

# Health care and cost containment in Europe

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# Outline of lecture

- Some background
- Some theory
- Some practice
- Challenges

# Three Eras of Health Care

## 1) 1980s **Cost containment**

- Control hospital expenditure –
- Negotiate over physician payment
- Contain nursing salaries

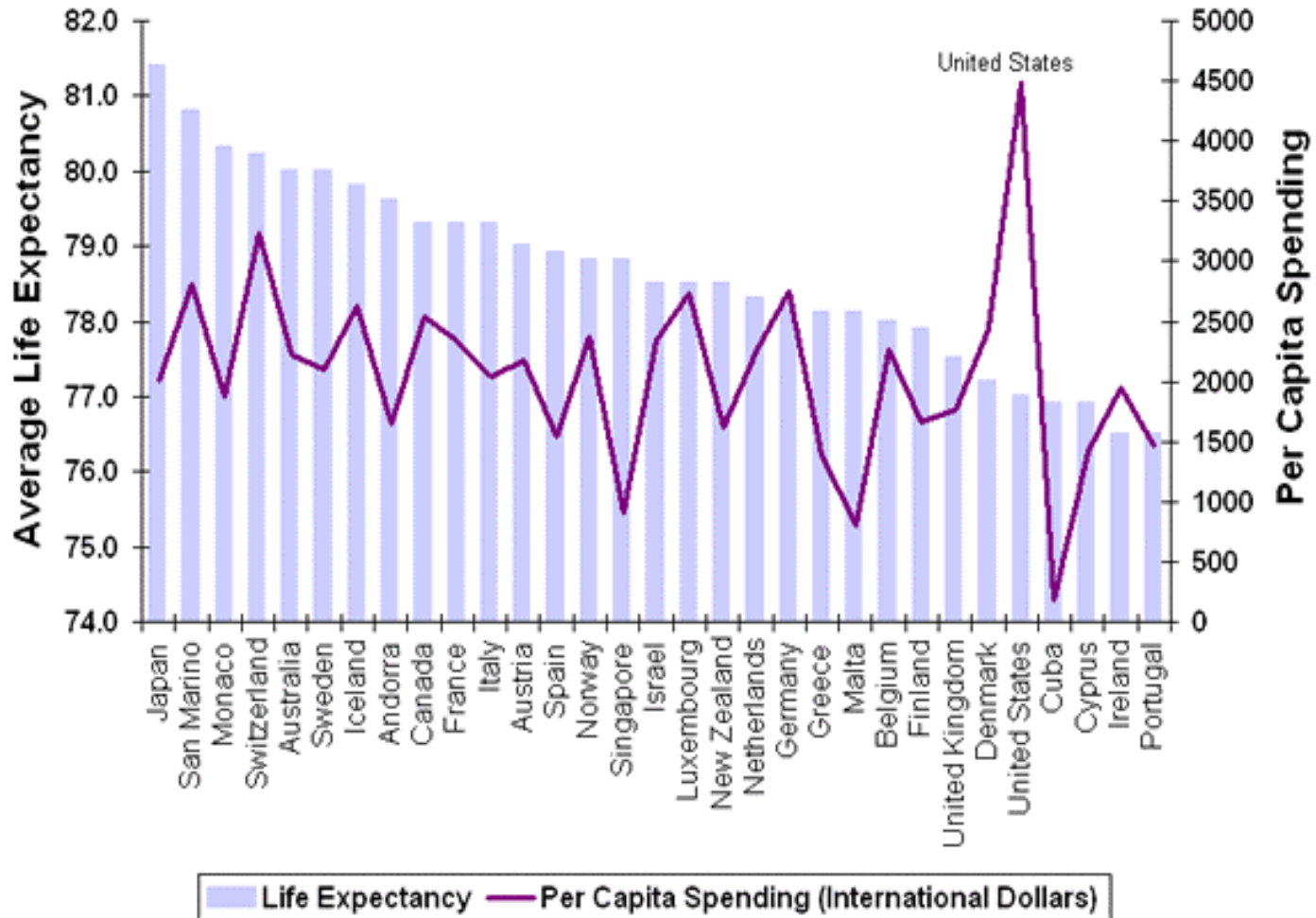
## 2) 1990s **Efficiency and markets**

- Resource allocation mechanisms
- DRGs -Implies yardstick competition and efficiency
- Incentives
- Purchaser-provider split

## 3) 2000s **Assessment, accountability and quality**

- Contain technological diffusion
- Maintain quality of care
  - Clinical guidelines/HTA/CEA
  - Selecting health services based on their effectiveness is a way to allocate scarce resources efficiently (Cochrane, 1972)

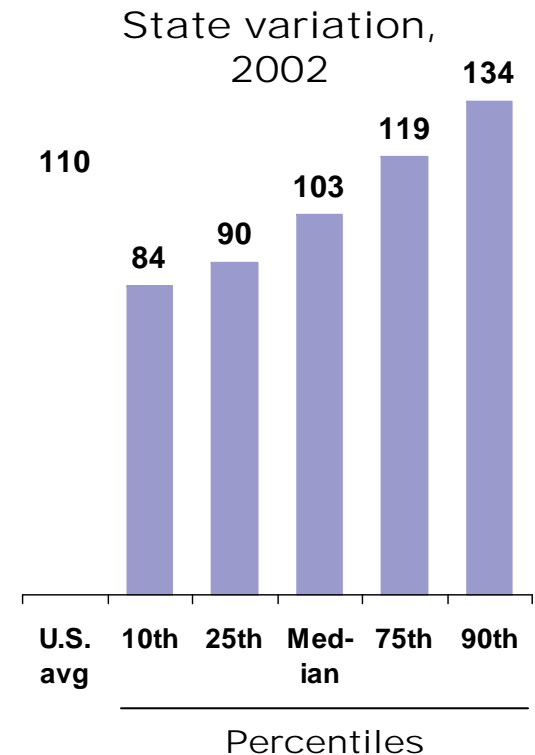
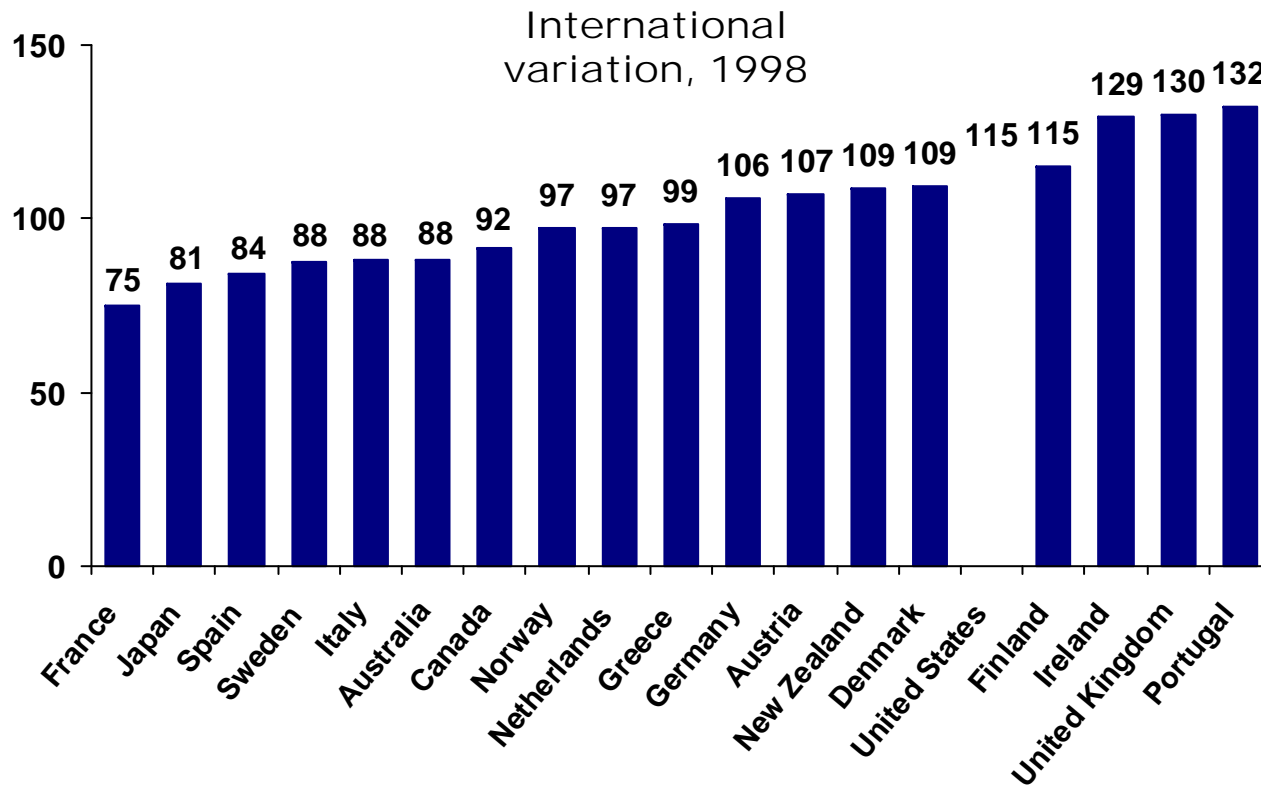
## The Cost of a Long Life



# Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

Deaths per 100,000 population\*



\* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease. See Technical Appendix for list of conditions considered amenable to health care in the analysis. Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.

# Background

- Quality of care in the U.S. is uneven and often inadequate

- 55% of adults receive recommended outpatient care

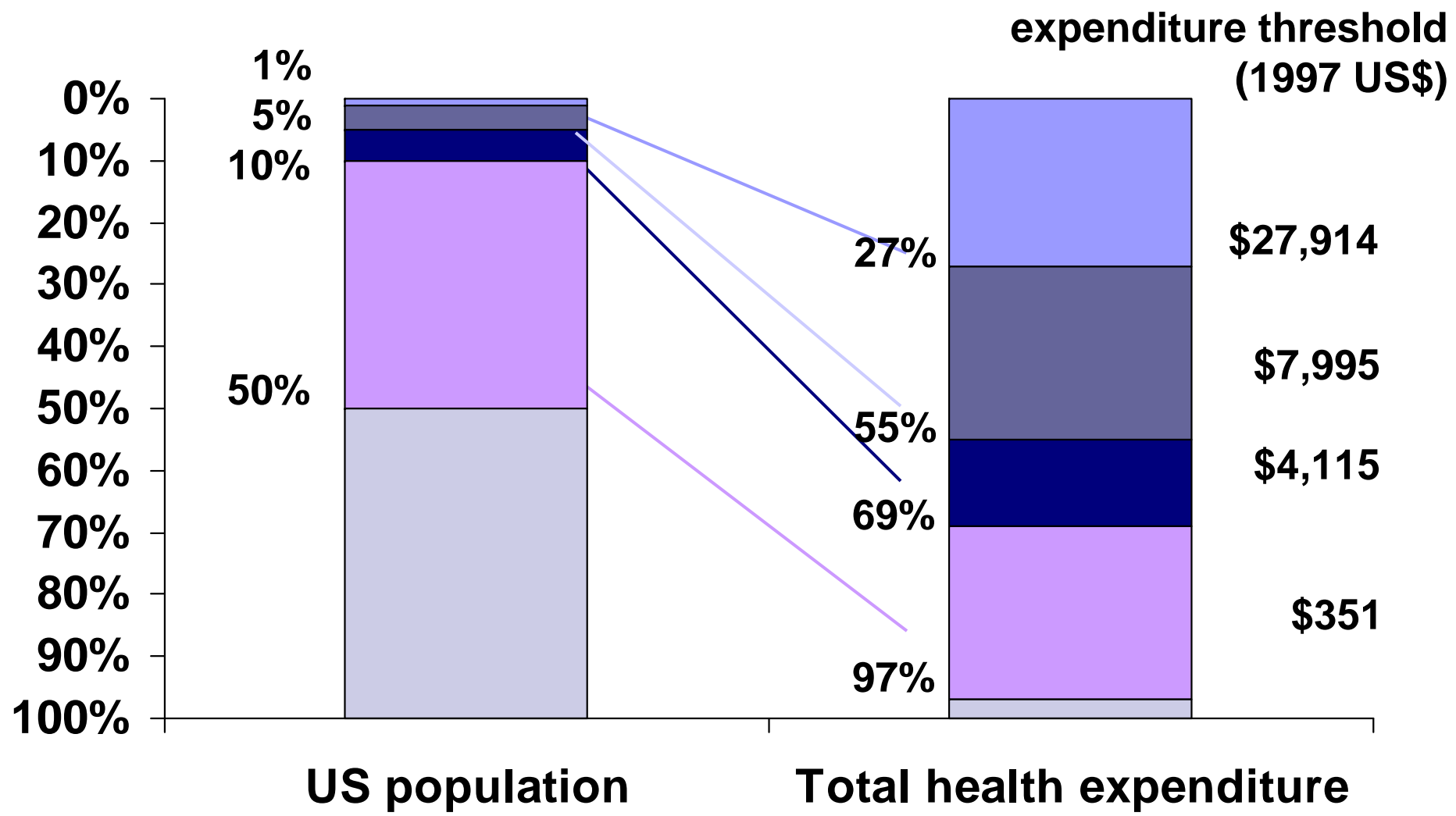
McGlynn et al. (2003) *NEJM*

- Care received for common acute conditions varies significantly across hospitals

Jha et al. (2005) *NEJM*

- Quality measurement is essential for quality improvement

# Distribution of health expenditure for the US population, by magnitude of expenditure, 1997



Source: Monheit 2003 and Berk and Monheit 2001



# Health insurance: function and objective

- risk: health and financial
- pooling risks (costs) across people and over time
- uncertainty: timing, severity, costs
- contracting and re-contracting problems
- pre-payment
- ability to pay

# Policy objectives and reality

- First define objectives and then the means to achieve them
- Often about how much rather than whether
- Cost containment = efficiency – wrong!
- Cost **'Nation' can't afford to pay**
  - Expenditure ← choice
  - If  $U(\text{health}) > U(\text{elsewhere})$   
then  $\uparrow$  health
- Caveat
  - Expenditure must be efficient

# Efficiency and equity

- Who pays, who gets, who gets paid
- value for money?
- does the health system cost more than it **should** or **could**? if so, why?
- purchasing power?
- provider payment methods?
- transaction costs?
- ability to regulate?
- information needs
- equity-efficiency trade-offs

# Resources, payments and outputs

$$\begin{aligned} TF+SI+UC+PI &= P \times Q = \\ W \times Z &= \text{Expenditure} \end{aligned}$$

# compulsory coverage

link between contribution + benefit

free choice  
co-payments

public / private mix

**Population**

**Provider**

obligation to treat

Taxes or wage-related contribution

defined benefit package

negotiated rates of reimbursement

shared between employer + employee?

collective / selective contracting

choice of fund?

**Payer**

usually found  
sometimes found

Government or independent self-governing fund(s) (bipartite or tripartite)

# Major approaches to reform: supply side

- Funds pooling and coordinated care
- Resource allocation based on adjusted capitation funding
- Competition in insurance markets
- Opting out from social insurance
- Purchaser-provider split
- Budgets, service agreements or performance contracts (plus penalties and bonuses)
- Unit-cost funding (including case-mix)- Implies yardstick competition and efficiency
- Group administration (hospital networks and GP divisions)
- Privatisation (dental care and hospitals)
- Service substitution (home- and day-based care)



# Purchaser markets

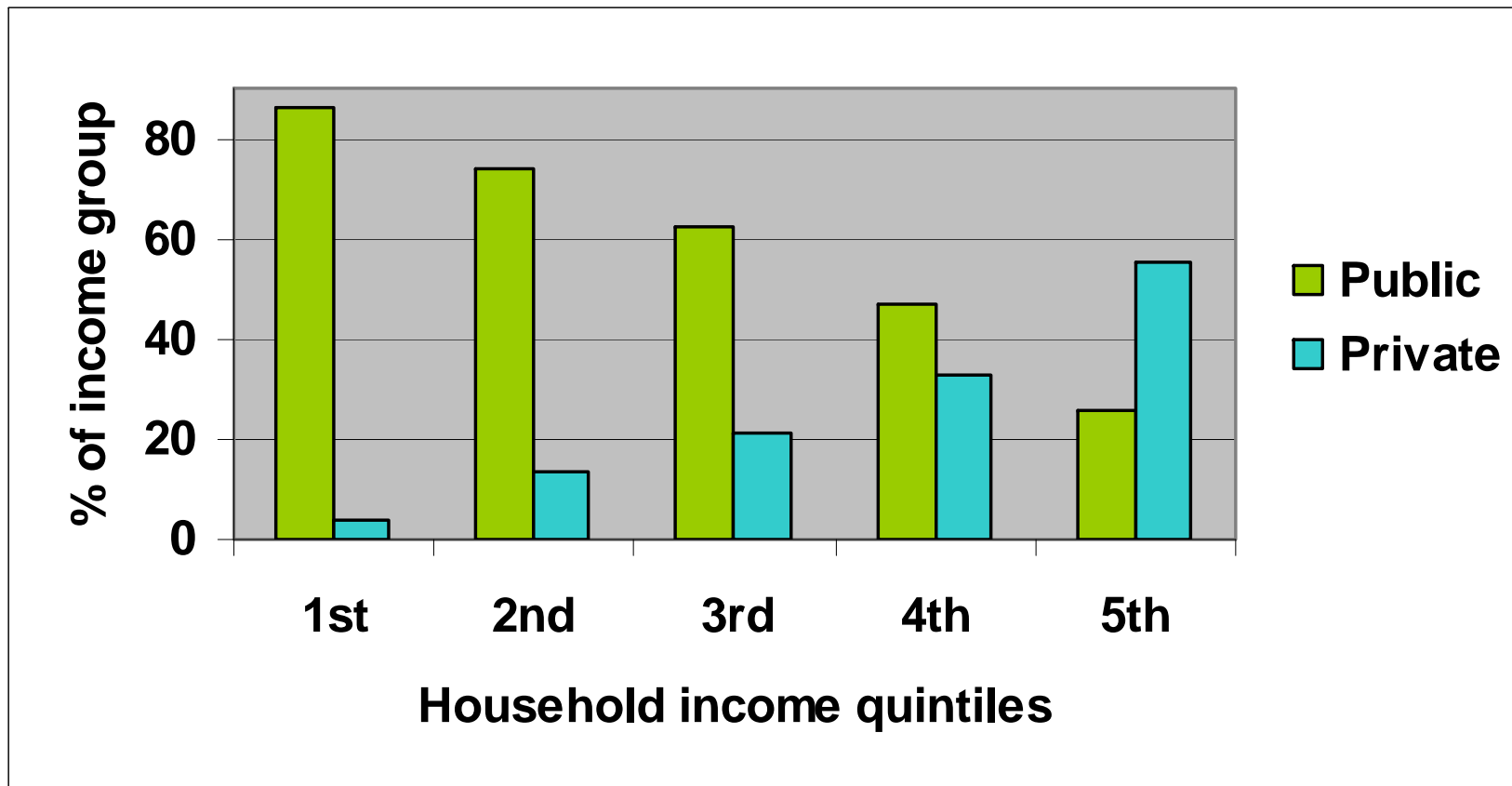
- Payers for health care (local governments or insurance funds) have tended to reimburse passively
- Major efforts to make sickness funds competitive in social insurance systems (Netherlands, Germany, Belgium)
- Early experience suggests the a concern with the risk adjustment process, needed to create a fair market and prevent cream skimming of rich, healthy patients
- Little evidence of benefits in terms of quality or efficiency
- Key issue: how to reconcile active purchasing with the patient's traditional freedom to use any provider and fixed fee schedule.

## Netherlands and insurance competition: non-medical costs of insurers in 1998 (€per capita)

Costs	SHI funds	Private health insurers
Efficiency	3	2
Selection	10	28
Other	47	59

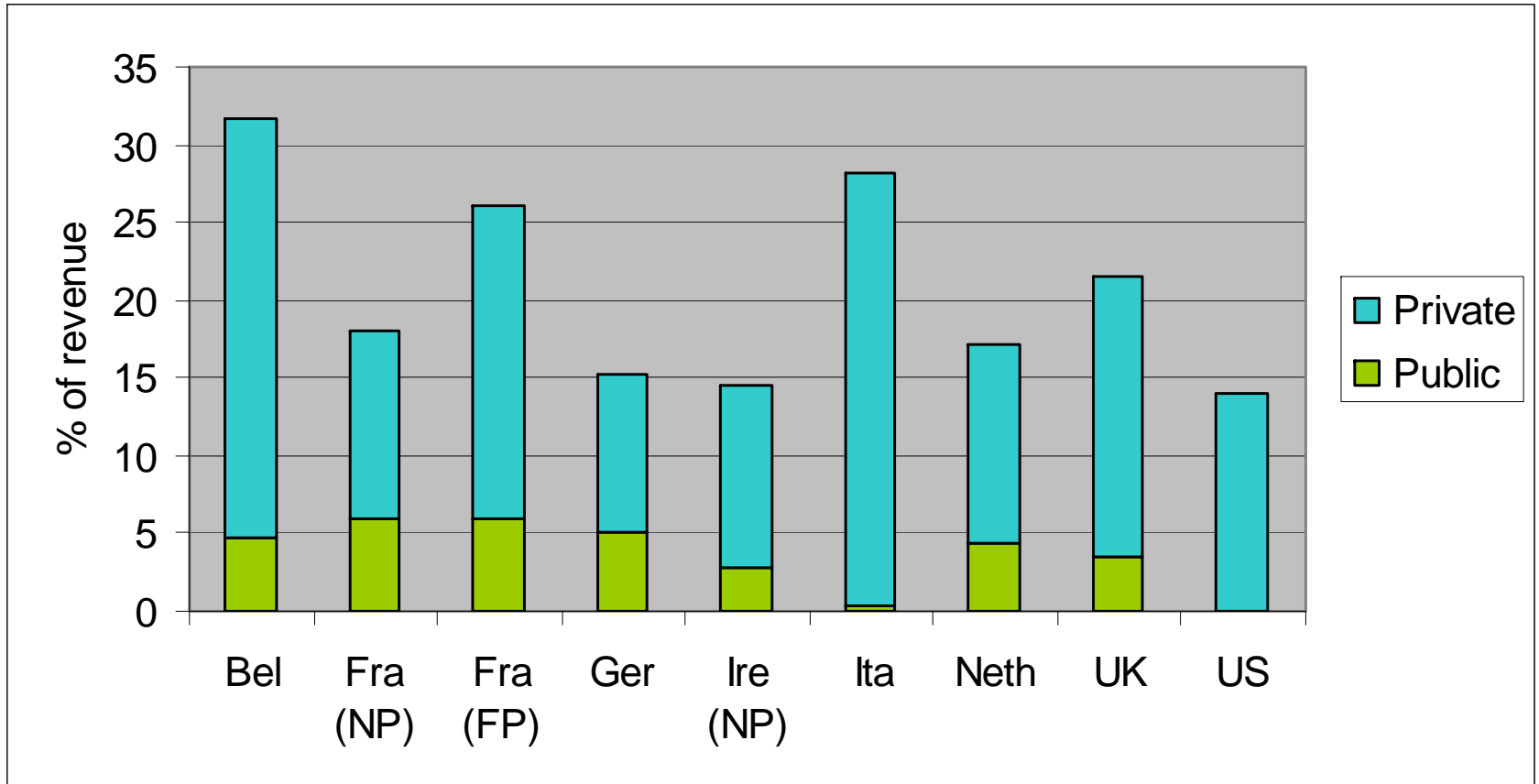
Source: Douven and Westerhout 2000

# Opting out from SHI in Chile: income distribution by type of cover, 1998



Source: Barrientos and Lloyd-Sherlock 2000

# Administrative costs as % of revenue, late 1990s



Source: Mossialos and Thomson 2002



# Major approaches to reform :

## Supply side II

- Price controls: medicines and medical devices
- Volume control?
- Substitution policies – me-too products?
- HTA – defining benefits and beneficiaries



# HTA: Selection of Topics

- Unlikely to be cost-effective to assess every new technology
- Sometimes the choices have been strange (e.g. appraisals when a major trial will report in 1-2 years)
- Procedures are required to ensure appropriate use of technologies that are not appraised
- Groups of similar technologies should be compared - Main problem is the lack of head-to-head clinical studies

# Are Cochrane-Style Reviews Always Helpful?

Respite care for frail older people: an appraisal of effectiveness and cost-effectiveness

Number of hits (in the literature review)	12,927
Papers retrieved	379
No. of potential studies	171
Potential economic evaluations	41
Actual number of economic evaluations (EEs)	22
Number of EEs of respite care meeting criteria for inclusion	5
Number of such studies undertaken in the UK	1



# Major approaches to reform: proxy-demand

- Payment methods: doctors, pharmacists, dentists
- Budgets
- Incentives
- Practice guidelines and monitoring of prescribing



# Major approaches to reform: proxy-demand II

- Major efforts to make provider markets more competitive and contestable
- Relevant to some aspects of acute care, but concerns at implications for chronic care
- Little evidence on effectiveness of provider markets
- Little evidence on relevance of ownership of providers



# Major approaches to reform in 1990s: Demand side

- Increase co-payments
- Private health insurance incentives


# Copayments

- Traditionally low levels of copayment in European systems
- Widespread voluntary insurance against copayments in some systems, diluting incentive effect (France, Ireland)
- Reference pricing as a form of copayment for pharmaceuticals (Germany, Spain etc.)
- Differential copayments – services or products
- Differential copayments according to lifestyle?  
Not yet tried.



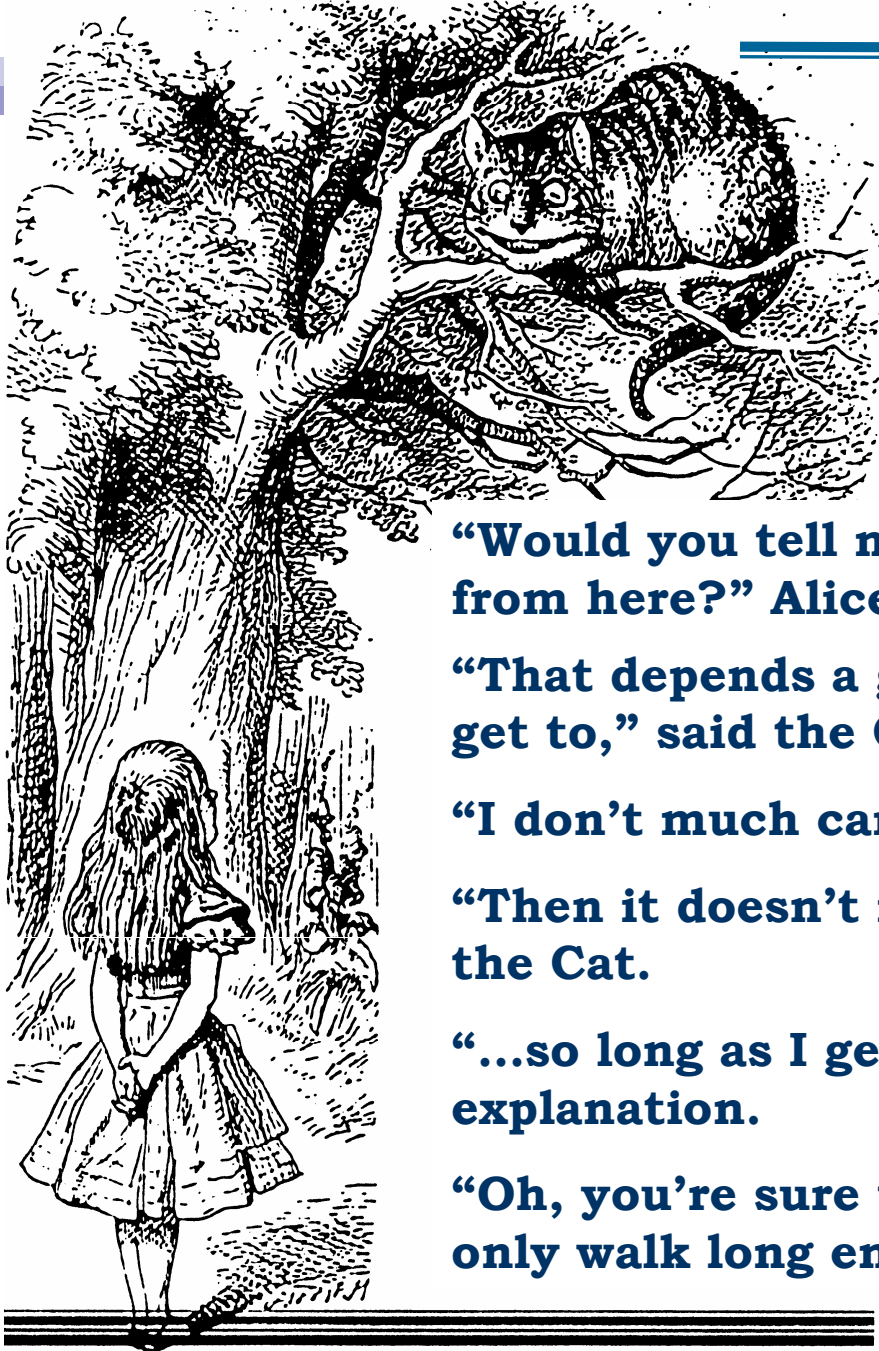
# Reforms and information

- Information is a key resource in the functioning of health care markets
- Traditionally poor level of information on costs and quality
- Great opportunity to enhance information base for patients and collective purchasers
- Concern about distortions induced by public reporting.



# The future - challenges

- Frequency of elections and government/policy changes
- Multiple and simultaneous reforms
- Administrative databases capture limited information
- Management of chronic diseases and incentives (contradictions and solutions)



## *Where Do I Go From Here?*

**“Would you tell me, please, which way I should go from here?” Alice asked the Cheshire Cat.**

**“That depends a good deal on where you want to get to,” said the Cat.**

**“I don’t much care where...” said Alice.**

**“Then it doesn’t matter which way you go”, said the Cat.**

**“...so long as I get somewhere”, Alice added as an explanation.**

**“Oh, you’re sure to do that,” said the Cat, “if you only walk long enough”.**