON. Well, first of all, we don't have in place the structures that they have, so that it is not so easy for us to do this. Now, we do have coming on stream in the Medicare program this physician fee schedule that is being adopted and phased in starting next January, and something called volume performance standards. The idea there is that we will have targets and that if the total spending exceeds the targets, then we will take that into consideration next year when we adjust—or two years later when we adjust—the level of the fee schedule.

Senator SPECTER. Do you think we could utilize the experience they have had by putting teeth in the system to contain costs in this country?

Mr. THOMPSON. Well, the first thing we don't have is we are only paying something like 25 percent of the physician bills through the Medicare system, so that the other 75 percent is not being influenced at all by this mechanism. One of the lessons you learn from looking at these other countries is that they have figured out a way to coordinate payments so that virtually all of the health care is being paid for on rates that either are identical or close to being identical for all payers, so that you don't have cost-shifting.

In this country, when one payer squeezes a provider, the first reaction of the provider can be to see if he can find some other payer to pick up the difference. It is especially dramatic in hospitals where Medicare pays less than the total costs and so somebody else is going to have to pay more than the total costs. Indeed, the somebody else, unfortunately, in this country too often turns out to be the insurer that is trying to sell insurance to small businessmen, so that the small businessmen find out that their insurance costs much, much more than anybody else's insurance does because they are the ones to whom all the costs are being shifted.

So one of the keys is that you have a mechanism that covers virtually all of the payers so that they are all paying the same rate. Therefore, when you have some sort of budgeting with teeth, the institutions can't go find somebody else to make up the difference.

Senator SPECTER. I know that you had made a point about the cost-shifting which exists in the United States, and they have pretty much eliminated that?

Mr. THOMPSON. Pretty much; that is right.

Senator SPECTER. If you had to pick a central point of the experience of these three countries that might be applied in the United States, what would it be?

Mr. THOMPSON. I want to emphasize that we are looking at how to control costs, and as we looked at that, we found, first, that a system that is going to be effective at controlling costs must have some mechanism where you can coordinate the payment. It doesn't have to be a single payer, like Canada, and that is one of the points we make in this report. It doesn't have to be a single payer. It can be multiple payers, but you need to have a mechanism for coordinating what they are paying.

You have to have everybody covered. If you don't have everybody covered and you try to cut down on how much you are paying hospitals, the first hospital that goes out of business is going to be the one that is taking care of all the inner-city poor, and that is not an acceptable solution. You have got to have everybody covered.

Then if you have everybody covered and you have coordinated payments—ideally, coordinated payments that are developed through some sort of negotiation process so that the important actors feel that they have a stake in this and their voices have been heard—then you can go to some sort of global budgeting which can be effective in holding down your total spending. But that has not solved everything. You can do this, I think, without necessarily harming quality, but there is nothing in what I have laid out that is going to facilitate quality. That is a different issue.

Senator SPECTER. Mr. Thompson, I join my colleagues in thanking you for this report. It is a thick volume and one which warrants a lot of study, and hopefully there will be some real insights into dealing with such an important national problem.

I thank you, Mr. Chairman and Mr. Chairman, for convening the session, and close with a brief note of regret. This study was requested initially by Senator Heinz, my colleague from Pennsylvania, and it is a continuing legacy to his efforts if we carry forward on this important subject. Thank you, Mr. Chairman.

Chairman GLENN. Thank you, Senator Specter.

I really hate to end this, and what I would like to do is maybe make another round here of the last question or two that people may have. It has been very productive, and Senator Pryor and I were just talking about whether it might be productive to have another hearing where we could flesh out some of these things that we don't have time to get into this morning. I think maybe that would be a good idea. I don't know quite when we could do it, maybe after we are out of session here.

But there are just so many things; I have noted just about 25 or 30 things here that I still have questions about—the levels of doctor expertise, longevity statistics, comparably considered diets,

lifestyle, cap on absolute out-of-pocket, number of people entering, the quality of medicine, cost breakdowns and things like that that I think we all would have additional questions on. I think it would be worth having maybe another hearing, if we can figure a time to do it, and subject to your availability, also. I didn't even complete my list. There are another dozen or so things here.

But I think what we would like to do is have one last round here and let everyone ask just one or two questions, if we could limit it, before we go on to our next panel. We do have another panel still waiting.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman. Mr. Thompson, this has, as the Chairman says, been a fascinating hearing. I am sorry I had to leave for a portion of it. Governor Richards of Texas was testifying downstairs in the Finance Committee on the matter of Medicaid that is very near and dear to all of us.

I would like to ask one area that I know this morning you are not prepared to discuss in detail, and that is the price of pharmaceutical drugs. Senator Cohen and myself and others are going to introduce tomorrow a cost containment package piece of legislation that we hope will begin to contain the cost of prescription drugs. We won't get into that right now.

My question to you is, in the countries that you have studied—Germany, Japan and France—have you sensed that the countries themselves negotiate with the pharmaceutical manufacturers? Do they strike a bargain; do they get the best price? I know that we are paying 50 and 60 percent more for the same bottle of capsules and pills and prescription drugs in this country as they are in Germany, Japan, and in France. Are they negotiating a better deal than we are, or what is happening?

Mr. THOMPSON. They have price controls in those countries, and I am not really well-versed in exactly how they work right now, but I know that——

Senator PRYOR. We have requested the GAO, by the way, as you know, to go forward in this area, and it is going to be, I think, very revealing to see what a good deal they are getting and what a bad deal we are getting. We are going to attack this problem.

Mr. THOMPSON. Yes. We are doing that study for you right now and it will be a fascinating study.

Senator PRYOR. Thank you, sir.

Chairman GLENN. My question would be—and we will either submit additional questions or try and schedule an additional hearing where we can go into these things publicly so everyone can benefit from it. But mine would be, do you have any cost breakdowns, sort of like a pie chart that would compare the different systems you have looked at as far as doctors, hospitals, drugs, the research that comes from these drug companies, the administrative overhead? Can you compare these different systems so we have an idea of how their health dollar is distributed and how our health dollar is distributed?

Mr. THOMPSON. We have a little bit of that. Could I try to work that up and supply you something for the record?

Chairman GLENN. That would be fine. We would appreciate that very much, if you could, and supply it for the record in whatever detail you can. That would be fine.

RESPONSE TO CHAIRMAN GLENN'S REQUEST

The data on each country's spending of hospital and physician care are not adequate for making meaningful comparisons. This difficulty reflects the absence of a uniform international definition for simple concepts, such as a hospital. For example, an element of health care spending that is counted as inpatient spending in Germany may be considered outpatient or ambulatory care spending in the United States. An additional problem is how the services of hospital physicians are categorized. In the United States, these services are counted as physician services, while in other countries they are counted as hospital services. Comparative data are also lacking on research from drug companies and on administrative overhead—both concepts that are difficult to define.

Chairman GLENN. Senator Cohen.

Senator COHEN. Mr. Chairman, just an observation or two. Number one, with respect to the price of drugs in France, according to that Economist article that Senator McCain mentioned, apparently the drug budget in France is out of control. This is also going to necessitate some kind of legislative action on their part.

Number two, there have been a number of inquiries for some kind of a comparative analysis of what types of packages they offer in France and Germany and Japan, compared to the health care packages that we might offer here in the United States. We need more analysis of the differences in terms of physician reimbursement, education, and so forth. I want to at least offer a caveat.

We are dealing with a situation in which there are very, very diverse populations involved. If you look at Germany, it has not nearly the diversity that we have in this country. France is perhaps more diverse, but Japan certainly can hardly be called diverse. With each population or group that we have or segment that we have in this country, we have different cultural habits, different education levels, different health problems associated with various groups.

You mentioned, for example, that in Japan they smoke a great deal more than we do here, thanks to a lot of educational efforts on our part. Yet, I recall reading or seeing a study that was conducted that indicated they have a lower problem with lung cancer in Japan than we do here, and one study suggested it was because they drink a great deal of green tea.

Now, I want to point out that we have different diets. In Japan, they have a much heavier reliance upon fish than meat, example, and that may be associated with cholesterol levels.

So I think that as we are seeking these comparisons to decide which system might be more applicable for the United States or for what elements of each system might be adaptable, we also must keep in mind that we have very diverse populations, histories, and cultures. You have touched upon this. We have a bigger drug problem in this country: Look at crack, for example. Look at what this is doing to crack babies, what that is doing to our high costs of health care. Also, violence, especially from gunshots wounds, in this country, and what that is doing to our bills. I think we have an even bigger problem with AIDS in the United States compared to either Canada or France or Germany or Japan.

So I think it is important that we look for these comparative analyses, but we also have to be cautious that just because one country seems to be doing something better—either they have a lower per-cost or per capita expenditure—it doesn't necessarily mean that system is going to be adaptable in a way that will produce a comparable lower per capita cost for us.

I have other questions I want to raise, Mr. Chairman. I am still not sure about global budgeting and how it really works in terms of giving a disincentive for someone to compensate for the reduction in services, but I will save that for the next round of hearings.

Chairman GLENN. Thank you.

Senator Kohl.

Senator KOHL. Thank you. I just have a quick question to follow up on Senator Cohen. You thought about this and studied it, clearly. That is why we have you here today. I also have the same question and I am interested in your surmise.

When we do get our ducks in line and our system in place, and presumably choose the best system we can, and a few years go by, do you think it is still likely that our costs per person, our expenditures per person in this country, are not going to be as good as or as low as what they have in Germany or Japan—just a surmise—for all of the reasons that Senator Cohen mentioned, and others?

Mr. THOMPSON. My prediction would be that we can slow the rate of increase, but we probably will spend more.

Senator KOHL. Thank you.

Senator COHEN. Mr. Chairman, could I add one other factor that we don't have in this country? We don't have a comprehensive health education program beginning at the earliest years, or a wellness program in this country. The cheapest cost of health insurance is not going to the hospital and not needing the services, and the fact is we don't take very good care of our bodies. We overeat, over-indulge, drink too much, smoke too much, exercise too little, and then we get ill and complain about the high cost of getting well again.

So perhaps we need health education perhaps as much, if not more, than all of these attempts to hold down the costs. We can hold down the costs by changing the way in which we conduct ourselves.

Chairman GLENN. At the risk of really running over, do you have any comment on whether they really do have more wellness programs? That is an area I have been very interested in since some of my earlier incarnation experiences in the NASA program, where they really stressed this idea. How do you make well people weller, if there is such a word, because you don't have doctor access in space? You do now in the big ones, but you didn't back in those days, and so they really put a tremendous amount of emphasis on research in these areas of preventive medicine. Do other nations have a lot more programs like Senator Cohen is referring to than we do?

Mr. THOMPSON. I can't comment on what they do in the school system, whether they may or may not; I just don't know. I know that I have had Germans ask me how we got smoking down in this country. What did you do? How were you able to succeed at that? And my impression is that the corporations aren't quite as much

into it as ours are now in terms of health club memberships and things like that, but that is just an impression. I really can't give you a good answer to that.

Chairman GLENN. I am violating my own rule. We talk about drug costs—Senator Pryor, who had to leave to get back to the other meeting. Do their drug companies do as much research as ours do? Now, our people say they need the high costs, and they have the profitability so they can then put that money back into research, and a lot of them do. Do their drug companies in these other countries do as much research as ours do?

Mr. THOMPSON. Well, it is basically the same companies that operate throughout the world.

Chairman GLENN. OK, that is the answer. We are going to have to move on, unfortunately. It has been intensely interesting. We may want to schedule something else. We will be back in touch with you, and we appreciate your being here this morning. Obviously, there is a great deal of interest in this.

Mr. THOMPSON. Thank you very much.

Chairman GLENN. Our next panel is Dr. George Schieber, Director, Office of Research, Health Care Financing Administration; Dr. Stuart Altman, Chairman, Prospective Payment Assessment Commission; Dr. Paul Ginsburg, Executive Director of the Physician Payment Review Commission.

Gentlemen, we welcome you this morning, and I believe I have seen all of you here all morning, so you have heard all of this going on. We would appreciate your comments on what has gone on this morning, in addition to your own statements that you had prepared. If you choose to give an abbreviated version of your statements, your entire statements will be included in the record.

Dr. Schieber, if you would lead off, please? Am I saying that right, Schieber?

Mr. SCHIEBER. Schieber.

Chairman GLENN. Schieber; OK.

TESTIMONY OF GEORGE J. SCHIEBER, PhD.[1] DIRECTOR, OFFICE OF RESEARCH, HEALTH CARE FINANCING ADMINISTRATION

Dr. SCHIEBER. Thank you, Mr. Chairman. I would like just to highlight my statement and leave the written statement for the record.

It is a pleasure for me to be here today to provide an overview of the performance of the health care systems in Japan, France, and Germany. I would also like to include Canada and the United Kingdom in the analysis, since these are systems, obviously, of interest and have been part of the current debate.

Health sectors in all these countries are important. In 1990, the five other countries spent 7.7 percent of their gross domestic products, about 1/13 of their total production, on health care. The United States, in contrast, spent 12.4 percent of its gross domestic product, or almost 1/8 of its total production, for health care. These other five countries spent, on average, about $1,300 per person for health care; we spent about double that. In the United States,

[1] The prepared statement of Mr. Schieber appears on page 150.

about 42 percent of all health spending is done by the public sector; in these other countries, over 70 percent is. The health sector is obviously a major employer in all countries, accounting for 4 to 5 percent of total employment.

What I would like to do very briefly is three things. First of all, I will talk a little bit about the difficulties of international comparisons. I don't want to belabor that. I would like to spend the bulk of my time going through the tables in my testimony, talking about the expenditure performance of these different systems, and then, lastly, make some generalizations about how the U.S. system differs generally from these five other countries.

There are generic models I describe in my testimony. I don't think the models, in fact, are very useful. No country fits any one model; all countries are mixtures of these models. I think what is particularly important is understanding the performance of these systems and then attributing performance to specific features of these systems or to particular policies that individual countries have undertaken. I think this is exceptionally difficult to do.

All health care systems try to provide universal access to medically-appropriate, medically-effective services in a cost-effective manner, and I think the problem is that it is extremely difficult to assess any of these things. Access is a difficult thing to measure, and certainly to measure objectively. To look at medical appropriateness, medical effectiveness and cost effectiveness, you have to be able to measure the outputs or the outcomes of medical interventions. We are just in our infancy in terms of being able to do that at the level of detail we really need to in order to really understand the specific policies or specific characteristics.

There are the problems in international comparisons that I am not going to get into right now in terms of data. I think there are generic problems to any sort of analysis of social problems even within individual countries. It is very hard to attribute behavior and analyze social policies. I think all we need to do is witness the debate that has taken place in this country on physician responses to fee schedules, or indeed the tremendous controversy that took place over trying to estimate what the cost of the Medicare catastrophic pharmaceutical benefit would be. It is very hard to do these things even within an individual country, much less comparing them across the countries.

Having said that, what I would like to do is just quickly walk you through some of the data in the tables in my prepared statement. What I would like to do is focus on the performance of these six systems in terms of expenditures, availability and use of services, and gross outcome measures.

I think the first thing I would say with respect to expenditures is there are a lot of different ways of measuring expenditures, and people pick their favorite measure to make their case in point. You can measure expenditures in each individual country's own currency. You can measure it in one currency, such as U.S. dollars. You can look at expenditures at a point in time; you could look at it over time. You can adjust it for population and inflation. You can compare expenditures to overall economic performance.

The other point here is that the time periods you choose can be very critical. If you pick a time period shortly after a country has

had a major expansion, you are obviously going to get much lower rates of growth than if you pick a time period shortly before the expansion. So I think these comparative analyses are sensitive to all these things.

I think in trying to understand what has been happening in any of these countries, you need to look at more than one measure. The most commonly used measure is the ratio of health spending to gross domestic product—in a sense, the amount of total production in each country that goes to the health sector. My Exhibit 1 shows that for the six countries in question from 1970 to 1990, and you can see that in 1990 the United States spent 12.4 percent of its gross domestic product on health care, compared to 9 percent in Canada, 8.9 in France, 8.1 in Germany, 6.5 in Japan, and 6.1 in the United Kingdom.

I think if you look at the graph, two things really jump out at you. One is the near equivalence of the U.S. and Canadian ratios in 1971 and the U.S. and German ratios in 1975. I think the second thing that is perhaps troubling from a cost perspective in this country is if you look from the early 1980's onward, you can see that virtually all five of the other countries have stabilized their shares of health spending as a percentage of the gross domestic product, whereas our percentage keeps increasing. In fact, the preliminary estimates for the United States for 1991 will take us from 12.4 to some place over 13 percent. I just recently received these data about two weeks ago. In comparing the 1989 to 1990 increase, we went up 9/10 of a percentage point, which was more than double any other country's increase during that one-year period.

Now, this ratio, of course, is a function of a number of things. The way this ratio changes really depends on how much health spending changes, but it also depends on how the gross domestic product changes. So, to get a fuller picture of what is happening, you really need to look at both pieces.

My Exhibit 2 looks at growth in per capita health spending. This is not adjusted for inflation, just per capita health spending in different countries. What I have done here is created an index by assuming that each succeeding year is just that year's expenditures divided by the 1970 base year. So if you look at the table, you can see that in 1990, the value of the United Kingdom being 13.86 means that its spending in 1990 was 13.86 times what it was in 1970.

Well, you get a rather different picture if you look at growth in nominal per capita health spending. Indeed, people who are opposed to the Canadian system will often look at these numbers to show that, in fact, Canada has increased quicker than the United States on this measure over certain time periods. In fact, for the entire 1970 to 1990 period, the 20-year period, the U.S. is really the third lowest, with the United Kingdom, France, and Canada increasing at higher rates. Indeed, Germany is the lowest for most of the time period. So here is one measure—you can get a different picture of performance using this.

Now, on the other hand, it is a rather incomplete picture. I think you really want to see how health spending has been going up in relation to gross domestic product. Indeed, some economists will argue that countries that have had faster growth in their gross do-

mestic products will, in fact, have faster health spending because of increases in wages and input costs being generated by the higher economic growth in the country.

Exhibit 3, explains some of the mystery with what has been happening to the U.S. health-to-GDP ratio. It shows growth in nominal per person gross domestic product for the 20-year period, and you can see here that for the 1970 to 1990 and the 1970 to 1980 period, the U.S. had the second lowest rate of growth in its per capita output.

Perhaps most importantly, without getting too bogged down in these numbers, if you look at just the 1980 to 1990 time period and compare our rate of growth in gross domestic product with our rate of growth in health spending, we have, by far, the largest difference of any of the countries. Between 1980 and 1990, our per capita health spending went up 9.2 percent a year. Our GDP went up 6.2 percent a year. That is a three-percentage-point difference. Germany, in fact, had GDP going up faster than health spending, which accounts for the fact that their ratio is falling about a half a percentage point less rapidly. In Japan and the United Kingdom, health spending only went up 1.2 and 0.8 percentage points, respectively, a year faster than the GDP. In France, it was 1.8, and Canada had health spending only going up 2.1 percentage points quicker than GDP, compared to a 3-percent difference in the United States.

Now, another way you can look at health spending is to try to adjust for inflation. Once you have taken account of the fact that wages and salaries go up and equipment costs go up what has been happening to health care—let me put it this way, to the real volume and intensity of health care services being provided——

Senator COHEN. Mr. Chairman, could I ask one question here on the point he just made?

Doctor, did you mean to suggest that there was a correlation between sort of economic prosperity and lower health care expenditures, because you started saying that this is the critical chart? When the GDP starts to go up in Germany, the costs start to go down. You are implying that there is some kind of a correlation between one's general productive capacity and prosperity and lower health costs.

Dr. SCHIEBER. Well, I think there is a mathematical relationship. Obviously, the ratio depends on the two pieces. The point I was making, which some economists have made, is that higher GDP growth may be associated with higher wages, in general, and therefore push health spending up at a relatively higher rate. That was the only point I was trying to make, Senator.

As I said, another measure of looking at health care spending is to try to adjust for what has happened in terms of inflation. How much has the real volume and intensity of services gone up? This is a particularly difficult area for international comparisons because you don't really have comparable medical care price indices across countries.

But one way you can do this is you can try to deflate health care spending by the increased costs of all goods and services in the economy and this gives you a measure of the opportunity costs or

the value of the foregone consumption and investment opportunities in the non-health sector.

When we do that in Exhibit 4, as you can see here, the United States has the second highest rate of growth after Japan. The other point that needs to be made here is that our 1970 base year level was a lot higher, so we have a very high rate of growth off a very high base year. I would just point out if you look at the compound annual rates of growth in health spending or the opportunity costs foregone from 1980 to 1990, we find the U.S. has by far the highest. Our rate of growth of 4.8 percent per year is much higher than any of the other countries, Canada being the second highest at 4 percent per year. That is a fairly large difference when you are compounding it over a 10-year period. So, based on this measure, it would appear that, again, U.S. costs are going up, and indeed departing substantially from those in other countries in terms of rate of growth.

Now, another way to look at health spending is done in Exhibit 5, where we can compare health spending in a common currency. In Exhibit 5, we use a special exchange rate to put health care spending into U.S. dollars; it is a special exchange rate that, in effect, corrects for price differences across countries. We can see both the trends and the 1990 values, and in 1990 the U.S. spent $2,566 per person. This is 43 percent more than the $1,795 spent in Canada, the second highest country. We spent 86 percent more per person than France; 99 percent more, almost double, what is spent in Germany; 131 percent more than spent in Japan, and almost three times what is being spent in the UK. Again, here you see, as with the health-to-GDP ratio, a widening gap between the U.S. and each of the other countries.

There is a well-known economic relationship between health spending and the wealth of individual countries, which Exhibit 6 looks at. Exhibit 6 shows the trend line between the country's wealth as measured by its gross domestic product and its health spending. When we look at the average relationship, which is the solid line, we find that our health spending is about $300 higher than would be predicted based on the average relationship between health spending and GDP found for these six countries.

Interestingly, if you drop the United States from the trend analysis—in other words, we just look at the relationship between health spending and GDP just for the other five countries, which is the dotted line in Exhibit 6—the United States is about $700 above the trend line.

Now, I have been fitting these trend lines for the last several years for the 24 Western industrialized countries that are members of the OECD. In 1987, we were $450 above the trend line for the 24 countries. In 1989, we were $600 above the trend line. I ran it again last night just for the heck of it for the 1990 data and we were $750 above the trend line. So this again suggests that we are moving away in terms of our spending based on these measures, after trying to correct for differences in GDP across countries.

Now, these spending figures obviously translate themselves into service use and availability. Exhibit 7 is an attempt to look at the availability and use of inpatient medical care services and physician services in these six countries. As you can see here, in terms

of inpatient medical care beds per 1,000 people, the U.S., at 5.1, has about the lowest. In terms of inpatient days of care per person, 1.3; we are the lowest. In terms of percent of the population admitted to inpatient medical care, we are the second lowest, after Japan.

In terms of average length of stay, we have the lowest average length of stay. I think the 52 figure for Japan obviously comports to something that Mr. Thompson said, that certain countries use hospitals for long-term care for nursing home care patients, and there obviously are some problems in comparability here. But I will say, when I have done this same analysis at detailed diagnosis levels for only acute care hospitals, you get the same kinds of patterns, that the stays in the United States are much shorter than they are in other countries.

In terms of occupancy rate, we have the lowest occupancy rate of the six countries here, at 69 percent. We have about an average number of physicians in terms of physicians per 1,000 population. In terms of outpatient consultations—I believe also a point Mr. Thompson made—we are relatively low compared to a number of these other countries.

Other data which I have not presented here on costs show that we basically have the highest cost per bed, cost per admission, cost per stay. Our fees are higher than any of these countries. What you seem to have is a situation—and perhaps I could characterize it just using a rough German example—where we have twice as many employees per hospital bed as the Germans. Our stays are substantially shorter. Yet, our costs per stay and per day are substantially higher.

We tend to practice a much more intensive style of medicine in the United States than is practiced in these countries. We use fewer services, but we tend to do much more intensive things to people during these shorter stays. I think the key missing ingredient, though, from this, is that we don't really know what the effect is on outcomes, and that is the thing that, with all these international comparisons, troubles me the most.

We don't really know at a detailed enough level that the quality outcomes in the United States are better, or much better, or worse than they are in these other countries. We just do not have the data to show that, at the level I think we need, to evaluate the kinds of policies that this Committee has raised.

The kinds of outcome measures we do have are in Exhibit 8. These are the usual ones we tend to look at in terms of infant mortality and life expectancy. And as you can see here, in terms of the infant mortality statistics, the United States, with 10 deaths per 1,000 live births, has the highest among these six countries. It actually ranks 20th out of 24 for the OECD.

Life expectancy at birth—again, with males, we are the lowest of these countries. We rank 17th among the 24 OECD countries. For females, we are slightly better than the UK, but fifth of the six countries here, and rank 16th. Actually, I don't think these measures are terribly useful in terms of portraying the effectiveness of the health care system because there are so many other things that affect infant mortality and life expectancy—lifestyles, nutrition, housing, the whole list of social factors.

Interestingly, for life expectancy at age 80 we get a rather different result. One might argue that this is an area where the availability of a lot of extensive technology might make a difference, where the lifestyle factors might be a little bit less important than they are in the other two measures. For life expectancy at age 80, we see that, for males, the United States is tied for first with a couple of the other countries, and for females we are second. Indeed, when you look at it for the 24 OECD countries, we also rank second, tied with a couple of these other countries. But, nevertheless, we seem to do a lot better on that measure.

Senator COHEN. So if you make it past your first year, you have got a better chance of surviving to 80 in this country.

Senator PRYOR. Why do we do well on that end of the spectrum and very pitifully on the lowest end? What makes that?

Dr. SCHIEBER. Well, as a researcher, I will say that, obviously, we need to do a lot more in this area, but I am hypothesizing that this may be an area where the fact that we seem to have a heck of a lot more technology and a lot more availability of high-tech equipment might make a difference. For life expectancy at birth, I think the social factors may dominate.

But even in infant mortality—this was a point that was made earlier and I think it is a terribly important one—when you look at death rates for low birth weight babies, to the extent you can get data, we actually do better than a lot of other countries. However, because the death rates for low birth weight babies are so much higher than they are for non-low birth weight babies, and we have such a larger proportion of low birth weight babies than other countries, it raises our infant mortality rates, so our statistics look terrible. On top of that, it adds tremendously to our health care costs. But we don't have a refined enough measure, I think, to get at that, and you need to get at better measures to better understand what these gross statistics mean.

Senator PRYOR. [Presiding.] Doctor, I wonder if we could begin now winding up and moving to Dr. Altman. Senator Glenn has to meet the Attorney General from Ohio in a few moments. Senator Cohen and I have to leave in a few moments, so we want to kind of move along as quickly as we can and get a few questions in, I assume.

Could we move to Dr. Altman now?

Thank you very much, and your full statement will be placed in the record.

TESTIMONY OF STUART H. ALTMAN,[1] CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. ALTMAN. Thank you, Mr. Chairman. I am the Dean of the Heller Graduate School at Brandeis and Chairman of the Prospective Payment Assessment Commission. This is a subject about rising health care costs which I have been focusing on for 20 years in my life. I want to make it very clear that while the Commission itself has spent a lot of time studying this, it has not reached any

[1] The prepared statement of Mr. Altman appears on page 177.

conclusions. So the comments I am going to make this morning are my own and not those of the Commission.

Let me just focus on one overriding issue which has been touched on several times this morning, and that is what has happened in this country is not only that our costs are rising so fast—I think George and others have documented that very well—but that because there are so high, everyone is trying to figure out ways to avoid them. We have developed a gigantic ponzi game in this country where they are being shifted right and left, and we here in Washington are now joining in in a substantial way in that game, which we never were in before.

We at ProPAC just recently did a study, and just to give you some orders of magnitude, uncompensated care—basically, a hospital gets back about 20 cents on the dollar. From Medicare, it is now getting back 90 cents on the dollar. From Medicaid around the country, it is getting 75 cents on the dollar. But a private payer from a commercial insurance or Blue Cross company is paying almost 130 cents on the dollar.

Senator PRYOR. Excuse me. What do you mean? Translate that.

Mr. ALTMAN. In other words, the cost to that patient is, say, one dollar. The private payer is paying $1.30, where Medicare is paying 90 cents and Medicaid is paying 75 cents. So if the same patient were to go into a hospital, one being insured by Medicare and the other being insured by Blue Cross, say, for example, the Medicare patient would pay 90 cents for every dollar of costs, where the private payer would pay $1.30. The difference is 45 percent, on average, and this gap is getting wider and wider and wider.

I spend a lot of time with American corporations these days. The biggest difference in our country between what existed when I was at this in the early 1970s when I was in the Nixon administration and where I am today is American corporations now no longer can bear this burden, from the biggest companies we have down to our smallest. So they are pulling back in their benefit packages; they are not insuring spouses. They are, in fact, not insuring anybody, which is adding to the uncompensated care. That gap is getting wider and the system is exploding.

When you look at other countries and you say what can we learn from them, I thought, as Senator Glenn has pointed out, and all of you. One overriding issue comes at us over and over again. Every one of these other countries has a level playing field; everybody pays the same rate. You can't shift.

There are differences in utilization—you didn't get into this—in the German system. German funds are different. They are not exactly the same, but they pay the same rate when their patients go to the hospital, and they pay the same rate when their patients go to the doctor, except for a few that are at the high income levels. The second is every country in one form or another has developed a national policy vis-a-vis how much they are going to allocate for health care. Some of it is very tight and some of it is sort of loose.

Now, in my testimony I have proposed a solution or a proposal which builds on the German system in the following way. I believe, having watched this for 20 years and having watched what is going on in ProPAC from the Medicare program, that if we were to level

the playing field, we need to establish some overarching national expenditure target, not necessarily a tight limit.

Senator COHEN. Can I interrupt just for a second here?

Mr. ALTMAN. Yes, sir.

Senator COHEN. When you talk about other countries having the same rate for hospitals or doctors, isn't there a difference between looking at Germany or France or Japan that might have a fairly small geographical area with very little discrepancy between weather, and the United States, where we have got higher costs to do business here in D.C. or New York or Bangor, Maine, than Seattle, Washington?

Mr. ALTMAN. Yes; a fair comment, Senator. I did not mean that the rate should be exactly the same in Maine as it is in Florida or it is in Texas, but everybody in Maine, in Bangor or in Augusta, should be paying the same rate for the same procedure. That is what I meant.

We, in Medicare, have developed such a system. What we pay your hospitals in Augusta and Bangor is different than in Boston or in New York, but they would be the same for the same service, and everybody, including the Federal Government and the State Government, would have to pony up the same amount.

Now, to make this thing tolerable in terms of expenditures, we need to set guidelines, make priority calls in a society that is as diverse as ours, and yet allow a lot of diversity to go on. So in my testimony I talk about the need to create a national expenditure board. I think it is very important, because of the nature of our system, that it be outside the day-to-day operations of Government.

If we are going to maintain a public-private partnership, that expenditure board should be a public-private board. I liken it to the Federal Reserve Board. We count on a group of individuals that are not Government employees. Even though you have ultimate responsibility for the people indirectly, you allow the Federal Reserve System to operate our banking system independent of day-to-day operations. I think it is very important that we do the same thing for health care.

The Congress would have an important role, similar to what goes on in Germany. When Larry Thompson said the German Government backs away, it backs away, but it looks over their shoulder every day. What it does is it says, if you allow that payroll tax to grow, I am going to impose restrictions on you. And every three years, the Federal Government in Germany comes in and reviews the situation. Like it did with prescription drugs. It said, we told you six years ago to control prescription drugs; you didn't do it, we are going to do it. They did the same thing in the 1970's on physician fees.

But on day-to-day operations—it is independent. It is operated independent, like our Federal Reserve System. If you do that, you can equalize the payment system. One of the things I want to make clear—underneath it, we should allow competition to prevail. We have a lot of advantages in this country and we should not lose them. Our length of stay is significantly lower, our admission to hospital is lower. We make much better use of outpatient care, of home care. Those other systems are much more rigid than ours. They are more rigid; they have not the flexibility.

We ought not to lose that advantage, and I think the advantage comes from independent competition, independent providers trying to do a better job, and corporations worrying about the health of their workers. I think it would be a big mistake to pass this all to Government. I spend a lot of time; they worry about wellness, they worry about utilization. We can't do this here in Washington; it is not possible. Yet, we need a national target; we need a national set of limits.

So, that is what we have learned from Germany, and I think we have learned from Canada and the UK that when you tighten the system too tight, whether you call it rationing or whatever, they do restrict their system more than we do. Some restrictions are inevitable because you can't cut back on the rate of growth of health care spending and not put restrictions. I mean, that is an oxymoron; you just can't do it. But how you impose those restrictions is very important.

So I think there is a lot to learn from these other countries, but I agree with many of you. There is no way we are going to just lean into Germany or into Canada or into the UK and pluck that system and put it in ours. We are too different a country, but there are things to learn.

Senator PRYOR. Dr. Altman, if I might—with Senator Cohen's consent, if we could get Dr. Ginsburg to join in and make his statement, then for a few moments we might have a little free-for-all here. Thank you, Dr. Altman.

Dr. Ginsburg.

TESTIMONY OF PAUL B. GINSBURG,[1] EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. GINSBURG. I would be glad to just hit the highlights of my statement.

Senator PRYOR. And we will put your full statement in the record.

Mr. GINSBURG. I focused on the prospects for cost containment and commented on the relevance of the experience in other countries. The Physician Payment Review Commission's mandate has evolved over a short number of years from an initial focus on prices in the Medicare program, to additional considerations of rising volume of services in Medicare, to examination of prices and volumes in the health care system. Increases in physician expenditures are due to rising prices and increased services per capita. Both have played a substantial role and have dwarfed the contribution of demographic change to expenditure increases.

The major obstacle to containing costs through price is the fragmentation in our system. Payers' ability to constrain price is limited by inability to coordinate with other payers. While Medicare has had success in this area due to the size of the program, the point may arrive at which further constraint limits access to care. Medicaid has already passed that point in many states. All-payer mechanisms deserve attention as more effective methods to deal with price, especially in conjunction with health care reform.

---

[1] The prepared statement of Mr. Ginsburg appears on page 185.

Controlling volume can be addressed through a wide range of options. The Federal Government can play a key role beyond managing its own programs by supporting outcomes and effectiveness research and the development of practice guidelines and reforming the malpractice system. In addition, the development of uniform data systems could permit payers to substitute profiling of medical practice for the more intrusive methods of reviewing utilization on a service-by-service basis.

The Commission's work on cost containment has benefitted from studying the German health care system. The insights have included how to estimate resource-based practice cost components of the relative value scale, how to coordinate rates among numerous private payers, and how to use profiling to monitor the appropriateness of service use. Without contemplating whether the German system would be appropriate for the United States—no system would transplant well, as other speakers have said—we have learned a great deal about the feasibility of some policies that have not yet been tried in this country.

Thank you, Mr. Chairman.

Senator PRYOR. Thank you very much, Dr. Ginsburg. The question I have—in the three countries that the GAO studied, does this panel happen to know in those three countries—and this may have been asked while I was out of the room—about the malpractice situation in those countries? Do you have the number of malpractice cases? I probably should have asked that to GAO.

Mr. ALTMAN. We were with GAO in Germany, and I have looked at the other countries, and they are infinitesimal in comparison to ours.

Senator PRYOR. Is it harder to get into court or——

Mr. ALTMAN. It is much harder. First of all, they have a different judicial system and they have a different set of expectations about what they can expect. And because they have universal coverage, they don't worry so much about the health care cost because it is going to be picked up, and there is a more uniform standard of expectations on the part of a physician. So it is a different legal system and it really is different expectations.

Senator PRYOR. Dr. Altman, thank you. Let me ask Dr. Ginsburg one question, then I will yield to my friend, Senator Cohen. If we had ten doctors practicing medicine, practicing physicians at this table, and we said, why are your costs so high, probably eight of those doctors, would say, well, if it weren't for all these lawyers suing us all the time and all these malpractice cases right around the corner, we could really reduce our fees. We could really do a lot, but we have to build in those fees.

Is that a valid response, and if so, how much could we save, if any, if we removed that argument from the physicians?

Mr. GINSBURG. Well, there really are two costs of the malpractice system. One is the premiums that physicians pay, which need to be passed through in their fees, and I believe that physicians' premiums for malpractice are about five or six percent of the revenues that they take in. So, that is substantial.

Senator PRYOR. So the insurance premiums are five or six percent?

Mr. GINSBURG. That is right. That is the premiums they pay for liability insurance. Now, that we know pretty accurately. What we don't know is the cost of the extra procedures that they pursue because they are concerned about being sued, and this is something that it is, as you can imagine, very difficult to do a quantitative estimate of. I believe Congress recently asked the OTA to do a very substantial study of that, but they are just beginning.

One thing that always strikes me is that it is certainly on the minds of enough physicians, in the sense that it is a barrier to their practicing in a more efficient, frugal manner. Other aspects of the malpractice system are problematic in the sense that it is not compensating injured patients very well and it is not providing a very good spur to physicians to practice quality care. So it seems to me, as part of reforming this system, reform of malpractice has to be a component.

Senator PRYOR. Thank you, sir.

Senator Cohen.

Dr. SCHIEBER. If I could just add——

Senator COHEN. Go ahead, doctor.

Dr. SCHIEBER. The AMA estimates that in 1989 the premium costs were about $5.6 billion, and the defensive medicine costs—I don't know how the estimate was derived, but the defensive medicine and the premiums would be $20.7 billion.

Senator PRYOR. Wait a minute. Billion?

Dr. SCHIEBER. Billion. That is the AMA's estimate.

Senator PRYOR. Thank you.

Senator COHEN. Dr. Schieber, as I listened to your recitation of a cascade of numbers, it occurred to me that we have to at least look behind the numbers themselves. After all, a person can drown in a body of water that averages about three feet; it depends on which end you are swimming in.

But lower hospital stays, less inpatient days, lower occupancy—those all sound very positive, but is that due to the high costs of going to the hospital, so that people don't go in or they are pushed out because the hospitals aren't getting reimbursed for the full cost? So we have, in fact, set up a system whereby people, number one, are discouraged from going in; number two, they are pushed out once they get there because they can't afford to stay. So the numbers look terrific, but does that account for a healthier population?

Mr. ALTMAN. No. I think it is fair to say that for some sub-populations, it is an issue of lack of insurance, but if we take the Medicare program, which has a good hospital coverage system, even in the Medicare program, because of the nature of our health care delivery system, we hospitalize less often in comparison to other countries, and when they are there, they come out quicker.

We have changed fundamentally the style and practice of medicine in this country. I think from what I am able to see it is dominated by the fact that we realize that we are dealing with a very expensive commodity. I think the health care community should be commended. We are so busy criticizing them all the time. We should commend them for doing that. Other countries have not done that because they have not had the incentive.

On the other hand——

Senator COHEN. The question is about not having the incentive. In Japan, for example, they have longer stays in hospitals. It was suggested that the reason they have longer stays in hospitals is because they have no place else to put them. They don't have nursing homes, they don't have a long-term care program.

Mr. ALTMAN. That is right.

Senator COHEN. So it is cheaper to keep them in hospitals, and that accounts for it. But how do we apply that here? Do we say the cost is driving our practice of medicine in the sense that we are developing more costly, more sophisticated, and more successful technology for our population, so we are paying a much higher premium, but we are also seeing—you told us to be very careful of this, Dr. Schieber—a better result as a result of that development?

Mr. ALTMAN. Well, I think George indicated very clearly that we don't know. It is difficult to gauge results. In terms of the aggregate statistics that we see, I think the statistics are mixed to very negative, not better results. Now, if you define it differently, though—style of living, and at least for most of us we would prefer not to be in the hospital than to be in the hospital, and the less time we have to spend in the hospital is a positive statement—I think you would have to give this country high marks. We do not keep our people. In other countries, their lengths of stay are 50 to 100 percent higher for the same procedure.

Senator COHEN. Is it because the cost is lower? I guess I am coming back to that. Are they staying longer because it is less expensive, or are they staying there because they need the treatment?

Dr. SCHIEBER. I think, Senator, that is a hard question to answer. It has been stated in a number of these countries that you may have longer stays because the global budgets for those hospitals depend on having the beds filled, and that has been cited as an adverse effect previously encountered in some other countries.

I would agree with what Stu has been saying. You see these big differences. We don't know the outcome side, which I think is one critical missing ingredient, but there are four factors if you look at a cost per hospital stay. Do we have a sicker population? Do we have more amenities in our hospitals? If you compare us to the United Kingdom, that is true. You have people in 100- or 200-year-old hospitals who are largely in wards, as opposed to Americans in semi-private rooms who would probably not going to put up with that level of care. That is a factor; it is probably not a huge one, I wouldn't think. A third one is are we more inefficient than these other countries, and the fourth one is the quality outcome issue.

These are very difficult questions to answer, and I think they are even difficult for us to answer in this country. I am sure you gentlemen are continually asking my bosses the question of, with negative Medicare hospital margins, how can Medicare continue to do this. And the response comes back, well, with a 60-percent occupancy rate, an efficiently operating hospital should be able to live off Medicare. But can we define an efficiently operating hospital even in this country? It is a very difficult thing to do.

But I would agree with Stu. I don't think the statistics really reflect lack of access. I think for certain sub-populations, that may be

true in this country, but on the other hand, generally, I don't think that is the reason we tend to have lower rates.

Mr. ALTMAN. Let me just, if I might—we have heard a lot of discussion about administrative costs and how negative they are. I think one ought to be careful on this issue. In the 1970's, we put tremendous pressure on hospitals in terms of overuse. When I say "we," I am talking about the private sector and the Government. We created all kinds of administrative mechanisms to go in and review hospitals to find out why patients were there longer, and we significantly cut the length of stay.

Now, how did we do that? It wasn't magic; it didn't just happen. It happened because a lot of people were looking over the shoulders of doctors and hospitals and said, why do you need to put people in on a Friday when you are not going to operate on them until Wednesday; why do you need to leave them in for two extra days? They kept asking questions. I think those administrative costs paid off.

Now, your question—I think it was the costs that generated a concern on our part throughout the country, in the private sector and in the public sector, to reduce the length of stay and the use of this high-cost system. I think we should take credit for that.

On the other side, we have allowed the outpatient side and the home side to explode with no controls. I think our hospitals today in many senses are the most efficient hospitals in the world, if you define efficiency in terms of getting people in there only when they need to be there and getting them out as quickly as possible. Once they are in the hospital, a lot of things happen to them and there is some concern that all of it isn't really that necessary. But if you take a bigger view, our hospital systems have changed fundamentally from where they were 20 years ago.

Now, I am very critical of a lot of parts of our system, but I think we should give some credit occasionally. It is not all negative.

Senator COHEN. No one has mentioned paperwork, the burden of paperwork. Any analysis on that? Dr. Altman, you say that the administrative costs are well justified because——

Mr. ALTMAN. Well, I don't want to overdo that. I think that there are administrative costs in terms of complexity of plans that should be abolished, different billing systems that could be abolished. But I think when we just toss around $100 billion for administrative costs, I think the amount of paperwork there is quite trivial compared to a lot of others. I know my friend, Dr. Ginsburg, wants to talk about it, so I won't take it away.

Mr. GINSBURG. Yes. What I would like to do is really to suggest directing your attention not so much on the bill-paying parts, because many physicians have told me that they have got it all computerized now; they just punch in a button as to which insurer it is and the computer spits out the right form.

I think where we have very large administrative costs that other countries don't have is on the side of marketing and distributing the insurance, the fact that when insurance companies sell to individuals or to small companies the costs of marketing are a very significant part of the premium, and I think that is where there is some potential for some administrative savings.

Senator COHEN. David, you were going to——

Senator PRYOR. Yes. Dr. Altman, you seem to me to be a real advocate for Medicare and the efficiencies of Medicare. We find very few witnesses who come before any committee in the Congress and say that, and I am very proud to hear you say it.

Some system of health care is going to emerge in 1992. There is going to be a national health plan of some kind. The question is what kind, and who is going to pay for it and how it is going to be structured.

Mr. ALTMAN. Right.

Senator PRYOR. So it is not a question of is something going to happen in 1992. The answer is yes.

Mr. ALTMAN. I hope so.

Senator PRYOR. Now, what would happen if we, rather than starting at the lowest end with infants and workers, and whatever, we build upon the Medicare structure? Say, 65 and over, you are covered with Medicare; what about moving that down to 55 and taking that burden off of the employer and putting that burden on a gradual basis onto the Medicare system? Does that work or not work?

Mr. ALTMAN. Well, anything could work. I mean, the answer is, sure, it could work. I think that is one way of looking at it. The other way of looking at it is to take some of the characteristics of the Medicare payment system and impose it onto the private—I mean, there are different ways of going about doing this. That would be my preference.

Senator COHEN. In other words, you pay 90 cents on the dollar for——

Mr. ALTMAN. Well, I think you need to get the dollar down. I talk to a lot of hospitals. I suspect that if they got 90 cents on the dollar from every payer, from every patient, they would take it tomorrow, and be guaranteed that we would wipe out uncompensated care. They would gladly take—now, I don't want to speak for the industry. I am not in it, but I think if we could get 90 cents on the dollar for every patient and we stabilized that and we didn't have them having to send out all the bills the second and third time and have collection agencies and have different forms, they would buy it.

Senator PRYOR. As a bottom line, don't we really at this time in 1991 have a national policy on health care, and that policy is those who have insurance pay for the ones who don't? Isn't that our policy?

Mr. ALTMAN. We have created, as I said to you, the biggest, most complicated ponzi game the world has ever seen. You are absolutely right. We have a hidden tax here of 40 percent. You know, people talk about no tax increases. We have a gigantic tax increase, the health care hidden tax increase on private insurance.

Senator PRYOR. In the State of Maine and in the State of Arkansas, I would venture to say—and the figure was about eight percent a decade ago, where they just wrote off eight percent of all the bills collectible. I would venture to say that today it is 20 percent.

Mr. ALTMAN. No.

Senator PRYOR. Fifteen?

Mr. ALTMAN. I think it varies a lot from hospital to hospital, but the big issue isn't what you write off. As I said, Medicaid—that is

not a write-off, but they are paying, depending on which State you are in—if you are in Illinois, they are paying 55 percent of the average costs. In California, they are paying 60 percent. In some States, they are paying 80 percent. On average, it is between 70 and 75. So there is 25 cents per dollar of costs that are being shifted, then, to the private. So it is not only the uncompensated care.

Senator COHEN. Could I ask a final question? We keep citing the German system as a model in many respects. I would suggest that the history of the German people and the nature of their relationship with their Government as far as authority and discipline is quite different than what we know here in the United States. They are much more accustomed to taking directives from the Government in terms of setting guidelines and then adhering to them than we might be in this country, and I think there is probably more discipline in the Bundestag than there is in the United States Congress. And I am understating that in terms of the discipline aspect.

What would be your assessment of the likelihood of hospitals and doctors in this country being willing to negotiate with an outside authority, something outside of the Federal Government or quasi-governmental authority, to negotiate their fees and reimbursement rates?

Mr. ALTMAN. Well, let me take a shot at it. I think if they thought the system was fair and that it wasn't jammed down their throat, and if they participated in it, we would have a shot at it. I think I, along with most Americans, don't like the idea when we are told what it is and we have to abide by it. But I think if we participated in it and it was viewed as fair, I think they would, and that is why I am proposing that it be outside Government and it be negotiation, but that there be targets that say, you know, we just can't continue to have health care going up three times faster than our GNP and we begin to slow that down. So maybe I am being overly optimistic, but I do believe we have a shot if it is done fairly.

Dr. SCHIEBER. I think the other factor that I would add to what Dr. Altman said is especially if the physicians saw the trade-off as having increased clinical autonomy for giving up a little bit of the flexibility of setting fees, it might be more attractive to them. They feel horribly overregulated now with the Government breathing down their throats. You don't have this kind of a situation, necessarily, in Germany or Canada.

Mr. GINSBURG. From speaking to physicians, I gather that perhaps it is the experience they have had over the last few years with the policies that have affected them from governments has made them think that if they could somehow set up a process that involved the key interests but that was insulated somewhat from annual budget reconciliation decisions, they would take that chance and proceed, despite the different culture here.

Senator COHEN. That is all I have. Thank you very much.

Senator PRYOR. Senator Cohen, I want to thank you for participating and being an integral part of this, requesting the GAO to do this study, and also being a part of choosing our very splendid witnesses this morning.

In conclusion, I was just sitting here kind of thinking. It looks to me that the Federal Government generally does a pretty good job

in one thing, raising money. We are pretty good at raising money. We can extract dollars from people; we are good at it. We are not very good at spending money and we are not very good at running businesses.

We are not very good, for example, I don't think, at running hospitals. There are some exceptions and some good ones. I don't think we are going to be very good at running a national health program where we do the actual day-to-day running of that program. I can't speak for Senator Cohen, but I hope we can have national access somehow or another, with private enterprise being involved in this thing, and I bet it will be a lot better.

But your statements today and the information you have given us—Senator Cohen has so eloquently used the word "cascade" of facts and figures—have been very, very enlightening to me, and I am sure to all of the Committee. We may, in fact, as Senator Glenn said, want to have you back to participate in a subsequent hearing in this area.

Mr. ALTMAN. It would be our pleasure.

Senator PRYOR. We want to thank you, and we will put your full statements in the record.

Our meeting is adjourned. Thank you.

[Whereupon, at 12:30 p.m., the committees were adjourned.]

54-832 O - 92 - 3

APPENDIX

United States General Accounting Office

GAO

Report to Congressional Requesters

November 1991

HEALTH CARE
SPENDING CONTROL

The Experience of
France, Germany,
and Japan

GAO/HRD-92-9

Printed copies of this document will be available shortly.

U.S. GOVERNMENT PRINTING OFFICE

GAO Form 171 (12/87)

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-244648

November 15, 1991

The Honorable William S. Cohen
Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable David H. Pryor
Chairman, Special Committee on Aging
United States Senate

The Honorable John Glenn
Chairman, Committee on
Governmental Affairs
United States Senate

This report, prepared at the request of the late Senator John Heinz, reviews aspects of the health care systems of France, Germany, and Japan. The report describes these countries' methods of providing universal coverage through their health insurance and financing systems, their policies intended to restrain increases in health care spending, and the effectiveness of these policies.

Last spring we issued a report on the Canadian health care system: Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90, June 4, 1991). As in that report, we do not endorse in this report adopting the health systems of the countries we reviewed. Instead, we believe that the merits and flaws in these countries' systems provide the United States with information that may be useful in solving U.S. health care problems.

Unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time, we will send copies to interested parties. The report was prepared under the direction of Janet L. Shikles, Director, Health Care Financing and Policy Issues, who may be reached on (202) 275-5451 if you or your staff have any questions. Other major contributors to this report are listed in appendix III.

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

EXECUTIVE SUMMARY

PURPOSE

For two decades, the growth of health care spending in the United States has outpaced the growth of the rest of the economy--a pattern with troubling consequences for business, consumers, and government. Persistent pressures caused by rising spending have called forth various remedies, but success in containing spending has been elusive.[1] Consequently, policymakers and analysts have sought insights from the experience of industrialized countries that appear to control spending growth better, provide universal access to health care, enjoy better health, and spend a smaller share of their national income on health care.

The Ranking Minority Member, Senate Special Committee on Aging asked GAO to report on the lessons that the United States can draw from industrialized countries that spend less on health care. The Chairmen of the Senate Governmental Affairs Committee and the Senate Special Committee on Aging later joined in this request. In response, this report (1) describes how three of these countries--France, Germany, and Japan--organize their health insurance systems, achieve universal coverage, and regulate payments to providers; (2) describes the policies used in each country to contain spending for physician and hospital care; and (3) determines whether these policies were effective in moderating the rise in health spending.

BACKGROUND

A rapid escalation in spending and a noticeable narrowing of access characterize the recent experience of the U.S. health care system. Between 1970 and 1990, the share of national income spent on health care grew by more than half: from 7.3 percent of gross national product (GNP) in 1970 to 12.3 percent in 1990; projections to the year 2000 imply a share that would most likely exceed 16

---

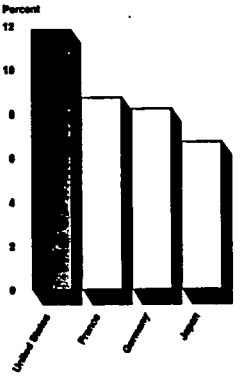
[1]The consequences of rising health spending are described in U.S. Health Care Spending: Trends, Contributing Factors, and Proposals for Reform (GAO/HRD-91-102, June 7, 1991), pp. 8-11; the record of various spending control initiatives is reviewed in the same report, pp. 14-16.

percent. Notwithstanding the high and rising level of spending, more people lack ready access to health care. Between 1979 and 1987, the number of Americans without health insurance rose by a fourth--from 29.9 million to 37.4 million.

Other industrialized countries have had more success than the United States in controlling health care spending while also providing health insurance to virtually all their citizens. For example, France, Germany, and Japan each spends a significantly smaller share of its national income on health care than does the United States (see fig. 1). The lower spending in these countries has not meant less access to basic health services or deterioration in broad measures of health status, such as life expectancy and infant mortality.

Figure 1: Health Care Spending as a Share of Gross Domestic Product (1989)

Figure 1: Health Care Spending as a Share of Gross Domestic Product (1989)



This study examines the policies that have been used in France, Germany, and Japan to control health care spending. In conducting this analysis, GAO obtained data on health expenditures and health status, reviewed literature on each country's health care system, and interviewed experts from the United States and from each of the countries reviewed. GAO also analyzed the likely effects of various spending control policies and statistically estimated the effects of several policies' effectiveness. Our statistical analysis was limited to France and Germany for technical reasons.[2]

RESULTS IN BRIEF

France, Germany, and Japan achieve near-universal health insurance coverage within health care systems that share three major traits with the U.S. system: (1) medical care is provided by private physicians and by both private and public hospitals, and patients have free choice of physician; (2) most people receive health insurance coverage through their workplace; and (3) health insurance is provided by multiple third-party insurers.

These similarities to the U.S. system coexist with several notable differences that follow from the far-reaching regulations used to guarantee coverage. First, insurers--who are predominantly non-profit--are required to provide minimum coverage that includes a wide range of health care benefits. Second, insurance enrollment is compulsory (with minor exceptions) for all residents, and they have little or no choice of insurers. Third, workplace-based insurance is financed not by premiums that reflect each individual group's expected costs of care, but largely by employer and employee payroll contributions that reflect the average cost of a larger cross section of the population.

[2]Unlike Japan, France and Germany made major changes in reimbursement policy during the 1970s and 1980s; those changes permitted the necessary before-and-after comparison between spending under the new policy and spending under the previous policy.

In addition to mandating insurance coverage, all three countries standardize reimbursement rates for almost all physicians and hospitals and set ceilings (price controls) on these rates.[3] Virtually all payers must, when reimbursing providers, abide by the standardized rates. Reimbursement rates are not promulgated by the government unilaterally, but emerge from formal or informal negotiations between physicians, hospitals, third-party payers, and (in France and Japan) the government.

Budget controls--policies that augment price controls by setting limits on overall spending for hospital care or for physician services--can moderate spending growth, particularly when they are enforced. Each country sets limits on overall health spending as national goals, but only France and Germany have added policies with teeth to achieve compliance with the limits. GAO estimated that French budget controls, between 1984 and 1987, reduced real (inflation-adjusted) hospital spending by as much as 9 percent, compared with what would have been spent had price controls alone been used. Likewise, GAO estimated that for physician care services, German budget controls reduced real spending by as much as 17 percent between 1977 and 1987, compared with what would have been spent without the budget controls. By contrast, overall spending limits on German hospitals did not reduce spending growth; these limits were not, however, accompanied by a mechanism to achieve compliance.

The budget controls that successfully moderated spending growth in France and Germany are not a panacea for concerns about spending. Budget controls have not relieved all pressures on spending, in part because these controls have not been applied to all segments of the health care industry. Moreover, budget controls do not assure high-quality care or efficient delivery of services. In light of these concerns, both France and Germany are exploring modifications and

[3]In addition, all three countries have some controls on spending for hospital construction or the purchase of new, high-cost medical equipment.

supplements to their current strategies for controlling the rise in health spending.

GAO'S ANALYSIS

Three Countries' Health Care Systems Retain Private Medicine, Patient Choice

In France, Germany, and Japan, as in the United States, patients generally can choose their own physician; outpatient services are provided by private physicians; and inpatient care is provided in both private and public hospitals. Physicians who provide outpatient services are paid on a fee-for-service basis--as are most U.S. physicians. (Unlike in the United States, however, physicians who deliver inpatient care are often employed by a hospital on a salaried basis.)

Countries Provide All Residents With Health Insurance Through Regulated Multipayer Systems

Each country guarantees virtually all their residents health insurance that offers a broad minimum level of benefits. Near-universal coverage is achieved by making enrollment for health insurance compulsory, with few exceptions, and virtually automatic. Health insurance is provided through a diverse mix of third-party payers that emerged from each country's particular social institutions and political history. Independent action by each payer is limited due to national regulation of enrollment, benefits, premiums, and reimbursement of providers.

Broad Package of Benefits Is Mandated

The mandated package of health benefits covers a wide range of services. Benefits generally include coverage for physician services, hospital care, laboratory tests, prescription drugs, and some dental and optical care. Patients in all three countries do not pay deductibles for health care services; copayments for physician and hospital care

range from nominal amounts in Germany to as much as 20 to 30 percent of regulated fees in France and Japan.

Insurance Financed by Payroll-based Contributions From Employer and Employee

Workplace-based insurance in France, Germany, and Japan is largely financed by mandatory payroll contributions from both employees and employers. In contrast to private insurance financing in the United States, which generally reflects each individual group's expected costs of care, these mandatory contributions reflect the average cost of a larger cross section of the population than typically used by U.S. insurers in calculating premiums. (In France and Japan, payroll-based financing is supplemented by subsidies from general tax revenues.)

Countries Set National Limits on Spending and Require Uniform Payment Rates

Each country has national procedures for setting limits on health care spending and for determining standardized reimbursement rates for providers. Generally, a government agency or other authorized body sets broad targets for all or some components of health care spending. The targets may serve as guidelines or they may be binding. National laws also require that payers reimburse providers according to rates that are, for the most part, uniform; a given service is usually reimbursed at the same rate, regardless of payer.

Each country also has a formal process for setting payment rates for physicians and hospitals. The health care system's major stakeholders--third-party payers, physicians and hospitals, and (in France and Japan) the government--participate in this rate-setting process. In France and Germany, the rates are set in formal negotiations. In Japan, they are set by the government in consultation with a body that represents insurers and health care providers.

Countries Adopt Direct Controls on Prices and Overall Spending

Seeking to moderate the rise in health care spending, all three countries have imposed direct controls on health care prices and overall spending. These controls are comprehensive--applying to the entire health care industry or to a major health care sector. By use of standardized payments, mandated coverage, and mandated benefits, the three countries have alleviated a potential problem with direct controls, known as cost shifting (that is, providers offset both the cost of charity care and the lower reimbursement from some patients' insurers by raising charges to other, more generous insurers).

Budget Controls With Teeth Work Better Than Price Controls At Containing Spending

France and Germany implemented budget controls that were subject to different degrees of enforcement--Germany, starting in the late 1970s; France in the mid-1980s. These controls supplemented or replaced price controls that were already in place. Both countries set annual targets to limit total spending on hospital services, and Germany set targets and, later, caps, to limit total spending on outpatient physician services. GAO's econometric analyses confirm that stringent enforcement makes budget controls more effective.

Hospital spending in France and Germany: Spending limits restrained hospital spending in France but not in Germany. Beginning in 1984, the French government replaced its fixed daily rates for hospital care with targets for total public hospital spending. To enhance compliance with the targets, the government participates in budget negotiations with each individual public hospital. GAO estimates that between 1984 and 1987, the targets reduced French spending on hospitals by about 9 percent below what would have been spent had price controls remained in place. By contrast, Germany in 1985 established targets for total hospital spending, but did not design the means to enforce them. GAO found

no statistical evidence that the existence of targets affected German spending for total hospital services between 1985 and 1987.

Physician care spending in Germany: Stringent enforcement enhanced the effectiveness of Germany's budget controls on physician spending. In 1978, Germany complemented its existing price controls with spending targets (though not with a formal enforcement mechanism). In 1986, however, Germany replaced targets with caps that were binding. GAO estimates that between 1977 and 1987, Germany's use of budget controls reduced inflation-adjusted spending by as much as 17 percent below what would have been spent on physician care under price controls alone. In addition, GAO found that caps reduced the rate of spending growth more than targets. Spending growth in the physician sector averaged 2 percent annually under caps, compared with 7 percent annually under targets; caps account for part, but not all, of this difference.

Countries Seek Additional Policies to Better Restrain Spending, Assure Quality, and Enhance Efficiency

In the countries reviewed, budget controls that successfully tempered the pace of spending growth have not relieved all pressures on spending, nor have they attempted to address concerns about the quality and efficiency of health care. Increased spending can be attributed, in part, to sectors not controlled through budgets, such as physician services in France or prescription drugs in all three countries. Continued pressure to increase health care spending in the future is also expected, as the elderly's share of the population rises further and new, expensive medical treatments are introduced.

In addition, the continued tightening of budget controls may, over time, both create political pressures for a relaxation of the controls and make a health care system less able to provide high-quality services. In France, new proposals for stronger budget controls recently sparked widespread

protests by physicians. In Germany, some controls on physician spending were relaxed in mid-1991 due to pressure applied by physicians. With respect to quality, GAO found no evidence in the countries reviewed of a decline in broad measures of health status during the relatively brief period that budget controls were in effect. Experts in France, however, believe that tight hospital budgets there are discouraging hospital maintenance and the development of innovative procedures. In other countries that have used budget controls for longer periods than France and Germany, some shortages of services have appeared, indicating the potential for problems in the long run.

Health care experts in these three countries are exploring policies that enhance efficient delivery and better assure quality. For example, efforts are being made in France and Germany to develop a prospective payment system for hospitals--following the same general principles used in the U.S. Medicare program since 1983--that offers incentives for more efficient delivery of hospital care. Germany is developing programs that enhance quality by increasing physician monitoring, formalizing quality assurance procedures, and increasing the coordination of inpatient and outpatient services.

RECOMMENDATIONS

GAO is not making recommendations in this report.

AGENCY COMMENTS

GAO did not solicit agency comments.

Contents

ABBREVIATIONS

CON	Certificate of Need
GDP	gross domestic product
GNP	gross national product
HMO	health maintenance organization
OECD	Organization for Economic Cooperation and Development
RVS	relative value scale

CHAPTER 1

INTRODUCTION

For over two decades, the growth of health care spending in the United States has substantially outpaced the growth of the rest of the economy--a pattern with troubling consequences. For consumers, the resulting rise in the share of national income spent on health care means less housing, education, and other nonhealth goods. For businesses, it means greater financial difficulty in offering health insurance to employees and in maintaining retirees' health benefits. For the federal government, it means that in an era of fiscal restraint, federal health care outlays crowd out nonhealth programs.

Increases in U.S. health spending might be easily justified if they bought commensurately better health or wider access. Although medical technology and procedures have made notable advances, indicators of health status (such as infant mortality) have improved only modestly relative to the gains made in several other industrialized countries. Moreover, access to care has narrowed: between 1979 and 1987 the number of Americans without health insurance rose by a fourth--from 29.9 million to 37.4 million.

Persistent pressures caused by rising spending have called forth various remedies, but success in containing spending has been elusive. Consequently, policymakers and analysts have turned with interest to industrialized countries that appear to control spending growth better, provide universal access to health care, enjoy better health outcomes, and spend a smaller share of their national income on health care. This report examines certain spending control policies that have been adopted by three of these countries: France, Germany,[1] and Japan.

U.S. HEALTH CARE SYSTEM CHARACTERIZED BY RAPID SPENDING GROWTH, SHRINKING ACCESS

Health Spending Has Grown Faster Than the Economy for 20 Years

Health care spending in the United States has grown faster than national income for over two decades. Between 1970 and 1990, health care spending rose at an average annual rate of 11.6 percent, while national income, as measured by gross national

---

[1]References in this report to Germany apply to the old Federal Republic of Germany. Characteristics of that country's health care system have been extended to the new Federal Republic of Germany since January 1, 1991.

product (GNP), increased more slowly at an average annual rate of 8.8 percent (see fig. 1.1).

Figure 1.1: U.S. Health Care Spending Grew Faster Than Gross National Product (1970-90)

Consequently, between 1970 and 1990, the share of GNP spent on health care grew by more than half: from 7.3 percent of GNP in 1970 to 12.3 percent in 1990. Furthermore, according to Health Care Financing Administration projections, health care in the year 2000 will most likely absorb over 16 percent of GNP.[2]

Implications of Health Care's Rising Share of National Income

The growing share of U.S. national income spent on health care affects major sectors of U.S. society differently--but none benignly. Consumers, for example, pay higher health insurance premiums, devote larger personal outlays to medical care, and incur higher taxes. Likewise, health care outlays of businesses have more than doubled relative to total employee compensation since 1970.[3] In turn, businesses have, in some cases, dropped

[2]Office of the Actuary, Health Care Financing Administration.

[3]From 3.1 percent of compensation in 1970 to 7.0 percent in 1989.

Figure 1.1: U.S. Health Care Spending Grew Faster Than Gross National Product (1970-90)

insurance coverage for their employees and, in other cases, restricted benefits for both employees and retirees. Finally, the near doubling of federal health care outlays relative to all federal outlays has pushed nonhealth programs against the fiscal ceiling,[4] whether that ceiling was established by statute, budget summit, or public opinion.

Part of this increase in health care spending has paid for widely acclaimed improvements in procedures and technology, but higher spending has neither prevented reductions in coverage nor spurred a sizeable improvement in health status relative to other countries. Specifically, many new procedures have improved--sometimes dramatically--patients' health and quality of life. But the growth in spending associated with these medical improvements has not always been accompanied by commensurate improvements in aggregate health outcomes.[5] While there have been improvements in life expectancy and infant mortality rates in the United States, these improvements are no better, and often less, than the gains made by other industrialized countries that have had smaller increases in health care spending.

Furthermore, there is concern that increases in the costs of providing health care have led to decreases in access to the insurance that pays for most of that care. High and rising insurance premiums are making insurance unaffordable for many Americans.

U.S. LESS SUCCESSFUL THAN OTHER COUNTRIES AT CONTROLLING SPENDING

Federal and state policymakers have developed numerous programs in response to recurring discontent with health care spending growth.[6] Program initiatives by governments include hospital rate

---

[4]Government spending on health care has risen from 7.6 percent of total federal outlays in 1970 to 14.4 percent in 1990.

[5]Changes in these broad measures of quality can also reflect the influence of factors other than medical care expenditures, such as lifestyle--for example, the amount of smoking and exercise--and social conditions--for example, the extent of poverty.

[6]Efforts to restrain spending growth have not been confined to the public sector. Private employers have sought lower health care outlays, offering their employees insurance plans built around delivery modes that are paid on a per patient basis rather than fee-for-service (for example, health maintenance organizations) or that offer lower rates for services provided by selected providers (for example, preferred provider organizations). Private employers have also reduced the benefits their insurance plans provide, and have shifted the costs of medical care to their employees by

regulation, encouragement of competition between health maintenance organizations (HMOs) and traditional insurers, and certificate-of-need (CON) regulation of capital investment. Few of these programs have been highly successful, though, and none has been adopted systemwide.[7]

Other industrialized countries have had more success than the United States in controlling the growth of health care spending without adversely affecting coverage or broad measures of health care status. These countries had lower growth in per capita inflation-adjusted spending during the 1980s than the United States (as shown in fig. 1.2 for six major industrialized countries). Partly as a result of their lower spending growth rates, these countries spend a far smaller share of their gross domestic product (GDP) on health care than does the United States (see fig. 1.3).[8]

Figure 1.2: Growth in Real Health Spending Per Capita (1980-89)

---

increasing the amount of deductibles and co-payments. Insurers, for their part, have implemented utilization review to limit the number of unnecessary or marginal procedures they pay for; insurers also have dropped coverage of particular employers or industries with especially high-cost individuals.

[7]In Karen Davis and others, Health Care Cost Containment (Baltimore: The Johns Hopkins University Press, 1990), cost and spending containment efforts by businesses, state governments, and the federal government are assessed.

[8]This pattern holds for all members of the Organization of Economic Cooperation and Development. See George J. Schieber and others, "Health Care Systems in Twenty-Four Countries," Health Affairs, Vol. 10 (Fall 1991), p. 24.

Figure 1.2: Growth in Real Health Spending Per Capita (1960-89)

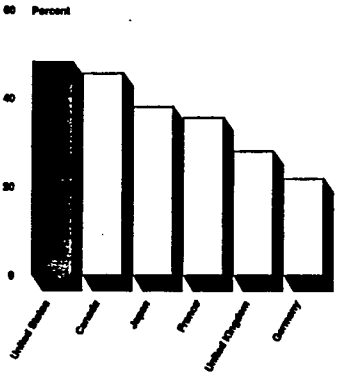


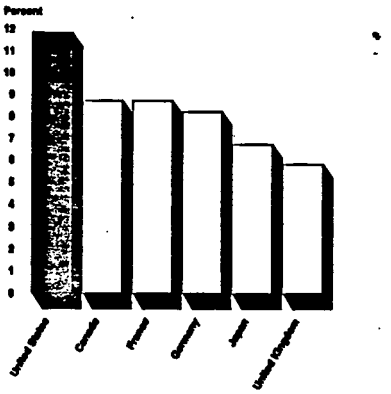
Figure 1.3: Health Care Spending as a Share of Gross Domestic Product (1989)

The lower spending in other industrialized countries has not restricted access to basic health services nor worsened broad measures of health status.[9] Data from the Organization for Economic Cooperation and Development (OECD) show that, on average, other industrialized countries have slightly fewer physicians per capita than the United States, but more inpatient beds and days of hospital care per capita (as well as longer average hospital stays).[10] In addition, life expectancy and infant mortality rates

[9]In some countries, patients may be put on waiting lists for elective surgery or for certain advanced treatments and tests. See, for example, Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90, June 4, 1991) and Henry J. Aaron and William B. Schwartz, The Painful Prescription: Rationing Hospital Care (Washington, D.C.: The Brookings Institution, 1984).

[10]This comparison is based on an average of OECD member countries. See "A Curmudgeon's Guide to Foreign Health Systems," statement by George J. Schieber, Ph.D., Health Care Financing Administration, before the House of Representatives, Committee on Ways and Means (Apr. 16, 1991).

Figure 1.3: Health Care Spending as a Share of Gross Domestic Product (1989)



in these industrialized countries are comparable with, or better than, those in the United States.[11]

OBJECTIVES, SCOPE, AND METHODOLOGY

The late Senator John Heinz, then Ranking Minority Member of the Senate Special Committee on Aging, asked us to report on what the United States can learn from health financing systems in industrialized countries that spend less on health care than the United States, but are able to provide universal access to quality care. We focused our analysis on countries that, like the United States, do not have a predominantly public insurance or delivery system, but that finance health care through a combination of private and public third-party payers and deliver services through private and public providers.

Specifically, the objectives of this study were to

-- describe how France, Germany, and Japan organize their health insurance systems to achieve universal coverage and pay the providers of health care;

-- describe the policies that these countries employ to contain increases in spending for physician and hospital care; and

-- assess the effects of these policies on spending for physicians and hospitals.

We reviewed the health care financing systems of three countries: France, Germany, and Japan. We selected these countries because they have financing systems with various combinations of public and private payers and because they have important similarities to the United States. All are industrialized democracies, have relatively large populations, and retain a significant role for the private provision of health care services. We reviewed the technical literature, conference papers, and government documents that describe health financing and spending control policies in these countries; we interviewed experts on the financing systems from both the United States and the three countries; and we

---

[11]Life expectancy and infant mortality data may be poor indicators of the relative quality of health delivery systems. A more discriminating measure of quality would be a comparison of incidence rates for medical conditions or stages of conditions that indicate a lack of access to quality primary care (such as measles or mumps in children and advanced breast cancer or uncontrolled hypertension in adults). Such data, however, are not readily available on a comparable basis.

obtained data on foreign health care spending and health status from the OECD.

In addition, we did statistical and econometric analyses to estimate the effectiveness of alternative spending control policies. Our quantitative analysis of these policies was limited to France and Germany. These countries made major policy changes that permitted a before-and-after analysis that statistically controls for other factors. Japan's experience during the past 30 years did not permit such an analysis. We did our review from February 1990 through May 1991 in accordance with generally accepted government auditing standards.

CHAPTER 2

MULTIPAYER SYSTEMS ACHIEVE UNIVERSAL COVERAGE AND SET SPENDING GOALS AND UNIFORM RATES

In several key respects, France, Germany, and Japan resemble the United States in their methods of delivering and financing health care. As to the delivery of care, people in these countries have free choice of physicians.[1] Private physicians provide most outpatient care and charge on a fee-for-service basis; private as well as public hospitals deliver inpatient care. As to financing, the provision of insurance involves at least several payers; the three countries differ in the number of their payers and these payers' basis of organization (national/local, employer/region).[2] In addition, access to health insurance is typically workplace-based; a person's employer or occupation determines which insurer (payer) provides the employee coverage.

Despite important similarities, however, health financing in these three countries diverges from U.S. health financing in three distinctive and fundamental ways. First, insurers generally are subject to extensive nationwide regulation, so that despite the nominally private status of many insurers, they are better described as quasi-public. Second, these countries' insurance systems operate under government regulations that guarantee almost all residents access to insurance. The regulations also require insurers to offer a minimum package that includes a wide range of health care benefits. Enrollment for health insurance generally is compulsory. Workplace-based insurance requires payroll contributions from both employers and employees. Special groups, such as retirees, the self-employed, and the unemployed are granted insurance coverage either through a quasi-public payer or a public insurance program.

Third, France, Germany, and Japan have national policies and institutions that set goals for much or all of health care spending and that govern the rates for reimbursing providers. All three countries grant the government or a nongovernmental body the authority to set goals for spending on all health care or for an entire health care sector (for example, physician services). In addition, all three countries combine government

---

[1]In the United States, most insured people have considerable choice of provider, but some have limited choice: in some rural areas and inner cities, alternative providers are few. Moreover, some have opted for limited choice: those enrolled in HMOs and other forms of organized care, such as preferred provider organizations.

[2]The payers in these countries are largely nonprofit and have no precise counterpart in the United States.

regulation with participation by the health system's stakeholders in determining providers' reimbursement for specific services and budgets for individual hospitals. National laws require that payers reimburse providers according to uniform rates. Laws also designate institutions (such as payer alliances and physician associations) to negotiate or otherwise participate in setting the levels of these rates each year.

LIKE THE U.S., THE THREE COUNTRIES HAVE PRIVATE MEDICINE, INSURANCE PROVIDED THROUGH EMPLOYERS, AND MULTIPLE PAYERS

Health care financing and delivery in France, Germany, and Japan share important institutional traits with those of the United States. First, most outpatient care is given by private, office-based physicians; hospital care is given in both public and private institutions, and people generally have free choice of physicians. Second, most people obtain their health insurance through their employers or their occupations. Third, health insurance is offered by multiple third-party payers. These similarities are interesting because they suggest that the United States could, if it chose to do so, achieve universal coverage and other large-scale goals in health financing while retaining key features of its current health care system.[3]

Private Medicine With Patient Choice

As in the United States, choice by patients and private delivery of care are important features of the health systems in France, Germany, and Japan. Specifically, patients generally can choose their own physicians. With respect to the delivery of care, outpatient services generally are provided by private physicians. Although much hospital care is given in public facilities, private hospitals in all three countries also play an important role. Private hospitals provide about one-third of the inpatient beds in France, about one-half of the beds in Germany, and about two-thirds of the beds in Japan.

---

[3]Other approaches to achieving universal coverage while retaining private medicine, multiple payers, and workplace-based insurance are possible, and have been discussed by health policy analysts. For example, two different models (one proposed by Karen Davis, the other by Alain C. Enthoven) are described in Shelah Leader and Marilyn Moon, eds., Changing America's Health Care System: Proposals for Legislative Action (Washington, D.C.: American Association of Retired Persons and Scott, Foresman and Company, 1989), pp. 1-19 and 21-42. Davis advocates a regulated multipayer system that uses price controls to restrain spending, while Enthoven proposes a framework of "managed competition" among health insurance carriers. The Netherlands is initiating a reform that resembles Enthoven's approach.

Physicians who provide outpatient services in an office-based setting are paid on a fee-for-service basis--as are most U.S. physicians.[4] Physicians who deliver inpatient care are often employed by a hospital on a salaried basis. In determining the appropriate medical procedures for patients, physicians enjoy a high degree of clinical autonomy. Utilization review--scrutiny by payers or others of providers' medical decisions--is conducted in all three countries, but its amount is limited and its purpose is more to detect overbilling by individual providers than to assess the appropriateness of treatment.

The Role of Employers and Payers in the Provision of Insurance

The countries reviewed resemble the United States in having health financing systems with multiple payers and in providing much health insurance through the workplace. These skeletal features of health financing--multiple payers and workplace-based insurance--are fleshed out differently in the three countries reviewed, as revealed in the consideration of two issues:

-- First, the extent to which consumers acquire insurance through their employers versus directly from insurers. People in these countries typically do not purchase their insurance policies directly from insurance carriers (payers). Instead, their employers serve as middlemen who offer the employees insurance plans provided by particular insurers. Such insurance can be termed workplace-based, in that, typically, which insurer provides a person's coverage is determined by the person's status as an employee of a particular firm or member of a particular occupation.

   In the United States, insurance need not be provided to employees through the workplace: employers are not required to offer coverage to their employees, and individuals may purchase insurance policies directly from insurers. In France, Germany, and Japan, by contrast, most people are not permitted to purchase insurance

[4]Alternatives to fee-for-service payment for outpatient care are much more prevalent in the United States than in the three countries reviewed. HMOs are particularly known for their use of capitated payments in place of payments for each specific service rendered. Use of capitated payments is rare or nonexistent in the three countries reviewed.

directly from insurers, in lieu of their workplace-based plan.[5]

-- Second, the extent to which the provision of insurance in the countries reviewed is highly concentrated in a small number of payers or is dispersed among many payers. Like the United States, Germany and Japan have large numbers of payers. Each of these two countries has over 1,000 autonomous payers that generally provide insurance through employers. These payers may draw their members (enrollees) from one of three sources: a particular company or type of employer (for example, a small business); a particular geographic locale; or, in Germany, a particular craft, trade, or occupation. The extent of concentration among payers is considerably greater, however, in France. It has only a few types of payers, one of which alone provides insurance to nearly 80 percent of the population. The greater concentration of French payers, compared with German payers, is consistent with the national organization of French insurance and the local or regional organization of German insurance.

Nonprofit and For-Profit Payers

The health systems of the three countries, like that of the United States, not only have more than one payer, but accord nonprofit payers a major role in the provision of health insurance. This qualitative similarity notwithstanding, significant quantitative disparities are evident: in the United States, nonprofit insurers (that is, Blue Cross-Blue Shield plans) cover a substantial proportion of the insured population--about 40 percent in 1988--but in the countries reviewed, they are predominant.[6] In France and Japan, nonprofit payers provide health insurance coverage for virtually all people; in Germany, they cover about 90 percent of the population.

Nonprofit payers in both the United States and the countries reviewed are major sources of workplace-based insurance. Indeed, in the three countries, workplace-based insurance is the

---

[5]The major exception to this generalization are people in Germany with high incomes. (See p. 27).

[6]See Source Book of Health Insurance, 1990 (Washington, D.C.: Health Insurance Association of America), pp. 22-23, tables 2.1 and 2.2. While the Tax Reform Act of 1986 removed the federal tax exemption for Blue Cross-Blue Shield organizations engaged in providing commercial-type insurance, they are still referred to as nonprofit organizations by the Health Insurance Association of America.

exclusive province of nonprofit payers. In France and Germany, these payers, known as sickness funds, also are the most common type of payer that offers insurance to those who do not obtain it at the workplace--such as retirees, self-employed people, and the unemployed.[7] In Japan, workplace-based insurance can be provided by "insurance societies" or "mutual aid associations." (Public insurance covers people not insured through their employers.) In addition, some nonprofit payers in France (mutuelles) provide supplemental benefits that are not covered by the sickness funds.[8]

In addition to nonprofit payers, the three multiple-payer systems reviewed include private for-profit payers but, compared with their U.S. counterparts, these payers occupy a modest niche. This niche is considerably smaller than what for-profit commercial insurers occupy in the United States, where they cover about half of the insured population; and this niche constitutes a significant difference between the U.S. insurance industry and those of France, Germany, and Japan. For-profit payers in France and Germany are available to provide coverage that supplements or replaces mandated coverage available through a nonprofit payer. (Mandated coverage is more fully described below.) In Germany, private payers also provide insurance to some people who prefer the benefits of a private health plan and who, by virtue of their high incomes, are not required to purchase workplace-based insurance. Compared with French and German private insurers, Japanese private payers offer a much more limited range of benefits (such as for specific diseases, cash benefits during hospitalization, and reimbursement of private-room charges).

REGULATED PAYERS, MANDATED COVERAGE, AND COORDINATION OF PAYMENTS DISTINGUISH THE THREE COUNTRIES' HEALTH FINANCING SYSTEMS

Notwithstanding the traits shared by the health care systems of France, Germany, and Japan with the U.S. health system, other key traits concerning health financing distinguish the three countries from the United States. Specifically, these three countries impose extensive, national regulations on payers; mandate insurance coverage of almost all residents; and require that the multiple payers coordinate their payments to physicians and hospitals.

---

[7]Dependents in all three countries are automatically covered through the insurance of a family member.

[8]This coverage might include (but is not limited to) patient copayments, nursing home care, and certain dental services.

Insurance Regulation Makes Nonprofit Payers Quasi-Public

The similarity between U.S. nonprofit insurers, like Blue Cross-Blue Shield, and nonprofit insurers in France, Germany, and Japan should not be overdrawn. Though in some sense private, these foreign nonprofit payers are sufficiently regulated that they are better termed quasi-public.[9] National regulation of enrollment, benefits, premiums, and reimbursement of providers limits the range of independent action by each payer. By contrast, regulation of U.S. insurers is largely conducted at the state level and is selective (for example, a mandate for alcohol treatment as a benefit) rather than comprehensive. Consequently, U.S. private insurers retain substantial room to maneuver vis-à-vis their competitors concerning what segment of consumers to pursue (for example, younger consumers), what benefits to offer, what premiums to charge, and on what terms to reimburse providers.

The quasi-public character of the three countries' nonprofit payers may explain the greater reliance on public insurance in the United States than in either France or Germany. Public payers cover about 23 percent of all Americans but insure only one percent of the population in France and are nonexistent in Germany.[10] In these countries, nonprofit insurers tend to perform similar functions to public payers in the United States--providing health benefits to low-income and elderly people.

Mandated Coverage Entails Requirements for Enrollment, Benefits, and Financing

To achieve virtually universal health insurance coverage, France, Germany, and Japan retained workplace-based insurance as a foundation and extended coverage to those not included at the

---

[9]Although all German sickness funds and all Japanese insurance societies and mutual aid associations are subject to government regulation, they are administratively autonomous. In addition, Germany's sickness funds are, for the most part, financially self-sustaining. The French funds, however, are part of the social security system. Although they have private legal status and relative autonomy from the state, they are not only subsidized, but supervised, by the central government.

[10]The major public insurers in the United States are Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). France's public coverage extends to those publicly indigent who are not members of a sickness fund. Japan also has a public payer, which provides coverage to 37 percent of the population.

workplace. Specifically, the countries passed laws with mandates that require that

-- workplace-based insurance cover most employees and their dependents, and one or more payers--public or nonprofit--cover most of the remainder of the population;

-- the minimum package of benefits covers a wide range of specified services; and

-- health insurance be financed predominantly by payroll contributions.

Enrollment and Mandated Access

In the three countries reviewed, national legislation mandates most employees' access to insurance through the workplace. Employers are required to make contributions, for their employees, to an insurance plan with a wide range of benefits, and all employees (except for those with high incomes in Germany) are required to enroll in such a plan. In addition, all three countries require that the insurer of an employee provide coverage for that employee's dependents.

As a result of these countries' mandated approach to insurance, most people have little choice of insurer. Correspondingly, most insurers have no opportunity to seek out individuals with low risk of illness, nor to attract more customers by offering lower premiums or better packages of benefits, as shown in the following specifics:

-- In France and Japan, people have no choice of insurance carrier. (Moreover, French employers are legally restricted from choosing the sickness fund that will cover their employees.) Most French residents belong to a single national sickness fund (the régime générale), and virtually all other employees and their dependents--about 20 percent of the population--are insured by smaller funds whose membership is limited to a particular occupational group, such as agricultural workers, miners, railroad workers, and the self-employed.

Like France, Japan eliminates individual choice of insurer, but bases the placement of an individual into a specific sickness fund on different criteria. A major criterion is size of firm. Employees of large firms are insured by one of about 1,800 independent "health insurance societies," each organized to cover employees of a single company or group of companies. Employees of small and medium-sized firms typically are enrolled in Government-Managed Health Insurance--an insurer that is managed by the central government. A second criterion is

54-832 O - 92 - 4

status as public employees. Civil servants and teachers receive insurance through one of 82 "mutual aid associations," organized on either a national or local basis to provide insurance exclusively to these groups.[11]

-- In Germany, most employees must enroll in the sickness fund that their employer has selected.[12] Some people--those in white-collar occupations--can choose, however, to enroll in one of 15 special nationally based sickness funds, instead of in the fund chosen by their employer. Furthermore, people with sufficiently high incomes can choose not to enroll in employment-based insurance.[13]

Other members of the population--those who are not employed or have a special employment status--receive health benefits in one of two ways. The first method is illustrated by France and Germany, where the sickness funds that insure most employees also cover retirees and unemployed people.[14] France also has national

---

[11]In 1989, 24.9 percent of the Japanese population received health insurance through insurance societies; 27.3 percent through Government Managed Health Insurance; and 9.8 percent through mutual aid associations. Almost all the rest of the population--37.1 percent--was covered by public insurance (National Health Insurance). Less than 1 percent of the population were beneficiaries of small programs, administered by the national government, that insure seamen and day laborers.

[12]The types of sickness funds that a German firm might choose for its employees include company-based funds, whose membership is restricted to employees of a particular firm or set of firms; craft- or trade-based funds, whose membership is limited to people in a specific occupation; and local or regional funds, whose membership is limited to residents of a particular geographic area. The selection of a sickness fund for a given firm is generally made by the employer, but employees' views are often represented through their labor unions' participation in the selection process.

[13]In Germany, people with sufficiently high incomes (about US $36,000 per year in 1989) have this option, but it is tied to a significant disincentive. If a person exercises this option and declines to enroll for the mandated insurance, enrollment for mandated insurance at a later time is prohibited. Only about 8 percent of the population--about one-third of those eligible--choose this option. Most of these people buy private, commercial health insurance.

[14]Retirees are typically covered by the workplace insurers that provided them benefits during their working years. Unemployed people in Germany are covered by their previous employer's sickness fund; unemployed people in France are guaranteed coverage in the

sickness funds for self-employed persons and for agricultural workers. Germany requires self-employed persons below an income threshold to join one of the workplace-based sickness funds.[15] By contrast, in Japan, members of these groups are generally covered through a separate program of public insurance known as National Health Insurance.[16]

Despite the differences between countries in their evolution toward universal access to insurance, their paths display certain similarities. Each country, at some point in its history, instituted compulsory insurance coverage for specific groups of workers. Typically, the first group to have insurance coverage made compulsory was manufacturing workers and miners. Over time, coverage was extended to additional groups in the labor force: white-collar workers, employees of small businesses, agricultural workers, laborers and craftsmen, the self-employed, and the unemployed. By 1970, all three countries had achieved near-universal coverage.

Mandated Benefits

The mandated package of health benefits covers a wide range of services and supplies (see table 2.1). Benefits generally include coverage for physician services, hospital care, laboratory tests, prescription drugs, and some dental and optical care. Patients in all three countries do not pay deductibles for health care services; copayments for physician and hospital services range from nominal amounts in Germany to as much as 20 to 30 percent of regulated fees in France and Japan. Japan limits monthly copayments for catastrophic medical expenses;[17] France waives copayments for childbirth and for certain high-cost illnesses.

---

wage earners' sickness fund.

[15]Self-employed people with incomes above the threshold have the option of joining a sickness fund, buying private insurance, or self-insuring.

[16]Some retirees are insured by the workplace insurers that covered them during their working years.

[17]The catastrophic cap is about US $400 per month for each person (or about US $200 per month for people with low incomes).

Table 2.1: Health Insurance Benefits in France, Germany, and Japan

	France	Germany	Japan
Outpatient services and inpatient hospital care	Most treatment and diagnostic services covered		
Maternity care	Prenatal, maternity, and well-baby care services are covered	All necessary medical care covered	Costs not specifically covered by health insurance system, but rather by public health programs
	Cash benefit—about US $150 a month—paid for 9 months (5 months before birth, the birth month, and 3 months after birth)	Cash benefit paid 6 weeks before birth and 8 weeks after Home nursing for women in "childbed"	Cash benefits for childbirth and for mother's loss of wage income (for up to 6 weeks before birth and 8 weeks after)
	Additional 16-week maternity leave paid to mother; rate is based on previous income and is limited to a maximum of about US $50 a day		
Preventive care	Covered care includes (1) free preventive exam every 5 years and (2) mammographies for women over the age of 45	Preventive medical exams for (1) children to the age of 6, (2) women over the age of 20, (3) men over the age of 45, and (4) health check-ups after the age of 35	Generally covered by workplace-based insurance; not covered by public insurers, although local governments provide screening at little or no cost
	Immunizations also provided; funding comes from government		
Dental and optical care	Covered items include basic dental care, dentures, and eyeglasses	Preventive check-ups for people aged 12 to 20	Dental services covered
		Partial payment of dentures and crowns	
		Cost of eyeglasses	
Long-term care	Home care services, day care, and some inpatient chronic care services are covered	Long-term care given in the hospital setting, rather than in a nursing home or other chronic care setting, is covered by the insurance system	Services are covered, but there are few nursing homes or other long-term care facilities; long-term care provided by hospitals is covered

Prescription drugs	Covered, subject to some restrictions	Covered, subject to some restrictions	Covered
Income maintenance	Generally, workers are entitled to 50 percent of wages, up to about US $33 a day, for up to 360 days in any 3-year period (for certain diseases, such as cancer, benefits may be granted for an unlimited number of days, for up to 3 years)	Income support, for the most part, of up to 80 percent of lost income (not to exceed total net income), for up to 78 weeks in any 3-year period	Income support, of up to 60% of standard daily wage (40% if insured person has no dependents and is hospitalized), paid for up to 18 months
Cost sharing by patients	Standard cost-sharing rates: (1) 25% for physician visits, (2) 20% for hospital services, up to the 30th day of care (and 0% afterwards), plus a US $6 fee for daily room charges, (3) 30% for laboratory tests and dental services, and (4) 30%-70% for covered prescription drugs, depending on the necessity of the medication; patient must bear full costs of other (uncovered) prescription drugs Cost sharing for poor people is paid for by the social welfare system Cost sharing for hospital costs waived for maternity care and for certain high-cost illnesses	Limited cost sharing for hospital care (about US $6 a day) Cost sharing for some prescription drugs	Cost sharing ranges from 10% to 30% of costs, depending on insurance carrier, whether insured is an employee or a dependent (dependents sometimes have higher cost sharing) or whether treatment is in a hospital or in an outpatient setting Cost sharing waived after monthly payment reaches catastrophic cap of about US $400 (US $200 for low-income people)

Payroll-based Financing

Workplace-based insurers are largely financed through mandatory payroll contributions from both employees and employers (see fig. 2.1). This contrasts with the financing of most U.S. insurers, which is done through premiums that reflect actuarial estimates of expected future illnesses and health care expenses of an enrolled group. In France and Japan, payroll-based financing is supplemented by subsidies from general tax revenues.

Payments Regulated Through Spending Limits; Involvement of Payers and Providers in Rate Setting

France, Germany, and Japan eacn has national procedures for coordinating payments--setting targets on health care spending and determining reimbursement rates for providers. These procedures have three features in common:

-- In each country, a government agency or other authorized body sets broad targets for all or some components of health care spending. The targets may serve as guidelines or they may be binding.

-- Each country has a formal process for setting payment rates for physicians and hospitals. In one way or another, each country's process incorporates the views of the health care system's major stakeholders: the government, third-party payers, and physicians and hospitals.

-- National laws require that payers reimburse providers according to rates that are, for the most part, uniform; a given service is usually reimbursed at the same rate, regardless of payer.

Figure 2.1: Financing of Mandated Health Insurance in France, Germany, and Japan

Country	Financing structure	Government subsidy
France	**Source of funds:** mandatory payroll contributions **Contributions:** determined by central government Employers' share—12.6 percent of total wage bill Employees' share—6.8 % of wages [a] (no wage ceiling)	Subsidies from general revenue and specific taxes
Germany	**Source of funds:** mandatory payroll contributions **Contributions:** determined by individual sickness funds Contribution shared equally by employer and employee Average: about 13% of wages Range: 8%-16% of wages, subject to a wage ceiling	No government subsidy

Japan	**Source of funds:** mandatory payroll contributions	Central government pays most administrative costs and some insurers[b]
	Contributions: determined by the individual carrier	Subsidy ranges from 0 (for some of the insurance societies) to 52 percent of costs
	Average: about 8% of standard monthly salary	
	Employer pays at least 50% of contribution	
	Range: 3.5%-13.3% percent of salary	

---

a/ Employee contribution rate was 5.9 percent prior to July 1991.

b/ Local governments in Japan pay the administrative costs of the mutual aid associations (insurers) that cover local public service employees.

Governments or Other Bodies
Set Limits for Health Spending

All three countries vest the authority to set spending limits in either the government or a nongovernmental body. France's targets cover total spending, but spending limits on public hospitals are more rigidly enforced than are limits on other sectors. Germany's limits cover spending for several major sectors of health care services, and Japan's cover total health care spending. (See table 2.2.) The way these countries use their announced spending limits in controlling health spending is discussed further in chapter 3.

Table 2.2: Each Country Sets Overall Health Spending Goals

	Goals		
	Set by	Apply to	
Country		Entire system	Specific sector
France	Central government	X	Public hospitals
Germany	Nongovernmental body (called Concerted Action)	X	Hospitals, physician care, prescription drugs, and some other services
Japan	Central government	X	None

France and Japan

In France and Japan, the central government sets a desired growth rate for total health care spending. This rate is set unilaterally without participation by providers or payers: in France, the rate is set annually by the central government; in Japan, the rate is generally tied to the increase in the country's GDP.

France's announced target rate of increase for overall health spending is also used as a benchmark for limiting the annual increase in budgets for public hospitals.[18] By contrast, Japan does not set budgets for either outpatient physician services or hospital care, but rather has goals that are viewed as the government's preferences vis-a-vis increases in health spending.

[18]Most of the hospital services in France are provided in public hospitals.

Germany

In Germany, the government sets the stage for establishing spending limits, but is not otherwise a player. The 1977 Cost Containment Act required the formation of a body called Concerted Action, made up of representatives from the health care system's organized stakeholders--physicians, hospitals, and pharmacists; sickness funds and private insurers; drug manufacturers; employers and labor unions; and state and local governments. Spending limits are announced for health care overall and for major sectors, such as physician services, hospital care, and prescription drugs.

The statute mandates that Concerted Action meet twice each year to reach a consensus among its members on limits for spending increases. In the last few years, the political context for Concerted Action's deliberations has included the advocacy by elected officials of stabilizing the rate of the payroll contributions that finance most health care spending.

REGULATION OF PAYMENTS AND INSURANCE GENERATES POLITICAL PRESSURES ON SYSTEMS

The health care systems of France, Germany, and Japan are not free of pressures, both political and economic, so these systems are unlikely to remain frozen, as described above, but to evolve further. One important source of pressure on these systems is regulation itself. Providers as a group tend to act politically, seeking to undo or soften the effects of the regulation on their incomes. The extent to which providers succeed in changing the regulations, whether by amendment or repeal, depends upon the stringency of the regulatory tools applied, as well as on numerous political and other factors specific to the country.

Physicians' Responses to German and French Regulation

Physicians' trade unions in France have long fought efforts by the government to restrict physicians' incomes. Physicians ignored early efforts at controlling spending on their services, thereby rendering the controls ineffective, and subsequently physicians' unions called strikes to protest various proposals to control spending. Most recently, in June 1991, the French government's proposals that would restrict physicians' incomes stimulated street demonstrations by thousands of physicians; whether their opposition will prove successful is yet to be seen.

Physicians in Germany have been less successful than their French counterparts at blocking regulations that would limit physicians' fees and incomes. Nonetheless, German physicians have been able, at various times, to mobilize as a group and roll back government or third-party payers' restrictions on physicians' incomes. In September 1991, for example, the physicians' association negotiated

the partial removal of a cap on spending that had been in place since 1986.[19]

Pressures May Arise Due to Differences in Regulations of Insurers

Lack of uniformity in the regulation of insurers, particularly with respect to contribution rates and benefits, stimulates additional pressure on these countries' financing systems. For example, wide differentials in payroll contribution rates exist among Germany's sickness funds, despite the similarity in their benefit packages.[20] In response to these differentials, some large firms are taking their employees out of high-cost sickness funds and instead establishing company-based sickness funds whose actuarial costs may be lower. This switch may yield companies and employees substantial savings so long as the members of the company-based funds are relatively young and healthy.[21]

In Japan, national regulations permit differences not only in payroll contributions between payers but also in the benefits they provide. Employees of large firms tend to have a higher share of their contributions paid by employers, more extensive benefits, and lower cost sharing than dependents or than many employees of smaller firms. We were not able to determine the extent to which these differences contribute to pressures for reforming the insurance financing system.

---

[19]This change applies only to spending by the optional sickness funds that provide coverage for some white-collar workers (about one-fourth of the population). As of October 1991, caps are still being imposed on physician care spending by Germany's other sickness funds.

[20]In 1988, payroll contribution rates for workplace-based insurers ranged from 7.5 to 16 percent of gross compensation.

[21]Many sickness funds in Germany have advocated measures that would reduce or eliminate disparities in contribution rates. This approach is criticized by people who advocate a market-based insurance system, in which consumers would have more choice of sickness funds. The German government, as of this writing, has not addressed either of these approaches for resolving disparities in contributions that finance health care. See Uwe E. Reinhardt, Ph.D., "West Germany's Health-Care and Health-Insurance System: Combining Universal Access with Cost Control," U.S. Bipartisan Commission on Health Care (Sept. 1990), pp. 15-16.

CHAPTER 3

COUNTRIES SLOW GROWTH OF PHYSICIAN AND HOSPITAL SPENDING BY APPLYING CONTROLS SYSTEMWIDE

Seeking to moderate the unrelenting rise in health care spending, the governments of France, Germany, and Japan have imposed nationwide controls on health care prices and budgets within a regulatory framework that encompasses health insurance and provider payment. The existence of such a framework of financing institutions and policies made it easier for these countries to introduce controls on prices, spending, or both, and to sustain their use.

The connection between the financing framework and the nationwide controls is manifested in three ways: first, in France, Germany, and Japan, institutions have the authority to impose ceilings on payment rates for some or all providers. Second, institutions authorized to set spending limits are positioned to assure compliance with those limits. Finally, the three countries' use of price controls, mandated coverage, and mandated benefits alleviates a potential problem known as cost shifting.[1] With these three elements in place, physicians and hospitals have less reason to view the controls as inequitable, because the spending restraints affect providers relatively uniformly. That is, providers are less burdened than they would otherwise be by uncompensated care and by unequal reimbursements for the same service.

Efforts to restrain health spending increases in the countries reviewed have emphasized comprehensive and direct controls on prices and spending. Specifically, these countries' controls apply to virtually the entire health care industry or to a major health care sector, not simply to spending by one payer. These controls also are direct, placing limits on prices or overall spending. Each of these three countries has imposed price controls that limit the fees which physicians and hospitals can charge to insurers. In addition, France and Germany have each adopted budget controls that set limits for total spending within a segment of its health care industry. Moreover, France, Germany, and, to a lesser extent, Japan try to control spending on capital through regional planning; they may regulate the expansion of hospitals, the diffusion of high-cost medical

---

[1]Cost shifting, which is prevalent in the United States, refers to providers raising prices to more generous (or less price-sensitive) payers in order to recoup losses from uncompensated care or to offset lower reimbursement rates from other payers.

equipment, or both.[2] (See fig. 3.1 and app. I.) In the United States, by contrast, spending restraints typically are indirect, involving increased incentives for consumers to be cost conscious (for example, through cost sharing) and for providers to be efficient (for example, through the use of managed care and utilization review).[3]

The targets and caps applied in France and Germany, when accompanied by a meaningful mechanism of achieving compliance, were more effective than price controls. In two of three cases, budget controls significantly slowed the growth of spending, compared with price controls alone. Compliance was achieved in several ways: for example, through direct government participation in budget negotiations, as with French hospitals, or by tying the fee schedule directly to volume, as with German physicians.

Budget controls are not a panacea for problems of the three health care systems reviewed. Despite the success of budget controls in moderating spending growth in France and Germany, health care spending continues to rise. In this environment, government officials and health care experts in both countries are now considering the extension of budget controls to segments of the health industry currently uncontrolled. Moreover, budget controls were designed to restrain spending increases, not to achieve other objectives, such as quality assurance. Concerns exist, however, about the side effects of the controls on the efficiency of health care provision and (especially in the long run) on the quality of care. Given these concerns, health officials and analysts in France and Germany are considering certain measures that have been applied in the United States, such as prospective payment for hospitals adopted by Medicare.

---

[2]Data limitations prevented us from assessing the effectiveness of regional planning in restraining health care spending.

[3]In the United States, the Medicare program's prospective payment system for hospitals is an important though partial exception. This system is, in effect, a centrally administered system of direct controls on hospital prices; it is not, however, a comprehensive policy, because it sets prices only for the hospital care provided to Medicare patients. In addition to the ongoing prospective payment system, Medicare will soon implement (in 1992) a "resource-based relative value scale" method of reimbursing physicians. This method represents a form of price controls, but is also partial in scope.

Figure 3.1: Spending Control Policies Applied in France, Germany, and Japan

Policy	France	Germany	Japan
Price controls			
Physician fee schedules:			
Office-based services	✓[a]	✓[b]	✓
Hospital-based services	✓[c]		✓
Hospital fee schedules			✓
Hospital per diem payment rates:			
Public hospitals		✓	✓
Private hospitals	✓	✓	✓
Budget controls			
Physician services:			
Aggregate spending targets		✓[d]	
Aggregate spending caps		✓[e]	
Hospital services:			
Global budgets for individual hospitals	✓[f]	✓	
Aggregate spending targets	✓	✓	
Capital spending controls			
Hospital construction	✓	✓	✓[g]
High-cost medical equipment	✓	✓	

[a]Some office-based physicians in France (about 27 percent in 1987) are allowed to balance bill (that is, charges prices that exceed the fee schedule).

[b]Physicians treating the small proportion of privately insured patients in Germany may bill insurers up to 2.3 times the official fee schedule.

[c]Fee-for-service payments for hospital-based physician services in France apply only to those services provided in private hospitals.

[d]Germany's spending targets for physician services were in effect from 1977-85.

[e]Germany's spending caps for physician services were applied to all sickness funds from 1986-91; currently the caps are not applied to Germany's optional white-collar sickness funds.

[f]France's budget controls apply to public hospitals only.

[g]Limits on hospital construction in Japan do not apply to clinics (facilities with less than 20 beds).

PRICE CONTROLS IN THREE COUNTRIES LIMIT CHARGES FOR PHYSICIAN CARE AND HOSPITAL SERVICES

Price controls--which may apply to physician services, inpatient hospital care, or other services--set uniform ceilings on prices or reimbursement rates for health services covered by compulsory insurance.[4] All payers offering compulsory insurance must

[4]In France, some physicians are allowed to pass on additional charges to patients.

conform to these uniform prices when reimbursing providers of care. In general, annual negotiations between providers and payers determine prices. Two types of price controls are typically applied: fee schedules, which set uniform rates--either across the whole country or across particular regions--at which insurers will reimburse providers and administered hospital per diem rates, which are negotiated for individual hospitals and used by all compulsory insurers to reimburse these hospitals.

Price Controls in France

France's fee schedule for physicians sets nationally uniform reimbursement rates that apply to services provided outside of public hospitals (that is, in private offices and in private hospitals). Technically, the fee schedule does not set ceilings on prices charged by all physicians. Some physicians who bill under the compulsory insurance system are allowed to charge their patients additional fees.[5] The fee schedule has two components: a relative value scale, which defines the value of one procedure or test relative to another,[6] and a conversion factor that translates all the points on the relative value scale into monetary amounts. The conversion factor is determined in annual, government-supervised negotiations between the physicians' unions and the sickness funds.

France also regulates the rates charged by private hospitals,

---

[5]Physicians who want to charge prices in excess of the fee schedule are considered to be in a separate payment "sector." These physicians lose fringe benefits and financial advantages associated with the insurance system: they are restricted from joining the sickness fund for salaried workers, and must join the less generous sickness fund for the self-employed. Despite this financial disincentive, about 27 percent of all French physicians (in 1987) chose this separate sector. The figure is lower for general practitioners and higher for specialists. It is also much higher for physicians in urban areas: for example, about 50 percent of physicians in Paris are members of this sector. See Victor Rodwin and others, "Updating the Fee Schedule for Physician Reimbursement: A Comparative Analysis of France, Germany, Canada, and the United States, Quality Assurance and Utilization Review, Vol. 5 (Feb. 1990), p. 20.

[6]The French relative value scale is not a technical valuation of medical procedures based on time, complexity, or intensity. While the values assigned to surgical procedures are related to differences in these factors, they also tend to reflect interspecialty medical politics and/or societal preferences for different branches of medicine. See Rodwin and others, "Updating the Fee Schedule" (1990), p. 17.

that is, clinics (known in France as cliniques).[7] Clinics charge a fixed per diem rate that is not related to the type and number of procedures and tests provided to a patient. Per diem rates differ between clinics, but each clinic must charge the same rate to all sickness funds. That is, clinics are not allowed to cost shift. Annual increases in the per diem rate are determined in government-supervised negotiations between the hospital and the major sickness fund in the hospital's region.

Price Controls in Germany

Germany, like France, has fee schedules for outpatient physician services that are negotiated between sickness funds and physicians. In Germany, the fee schedules set the total amount that physicians can charge--in general, no balance billing is allowed (that is, physicians generally must accept the fee schedule amount as payment in full and may not bill their patients for any additional amounts). This situation contrasts with France, which allows balance billing by many physicians. Germany's price controls differ from France's in two respects: first, the government sets the context for negotiating the fee schedule, but otherwise has no formal role in the negotiations; second, there is no single national fee schedule but rather a set of regional schedules.

Physician prices are determined by regional fee schedules that are based on a national relative value scale (RVS) that assigns points to each medical procedure. The monetary equivalent of a point on the RVS is determined, for all sickness funds in a given region, in annual negotiations between the regional association of sickness funds and the corresponding association of sickness fund physicians.[8] Like collective bargaining in the United States, these negotiations in Germany are conducted without any participation by the federal, state, or local governments. (Monetary values for the substitute sickness funds are negotiated separately from those of other sickness funds.) Fees tend to vary by region and to be higher for the national substitute sickness funds than for the regular sickness funds. The RVS, revised infrequently, is negotiated at the national level between the national associations of sickness funds and sickness fund physicians.

---

[7]Per diem rates were also applied to public hospitals before the development of global budgets.

[8]By law, physicians must join the association of sickness fund physicians in order to treat sickness fund patients.

Price Controls in Japan

Japan has a single fee schedule that applies to both outpatient physician and inpatient hospital care (there is little differentiation in Japan between inpatient and outpatient services--hospitals and physicians' clinics both can provide either inpatient or outpatient care). The fee schedule applies nationally and sets one fixed price that providers can charge (that is, balance billing is not allowed).

In contrast to France and Germany's reliance on payer-provider negotiations, the fee schedule in Japan is set by the central government's Ministry of Health and Welfare. Payers and providers do have a consultative role, however. In setting the fee schedule, the Ministry is required to work with the Central Social Insurance Medical Council, a body composed of eight providers (five of whom are physicians), eight representatives of payers (four from insurers and two each from management and labor), and four representatives of the public interest (one lawyer and three economists).

BUDGET CONTROLS USED TO LIMIT TOTAL SPENDING FOR PHYSICIAN OR HOSPITAL SERVICES

As health care spending continued to rise in the 1970s despite nationwide controls on most health care prices, France and Germany began introducing additional policies to further limit spending growth. Budget controls, both spending targets and spending caps, were designed to limit all spending within a particular health care sector (such as physician services or hospital care). These controls differ in the extent to which they rely on formal mechanisms of achieving compliance with spending limits.

For hospitals, budget controls are designed to restrain operating expenses only; another policy tool--regional planning--is used to control capital spending. Under this approach, a government agency determines the appropriate level of hospital beds and medical equipment for a given segment of the population (for example, for every 100,000 persons). The resulting "needs plan" guides government decisions on authorizing additional facilities and new equipment. (See app. I.) France and Germany have less high-cost medical equipment per capita than does the United States, and they both experienced a decline in the number of hospital beds, but these facts are only suggestive; we do not have sufficient data to attribute such facts to the use of regional planning. The mere presence of a planning mechanism does not ensure effective control of either capital spending or

overall health spending, as the U.S. experience with the CON program demonstrates.[9,10]

The following sections describe budget controls applied to physician spending in Germany since 1978, to hospital spending in France since 1984, and to hospital spending in Germany since 1986.

Germany's Controls on Spending for Physician Care

Germany imposed two types of budget controls on physician care expenditures: spending targets, which were in effect between 1978 and 1985, and spending caps, a more stringent type of control that has been in effect since 1986.[11] The spending targets established annual goals or desired limits for the growth in outpatient physician expenditures. These targets were based on spending in the previous year, anticipated changes in service volume, and changes in the wage base of sickness fund members. The spending targets coexisted with price controls, but the two policy tools were not otherwise coordinated. Targets were not binding; when spending exceeded the target, allowable spending for the subsequent period was not reduced. Despite the prevailing policy to do just that, the policy was not enforced.

Because spending consistently exceeded targets, Germany in 1986 adopted caps on physician expenditures. Unlike targets, spending

---

[9]See, for example, Rising Health Care Costs: Causes, Implications, and Strategies, U.S. Congressional Budget Office (April 1991), p. 48.

[10]Unlike the CON program in the United States, the approach used in Germany to control capital spending places planning and budgetary decisions in the same hands. That is, in Germany, if the planning body authorizes a certain level of capital purchases, that same body must, when allocating funds for those purchases, also draw upon its own fixed budget. In the American CON program, however, planners at the state level could authorize levels of capital spending without regard to how they would be funded. Further research is needed to determine whether the linkage of planning and budgeting makes regional planning effective in limiting spending.

[11]As of September 1991 (and retroactive to July 1991), the optional white-collar funds removed spending caps on physician services. The decision to remove these caps was made in recent negotiations between the sickness funds and the national association of sickness fund physicians. (As of this writing, Germany's other sickness funds have maintained the use of spending caps.)

caps set binding limits on what can be spent for physician services in a given year. Increases in the caps are tied to the growth rate in allowable spending to the growth rate in sickness fund members' wages.

Key to the enforcement of the spending caps is the "flexible fee schedule." Under the flexible fee schedule, physician fees for each medical service are adjusted downward when the volume of services provided exceeds the level consistent with the spending limit. These downward adjustments in price guarantee that total expenditures stay within the level of the cap.[12] By contrast, the targets had no mechanism for reducing prices when expenditures exceeded the target. Instead, the amount of excess spending was carried over from one year to another.

France's Controls on Spending in Public Hospitals

Beginning in 1984, France sought to restrain spending in public hospitals by adopting a policy that combined hospital-specific global budgets with sectorwide spending targets.[13] This policy replaced one that relied on administered per diem rates. Each public hospital negotiates its proposed budget with the predominant sickness fund in its region and with representatives of the national government. This budget covers operating costs as well as debt service costs for construction and high-cost medical equipment.

The nationwide hospital spending target, set by the government, provides the context for the negotiations of each hospital budget, and the government uses its participation in the budget negotiations to keep total spending from growing faster than specified by the target. Not all budgets increase at the target rate--some are allowed to grow more and others less. But by

---

[12]Since 1987, some regions in Germany have adopted separate spending caps for three categories of physician care: direct consultation services, laboratory testing, and other services. Under this system, a high volume of services in one category does not affect the fees in other categories. For example, if laboratory tests exceed anticipated volume, then the fees for all laboratory tests are reduced while the fees for consultation and other services remain unchanged. See Bradford Kirkmann-Liff, "Physician Payment and Cost Containment Strategies in West Germany: Suggestions for Medicare Reform," Journal of Health Politics, Policy, and Law, Vol. 15 (Spring 1990), pp. 80-81.

[13]The budget controls were adopted in two stages. In 1984, the controls were applied to regional hospitals. In 1985, they were extended to local hospitals (about two-thirds of all hospital beds in France are in public hospitals).

participating in all budget negotiations, the government is able to monitor the direction of these negotiations and to use its influence with the negotiating parties to restrain the growth of hospital spending overall.

Germany's Controls on
Public and Private Hospitals

Beginning in 1986, Germany required all its hospitals to adopt global budgets. This policy was coordinated with existing targets for annual hospital spending. Unlike French policy, the German spending targets for hospitals are not reinforced by government participation in budget negotiations or by any other formal mechanism.

Under the German statutes governing health care, an advisory body on national health policy recommends annual spending targets for hospitals, while global budgets for individual hospitals are negotiated between each hospital and the association of sickness funds for the hospital's geographic region. The overall spending target is not binding on the budget negotiations. Although the target is an informal guideline in the negotiations for individual hospital budgets, neither the government nor the health advisory body can formally enforce compliance with the targets.

BUDGET CONTROLS IN TWO OF THREE CASES SLOWED SPENDING BETTER THAN PRICE CONTROLS ALONE

In our analysis of two of the health sectors where budget controls were applied--German physician services and French hospital services--budget controls were more effective in constraining spending increases than price controls alone.[14] These controls were accompanied by a formal mechanism to achieve compliance with the announced spending limits. In contrast, budget controls applied to a third sector--German hospital services--were no more effective at limiting spending increases than price controls used alone. These controls lacked a formal means for ensuring compliance.

A basic fact--that total spending on health care services equals their price times their volume--helps in understanding why budget controls can be more effective than price controls at controlling spending. Price controls can limit only the price component of spending. The effect of price controls on spending may be blunted, therefore, when providers respond to lower prices by

---

[14]We could not evaluate the effectiveness of price controls alone compared with a situation with neither price nor budget controls. See p. 19.

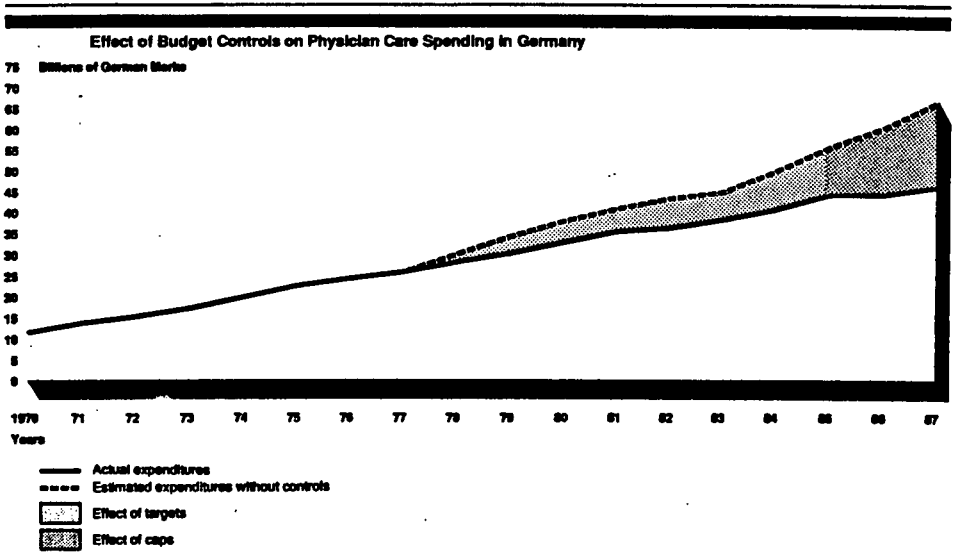
raising the volume of services to maintain their incomes. By contrast, budget controls limit total health spending in a sector, regardless of the volume of services.

Germany's Budget Controls Reduced Real Physician Spending by as Much as 17 Percent

For the period covered by our analysis, Germany's spending targets and caps--used in conjunction with fee schedules--slowed the growth of physician care spending significantly,[15] relative to its growth if price controls alone had prevailed. We estimate that the targets and caps reduced inflation-adjusted spending on ambulatory care, between 1977 and 1987, by as much as 17 percent (compared with what would have occurred without the budget controls). The rate of increase in nominal spending slowed to an average annual rate of 6 percent, compared with the 9 percent rate that our estimates suggest would have occurred under price controls alone (see fig. 3.2).

Figure 3.2: Effect of Budget Controls on Physician Care Spending in Germany

[15]While data on ambulatory care spending include many outpatient procedures and laboratory tests, the bulk of such spending is for outpatient physician services.


Effect of Budget Controls on Physician Care Spending in Germany
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0
Billions of German Marks
1970
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
Years
Actual expenditures
Estimated expenditures without controls
Effect of targets
Effect of caps

Our estimates show that a binding spending cap controlled the growth in Germany's physician care expenditures better than a spending target. This finding is consistent with the nature of caps that, unlike targets, build in a mechanism designed to make a spending limit stick. We could not quantify how much more effective caps would be if maintained over the long run (for instance, over the next 5 to 10 years), because we could only get data on Germany's caps for the 2-year period 1986-1987.[16] During that short period, however, physician care spending--unadjusted for inflation--increased at an average annual rate of 2 percent, much slower than the 7 percent average rate of increase that prevailed during 1977 through 1985, when targets were in place.[17] If caps were maintained over the longer run, they would be expected to retain their advantage as spending controls, but (as explained in app. II) the size of that advantage would undoubtedly be much less dramatic.[18]

France's Budget Limits Cut Real Hospital Spending by as Much as 9 Percent

During the 3-year period we examined, the budget controls used in France slowed the growth of hospital spending significantly, compared with what would have occurred under price controls (see fig. 3.3). We estimate that global budgets and sectorwide spending targets, which were in place between 1984 and 1987, reduced the 1987 level of inflation-adjusted inpatient care spending by as much as 9 percent. The effect of budget controls can also be seen in terms of the rate of spending growth: the increase in nominal spending (shown in fig. 3.3) slowed to an average annual rate of 5 percent, compared with the estimated 9 percent rate that would have occurred if France had continued to use price controls. We cannot determine from our estimates

---

[16]Furthermore, caps for some components of physician care spending were removed in 1991 (see fn. 11).

[17]Only part of the difference in rates of increase between these two periods can be attributed to the different effects of targets versus caps. Other factors, such as the slowdown in the average rate of inflation between 1977-85 and 1986-87, also help explain the slower rate of growth when caps were in place. (Inflation-adjusted spending increased 3.3 percent between 1977-85, and was virtually unchanged between 1986-87.)

[18]Our estimates suggest that the share of national income spent on physician care would drop continuously if the short-run effect of caps was sustained. We believe that caps would be applied less stringently if this pattern was to persist in the long run since there is no evidence that German policymakers' objective is a persistent decline in health's share of national income.

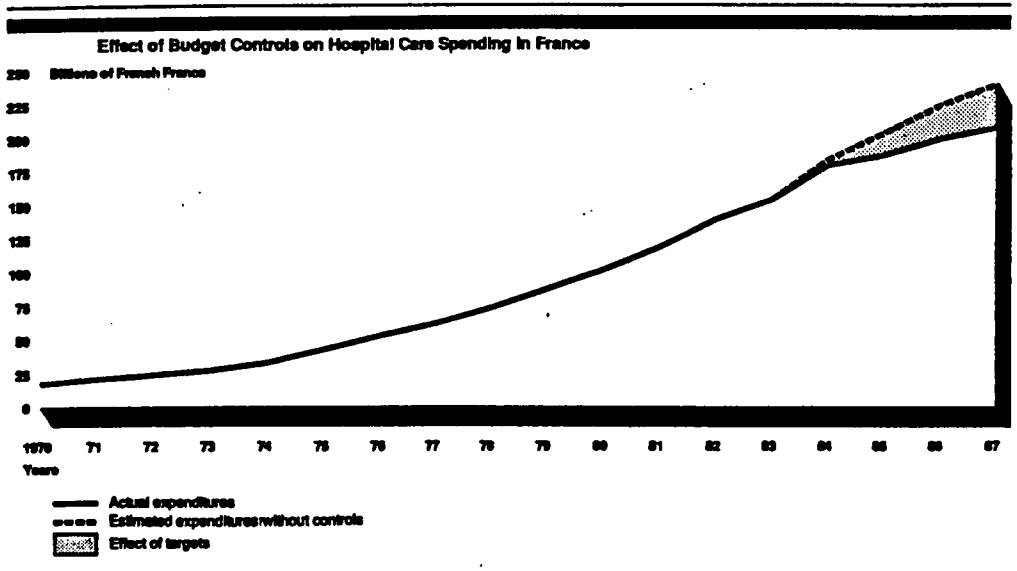
whether this slowdown in growth would persist over the long run, because these controls have only been in place for a few years.[19]

Figure 3.3: Effect of Budget Controls on Hospital Care Spending in France

Germany's Budget Limits on Hospitals Failed to Contain Spending

Our econometric analysis suggests that Germany's budget limits for hospitals, which do not have a formal mechanism to assure compliance, did not slow the growth rate in hospital spending, at least in the short run (see app. II). This failure to moderate the rise in hospital spending cannot be definitively attributed to the absence of a formal mechanism to assure compliance with the budget limits. Some experts on the German health financing system do assert, however, that the persistent increases in Germany's hospital care spending are the byproduct of a fragmented system of hospital financing, in which no policymaker or entity has the authority to restrain overall spending increases.

[19]Our econometric estimates are discussed in appendix II.


Effect of Budget Controls on Hospital Care Spending in France
Billions of French Francs
250
225
200
175
150
125
100
75
50
25
0
1970
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
Years
Actual expenditures
Estimated expenditures without controls
Effect of targets

MODIFICATIONS MAY BE NEEDED TO EXTEND SCOPE OF CONTROLS, ASSURE QUALITY, AND ENHANCE EFFICIENCY

Despite the effectiveness of budget controls at reducing the growth in spending for hospital services in France and physician services in Germany, officials in these countries are still concerned with rising health care spending. Health care spending in France, adjusted for inflation, rose at an average annual rate of 2.1 percent between 1984 and 1987 (the last year for which comparable data are available). This rate of increase can be explained, in part, by the scope of French budget controls, which do not apply to outpatient physician services or to the purchase of prescription drugs. Moreover, the French national insurance fund is expected to face a US $1.6 billion deficit in 1991. In Germany, real health care spending has grown more slowly--at an average annual rate of 1.9 percent between 1984 and 1987.[20]

This increase in spending can be attributed to factors such as the aging of the population and the introduction of expensive new medical treatments. Faced with these spending pressures, France and Germany are either expanding the scope of their budget controls or are supplementing these budget controls with policies designed to further moderate the rise in health care spending.[21]

There is concern in the countries reviewed that some cuts in spending may be at the expense of health care quality.[22] Our review of the three countries' spending control strategies shows that officials and analysts are increasingly aware of the desirability of developing policies that promote high-quality care as well as limiting spending growth.

---

[20]Health care spending in the United States, adjusted for inflation, rose by 5.9 percent in the same period.

[21]Officials in Japan are exploring policies to improve the efficiency of health care delivery within the existing framework of price controls.

[22]In line with other health care literature, we use the term quality of care to refer to several aspects of quality: (1) the mix of inputs available in providing care, (2) the manner in which services are provided, and (3) the outcomes of care. For additional references and discussion, see Michael D. Rosko and Robert W. Broyles, The Economics of Health Care (New York: Greenwood Press, 1988), p. 125.

Budget Controls Might Not Promote Efficient Behavior by Individual Providers

Policies that limit aggregate spending may not reward individual providers for achieving economies that permit the same volume of services to be delivered for less than the budgeted amount of spending. Nor do these policies necessarily penalize providers who, despite keeping spending within the prescribed budget, are wasteful and inefficient.

For example, where hospitals' global budgets are based on past spending levels (as in France and Germany), hospitals may sustain high spending levels so that they will be allocated larger budgets in subsequent years. These lump-sum budgets--sometimes perceived as entitlements--may even help keep open inefficient hospitals that otherwise would be forced to close. Furthermore, the practice of basing budgets on previous levels of spending may have the perverse effect of reducing budgets for hospitals that achieve savings through more efficient practices.

Physicians practicing under a sectorwide expenditure cap may try to maintain or increase their incomes by increasing the volume of low-value or unnecessary services or by "unbundling" services.[23] Yet physicians who do not increase their billings may receive a reduced share of the mandated budget because their share of total services performed has decreased.

Experts' observations suggest that spending controls may contribute to inefficiency in the health care systems we reviewed. For example, a number of studies note that French and German hospital payment methods may induce lengthened hospital stays, irrespective of the severity of illness or the resources used in providing care.[24] In addition, some experts on the German system attribute increased volume of physician services (which occurred since the imposition of spending caps), in part,

---

[23]Unbundling refers to the practice of billing for narrowly defined units of service. Unbundling can increase the reimbursement received for performing a treatment compared with what would be received when the payment is calculated for some combination, or bundle, of services.

[24]See, for example, Jean-Jacques Rosa and Robert Launois, "France," in Comparative Health Systems: The Future of National Health Care Systems and Economic Analysis, ed. Jean-Jacques Rosa (Greenwich, Conn.: JAI Press, Inc., 1990) and J.-Matthias Graf v.d. Schulenburg, "The West German Health Care Financing and Delivery System: Its Experiences and Lessons for Other Nations" (Paper presented at the International Symposium on Health Care Systems, Taipei, Dec. 18-19, 1989).

to the spending control policies, not to increased medical need.[25]

Countries Are Adopting Reforms to Further Reduce Spending and to Improve Cost-Effectiveness

Government officials and other health care experts in the countries reviewed are exploring additional approaches to improve the cost-effectiveness of these countries' health care spending. For example, the French government is considering measures to expand the use of budget controls for physician services and to reduce the reimbursement rate to private hospitals for prescription drugs. In 1989, Germany instituted a set of health care reform measures that were designed to increase efficiency in the delivery and payment of services; these measures included allowing sickness funds to deny payments to inefficient hospitals and promoting greater coordination between inpatient and outpatient medical services.

Some of the approaches being explored in these countries have already been employed successfully in the United States. For example, experts in Germany and France are exploring ways to implement a prospective payment system for hospitals--similar to the DRG-based system that the U.S. Medicare program uses--that offers incentives for more efficient delivery of hospital care.[26] Some proposals have been made in France to incorporate HMOs, on a limited basis, into the national insurance framework.[27]

Budget Controls' Effect on Quality Is Modest in the Short Run, Uncertain in the Long Run

Stringent budget controls that successfully stem the rise in health spending also can conceivably reduce the availability of services and, hence, the overall quality of care received by patients. Too-low payments to hospitals and too-low capital investment can hinder the ability of hospitals to maintain their

---

[25]The increase in physician services has also been attributed to increased competition among physicians, whose numbers are rising despite restrictions in aggregate physician income.

[26]Under Medicare's DRG-based prospective payment system, hospitals are paid a fixed amount for a patient's care, with the payment rate determined by the patient's diagnosis.

[27]For a description of the proposals, see Victor Rodwin, "American Exceptionalism in the Health Sector: The Advantages of 'Backwardness' in Learning from Abroad," Medical Care Review, Vol. 44 (Spring 1987), pp. 138-40.

facilities, inhibit the development of innovative treatments, and reduce patient access to high-cost treatments involving expensive medical technology and equipment. Excessively low reimbursement rates for physicians can skew the provision of services away from those services that receive relatively low payments. Germany, for example, is reviewing how quality assurance programs can be applied to maintain and improve the quality of medical care received.

We were not able to locate data on which to base a rigorous evaluation of budget controls' effects on the quality of care, but the evidence that does exist is inconsistent with a significant decrease in health care quality. First, these countries have experienced increases in average life expectancy and decreases in infant mortality rates since the imposition of budget controls.[28] Second, the level of public dissatisfaction with health care in these countries is generally low, according to public opinion surveys. Third, our review of the literature and interviews with government officials and providers revealed little evidence of queuing for services in the countries. For example, in Germany, access to outpatient services seems unaffected, despite the relatively stringent controls on physician spending.[29]

Other evidence, however, indicates that budget controls have reduced the quality of care to some extent, but not dramatically. In France, where hospital spending controls are relatively stringent, hospitals are having difficulty, officials say, in maintaining their facilities and acquiring up-to-date medical equipment. Moreover, experts on the French system believe that French global budgets discourage institutional innovation and improvements in the quality of care.

In the long run--a decade or more--as spending controls become more stringent, the likelihood of an adverse effect on quality increases. The experience of Canada, Sweden, and the United Kingdom with budget controls has been relatively long, and

---

[28]These facts alone are not sufficient to demonstrate that budget controls have not harmed quality of care, because changes in other factors may have offset any true adverse effects of the controls. Furthermore, we were unable to locate data on less tangible factors, such as pain and suffering, or on the quality of health care procedures.

[29]The relatively large supply of physicians in Germany may have prevented any adverse effects of controls on outpatient care from appearing.

suggests the need to observe the effects of controls on quality in France and Germany during the 1990s.[30]

---

[30]In Canada, Sweden, and the United Kingdom, queues for some services have emerged, leading hospitals to ration services to patients. The United Kingdom, in particular, where health care spending growth has been severely restricted in recent years, appears to be experiencing significant problems with access to expensive medical treatments. See, for example, Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90, June 4, 1991); Henry J. Aaron and William B. Schwartz, The Painful Prescription: Rationing Hospital Care (Washington, D.C.: The Brookings Institution, 1984); and Richard B. Saltman, "Competition and Reform in the Swedish Health System," The Milbank Quarterly, Vol. 64 (1990), pp. 597-618.

CHAPTER 4

CONCLUSIONS AND POLICY IMPLICATIONS

Twin ailments afflicting U.S. health care--chronic escalation of health care spending and the lack of health insurance for more than one in eight Americans--have been recognized by observers as diverse as senior officials of the executive branch, Members of Congress, and leaders of the American Medical Association. Consensus on a solution to these problems, however, has been elusive, as the public debate proceeds on the merits of divergent regulatory and market-oriented approaches. In this context, the findings of this report suggest four lessons that should be considered:

1: UNIVERSAL COVERAGE CAN BE ACHIEVED WITH MANY PAYERS (INSURERS)

Each of the three countries offers near-universal coverage and a mandated package of benefits in an insurance system with multiple payers. Each system employs a distinctive combination of nonprofit and public payers that reflects the country's unique political and social institutions.

Universal coverage serves the primary function of guaranteeing all residents access to a minimum benefit package that covers primary and acute care. Universal coverage has a secondary function of alleviating difficulties faced by providers of health care. For example, in a health care system with universal coverage and a broad package of standard benefits, providers face less financial stress and uncertainty than many American physicians and hospitals currently do. Providers, who might otherwise bear the burden of charity care, know that each patient's medical expenses will be paid by some insurer. Moreover, knowing the standard benefit package, providers can make medical decisions without having to guess which services are covered by the patient's insurer.

2: REIMBURSEMENT RATES CAN BE STANDARDIZED WITHOUT GOVERNMENT SETTING RATES UNILATERALLY

In each of the three countries, payment rates for providers are typically standardized, although exceptions exist.[1] These rates may be determined through formal negotiation between, for

---

[1]A uniform pricing system, when compared with a system like that in the United States--in which the diversity of payment policies mirrors the diversity of insurers--seems likely to realize substantial administrative savings. These tend to be one-time savings, not a flattening of the long-term trend of health care spending.

example, a physicians' association and an alliance representing payers.[2] Payment rates may also be set by a government agency in consultation with payers and providers. Regardless of the rate-setting process, all payers must abide by the established rates when reimbursing providers.

This arrangement differs greatly from that in the United States, where physician fees are largely determined in a market involving the interaction of thousands of physicians, millions of patients, and hundreds of insurers.[3] The uniformity of reimbursement in these countries prevents providers from shifting costs of care from less generous payers to more generous ones. In addition, the more standardized prices are, the less incentive providers have to withdraw their services from people whose payers otherwise might reimburse less generously. (In the United States, people insured by the Medicaid program have encountered reluctance by providers to serve them because of Medicaid's relatively low rates.)

3: CONTROLS THAT SET BUDGETS FOR ENTIRE SECTORS OF HEALTH CARE CAN MODERATE SPENDING INCREASES

Budget controls that are enforced are effective in slowing spending growth when they set spending limits for whole categories of services, namely all physician care or all hospital care. That they are budget controls is important because price controls alone have a potential limitation: price controls can induce providers to protect their incomes by increasing the volume of services provided. But budgets set limits on the product of price and volume--and therefore a budget that is fixed and binding must limit total spending. That these budget controls apply to all physician services or all hospital services--and to all payers of those services--is also important. Budget controls that are comprehensive are likely to have greater impact than those that are limited in scope. That is, controls that reduce spending increases for all payers tend to trim total spending more than controls that apply to only half of the payers.

---

[2]To engage in bilateral negotiations, payers in an alliance must coordinate their negotiating strategy. This coordinated approach enables them to act as a single purchaser of medical services, thereby giving them market power (technically, "monopsony power"). Such market power tends to enable payers to obtain prices that are lower than those prevailing in an unregulated, competitive market.

[3]Beginning in 1992, when the Medicare program introduces an RVS for physician services, physician payment rates for a substantial proportion of the U.S. population will be determined administratively, not through market interactions.

4: BUDGET CONTROLS DO NOT RELIEVE ALL SPENDING PRESSURES, NOR DO THEY ASSURE QUALITY OR EFFICIENCY

The success of budget controls at slowing health spending growth in France and Germany has not relieved pressures for increased spending in those countries. These countries' health care expenditures continue to rise, in part because some sectors (such as prescription drugs or, in France, physician services) are not subject to spending caps or targets.[4] In addition, the budget controls do not address the anticipated spending increases associated with the aging of populations in these countries and with the introduction of expensive medical treatments.

Furthermore, spending targets and caps are not designed to maintain the quality of care or curb waste in the provision of health services. The singleminded and sustained pursuit of spending containment through the use of targets and caps may, however, harm quality. Budget controls can so restrict funding that some services are made less available, and some hospitals and medical equipment are not maintained properly or modernized. As the experience of countries such as Canada and the United Kingdom suggests, such threats to availability of services are probably most noticeable in hospitals' provision of expensive acute care; these threats are most likely to emerge after controls have been in place for a protracted period of time. Moreover, as new medical needs emerge (for example, the AIDS epidemic), budget controls that rigidly link health spending to national income might prevent a country from responding adequately.

Effective budget controls also may not encourage individual providers to deliver care efficiently. For example, fixed budgets for hospitals do not reward administrators and physicians for making cost-saving innovations. Likewise, fixed budgets can permit the continued operation of inefficient hospitals that otherwise might succumb to market forces and shut down.

---

[4]To infer from continued spending growth in France and Germany that their budget controls were ineffective would be incorrect. Determining the effectiveness of a policy requires a comparison of actual spending growth under the policy in place with spending growth that would have occurred without the policy. By this standard, budget controls were effective in two of three cases reviewed. Policies that are effective may still be insufficient to relieve all spending pressures or reduce spending growth to the extent some may wish.

54-832 O - 92 - 5

To complement spending control with assurance of quality and promotion of efficiency, budget controls (similar to those used in France and Germany) need to be modified or supplemented with additional policies. This point has been recognized in France and Germany, where proposals and policy reforms have recently been made to improve the efficiency with which health care is provided. These proposals include the use of prospective payment for hospitals and, in Germany, increased coordination between the inpatient and outpatient sectors. Moreover, further refinements of budget controls to promote efficiency may be possible. For example, fixed budgets might be accompanied by rewards for providers that generate less than the budgeted level of spending.

APPENDIX I

USE OF REGIONAL PLANNING TO ALLOCATE CONSTRUCTION AND HIGH-COST MEDICAL EQUIPMENT

France	Hospital construction must be approved by national government. Any addition of hospital beds must be offset by closings elsewhere. High-cost medical equipment must be authorized by national government.
Germany	Hospital construction and high-cost medical equipment are licensed and financed by the states.
Japan	Hospital construction subject to regional planning, but limits do not apply to private clinics (defined as facilities with less than 20 beds). No planning to control growth or distribution of high-cost medical equipment.

APPENDIX II

ECONOMIC ANALYSIS OF THE EFFECTS ON SPENDING GROWTH OF CHANGES FROM PRICE CONTROLS TO BUDGET CONTROLS

Did a change from price controls to budget controls slow the growth of nominal health care spending relative to the growth of the national economy? This question has different answers in different sectors--German physician care, German hospital care, and French hospital care. To provide a basis for answering the question, we developed an economic model and used it to evaluate the relative effectiveness of these two types of policies in controlling health care expenditure growth. This model relates spending levels in a sector (physician care or hospital care) to key policy and nonpolicy determinants. Using multiple regression analysis, we estimated the model on time-series data for each of the three sectors cited above. This technique enabled us to control for other factors that affect health care spending and to determine whether a new policy was accompanied by a lower rate of growth of health care expenditures relative to national income.

Price controls seek to limit spending growth indirectly (by fixing prices), and budget controls (that is, spending targets and spending caps) seek to limit expenditures directly. Targets suggest maximum spending levels, but may lack formal enforcement. Caps set maximum spending levels and have the means to enforce these limits.

During the late 1970s and 1980s, France and Germany altered their approaches to containing health care spending and adopted budget controls for at least one sector. With respect to physician services, Germany moved, in 1977, from price controls (on physician fees) to spending targets, used in conjunction with price controls. In 1985, it converted these targets into binding caps. With respect to hospital care, both Germany and France moved, in the mid-1980s, from regulated per diem rates to global budgets and aggregate spending targets for hospital services.

SPECIFICATION OF THE MULTIPLE REGRESSION MODEL

In our model, total nominal spending,[1] in a particular health care sector (physician or hospital),[2] depends on both policy and nonpolicy variables. The nonpolicy variables included are the country's national income and population,[3] as well as a measure of resources in the particular sector--the number of practicing physicians (for the physician care sector) or the number of inpatient medical care beds (for the hospital sector). These nonpolicy variables are commonly used as control variables in regression analysis of health care spending.[4] We expect spending to rise with national income--previous work has shown national income to be the prime determinant of health care spending levels.[5] We also expect spending to rise as population rises.[6] Finally, we also expect the amount of resources in a sector (number of physicians or of hospital beds) to have a positive

---

[1]Nominal spending, not real spending, is used, because the policies analyzed are "nominal" in nature; that is, they are designed to limit the growth of current (nominal) spending relative to current national income.

[2]We use ambulatory care expenditures data as an estimate of spending on physician services because spending on physician services is the dominant component of ambulatory care spending. Expenditure data on physician services alone were not available.

[3]In our regressions, income is represented by GDP for France and by total employee compensation in the national economy for Germany. Total employee compensation, while not a complete measure of national income, is used because Germany's ambulatory and inpatient sector targets are tied to this variable.

[4]See Thomas E. Getzen, "Macro Forecasting of National Health Expenditures," Advances in Health Economics and Health Services Research, Vol. 11 p. 27-48, and A.J. Culyer, "Cost Containment in Europe," in Health Care Financing Review, Annual Supplement, Vol. 11 (Winter 1989), pp. 21-32.

[5]Articles by Culyer and Jonsson cite several studies on the determinants of national health care spending. See Culyer, "Cost Containment," p. 32, and Bengt Jonsson, "What Can Americans Learn from Europeans?" Health Care Financing Review, Annual Supplement, Vol. 11 (Winter 1989), pp. 79-93.

[6]Unlike our model, other studies of health care spending calculate spending and its determinants in per capita terms. This specification is plausible, but the data available may not permit it. Consequently, we adopted a more general specification that is consistent with the conventional specification, but is not restricted to that hypothesis.

effect on spending. Previous studies have found evidence of providers autonomously increasing the utilization of their services, so we included this variable to control for the possibility of provider-induced demand for medical services.[7]

To capture the influence of budget controls, the model includes a pair of variables: the first, an additive dummy variable, indicates for each year the policy regime in effect--price controls or budget controls--and the second, a variable that indicates the interaction or product of the policy dummy and national income.

The coefficient on national income measures the responsiveness of spending to changes in national income under price controls alone. The coefficient on the policy interaction term answers this question: Did the policy change lead to smaller increases in health care spending for given increases in national income? If the estimated coefficient on the interaction term is negative, the change from price controls alone to budget controls succeeded in slowing health care spending growth (relative to the growth of the economy as a whole).[8] The sum of the coefficients on national income and the interaction term measures the responsiveness of spending to income under budget controls.[9]

The model is estimated in a double-log specification: all numerical variables are evaluated at their natural logarithms. As a result of this specification, a coefficient estimate can be interpreted as an elasticity, that is, the percentage change in expenditures resulting from a percentage change in the explanatory variable. For example, a coefficient estimate of 0.5

---

[7]For references to studies that document this effect, see Burton A. Weisbrod, "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," Journal of Economic Literature, Vol. 29 (June 1991), p. 525. (For evidence on physicians' responses to price controls, see Physician Payment Review Commission, Annual Report to Congress 1991 (Washington, D.C.), pp. 387-96.)

[8]For the additive dummy variable, a positive coefficient estimate indicates that the change in policy is accompanied by an increase in the intercept of the expenditure function.

[9]The sum of these two coefficients equals the partial derivative of log(health spending) with respect to log(national income). A different issue--the total effect of the policy change on spending--can be addressed by examining the partial derivative of log(spending) with respect to the policy change: the coefficient on the additive dummy plus the product of the interaction term coefficient and log(national income).

implies that a 1 percent increase in the explanatory variable results in a 0.5 percent rise in spending.

The variables used and brief descriptions of each are given in table II.1.

Table II.1
List of Variables

Physician care spending:	Total expenditure on ambulatory medical services, including expenditures for outpatient physician services (such as office visits and procedures performed in a physician's office) and outpatient lab tests
Hospital care spending:	Total expenditure on inpatient care, including expenditures for conventional hospital services and physician care in the hospital
National income:	Gross domestic product (GDP) for France and total employee compensation in the national economy for Germany
Population:	Mid-year estimates
Number of physicians:	Number of active practicing physicians, including physicians practicing in hospitals (number of hospital physicians not available separately)
Hospital beds:	Average daily census of inpatient medical care beds
Spending target:	Dummy variable with the value of 1 during periods in which spending targets are in effect, 0 otherwise
Spending cap:	Dummy variable with the value of 1 during periods in which spending caps are in effect, 0 otherwise

DATA

The data used in our regression analysis were compiled by the Organization for Economic Cooperation and Development (OECD);[10] these data are the most comprehensive and carefully assembled source of international health care statistics. They are not, however, well suited for comparing health expenditures by sector (for example, hospital care) across countries because no commonly accepted international accounting system exists for measuring economic activity in the health care industry. This lack of comparability across countries, however, does not impair our analysis because we examine specific sectors within individual countries across time.

RESULTS

Our empirical results indicate that budget controls are more effective than price controls in limiting health care spending growth. The effectiveness of budget controls, however, is enhanced by the presence of strict enforcement mechanisms. Without such enforcement mechanisms, the change from price controls to budget controls had an insignificant effect in one case. In another case, a target without enforcement did slow spending growth, but incorporating an enforcement mechanism achieved greater spending restraint.

For the German physician care sector, the shift--from price controls to sectorwide spending targets and then to spending caps--was accompanied by slower growth of expenditures relative to the growth in total employee compensation, as indicated by the negative parameter estimates for the interaction terms. This effect is estimated to be statistically significant (see table II.2).[11]

---

[10]See Health Care Financing Review, Annual Supplement (Winter 1989), pp. 111-94, for data used and a detailed description.

[11]An estimate is considered statistically significant if the probability is low that the true value of the coefficient is 0. A conventional significance level is 0.05: that is, the probability of the true coefficient being 0 is no greater than 0.05.

Table II.2
The Effect of Targets and Caps on Physician Care Spending--Germany (1970-87)[a]

Variable	Coefficient estimate	Standard error
Intercept	-17.93	19.62
Log-population	-0.74	1.66
Log-national income	0.73[b]	0.31
Log-number of physicians	1.82[b]	0.72
Spending target	9.30[b]	2.72
(Log-national income)* (spending target)	-0.46[b]	0.13
Spending cap	33.58[b]	7.94
(Log-national income)* (spending cap)	-1.62[b]	0.38
R-squared	0.99	
Durbin-Watson statistic	2.67	

[a]All figures are nominal, that is, unadjusted for inflation. Expenditure targets were implemented in 1977, caps in 1985. "National income" refers to total employee compensation in the national economy.

[b]Significant at the 0.05 level.

Furthermore, our results confirm our expectation that binding spending caps should have had an effect significantly greater than that of nonbinding spending targets.[12] We are reluctant, however, to attach too much weight to the value of the point estimates because spending caps, in our data set, were in effect for only 2 full years. The point estimates indicate that with caps in place, increases in national income led to decreases in physician care spending rather than to the moderation in spending increases

[12]Based on an F-test, we rejected the null hypothesis that the effects of targets and caps are equal.

that would be expected.[13] We believe that this is a short-term phenomenon that cannot persist in the long run; the policy is designed to dampen the relationship, not reverse it. The large absolute value of the point estimate is explained by the rather severe imposition of the cap--total spending essentially did not rise in the initial year (whereas the year before, spending grew at 9 percent, and the year after, at 4 percent.) Given that we have an observation for only 1 full year after that, this initial period of zero-growth drives the large size (in absolute value) of the negative point estimate of the interaction term. We expect zero-growth under the cap to be an anomaly since zero growth is not the goal of the cap. Consequently, as more years of data become available, we still expect to find a significant negative effect for caps if the policy remains unchanged. The point estimate of the interaction coefficient should no longer, however, be larger than the coefficient on national income.

The estimated elasticity of physician spending with respect to national income before the policy changes--0.73--may appear somewhat low, given the common finding that health care spending is elastic--that is, the estimated elasticities are equal to, or exceed, 1.[14] In fact, several considerations suggest caution about drawing this conclusion from the literature. First, these estimated income elasticities are for total health care spending, not for a component such as inpatient care spending. No strong presumption exists that all components of total health spending should have the same income elasticity. In fact, we estimated an elasticity for German hospital spending of 1.40 (see table II.3.) Second, the estimated income elasticities are for cross-section data, but our estimates are for time series. Estimated elasticities from cross-section data may differ from those based on time series data.[15] Third, income elasticities based on time series data have been reported to equal or exceed 1, but these elasticities are not comparable with our estimates, because they were not estimated from regression equations. Instead, these elasticities represent arithmetical calculations--the percentage change in health spending between 2 years, divided by the percentage change in GDP over the same period.[16]

---

[13]The income elasticity of physician care spending was estimated to be -0.89 with caps, compared with 0.27 with targets and 0.73 without budget controls.

[14]Culyer, "Cost Containment," pp. 30-31.

[15]For example, this phenomenon is found in the literature on personal consumption spending and on production functions.

[16]Culyer, "Cost Containment," p. 30, table 2.

For the French hospitals, the shift from regulated per diem rates to sectorwide spending targets with global hospital budgets was accompanied by a statistically significant reduction in expenditure growth relative to economywide growth.[17,18] For German hospitals, which experienced a similar shift from price controls to budget targets, we did not find a statistically significant effect of budget controls (see table II.3). Differences in enforcement mechanisms could explain why targets had a significant effect in the French case but an insignificant one in the German case. The French government's participation in each hospital's budget negotiations encourages observance of the targets, but the German targets are guidelines that lack an enforcement mechanism to reconcile actual spending with the targets.[19,20]

These budget controls were typically in effect for only a few years (during the period for which we have data on France and Germany), and some might question whether this fact precludes meaningful analysis of the policies' effectiveness.[21] Our procedures take account of this issue, however. More precisely, the fewer the number of years for which the policy was in place, the more imprecise the estimate of policy effectiveness, other things being equal.[22] The conventional test of the statistical significance of the estimated policy coefficient, however, considers the imprecision of the estimate. The significance test will reject a nonzero effect if the imprecision of the estimate is relatively large. By contrast, the estimated effect of a policy can be properly viewed as nonzero if it passes the significance test, even

---

[17]As with the German ambulatory care sector, given that targets were in effect for only 3 full years in France, the point estimate of the coefficient should not be interpreted as a long-run elasticity.

[18]The estimated income elasticity of hospital spending decreased from 1.38 to 0.77.

[19]The effect of population is statistically insignificant in all three cases studied. This is not surprising, however, given the relatively small variations in population over the periods considered.

[20]The high R-squares obtained here are typical of time series analysis and, to some extent, reflect common trends in many variables over time. In the cases studied here, both expenditures and national income trend rapidly upward during the sample period.

[21]German physician spending caps were in effect for only 2 full years and French hospital spending targets were in effect for only 3 full years.

[22]Imprecision is measured by the standard error of the estimated coefficient in the regression analysis.

if the policy was in place for only a few years. In fact, GAO did find statistically significant effects for German spending caps and French spending targets that were in place for relatively brief periods.

Table II.3
The Effect of Spending Targets on Hospital Care Spending--France and Germany[a]

	France[b] (1960-87)		Germany[c] (1970-87)	
Variable	Coefficient estimate	Std. error	Coefficient estimate	Std. error
Intercept	-8.81	5.28	-54.53[d]	14.83
Log(population)	0.01	0.53	2.04	1.51
Log(national income)	1.38[d]	0.04	1.40[d]	0.03
Log(hospital beds)			1.03[d]	0.35
Spending target	9.37[d]	3.63	6.05	9.64
Log(national income)* spending target	-0.61[d]	0.24	-0.29	0.46
R-squared	0.99		0.99	
Durbin-Watson statistic	1.09		0.91	

[a]All figures are nominal, that is, unadjusted for inflation.

[b]Targets with global hospital budgets for public hospitals were implemented in 1984. Data on number of hospital beds are not available for 13 out of 28 years. National income is measured by GDP.

[c]Targets with global hospital budgets were implemented in 1985. National income is measured by total employee compensation in the national economy.

[d]Significant at the 0.05 level.

ADDITIONAL TECHNICAL ISSUES

A potential shortcoming of our approach is the simplicity of the model specification. Variables besides national income and population that one would expect to affect the level of health care spending--such as demographic characteristics, particularly the age distribution, income distribution, and health status of the population--are not included in the regression equation. This is due to a lack of available data. Furthermore, even if these data were available, the limited number of observations restricts the number of explanatory variables that can be included. In light of previous research showing national income to be the single most important factor determining health expenditures, we do not consider omitted variables to be a serious problem. We do not believe that their inclusion would change the qualitative results for policy outcomes.

Another potential problem with our estimation is serial correlation among the error terms, a common problem with time-series analysis. Serial correlation refers to the interdependence of the error terms in the regression equation. This statistical problem affects the accuracy with which the parameters of the model are estimated. Tests indicate evidence of serial correlation in the French hospital regression, and are inconclusive for both German regressions. Therefore, new regressions were run using Cochrane-Orcutt iterative least squares, a procedure correcting for the problem if it exists. The results remained basically unchanged--that is, the sign and statistical significance of all policy variables, and of most other independent variables, stay the same. In addition, the magnitude of the coefficients themselves generally is little changed.

54-832 O - 92 - 6

APPENDIX III

MAJOR CONTRIBUTORS TO THIS REPORT

HUMAN RESOURCES DIVISION, Washington, D.C.

Janet L. Shikles, Director, Health Financing and Policy Issues, (202) 275-5451
Jane L. Ross, Senior Assistant Director
Jonathan Ratner, Assistant Director
David J. Gross, Evaluator-in-Charge
Paul J. Yakoboski, Senior Economist
Hannah F. Fein, Technical Writer

BIBLIOGRAPHY

Readers interested in learning more about the health care systems of France, Germany, and Japan may wish to refer to the sources listed below. This list is not intended as a comprehensive bibliography.

Altenstetter, Christa. "Hospital Planners and Medical Professionals in the Federal Republic of Germany." In Controlling Medical Professionals: The Comparative Politics of Health Governance, London: Sage Publications, 1989.

Employee Benefit Research Institute. "International Benefits: Part One--Health Care," EBRI Issue Brief No. 106 (Sept. 1990).

Glaser, William. Health Insurance in Practice: International Variations in Financing, Benefits, and Problems, San Francisco: Jossey-Bass Publishers, 1991.

Graig, Lawrence A. Health of Nations: An International Perspective on U.S. Health Care Reform, Washington, D.C.: The Wyatt Company, 1991.

Hurst, Jeremy W. "Reform of Health Care in Germany," Health Care Financing Review, Vol. 12 (Spring 1991), pp. 73-86.

Iglehart, John K. "Japan's Medical Care System," New England Journal of Medicine, Vol. 319 (Sept. 22, 1988), pp. 807-12.

_____. "Japan's Medical Care System--Part Two," New England Journal of Medicine, Vol. 319 (Oct. 27, 1988), pp. 1166-72.

_____. "Germany's Health Care System (First of Two Parts)," New England Journal of Medicine, Vol. 324 (Feb. 14, 1991), pp. 503-08.

_____. "Germany's Health Care System (Second of Two Parts)", New England Journal of Medicine, Vol. 324 (June 13, 1991), pp. 1750-56.

Ikegami, Naoki. "Japanese Health Care: Low Costs, Regulated Fees," in Health Affairs, Vol. 10 (Fall 1991), pp. 87-109.

Kirkman-Liff, Bradford. "Physician Payment and Cost-Containment Strategies in West Germany: Suggestions for Medicare Reform," Journal of Health Politics, Policy, and Law, Vol. 15 (Spring 1990), pp. 69-99.

OECD Secretariat. "Health Care Expenditure and Other Data: An International Compendium from the Organization for Economic Cooperation and Development," Health Care Financing Review, 1989 Annual Supplement (Dec. 1989), pp. 111-94.

Powell, Margaret, and Masahira Anesaki. Health Care in Japan, New York: Routledge, 1990.

Reinhardt, Uwe E. "West Germany's Health-Care and Health-Insurance System: Combining Universal Access With Cost Control," U.S. Bipartisan Commission on Comprehensive Health Care, Supplement to the Final Report (Sept. 1990), pp. 3-16.

Rodwin, Victor. "American Exceptionalism in the Health Sector: The Advantages of 'Backwardness' in Learning From Abroad," Medical Care Review, Vol. 44 (Spring 1987), pp. 119-53.

Rodwin, Victor G., Harvey Grable, and Gregory Thiel. "Updating the Fee Schedule for Physician Reimbursement: A Comparative Analysis of France, Germany, Canada, and the United States," Quality Assurance and Utilization Review, Vol. 5 (Feb. 1990), pp. 16-24.

Rosa, Jean-Jacques, and Robert Launois. "France." In Comparative Health Systems: The Future of National Health Care Systems and Economic Analysis, ed. Jean-Jacques Rosa. Greenwich, Conn.: JAI Press, Inc., 1990.

Schieber, George J., and Jean-Pierre Poullier. "International Health Care Expenditure Trends: 1987," Health Affairs, Vol. 8 (Fall 1989), pp. 169-77.

_____. "International Health Spending: Issues and Trends," Health Affairs, Vol. 10 (Spring 1991), pp. 106-16.

Schieber, George J., Jean-Pierre Poullier, and Leslie M. Greenwald. "Health Care Systems in Twenty-Four Countries, Health Affairs, Vol. 10 (Fall 1991), pp. 22-38

Schneider, Markus. "Health Care Cost Containment in the Federal Republic of Germany," Health Care Financing Review, Vol. 12 (Spring 1991), pp. 87-101.

Wilsford, David. Doctors and the State: The Politics of Health Care in France and the United States, Durham, N.C.: Duke University Press, 1991.

(101164)

United States General Accounting Office

GAO

Testimony

For Release
on Delivery
Expected at
9:30 a.m. EST
Tuesday
November 19, 1991

Health Care Spending Control:
The Experience of France, Germany and Japan

Statement of
Lawrence H. Thompson, Assistant Comptroller General
Human Resources Division

Before the
Special Committee on Aging and
the Committee on Governmental Affairs
United States Senate

Chairmen and Members of the Committees:

We are pleased to be here today at this joint hearing of the Senate Committee on Governmental Affairs and the Special Committee on Aging. We are here to discuss the health systems in France, Germany, and Japan and the results of our report just issued.[1]

As you know, there is concern nationally about the twin problems that afflict the health care system in the United States: escalating spending and narrowing access to health insurance. How to address these problems remains under debate in the domestic policy arena, and it was in this context that the late Senator John Heinz asked us to undertake this review. We are reporting on lessons that the United States can draw from other industrialized countries. We are not advocating any one system or feature discussed. I will begin with a brief overview of the three countries' systems, pointing to their similarities and differences, and then summarize what we found to be significant.

HIGHLIGHTS OF THE FOREIGN HEALTH CARE SYSTEMS

We focused our report on France, Germany, and Japan, in part because these countries provide universal access to health

---

[1]Health Care Spending Control: The Experience of France, Germany, and Japan, GAO/HRD-92-9, November 15, 1991.

insurance while spending proportionately less on health care than the United States. In 1989 the United States spent 11.8 percent of its national income on health care, whereas France, Germany, and Japan spent 8.7, 8.2, and 6.7 percent, respectively.[2]

Similarities

These countries' better spending records and their similarities to the U.S. system have attracted the attention of health policy experts. They resemble the U.S. system in four ways: First, they provide health insurance using multiple insurers, or payers. Second, people typically get health insurance for themselves and their dependents at their place of employment. A person's employer or occupation determines which insurer provides coverage of health benefits. Third, people in these countries have free choice of physicians that charge on a fee-for-service basis.[3] Last, both private and public hospitals deliver inpatient care.

---

[2]National income refers to gross domestic product.

[3]In the United States, the choice of some Americans is limited. In some rural areas and inner cities, alternative providers are few. Moreover, some Americans have opted to limit their choices by enrolling in health maintenance organizations or other forms of organized care, such as preferred provider organizations.

Differences

We do not want to overstate the similarities, however. The French, German, and Japanese systems are notably different in that they are extensively regulated. This regulation has important consequences. The first is that almost all residents are guaranteed access to health insurance. The government achieves this by stipulating which insurers will cover which population groups. The government also mandates a minimum package of health care benefits, compulsory enrollment, and payroll contributions from both employers and employees (for insurance obtained at the workplace).[4]

The second consequence of regulation is that insurers' payments to physicians and hospitals are standardized. All three countries use price controls that place ceilings on physician fees or daily hospital charges. Insurers are required to reimburse providers according to the set rates. This means that a given service gets reimbursed at the same rate, regardless of insurer. The government does not set these payments unilaterally, however. Instead, insurers and providers help develop these rates--negotiating with each other, as in France and Germany, or advising the government, as in Japan.

[4]In Germany people with incomes over US $36,000 are not required to enroll.

Finally, regulation in these countries also is designed to control the rise in health care spending. Nationwide policies in the three countries set goals for overall health spending increases. In addition, France and Germany set goals for and impose spending budgets on inpatient hospital care. Germany has a budget that caps spending on physician services. As part of our review, we did an econometric analysis of the French and German budget controls to see how effective they were.

In Japan, the government targets a desired growth rate for total health care spending, but does not impose budgets on physician or hospital care. Rather, Japan relies much more on controlling prices in its efforts to restrain spending than do France and Germany.

GAO OBSERVATIONS

We have just identified important features of the French, German, and Japanese health care systems: multiple insurers, near-universal health insurance, regulation of provider payments, and price and budget controls. Taken together, these features suggest four main lessons that bear on the cost and access problems of U.S. health care.

First, these countries achieve universal health coverage using many insurers. To provide this coverage, these countries mandate

that a minimum broad package of health benefits be offered by all insurers. In addition, the government designates an insurer for those people not covered through the insurance offered at the workplace.

Universal health insurance in these countries precludes the need for physicians, hospitals, and insurers to shift the costs of otherwise uncompensated care to people with health insurance. The standard benefit package, moveover, allows providers to make medical decisions without having to be concerned about which services are covered by the patient's insurer.

Second, these countries standardize rates for reimbursing providers without the government setting rates unilaterally. Although there are exceptions, insurers' reimbursements to providers are usually made at a uniform rate. These rates are set with the participation of payers and providers. This arrangement differs greatly from that in the United States where physician fees are largely determined in a market with the interaction of myriad players--physicians, insurers, and consumers.[5]

Because reimbursement rates in these countries are standardized, providers have little reason to shift costs of care

---

[5]In 1992, when Medicare introduces a relative value scale for physician services, physician payment rates for a substantial proportion of the population will be determined administratively, not through market interactions.

from less generous payers to more generous ones. In addition, when prices are uniform, providers have less incentive to withdraw their services from people whose payer might otherwise reimburse less generously. In the United States, Medicaid is such a payer. Medicaid beneficiaries encounter difficulty finding physicians willing to accept Medicaid's relatively low reimbursement rates.

The policy of placing a ceiling on reimbursement rates for providers is not universally popular in these countries. Physicians in France and Germany, for example, have sought to undo or soften the effects of this policy on their incomes.

Third, these countries can moderate increases in health spending by putting entire sectors of health care on a budget. Our report details how budget controls worked in France and Germany. For example, budget controls in Germany restrained spending for physician care. In fact, we estimate that, by 1987, spending was 17 percent lower than it would have been without these controls. The story is similar in France: we estimate that French budget controls, by 1987, reduced spending on hospital services by 9 percent compared to the amount that would have been spent otherwise.

Our analysis also found that budget controls with teeth were more effective than those that were simply guidelines. Germany first introduced a target for physician spending that did not have

an enforcement mechanism and later adopted a cap that did. Because the cap had enforcement built in, it was more effective than the earlier target. Targets for hospitals, however, were not effective at reducing expenditure growth in Germany, but were effective in France. Again, we believe that enforcement was the key to effectiveness. That is, the French government enforced the national targets set for hospital care through its participation in budget negotiations with each hospital individually. By contrast, in Germany, no formal mechanism linked the nationwide spending targets set for hospital care to individual hospital budget negotiations.

Fourth, the experience of these countries shows that budget controls are not a panacea--they do not relieve all spending pressures, nor do they assure quality or efficiency. In fact, France and Germany's health expenditures continue to rise. For one thing, some sectors are not subject to budget controls. For another, social pressures on spending, such as the aging of the population or the spread of AIDS, are beyond the reach of budget controls.

In addition, budget controls in France and Germany offer little incentive for physicians or hospitals to deliver care efficiently. For example, fixed budgets for hospitals do not reward administrators or physicians for making cost-saving innovations. Likewise, fixed budgets can keep inefficient

hospitals open that might otherwise suffer losses and shut down. France and Germany have recognized these limitations of budget controls. They are exploring policy proposals and reforms, including a diagnosis-based approach to hospital reimbursement--similar to Medicare's system.

- - - -

Consensus on how to address the problems of cost and access in the U.S. health care system has been elusive, and Americans have begun to look abroad for insights. Given the complexity of the U.S. health care system and the diversity of the United States, no foreign model can be imported wholesale. Nonetheless, the debate over divergent approaches to health financing reforms will benefit from assessing the merits and flaws of foreign health care systems.

This concludes my statement. I would be happy to answer any questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

GEORGE J. SCHIEBER, PH.D.

DIRECTOR, OFFICE OF RESEARCH

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS

AND THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NOVEMBER 19, 1991

HEALTH SECTOR PERFORMANCE IN CANADA, FRANCE, GERMANY, JAPAN, THE UNITED KINGDOM, AND THE UNITED STATES: AN APPRAISAL

INTRODUCTION

Mr. Chairman and Members of the Committee, I am pleased to be here today to provide an overview of the performance of the health care financing and delivery systems of France, Germany, and Japan. Given the strong interest in the Canadian health care system and the importance of the general approach embodied in the British National Health Service, I have also included Canada and the United Kingdom in the analysis.

Health sectors account for a substantial percentage of total output in these five countries, averaging 7.7 percent of their Gross Domestic Products (GDP) and $1297 per person in 1990. To put this another way, on average one-thirteenth of all production in these countries is devoted to the health sector. The U.S., on the other hand, spends $2566 per person and devotes 12.4 percent of its GDP, one-eighth of its total production, to the health sector. Except for the U.S., where the public sector accounts for 42 percent of all health spending, public programs account for over 70 percent of all health spending in each of the other five countries. Health is the second largest public expenditure after public pensions, and these countries on average spend over twice as much on health as on national defense. The health sector is also one of the largest employers in all these countries, accounting for about four percent

of all employment.

Health System Models

The six countries discussed here represent the entire spectrum of generic models of health systems. France, Germany, and Japan represent the "Social Insurance" or Bismarck approach, characterized by compulsory universal coverage under social security, financed by employee and employer contributions to non-profit insurance funds, and mixed public and private ownership of health sector inputs. The U.K. represents the "National Health Service" or Beveridge approach, characterized by universal coverage, national general tax financing, and national ownership and control of health sector inputs. The U.S. represents the "Private Insurance" or Consumer Sovereignty approach, characterized by employer-based or individual purchase of private health insurance and private ownership of health sector inputs. The Canadian system has been defined as a "Provincial-Government Health Insurance" model characterized by compulsory universal coverage, joint Federal and provincial government tax financing, provincial government management, and public and private ownership of health sector inputs.

Problems in International Comparisons

In my view the models are not important. What is important from

a health policy perspective is understanding how well different health systems perform and attributing performance to specific features of these systems. Unfortunately, this is extremely difficult to do. The goal of all health systems is to provide universal access to medically-appropriate and medically-effective services in a cost-effective manner. Thus, in order to evaluate performance, we need to be able to define and measure access, medical appropriateness, medical effectiveness, and cost-effectiveness. Given the difficulties in measuring the outcomes of most medical interventions in other than gross terms, we cannot measure medical appropriateness, medical effectiveness, or cost-effectiveness. Moreover measuring access is difficult from both conceptual and objectivity perspectives.

Beyond the difficulties in evaluating the performance of health systems, there are substantial problems in international comparisons in obtaining comparable spending and utilization information and understanding the institutional features of other health systems in enough detail so that we can even crudely attribute performance to specific characteristics of the systems. Without belaboring these methodological issues, I need only point out the difficulties in obtaining a comprehensive description of the U.S. health care system, and the problems faced by health policy-makers in trying to disentangle the complex interactions among consumers, insurers, and medical care providers to understand the impacts on costs, quality, and access of specific policies such

as the Medicare hospital DRG system and the new Medicare fee schedule. For these reasons, it is exceedingly difficult to make definitive assessments about which countries' systems perform 'better' than others.

This overview is divided into three parts. First, the expenditure performance of Canada, France, Germany, Japan, the U.K., and the U.S. is analyzed. Second, the availability and use of services and health outcome measures are presented. Third, the policy implications for U.S. health care reform are discussed.

EXPENDITURE PERFORMANCE

Health expenditure performance across countries can be analyzed in a variety of ways. Expenditures can be analyzed in terms of each country's national currency or based on one nummeraire currency. They can be analyzed at one point in time or over time. Expenditures can be adjusted for population and inflation and can also be compared to general economic trends within each country.

It is essential to analyze several different measures of expenditure performance, since reliance on only one measure is likely to lead to an incomplete or incorrect assessment of relative performance. First, the amount of total output devoted to the health sector as measured by the health to GDP ratio is discussed both for the latest available year, 1990, and in terms of the

growth in this ratio between 1970-90. Second, to better understand whether changes in this ratio are due to changes in nominal health spending and/or changes in nominal GDP, growth in each of these two components is analyzed. Third, the increasing amounts of real (i.e. inflation-adjusted) resources being devoted to the health sectors in these countries is compared. Fourth, absolute levels of health spending denominated in U.S. dollars and their changes over the 1970-90 time period are discussed. Fifth, the relationship between countries' health spending and wealth is analyzed.

Health to GDP Ratio

The most widely used measure based on national currencies to compare expenditures is the ratio of health spending to GDP. Exhibit 1 displays the health to GDP ratios for Canada, France, Germany, Japan, the U.K., and the U.S. for 1970-90. In 1990 the U.S. devoted 12.4 percent of its GDP to health compared to: 9.0 in Canada, 8.9 in France, 8.1 in Germany, 6.5 in Japan, and 6.1 in the U.K. The graph vividly demonstrates the growth in the U.S. ratio relative to those in these other countries. Over the entire 20 year period the U.S. share of health in GDP increased from 7.4 percent in 1970 to 12.4 in 1990 compared to increases of: 7.1 to 9.0 for Canada, 5.8 to 8.9 for France, 5.9 to 8.1 for Germany, 4.4 to 6.5 for Japan, and 4.5 to 6.1 for the U.K. It is interesting to note the near equivalence of the U.S. and Canadian ratios in

1971 and the U.S. and German ratios in 1975.

Especially troubling from a U.S. perspective is that the most rapid growth in the U.S. ratio, both in absolute terms and relative to the other countries, has taken place since 1985. Between 1985-90 the U.S. health to GDP ratio increased from 10.7 to 12.4 percent compared to: 8.5 to 9.0 for Canada, 8.5 to 8.9 for France, 8.7 to 8.1 for Germany, 6.5 to 6.5 for Japan, and 5.8 to 6.1 for the U.K.

Growth in Nominal Health Spending Per Person

While the health to GDP ratio measures the total amount of each country's production devoted to the health sector, it provides no information about whether the ratios are changing because of changes in nominal health spending and/or changes in nominal GDP. To more precisely compare health expenditure performance across countries, it is useful to control for differences in population levels and growth by performing the analysis on a per person basis. Growth in nominal per capita health spending and nominal per capita GDP for the six countries from 1970-90 are presented in Exhibits 2 and 3. Indices of cumulative growth have been developed for each country, with the value of the index for each year being the nominal per capita health spending or nominal per capita GDP figure for that year divided by the 1970 base year figure. By plotting these values on a semi-logarithmic scale, the slope from year to year represents the annual rate of growth. This type of visual

display has the advantage of showing trends in rates of growth across several countries and for all sub-periods between 1970-90.

The trends in nominal per capita health expenditures displayed in Exhibit 2 paint a rather different picture of health expenditure performance. For the entire 1970-90 period, the U.S., at 10.5 percent, had the third lowest compound annual rate of growth in per capita health expenditures compared to: 8.0 percent for Germany, 10.2 for Japan, 10.8 for Canada, 12.8 for France, and 14.1 for the U.K. For the 1970-80 period, the U.S. and Germany, at 11.9 percent, had the lowest rates of growth compared to: 12.4 for Canada, 15.4 for Japan, 15.8 for France, and 18.6 for the U.K. For the more recent 1980-90 period, the U.S., with a compound annual rate of growth of 9.2 percent, had the third highest rate of growth compared to: 4.3 for Germany, 5.1 for Japan, 9.1 for Canada, 9.6 for the U.K., and 10.0 for France.

While one may be tempted to assert that for the entire 1970-90 period the U.S. did a better job of controlling health spending than Canada, France, and the U.K., one cannot draw this conclusion without taking into account other factors such as: the level of the base year spending, health sector and overall inflation, and overall economic growth. For example, much of the rapid growth in France, Japan, and the U.K. may be the result, as shown below, of their substantially lower base level spending. Moreover, relatively higher GDP growth, may drive health spending by

increasing real wages in the health sector.

Growth in Nominal GDP Per Person

Exhibit 3 shows the rate of growth in nominal per capita GDP. For the 1970-90 period, the U.S. had the second lowest rate of growth in nominal per capita GDP, a compound annual rate of 7.7 percent (verses 10.5 for per capita health spending), compared to: 6.3 for Germany (verses 8.0), 8.0 for Japan (verses 10.2), 9.4 for Canada (verses 10.8), 10.5 for France (verses 12.8), and 12.4 for the U.K (verses 14.1). Thus, much of the lower growth and stability in the health to GDP ratios of the other countries compared to the U.S. has been due to relatively higher rates of GDP growth rather than lower rates of increase in nominal health spending.

Similar patterns emerge for the 1970-80 and 1980-90 sub-periods. From 1970-80 the U.S. had the second lowest rate of growth in nominal per capita GDP, a compound annual rate of 9.3 percent (verses 11.9 for health spending), compared to: 7.9 for Germany (verses 11.9), 11.2 for Japan (verses 15.4), 11.9 for Canada (verses 12.4), 12.8 for France (verses 15.8), and 16.0 for the U.K. (verses 18.6). The especially large differences in health spending relative to GDP growth were responsible for the relatively large increases in the health to GDP ratios for France, Germany, and Japan over this period.

For the more recent 1980-90 period, the U.S. had the third lowest GDP growth, 6.2 percent compound annual rate (verses 9.2 for health spending), compared to: 4.8 for Germany (verses 4.3), 4.9 for Japan (verses 5.1), 7.0 for Canada (verses 9.1), 8.2 for France (verses 10.0), and 8.8 for the U.K. (verses 9.6). As shown in Exhibit 1, the U.S. with the largest relative difference in growth between health spending and GDP displayed the most rapid rate of growth in its health to GDP ratio for this time period.

Inflation-Adjusted Growth In Health Expenditures Per Person

The previous analyses do not provided any information on increases in the real volumes of health services after adjusting for price inflation. This is a difficult area for international comparative analyses, since the results of such analyses are heavily dependent on the price deflators chosen. One way to avoid the problems of unreliable and non-comparable medical care price measures is to deflate health expenditures by the GDP deflator, in order to obtain a measure of the opportunity cost, or value, of the resources foregone in the non-health sector. Exhibit 4 is similar to Exhibit 2, except per capita health expenditures are adjusted by each country's GDP deflator. Higher rates of growth in one country over another indicate larger amounts of non-health sector consumption and investment being foregone due to increases in health spending. In evaluating these growth rates, one must keep in mind that higher rates of growth off a relatively smaller base imply less total

resources being diverted into the health sector.

For the entire 1970-90 period the U.S. had the second highest compound annual rate of growth of real resources going to the health sector, 4.5 percent, compared to: Japan at 5.5 percent, France at 4.4 percent, Canada at 3.9 percent, Germany at 3.8 percent, and the U.K. at 3.7 percent. As shown below, considering that the U.S. had the highest 1970 base year per capita health spending level while Japan had the lowest, these data portray the ever increasing amounts of non-health sector consumption and investment opportunities being foregone due to growth in U.S. health spending. In fact, as shown below, these opportunity costs were even higher in the 1980s than in the period of major public program expansions of the 1970s.

Interestingly, different pictures emerge for France, Germany, Japan, and the U.K. for the 1970-80 and 1980-90 sub-periods. From 1970-80 the U.S. had the third lowest rate of growth, 4.2 percent, compared to: Canada at 3.7 percent, the U.K. at 4.1 percent, France at 5.4 percent, Germany at 6.3 percent, and Japan at 7.3 percent. As discussed above, the decade of the 1970s was a time of rapid health expenditure growth vis a vis the rest of the economy in France, Germany, and Japan.

A very different pattern emerges for the 1980-90 period. France, Germany, Japan, and the U.K. had substantially lower annual rates

of growth, about 25-75 percent lower, while Canada's rate was slightly higher, 0.3 percentage point or an eight percent increase, and the U.S. rate increased by 0.6 percentage points, or 14 percent. In the decade of the 1980's the U.S. had by far the largest annual growth in real resources devoted to the health sector, 4.8 percent, compared to: Canada at 4.0 percent, Japan at 3.7 percent, France at 3.5 percent, the U.K. at 3.2 percent, and Germany at 1.4 percent. Moreover, given the far higher 1980 level of U.S. health spending, these data indicate both the significantly larger and increasing levels of foregone non-health sector consumption and investment opportunities in the U.S. compared to the other five countries.

Health Spending Denominated in U.S. Dollars

Exhibit 5 shows per capita health expenditures denominated in U.S. dollars for the 6 countries for 1970-90. Special exchange rates, known as purchasing power parities, are used to convert other countries' currencies into U.S. dollars. The trends here are similar to the health to GDP ratio trends as the gap between the U.S. and each of the other countries widens. In 1990 U.S. per capita expenditures of $2566 exceeded: Canada by 43 percent, France by 86 percent, Germany by 99 percent, Japan by 131 percent, and the U.K. by 182 percent. By contrast, in 1970 U.S. per capita expenditures of $346 exceeded Canada by 26 percent, France by 80 percent, Germany by 74 percent, Japan by 175 percent, and the U.K.

54-832 O - 92 - 7

by 140 percent.

Health Spending and Wealth

Health expenditures are strongly related to each country's wealth as measured by its GDP. Exhibit 6 shows the strong positive relationship between per capita health spending and per capita GDP for these six relatively wealthy and high health expenditure countries for 1990. Every 10 percent difference in per capita GDP is associated with a 25 percent difference in per capita health spending (i.e. the elasticity is 2.5). The U.S. lies well above the trend line and is spending $300 more per person than would be predicted based on the average relationship between health spending and GDP found for these six countries. Interestingly, if the U.S. is dropped from the trend line estimation (i.e. the dashed line in Exhibit 6), the elasticity drops to 1.8 (i.e every 10 percent difference in per capita GDP is associated with an 18 percent difference in health spending), and U.S. expenditures are $700 above what would be predicted based on the average relationship between health spending and GDP found for Canada, France, Germany, Japan, and the U.K.

AVAILABILITY, USE OF SERVICES, AND HEALTH OUTCOMES

The availability and use of services have important implications for costs, access, and quality. Exhibit 7 contains information

for 1988 or the latest available year on the number of inpatient medical care beds per 1000 population, inpatient days per capita, admission rates, lengths of stay, occupancy rates, physicians per thousand population, and number of physician contacts per person per year. In particular:

-- The U.S. has the smallest number of inpatient medical care beds, 5.1 per 1000, compared to a 9.2 average.

-- The U.S. had the lowest number of inpatient days per capita, 1.3, compared to a 2.7 average.

-- The U.S. had the second lowest admission rate, 13.8 percent of its population, after Japan, compared to a 16.0 average.

-- The U.S. had the lowest average length of stay, 9.3 days, compared to a 19.9 average.

-- The U.S. had the lowest occupancy rate, 69.2 percent, compared to an average of 80.7 percent.

-- The U.S. physician population ratio of 2.3 per thousand ranked in the middle of the six countries which averaged 2.2.

-- The U.S. number of physician contacts per capita of 5.3 is the second lowest, after the U.K., and well below the 8.0 average.

Population Characteristics and Outcome Measures

Exhibit 8 contains information on population characteristics and gross outcome measures for 1988 or the most recently available year. In particular, information is presented on infant mortality, life expectancy at birth and at age 80, and percent of the population 65 and over. These data indicate:

-- The U.S. had the highest infant mortality rate of 10 deaths per thousand live births, compared to an average of 7.7.

-- The U.S. had the lowest life expectancy at birth for males of 71.5 years, compared to an average of 72.8 .

-- The U.S. at 78.3 years had the second lowest, after the U.K., life expectancy at birth for females, compared to an average of 79.4.

-- The U.S., Japan and Canada at 6.9 years were all first in terms of male life expectancy at 80, compared to an average of 6.7.

-- The U.S. at 8.7 years ranked second after Canada for female life expectancy at 80, compared to an average of 8.4.

-- The U.S. at 12.3 percent had the third lowest percentage, after Canada and Japan, of population 65 and over, compared to an average of 13.2.

Other information, not presented here, shows that U.S. costs per hospital day, stay, and person, and fees for physician services are the highest in the world. In general we appear to practice a much more intensive and costly style of medicine. Unfortunately, we don't know if these higher costs are due to a sicker population, inefficiency, more amenities, and/or better quality of care. Based on gross outcome measures the U.S. generally compares poorly to other countries. Perhaps this is due to our serious social problems, in particular teenage pregnancy, violence, substance abuse, and AIDS. On the other hand, the U.S. does quite well for life expectancy at age 80, a measure which may be more sensitive to the higher spending levels and availability of expensive high tech services. The costs to our country of the medicalization of our social problems and their adverse impacts on health outcomes are important questions for which we have very little hard information.

IMPLICATIONS FOR HEALTH CARE REFORM

The U.S. has the most expensive health care system in the world. Costs are increasing at rates substantially higher than those in other countries, and the gap between the U.S. other countries is widening. While there is currently a major debate about the causes of such growth encompassing areas such as administrative costs, the failure of private insurance companies to control health care costs, overinsurance due to excessive tax subsidization and excessive state benefit mandates, malpractice laws, technology growth, excess capacity, inefficient medical care provider payment methods, consumer expectations, etc., there is no consensus about how to deal with either the cost or the access problem.

One cannot simply transplant features of other countries' health systems and expect them to function the same way in an entirely different socio-economic environment. While the U.S. system would appear to perform poorly on cost and access grounds, we are presently unable to evaluate its comparative performance on outcomes and individual health status except in the grossest of terms. Moreover, for the vast majority of Americans with adequate health insurance coverage, the system offers enormous freedom of choice; access to state of the art technology, exceptionally well-trained physicians, and high levels of amenities; virtually no queuing for services; and organized quality assurance systems.

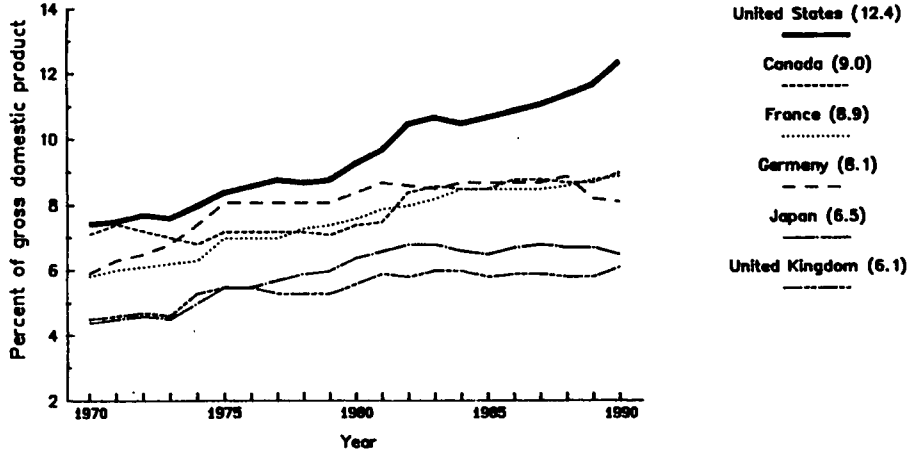
The other five systems analyzed here provide access to their entire populations at far lower cost than in the U.S. In general, there is likely to be less, sometimes substantially less, freedom of choice of physicians, especially specialists, and hospitals. Their is also queuing for services in some of these countries, especially documented in the U.K. and more recently in Canada, although queues and their effects are notoriously difficult to measure. Medical care providers and insurers have far less autonomy. There is little or no tax subsidization for the purchase of private health insurance. Hospitals are generally paid on the basis of global budgets, and physicians in inpatient settings, except in Canada and to a lesser extent in Japan, are generally salaried. There is either one payor or a single set of payment rules applying to virtually the entire system. Basically all these countries have institutional structures in place that permit the government and/or the insurance funds to negotiate with medical care providers. Several of these countries have stringent planning rules that prohibit or tightly regulate both inpatient and outpatient capital expenditures. Services tend to be rationed by supply side rather than demand side constraints.

The key question for U.S. policy-makers is determining the necessity, political acceptability and workability of these mechanisms in an American environment. Can all-payor reimbursement systems be adopted in the U.S.? Are we prepared to adopt global budgets for hospitals and physicians? Can we consider replacing

fee for service reimbursement for inpatient physician services with salary arrangements? Are medical care provider groups prepared to negotiate with government on payment issues in exchange for greater clinical autonomy? Are we ready to revisit the issue of health planning? Are we prepared to eliminate or reduce subsidies for the purchase of private health insurance? Are we prepared to require greater standardization of health insurance benefits? Can coordinated care, other market-based incentive schemes, and vouchers more effectively deal with our access and efficiency problems? Is the American public prepared to lower its expectations? Are we as a people prepared to accept some reduction in access and/or higher taxes for greater equity? Are we in favor of a larger government role? These are important questions as we approach the twenty-first century with the prospect of a one trillion dollar health sector consuming one out of every six dollars of our total production.

EXHIBIT 1

Total Health Expenditures As A Percent Of Gross Domestic Product: Selected OECD Countries, 1970–90



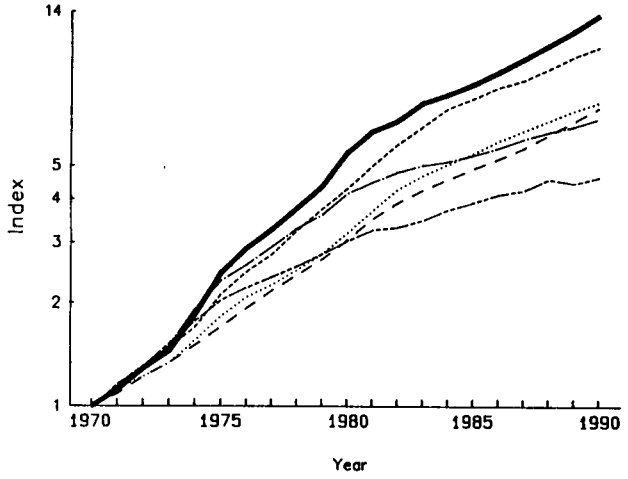
SOURCE: OECD, OECD Health Systems: Facts and Trends (Paris: OECD forthcoming).

NOTE: Countries are listed in descending order based on the value of the index for 1990 (in parentheses).

EXHIBIT 2

Relative Growth Index In Nominal Per Capita Health Expenditures, 1970–90

(Semi-Logarithmic Scale)



United Kingdom (13.86)

France (11.18)

Canada (7.72)

Unites States (7.42)

Japan (6.91)

Germany (4.70)

	Compound Annual Rates of Growth		
	1970–80	1980–90	1970–90
United Kingdom	18.6	9.6	14.1
France	15.8	10.0	12.8
Canada	12.4	9.1	10.8
United States	11.9	9.2	10.5
Japan	15.4	5.1	10.2
Germany	11.9	4.3	8.0

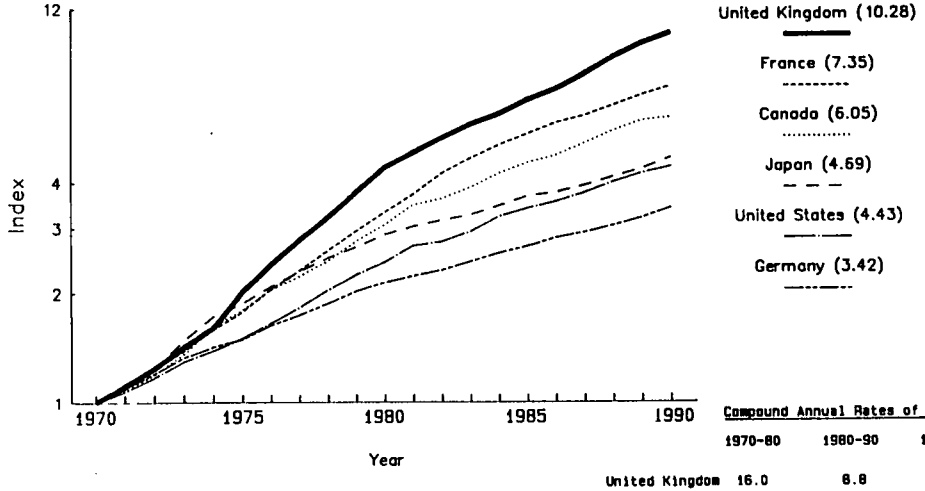
SOURCE: OECD, OECD Health Systems: Facts and Trends (Paris: OECD forthcoming).

NOTE: Countries are listed in descending order based on the value of the index for 1990 (in parentheses).

EXHIBIT 3

Relative Growth Index In Nominal Per Capita GDP, 1970–90

(Semi-Logarithmic Scale)



Compound Annual Rates of Growth	1970-80	1980-90	1970-90
United Kingdom	16.0	8.8	12.4
France	12.6	8.2	10.5
Canada	11.9	7.0	9.4
Japan	11.2	4.9	8.0
United States	9.3	6.2	7.7
Germany	7.9	4.8	8.3

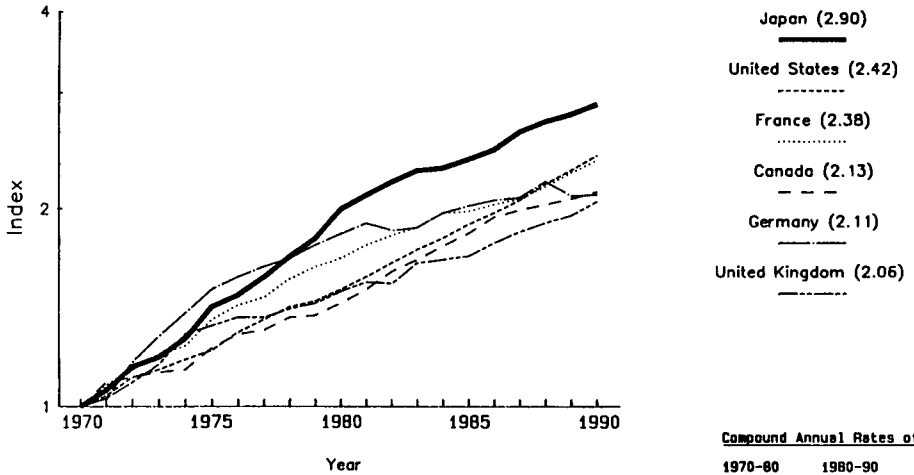
SOURCE: OECD, OECD Health Systems: Facts and Trends (Paris: OECD forthcoming).

NOTE: Countries are listed in descending order based on the value of the index for 1990 (in parentheses).

EXHIBIT 4

Relative Growth In Real Per Capita Health Expenditures, 1970–90

(Semi-Logarithmic Scale)



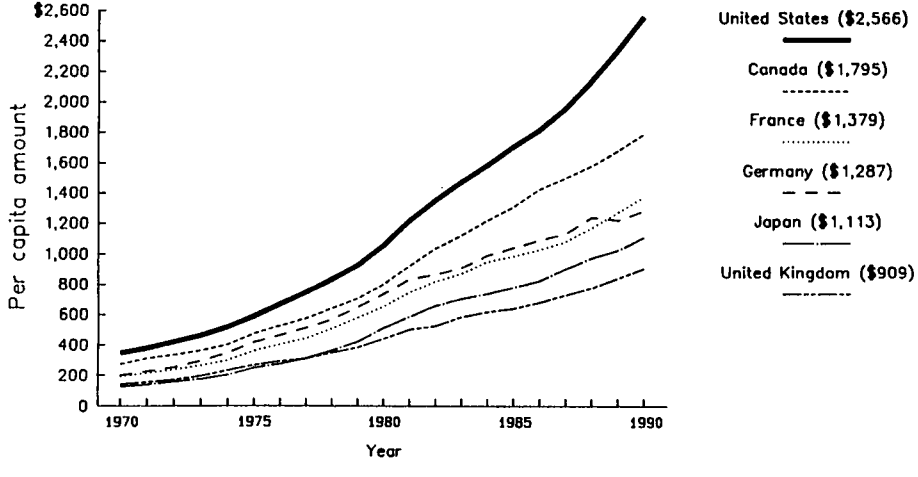
SOURCE: OECD, OECD Health Systems: Facts and Trends (Paris: OECD forthcoming).

NOTE: (1) Countries are listed in descending order based on the value of the index for 1990 (in parentheses).
NOTE: (2) Health Expenditures are deflated by the GDP deflator.

	Compound Annual Rates of Growth		
	1970-80	1980-90	1970-90
Japan	7.3	3.7	5.5
United States	4.2	4.8	4.5
France	5.4	3.5	4.4
Canada	3.7	4.0	3.9
Germany	6.3	1.4	3.8
United Kingdom	4.1	3.2	3.7

EXHIBIT 5

Per Capita Health Spending In U. S. Dollars: Selected Countries, 1970–90

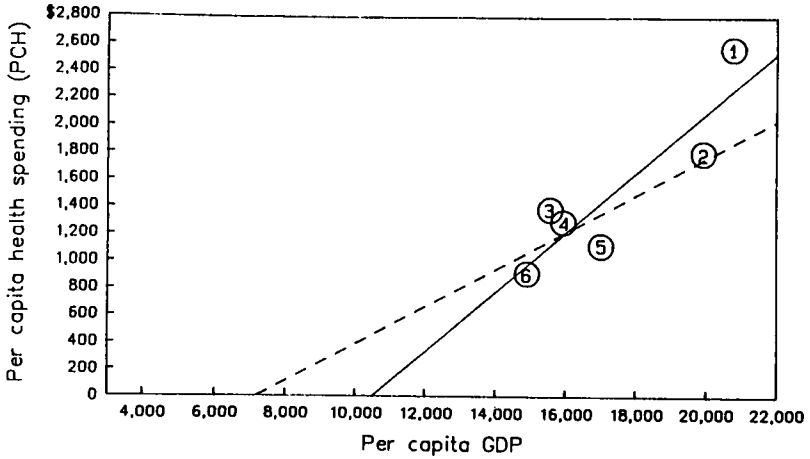


SOURCE: OECD, OECD Health Systems: Facts and Trends (Paris: OECD forthcoming).

NOTE: Countries are listed in descending order based on the value of the index for 1990 (in parentheses).

EXHIBIT 6

Per Capita Health Spending And Per Capita GDP, 1990



Rank (PCH)

1. United States
2. Canada
3. France
4. Germany
5. Japan
6. United Kingdom

Trend line: For all 6 countries (——)

PCH = − 2303 + .22* x PCGDP

r^2 = .80

* = Statistically significant at .01 level

Excluding United States (— — ·)

PCH = − 1014 + .14* x PCGDP

r^2 = .68

SOURCE: OECD, OECD Health Systems: Facts and Trends (Paris: OECD forthcoming).

EXHIBIT 7

Availability and Use of Services, 1988

	Inpatient beds Per 1000 Population	*Inpatient Days Per Capita*	*Admissions as Percent of Total Population*	*Average Length-of-stay (Days)*	*Inpatient Occupancy Rate*	*Physicians Per 1000 Population*	*Physician Contacts Per Capita*
Canada[b]	6.9	2.0	14.5	13.2	82.7	2.2	6.6
France	10.2	3.0	22.3	13.1	81.2	2.6	7.1
Germany	10.9	3.5	21.5	16.6	86.5	2.9	11.5
Japan	15.6	4.1	7.8	52.1	84.1	1.6[b]	12.9[b]
United Kingdom	6.5	2.0	15.9	15.0[b]	80.6[a]	1.4	4.5[a]
United States	5.1	1.3	13.8	9.3	69.2	2.3	5.3
Average	9.2	2.7	16.0	19.9	80.7	2.2	8.0

Source: George J. Schieber, Jean-Pierre Poullier, and Leslie Greenwald, "Health Care Systems in Twenty-Four Countries," Health Affairs Fall 1991: 22-38.

[a] 1986
[b] 1987

54-832

175

EXHIBIT 8

Population and Health Outcome Measures, 1988

	Infant Mortality, live births Per 1000	*Life Expectancy (Years)*				*Percent of Population Over 64*
		At birth		*At Age 80*		
		Males	*Females*	*Males*	*Females*	
Canada	7.2	73.0[a]	79.7[a]	6.9[a]	8.9[a]	11.1
France	7.7	72.3	80.6	6.8	8.6	13.6
Germany	7.6	71.8	78.4	6.1[b]	7.6[b]	15.4
Japan	4.8	75.5	81.3	6.9	8.4	11.2
United Kingdom	9.0	72.4	78.1	6.4	8.1	15.6
United States	10.0	71.5	78.3	6.9	8.7	12.3
Average	7.7	72.8	79.4	6.7	8.4	13.2

Source: George J. Schieber, Jean-Pierre Poullier, and Leslie Greenwald, "Health Care Systems in Twenty-Four Countries," Health Affairs Fall 1991: 22-38.

[a] 1986
[b] 1987

TESTIMONY

before the

COMMITTEE ON GOVERNMENTAL AFFAIRS

AND

SPECIAL COMMITTEE ON AGING

November 19, 1991

Stuart H. Altman, Ph.D.
Dean

HELLER GRADUATE SCHOOL FOR SOCIAL POLICY
BRANDEIS UNIVERSITY

Good morning, Mr. Chairman, I am Stuart Altman, Dean of the Heller Graduate School of Social Policy at Brandeis University and Chairman of the Prospective Payment Assessment Commission.

I am pleased to appear before the Committee this morning to discuss the important subject of national health care reform. This is a subject of utmost national importance because, in my view Mr. Chairman, unless we substantially change the way we finance health care services and restructure the payment system for these services, the United States faces the very real possibility of a breakdown in its health care system. Such national health care reform must have two components: a system to provide financial protection for all Americans against the high costs of health care, and effective mechanisms to control the growth of the cost of the health care services we use.

In my testimony this morning, I will focus on why health care costs continue to rise in the United States at rates two to three times faster than our national income and what we can learn from other countries with respect to controlling these costs. In addition, the experience of the other countries can help us to reform our health care financing system.

Although ProPAC staff has devoted substantial time to the subject of rising health care costs, and the problems of our health financing system, and the Commission has discussed these issues at several meetings, ProPAC has not developed an official position with respect to how to solve these serious national issues. Therefore, I am testifying this morning as an individual and not as the Chairman of the Prospective Payment Assessment Commission.

The basic structure of our existing health financing system was created during World War II when large employers began to offer private health insurance as a fringe "benefit" to keep and attract new workers. This private system grew rapidly in the 1950's for the working population but it left two groups uncovered -- the poor (working and non-working) -- and the elderly. The inability of the private sector to protect these groups led ultimately to the passage of Medicare and Medicaid in the mid-1960's. Such a breakdown is occurring again today, but unlike the 1950's most of those without health insurance now are in the labor force. Therefore, where the solution in 1965 was to create two government programs, the problem today requires us to restructure the market for employer based insurance.

All firms, I believe, should be required to either provide adequate health care coverage or pay into a government fund a percentage of a worker's earnings and require the worker to be covered under the fund's plan. Variants of such a system are currently in use in several countries including Germany and Japan. I understand that as part of this hearing you will review the report of the GAO which has analyzed the plans in those countries so I will not go into any further detail on how their programs operate. Instead, in the remaining portion of my testimony, I would like to focus on the second

important aspect of any needed health reform in this country -- the control of health care spending.

Strategies to Control Costs

Numerous approaches to control increases in health care spending have been implemented by government and private payers in the past decade. While these strategies have helped control the expenditures for specific types of services or for specific groups of payers, they appear to have had little impact on the overall growth in spending.

Our inability to effectively control the continuing increase in health care costs is related to two aspects of the American health care system. First, no single payer, including Medicare, has sufficient market power to force substantial reductions in hospital and other provider expenses. Second, controlling spending for one payer or one type of provider often does not result in system-wide cost containment because of the way in which expenses can be shifted to other payers.

The experience of the Medicare prospective payment system illustrates the difficulties in achieving system-wide cost containment. ProPAC, the Congressional Budget Office, and others have clearly shown that the rate of increase in Medicare program spending for acute hospital care as well as spending for each admission has slowed substantially since PPS was implemented. Most analysts believe that Medicare now pays substantially less than it would have under the previous cost-based system and in fact less than what it actually costs to furnish inpatient services to Medicare patients.

Despite the financial pressure of Medicare PPS to control hospital expenses, the effects are limited because hospitals are able to offset Medicare shortfalls by increasing revenue from other services and from other payers. Consequently, even a major payer, such as Medicare, has not been able to control the annual increase in hospital costs per admission.

In addition, while Medicare controlled its program costs for acute inpatient hospital care, Medicare spending for hospital outpatient, rehabilitation, and other ambulatory services has grown rapidly. Thus, Medicare savings on the inpatient side are offset by the growth in spending for other services.

This occurs because the American health care delivery system can quickly develop the capacity to furnish additional services if financing is available. And our health care financing and insurance system continues to pay for the increasing number of services furnished. Our insurance system, for those who are covered, has accomplished its goal of protecting individuals from the high cost of illness. It has also insulated individuals and providers from most of the financial implications of their decisions.

In addition, our financial incentives frequently work at cross purposes. While hospitals face financial incentives to decrease the number of services furnished to an individual during an admission, physicians generally have incentives to increase individual services.

Up to now, the pluralistic nature of our health care delivery and financing system has been highly valued by the American public. No single governmental or private payer, provider, or physician can control our total spending nor can any one provider or provider group control the total services furnished to an individual. Further, there are countless examples that the American public, insulated from many of the financial implications, wants the newest and most advanced services and has placed high value on the freedom to choose among available payment systems and providers to obtain care when they feel it is necessary.

Clearly something has to give. Pluralism, individual freedom to choose a provider, and effective health care cost containment are, in my view, ultimately incompatible. Every other Western country including Germany and Japan have chosen to limit either the number of payer units or to control the use of services. The debate that is taking place in this country today on the most effective method for controlling health spending centers around whether through regulation we should limit our pluralistic payment system to some version of a single payer approach or whether we should restrict individual freedom of choice of patients to choose their health care provider in such a way that competition would take place between a limited number of provider units. Under such a system major payers such as corporations and the government would contract with these limited number of provider groups based on the quality of the care they provide and the cost effective way they produce it.

In my view, truly effective competition among provider units would require such a change in the way most Americans receive their health care that total reliance on this approach will ultimately lead to what I have called "halfway competitive markets." Such halfway competitive markets often generate the worst of both worlds. They do force individuals to change their way of receiving medical care somewhat, but they do not generate the expected savings. The decade of the 80s has demonstrated all too many examples whereby the savings resulting from reduced utilization have been more than offset by added expenses for advertising, administrative costs, and added payments to entrepreneurs who have put such systems together. Proponents of competitive delivery systems recognize the limitations of the approaches of the 80s, but argue that substantial savings could happen in the future if we truly implemented fully competitive systems. Perhaps they are correct that truly competitive systems would generate the desired savings. But there is no indication that the American public would accept that much of a change in the way they receive medical care.

I therefore believe that an effective cost containment system in the United States must include limitations on the pluralistic nature of our health care financing system. Such a

system need not have a single payer, namely government, but it must have all payers integrated into a common and controlled financing system. Such a controlled all payer system can be organized at a state level, but there should also be an overall national structure which assures some degree of equality between regional systems. This controlled all payer system should allow sufficient flexibility for a limited form of competition among organized delivery systems. But such competition needs to be placed in a context of an overall control in our financing units.

Included in this system should be a set of restrictions on how capital is generated and used in upgrading and expanding our health care system. One of the aspects of the American health care system which separates us from other countries is the degree to which we have allowed new and expensive technology and delivery systems to proliferate throughout the country with very few economic restraints. No other country allows such uncontrolled growth.

I also believe such a capital control system must integrate the knowledge that is being generated about the types of medical interventions that have proven to be effective or conversely the types of interventions that have been shown to be either useless or in some cases even harmful. Linked to the use of these appropriate medical strategies should also be a limitation on the degree to which individual patients can sue health care providers for failure to use every possible intervention. Malpractice rates have directly and indirectly been an important component of the rise in medical care costs over the last 20 years. While providers should not be shielded from negligent practices, they should be protected against suits which hold them accountable for providing services that are considered to be in excess of what is believed to be acceptable medical practice.

Limits on Spending

I am normally not a strong supporter of central controls or any form of national expenditure limits. But, as I indicated previously, the 1980's have taught us that attempts to limit one sector of the health system leads to a shifting of the expenses to other sectors. This is dramatically illustrated by the fact that almost 30 percent of the increase in private sector health insurance premiums for 1990 were estimated to be a direct result of providers shifting the expenses of uncollected bills onto this sector of the system. Included in these uncollected bills as far as providers are concerned are the large discounts required by government -- Federal and State -- for patients covered by Medicare and Medicaid. Therefore, Mr. Chairman, I strongly support the inclusion of a national health expenditure limit and a single payment system for all payers in any form of a health care reform.

I would suggest, however, that such a national health expenditure limit not be a rigid formula tied to our growth in GNP after the first few years. Rather, I would advocate that the target limit be established by a "National Health Expenditure Board." Because

these expenditure limits would be all inclusive and include limits on both public spending and private spending, membership on the Board should include representatives from both the public and private sectors. I believe such a system would work much better if it was outside the day-to-day purview of the Administration and therefore would suggest that it be set up as an independent agency of the government, perhaps similar to the Federal Reserve Board. Membership on the Board would come from the Administration, Congress, and organizations designated in the legislation to represent providers, private insurers, business, and labor. This is the approach used in Germany and their system has been very effective in limiting increases in health care spending to the growth in their national income. Also, because it is administered outside of government and includes the active participation of the major provider groups as well as the private payers it has wide support throughout the country.

In this system I propose for the U.S., Congress would ultimately be a major determiner of the total budget because it would need to approve the federal component of the spending limit. Similar to the Federal Reserve System, there could be regional or state level units which would create budgets for their regions.

A critical component of such national or state budgets would be the establishment of payment rates which must be used by all payer groups so as to eliminate the current practice of cost-shifting against those groups with "deeper pockets" and/or weaker market power. These rates should be set so as to constitute payment in full for all services covered under either the mandated plan or through the government programs. I would not go as far as in Canada and make extra billing by physicians illegal, but I would create strict limits on extra billings and not permit any private insurance coverage for such extra billings. This is the approach used in Australia, which has a comprehensive government supported health financing system with extensive extra private insurance. Such private insurance, however, cannot be used to pay for the extra billing by physicians.

While I would not create through legislation a strict link between the national expenditure budget and the U.S. GNP because of the changing demographics of our population as well as the potential medical value of new high cost technologies, I do believe the long-term goal should be to have national health expenditures grow in relationship to our ability to pay for it from growth in national income. Because of the need to establish limits immediately, however, I initially would tie the rate of change in health care spending to the growth in our G.N.P. I also support for the short-term the use of the Prospective Payment System methodologies for hospital payments and the Resource-Based Relative Scale for physician services. In the long-term, the National Health Expenditure Board and/or the states should have flexibility to adopt alternative approaches to paying providers. The alternative systems, however, should be subject to approval by the National Health Expenditure Board to insure that they are not designed to give a competitive advantage to one group of payers over another.

Implementing health care system reform such as I have described will not be easy. Opposition to change is likely from one part of the health care system or another. A strategy that effectively controls the overall rate of growth in health spending will reduce the price and/or amount of labor, supplies, and services used to produce health care services as well as the administrative and overhead costs and the incomes and profits associated with our health care system.

Fears that effective cost containment strategies will threaten access to high quality care will be raised. Concerns will be voiced regarding the availability of technologically intensive services such as transplantation, advanced cancer treatment, and trauma care. We will also hear that innovation and the development of potentially curative or cost-effective drugs and technologies will be stifled and that cost containment may reduce the incomes of nurses, technologists, and other personnel and staff shortages will occur as workers choose other higher paying careers.

But these concerns must not dissuade you from moving forward to design a truly comprehensive national health plan this country can afford. To do that it is imperative that any all-encompassing financing system be linked with an effective cost containment strategy such as those I have outlined. Such systems have worked in other countries and they can work here as well.

I realize that big numbers come easily here in Washington and we have become used to talking about billions of dollars when we speak about the amount this nation spends for health care. But, Mr. Chairman, even conservative estimates indicate that by the year 2000 this nation will be spending at least $1.6 trillion for its health care which will consume over 16% of our GNP. If present trends continue this number could reach $2.0 trillion. What this will mean is that fewer companies will be able to afford comprehensive protection for their workers and families. We will almost surely witness the number of uninsured exceeding 40 million and it could even reach 50 million. For those insured, benefits will be cut back and patient cost sharing will grow substantially. For taxpayers, the cost of Medicare and Medicaid programs will continue to grow much faster than the current tax base, requiring further increases in the Medicare payroll tax plus added state taxes or further cutbacks in other state services. If these trends continue, I am particularly concerned about their impact on the ability of government to help solve the problems of those who truly need the help of government -- the elderly, the disabled and others who cannot function alone in our competitive system. And the litany goes on.

While I can't tell you at what point the entire structuring of our existing health financing system will crack under constant double digit inflation, 15 to 20 percent of our total national income for one service--important as it may be, is an incredible amount. Every other western democracy has kept the percentage of its national health spending for health care under 9%. If others can do it, so can we. While I'm not

suggesting we should or can roll the clock back to 9% of our GNP, we can try to stabilize growth over time in relationship to growth in national income.

In conclusion, Mr. Chairman, Congress must not let those who glibly recite all the negatives of health care cost containment stop you from moving forward. Because, I am afraid, if you don't do anything, just those negative consequences they suggest will befall our current system.

STATEMENT BY THE PHYSICIAN PAYMENT REVIEW COMMISSION

before the Committee on Governmental Affairs
and the Special Committee on Aging
United States Senate
November 19, 1991

by

Paul B. Ginsburg, Ph.D.
Executive Director
Physician Payment Review Commission
2120 L Street, NW
Suite 510
Washington, DC 20037

Consideration of proposals for health care reform has increasingly begun to focus on options to contain costs. Cost containment is important because existing programs are straining the ability of taxpayers, employers, employees, and individuals to pay for care. Expansion of coverage to those currently uninsured will likely add to this strain.

Recent consideration of cost containment has benefited a great deal from study of the experiences of foreign health systems. While the systems cannot be replicated here, study of them generates ideas concerning the range of choices that are open to the United States.

In 1990, the Physician Payment Review Commission determined that study of the mechanisms by which physicians are paid in the former West Germany could provide valuable perspective on many issues associated with Medicare physician payment. Two members of the Commission and I organized a brief trip to meet with officials of the federal government, sickness funds, private insurers, physician organizations, and academic scholars.[1] The experience has contributed a great deal to the Commission's work on cost containment.

My statement begins with a description of the work that the Physician Payment Review Commission has completed or has underway that is related to cost containment. Then, from a health system perspective, I outline the various approaches to cost containment and what the experience has been. I will draw on both my personal understanding of the evaluation literature on cost containment, which has been aided immeasurably by the excellent reports prepared for the Congress by the Congressional Budget Office and the Congressional Research Service, and on the Commission's experience with Medicare cost containment and with physician payment policies in state Medicaid programs. Finally, I briefly consider the potential for health care reform to enhance cost containment efforts.

WORK OF THE COMMISSION

Almost from its inception in 1986, the Physician Payment Review Commission has been concerned with approaches to slow the rate of increase in expenditures for physicians' services in the Medicare program. In 1987, the Congress asked for advice on how to cut outlays for physician services and the Commission recommended a series of price reductions designed to alter relative values in the direction of what would eventually become the resource-based Medicare Fee Schedule. In response to a subsequent mandate to advise Congress on methods to slow growth in the volume of services paid for by Medicare, the Commission in 1989 proposed that fee updates be based on an expenditure target mechanism. Later that year, as part of Medicare physician payment reform legislation, the Congress enacted a version of this mechanism called Volume Performance Standards.

The Commission has continuing responsibilities to make annual recommendations to the Congress on both standards for rates of expenditure increase and fee updates. It made such recommendations in 1990 and 1991, guided by a long term objective to reduce the rate of growth to that of GNP over a five-year period.

---

[1] We were accompanied by Dr. Stuart Altman of the Prospective Payment Assessment Commission and senior officials of the General Accounting Office.

The Commission also recommended federal initiatives to work with the medical profession and researchers to develop practice guidelines. When it created the Agency for Health Care Policy and Research (AHCPR), the Congress directed it to undertake such a program. This year, the Commission plans to assess the Agency's progress to date in developing practice guidelines and advise the Congress on changes in direction if called for.

When the Omnibus Budget Reconciliation Act of 1990 broadened the Commission's mandate, it expanded its responsibilities in cost containment beyond the Medicare program. Specifically, the Commission is to consider options to constrain the costs of health care to employers, including incentives under Medicare. In its 1991 Annual Report to Congress, the Commission described how Medicare's resource-based fee schedule could be employed by private payers, both voluntarily and under an all-payer rate setting mechanism. It also reported on how Germany uses an all-payer mechanism to set payment rates and review the quality and appropriateness of care. The Commission plans to continue to explore the potential of all-payer mechanisms and is currently analyzing what data would be needed to initiate and update them.

EXPERIENCE WITH COST CONTAINMENT

The debate over alternative approaches to cost containment often pits competitive strategies against regulatory approaches. I have found it more useful to approach this question by considering the various components of expenditure increases. Basically, expenditure increases are the product of price increases, demographic change, and increases in services per capita. Policies can be directed at two of these components: prices and volume of services per capita.

Components of Expenditure Increases

Physician fees have long increased far more rapidly than general inflation. This has continued despite substantial increases in physician supply and success by large payers in obtaining discounts. Economists have been hard pressed to explain the phenomenon as the outcome of normal market forces.

Demographic change tends to play a smaller role than many imagine. Population increases at about 1 percent per year in the United States. One economist has estimated that aging of the population will contribute 0.5 percent per year growth in the quantity of health care services.[2]

Changes in medical practice are probably the most important source of expenditure increases. In the Medicare program, for example, physicians' services per age-adjusted enrollee increased at an average annual rate of 7.4 percent over the 1986-1989 period. Changes in medical practice reflect developments in technology, increases in physician supply and specialization, defensive medicine, and other factors.

---

[2] Fuchs, Victor R., "The Health Sector's Share of the Gross National Product," *Science* 247:534-538, February 2, 1990.

Policies to Limit Prices

Price can be constrained by more aggressive purchasing on the part of payers or government regulation of prices. The research literature provides little support for the notion that prices can be constrained if individual patients have greater incentives to shop for lower prices.

Some large private purchasers have obtained discounts from providers by offering financial incentives to plan members to use those providers agreeing to the discount. Such mechanisms range from the health maintenance organization (HMO), where care outside of the network of providers is not covered, to the preferred provider organization (PPO), where services are covered but at higher cost sharing.

While some purchasers have saved money in this way, the potential saving is limited for a number of reasons. First, significant administrative costs are involved in setting up these networks. Second, the financial inducements to patients (lower cost sharing when the preferred providers are used) are often costly to payers. Third, providers may often be able to offset a portion of the discounts by raising fees to other purchasers and/or increasing service volume. Finally, the impact on trends in price growth, as opposed to levels, is uncertain.

Medicare has saved money by purchasing physicians' services aggressively. Since 1984, Medicare has substantially constrained its rates in relation to what physicians charge private patients. With accompanying limits on what physicians can charge Medicare patients, the program has precluded recoupment of these cuts by charging patients more. While some of these cuts may have been offset by changes in volume of services, volume did not grow more rapidly during this period than in the preceding period.

What is not clear is how much additional constraint can be applied by Medicare without a resulting reduction in access to care by beneficiaries. Physicians speak increasingly of the incentives they face to favor privately insured patients. In Medicaid, a program that accounts for a smaller proportion of physician services and has much lower payment rates than Medicare, low rates clearly have limited access to mainstream care. In a recent study, the Commission found Medicaid rates to average 64 percent of Medicare rates and physician participation to be a substantial problem in many states.[3] The Medicaid experience points out the limitations of policies to constrain prices that are conducted by individual payers.

Containing costs by limiting prices could be pursued more vigorously through an all-payer rate setting mechanism. Many foreign health systems have contained physician service costs through constraint on prices by either a single payer (for example, Canada) or for multiple payers acting in a coordinated fashion, as in Germany. In the Commission's 1991 Annual Report to Congress, a chapter is devoted illustrating how the Medicare Fee Schedule could be applied

[3] Physician Payment Review Commission, *Physician Payment under Medicaid*, Report to Congress No. 91-4, July 1991.

more broadly in the United States and identifying the design issues that would have to be addressed.

Policies to Limit Volume of Services

Containing costs by limiting the volume of services can be approached through a wide range of options. Financial incentives can be directed to patients (cost sharing) and/or providers (units of payment other than fee for service). Administrative controls can be used to limit the use of certain services. Physicians can be provided with additional information on appropriateness. Constraints can be placed on the proliferation of new technology. Tort liability can be revised.

While increased use of cost sharing can reduce the volume of services, few are eager to make much more extensive use of it. Research has shown that consumers have difficulty in distinguishing between important and unimportant services when reducing volume in response to cost sharing.[4] Despite cost sharing's theoretical virtue of having prices reflect the resources involved, consumers would rather not face stiff financial barriers to the use of care when it is needed. Medicare beneficiaries pay substantial premiums for Medigap coverage to reduce the degree of cost sharing faced when care is needed.

Health Maintenance Organizations (HMOs) have experimented with various financial incentives for physicians, such as capitation for primary care and placing physicians at partial risk for the costs of hospital admissions and specialist referrals. Little research is available on the effects of such incentives. Many believe, however, that the absence of fee-for-service incentives to provide additional services in traditional group and staff model HMOs plays a significant role in the documented savings in those organizations. Some have concerns that in less structured settings, strong provider incentives to reduce service use could limit appropriate as well as inappropriate services.

Use of administrative controls on utilization has increased substantially during the 1980s. Most private payers require prior approval of hospital admissions and major outpatient procedures and make advance determinations of appropriate lengths of stay. Research suggests that some of these efforts have been effective, though the costs of administration offset some of the gains and some of the reductions in service use become additional responsibilities of the patient's family. The effects on rates of service use by patients covered by other payers has not been examined. With improvements in data and more consensus on appropriate patterns of practice, administrative controls may become more effective over time.

A significant cost of administrative controls is physician loss of clinical autonomy. When compared to their counterparts in other advanced nations, American physicians face a substantial degree of review of their clinical decision making. Physicians have complained loudly to Congress and to state legislatures about the "hassle factor". They must consider whether to

[4] M.F. Shapiro, J.E. Ware, and C.D. Sherbourne, "Effects of Cost Sharing on Seeking Care for Serious and Minor Symptoms: Results from a Randomized Controlled Trial," *Annals of Internal Medicine*, 104 (1986), pp. 246-251.

seek to follow their foreign counterparts in sacrificing some economic freedom to protect their clinical autonomy.

Interest in practice guidelines and effectiveness research is based on the premise that physicians can practice in a more cost-effective manner if they have better information. The leadership of the medical profession has embraced efforts to work with the federal government to develop and disseminate this information. It will be some time before an assessment can be made of the impact of these efforts on aggregate costs.

Notions that better information can improve medical practice lie behind some of the newest experiments in managed care. Rather than service-by-service utilization review and financial incentives to individual physicians, some physician networks emphasize profiling of physicians and feedback of information to motivate more effective practice patterns. While evaluative research is not available, some major employers are highly enthusiastic about the potential of this approach.

A consideration in the Commission's development of its proposal that led to the Volume Performance Standard mechanism is that broad economic incentives to the profession could help stimulate activities on the part of the profession to increase the appropriateness of medical practice. Under VPS, a goal for an acceptable rate of increase in expenditures is set and future fee updates are based on the degree of success in meeting that goal. This linkage between expenditure growth and fee increases provides the incentive to physicians collectively. The activities that VPS could stimulate include both the development of meaningful practice guidelines and education of practitioners whose practice patterns deviate from patterns of appropriate practice.

Many believe that rapid adoption and dissemination of new technologies for which effectiveness has not been assessed contributes to rising costs. While foreign health systems have relied heavily on control over the dissemination of new technologies, attempts to do this in the United States through certificate-of-need regulation have not achieved substantial success. Some question whether the American political system can effectively perform this particular type of regulation without capital budgeting by government.

Some assert that reform of the malpractice system is critical to physicians being able to practice cost-effective medicine. It has been very difficult to quantify the magnitude of defensive medicine, though the Congress has recently asked the Office of Technology Assessment to conduct a major study. Many physicians have asserted that malpractice risks could limit the effectiveness of many policy initiatives to constrain the volume of services. While a number of states have implemented tort reforms, such as limitations on the size of awards, additional options, such as use of administrative mechanisms in place of judicial proceedings and various types of "no-fault" mechanisms need to be considered.

COST CONTAINMENT UNDER HEALTH CARE REFORM

While some cost containment policies have been successful, at least at the level of the individual payer, little effect is seen at the system level. Despite the introduction or intensification of many cost containment activities during the latter half of the 1980s, no slowdown in national health spending has been perceived. Analysis by the CBO shows the rate of increase in real national health expenditures per capita to have been 4.3 percent per year between 1980 and 1985 but 4.6 percent per year between 1985 and 1989.[5] It is possible that the fragmented nature of attempts to contain costs has led to gains in some areas being offset by losses elsewhere. Alternatively, achievements of cost containment policies could have been offset by unrelated factors, such as an acceleration of the cost-increasing effects of technological change.

Health care reform legislation provides the opportunity to pursue cost containment more effectively by coordinating the activities of different payers. In particular, policies to contain costs through the price side can be pursued much more effectively when a mechanism is in place to determine payment rates for all payers in a coordinated fashion. This would preclude the ability on the part of providers to shift reductions in payments from one payer to another and remove the risks of beneficiaries in one program having limited access because that program's payment rates are far lower than those of other programs.

An all-payer mechanism plays a prominent role in a number of the major pieces of health care reform legislation that continue private insurance. Given the potential of this mechanism to limit price increases more effectively than past efforts by individual payers, these proposals have made an important contribution to the coming debate on cost containment.

While the United States has no experience with all-payer rate setting for physicians' services, the ability to draw on the extensive experience of Germany increases the feasibility of this option. In the German system, sickness funds jointly negotiate with local associations of physicians over rates of payment. This system appears to maintain the pluralism of many payers without sacrificing the potential for cost containment from coordination among the payers.

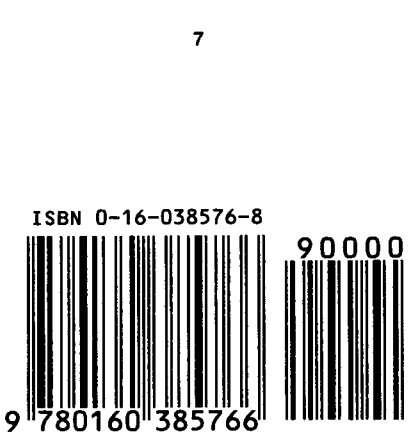
All-payer mechanisms may also provide opportunities to pursue cost containment on the volume side. For example, the database needed to administer such a system would provide payers with the ability to profile medical practices, thus permitting them to substitute this less-intrusive manner of utilization review for service-by-service examination. This is the case in Germany, where extensive profiling of physician utilization is conducted while claim-by-claim review is not used. In a given year, about 7 percent of physicians are called to explain their utilization. This implies that 93 percent do not have to deal with the "hassle" of review.

[5] Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies* (April 1991), p. 55.

CONCLUSION

The Commission is just beginning its work on the relationship between Medicare policies and employer attempts to contain costs. Its initial efforts have focused on the use of elements of the Medicare Fee Schedule by private purchasers, both on a voluntary basis and as part of an all-payer system. To build on last year's work of identifying design issues for an all-payer system, the Commission has begun to delve into the data requirements to administer such a system. This has proved to be a fruitful area to date, since such a database would have many additional applications dealing with cost containment and quality of care. The Commission will be discussing further activities in this area and has been holding discussions with Congressional staff concerning priorities.

ISBN 0-16-038576-8



54-832 (196)