Cost Containment and New Priorities in the European Community

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IN 1990, I VISITED THE 12 COUNTRIES OF THE European Community and consulted with local experts in order to study their cost-control measures for health care and to see what new priorities they had established. This article covers the period from 1983 to September 1990, updating an earlier study in which I described developments that occurred between 1977 and 1983 (Abel-Smith 1984).

My central aim was to view the types of measures that were being used and with what success. I also wanted to compare the measures that had been retained since my earlier trip with those that had been abandoned, either because they were impractical or because of political pressures. New initiatives were of particular interest. A further goal was to assess the impact of the publication in 1985 of targets for Health for All (HFA) by the World Health Organization on the European countries' priorities. Although all countries in the region had endorsed the document, nevertheless I wanted to see to what extent the publication had influenced these countries to redirect their energies toward primary health care and prevention and to invest in activities that promote health.

Containing the cost of health care has become the aim of virtually all countries in the world, both developed and developing. Among the

The Milbank Quarterly, Vol. 70, No. 3, 1992

countries that I studied, only Greece, where services were in any case poorly developed, was an exception to this rule.

I hope that documenting the experience of 12 Western European countries, which number among them the pioneers of compulsory health insurance, can be of value to countries that are grappling with similar problems. Solutions, however, may not be readily transferred. What is acceptable in one country may be unacceptable in another. Much depends on public attitudes, cultural expectations, the power wielded by different interest groups, and the market situation that faces particular providers at certain times. The salient lesson in the experience of Europe during the past 15 years is that measures previously regarded as unthinkable can not only be considered, but can also be adopted as policy once a government is under strong pressure to act.

The economic recession brought pressure that affected countries with varying degrees of severity at different times during the 1970s and 1980s. Once the containment of public expenditure, including the total amount for health spending, became a critical aim, governments, faced with low or declining rates of economic growth and tax resistance, became determined to combat the secular increase in health costs, which had grown faster than spending within the economy as a whole. In most European countries cost containment is seen as a problem of *public* expenditure. Thus, shifting expenditure from the public to the private sector is an acceptable solution, even though the total is not much reduced. In the Netherlands, where only about 60 percent of the population is covered by compulsory health insurance, containment is viewed, as in the United States, as a problem of both public and private health expenditure. The underlying theme of my study is the search for effective and acceptable ways of containing expenditure for systems that employ different methods of organizing and paying for health care.

The main conclusion of the study is that it is technically possible to contain health care costs by government regulating supply rather than demand. In Europe, it is acceptable for government to do this regulating and there is no question of the regulators being taken over by the regulated. The key to success is the use of monopsonistic power. Even when there are many insurers, they are forced by government regulation to act together.

A particular feature of the 12 countries is that, with the exception of the Netherlands, compulsory health insurance, as defined by the International Labour Office (ILO), covers more than 85 percent of the popu-

lation. Universal rights (or the same basic rights for all citizens) to health care have been extended during the past 15 years until they are to be found in five of the 12 member states of the Community: Denmark, Greece, Italy, Portugal, and the United Kingdom. Nearly universal rights (about 99 percent coverage) are now found in Belgium, France, Luxembourg, and Spain. Although coverage is compulsory for only about 60 percent of the population in the Netherlands, voluntary health insurance fills in virtually all of the gaps left by statutory insurance and the entire population is covered for major risks.

According to the calculations of the Organisation for Economic Cooperation and Development (OECD), there has been a notable reduction in the rate of increase of health expenditure judged in relation to the gross domestic product (GDP) (see table 1). The eleven countries for which data were available for both years showed substantial increases in the proportion of the GDP devoted to health expenditure between 1970 and 1980; three countries reduced the proportion between 1980 and 1989; and the proportion was unchanged in one. The maximum rates of increase were around 1 percent in two countries, compared with

TABLE 1
Health Expenditure as a Percentage of the Gross Domestic Product, 1970–1989

Country	1970	1980	1985	1987	1989	Percent public 1989
Belgium	4.1	6.3	6.9	7.3	7.2	89
Denmark	6.1	6.8	6.3	6.3	6.3	84
France	5.8	7.6	8.5	8.5	8.7	75
Germany	5.9	8.5	8.6	8.6	8.2	72
Greece	4.0	4.3	4.9	5.2	5.1	89
Ireland	5.6	9.0	8.3	8.0	7.3	84
Italy	5.2	6.8	7.0	7.3	7.6	79
Luxembourg	4.1	6.8	6.8	7.2	7.4	92
Netherlands	6.0	8.2	8.2	8.5	8.3	73
Portugal	—	5.9	7.0	6.4	6.3	62
Spain	3.7	5.6	5.7	5.7	6.3	78
United Kingdom	4.5	5.8	6.0	5.9	5.8	87

Source: Schieber and Poullier (1991, 109).

2 percent or more in five countries in the earlier period. Particularly remarkable was Denmark where, using the national definition of health expenditure, the percentage of the GDP was reduced by a full 1 percent between 1982 and 1988 (not shown). The last column of the table, showing the percentage that is public, combines three elements: purchase of over-the-counter drugs, private payment for services, which may be through a private insurer, and cost sharing in the statutory scheme.

The methods used by different countries to control costs differ according to how they organize and finance health care. Where the government or the main health insurers own their health care facilities and pay health professionals on a salaried basis—what the ILO calls the *direct* system of financing—control is obviously easier than a situation in which health care providers are under contract with either the government or the main insurers—the *indirect* system of financing. Financing from governmental budgets does not necessarily lead to the government's owning the services or to all health service staff being on government salaries. In fact, such a model is found only in Portugal and in the two largest health plans in Greece. Even then, private services may be contracted to supplement insurer-owned services. Nor does it follow that public hospitals are financed directly by government. They are so financed in Denmark, Ireland, Italy, and the United Kingdom, but not in the remaining countries of the European Community, where public hospitals rely wholly on revenue from compulsory health insurance and actively compete with other private profit and/or nonprofit hospitals. The experience of these countries is of the most interest to the United States.

Table 2 outlines the main systems of supplying services in the 12 countries or, in the case of Ireland, covers the General Medical Service (GMS) for lower-income groups. There is also a column showing the method of paying primary health care doctors. In Europe the insurers pay the providers for services to insured persons, except in France and Belgium where the insurers reimburse part of the cost of some services on the basis of receipted bills submitted to them; for other services they pay the provider directly. The American type of private insurance, or "conventional health insurance," is the exception in Europe.

Health services that are financed on a direct budget basis by government, central or local, have always been subject, at least theoretically, to cost containment. Overall budget financing can be applied irrespective of the share of resources collected in compulsory health insurance contributions. My study showed overall budgets operating in Denmark (through

TABLE 2
Principal Methods of Providing Services in the European Economic Community[a]

Country	Direct (employed)	Indirect (contracted)	Primary-care doctor payment
Belgium	—	All services	Fee-for-service
Germany	—	All services	Fee-for-service
France	—	All services	Fee-for-service
Luxembourg	—	All services	Fee-for-service
Netherlands	—	All services	Capitation
Denmark	Hospitals	GPs, specialists outside hospital, pharmacies, most dentists, and physiotherapists	Capitation, 25%; fee-for-service, 75%
Spain	Specialists, hospitals, GPs	Pharmacies, dentists, and private hospitals	Capitation
Greece	Doctors, dentists, hospitals	Private hospitals and pharmacies	Salary
Italy	Public hospitals and specialists	Private hospitals, GPs, and private specialists	Capitation
Ireland	Public hospitals and specialists (GMS)	GPs, nonprofit hospitals, and pharmacies	Capitation
Portugal	GPs, some specialists, public hospitals	Private hospitals, some doctors in rural areas, pharmacies, labs for X ray and pathology	Salary
United Kingdom	Hospitals and community services	GPs, pharmacies, most dentists and opticians	Capitation

[a] Main provision or provision for low-income persons.

local government), Italy, Ireland, Spain, Portugal, and the United Kingdom, and for the rural health insurance scheme in Greece.

In theory it may seem that separate health insurers cannot be bound by government restriction, but in practice government can use its power

to restrict or veto increases in compulsory health insurance contributions, to approve any charges levied on patients, and to control or impose reductions in the scope of the insurance offered. Moreover, the government can impose budgets on individual hospitals irrespective of their ownership, even when they receive their income from different health insurers.

Cost containment can be imposed on either consumer *demand* or *supply*. By describing measures operating on consumer demand as cost sharing, I give the term wider use than is current in the United States. Cost sharing means that the consumer ultimately has to pay part of the cost, either as a user charge or as partial, rather than full, reimbursement of the cost. However, patients may receive reimbursement for their share through supplementary insurance. This payment may be intended simply to raise revenue (and thus reduce *public* expenditure), to discourage user demand, or to signal to the doctor or dentist authorizing the use of resources that the user will have to pay, with the aim of encouraging more economical authorization. The extreme case is one in which the user bears the whole cost of a particular service.

There are further ways of restricting demand on an insurance scheme. One is a no-claim bonus, which has been tried on a small scale in Germany since 1989. A second involves income tax concessions to individuals who decide to buy services privately rather than use the ones they have paid for by statutory health insurance contributions or taxes. Such concessions have been applied in Ireland and Greece, in Portugal since 1989, and for persons over 60 years of age in the United Kingdom since April 1990. However, a government committee in Ireland has recommended phasing out tax relief for health insurance premiums and medical expenses. A third approach is to require prior approval, as in the case of certain auxiliary services in Luxembourg and for certain dental procedures in the United Kingdom. A fourth and more fundamental approach is to reduce the demand for health services by prevention and health promotion.

There is a much wider variety of cost-containment systems operating on *supply*; in recent years they have taken different forms, particularly services that operate on contract. The capital stock available to insurers can be restricted by limiting hospital construction or extension, closing hospitals, denying subsidies or insurance contracts to certain hospitals, and rationing expensive medical equipment by quota or by technology assessment. Health professionals may be restricted from entering medical practice that is covered by statutory health insurance or, in order to re-

duce the stock of trained manpower initially seeking to work for the health insurance system, access to medical or dental education may be limited.

Budget restrictions on current expenditure can be reenforced by controlling the number of personnel who are employed in the health care system. Current expenditure depends partly on the quantity of services supplied and partly on the price of either the goods or the manpower (salaries or fees) used to supply them. Costs can be contained by operating on either part. The authorizing behavior of doctors and dentists can be influenced through changing their incentives: the ratios between the payment rates for different services can be altered; their authorizing behavior can be monitored and high authorizers can be warned, threatened, or subjected to financial penalties. All these types of action have been initiated in different countries, thereby providing a long menu of options for intervention from which a country can choose.

Action on Demand

Although all the European Community countries have at some stage used modest cost sharing to reduce demand, it has not been the most important mechanism for cost containment nor has its role steadily increased. Its impact both as a revenue-raising measure and as an attempt to control demand directly or indirectly has been relatively small. Meaningful comparisons among countries of the revenue from cost sharing are impossible because of variations in the extent to which benefits like dentistry, glasses, and travel reimbursement are provided. Because of its visibility, it is a matter of heated controversy among the political parties of all countries. Cost sharing therefore may be strengthened at a time when the economic situation looks poor and then reduced in scope when prospects improve. Or the extent of cost sharing may depend on which political party is in the ascendant. Its role in the scheme of total health expenditure has been modest in every country that I studied except France, where it has played a greater part throughout that country's 50 years of health insurance. One reason is that many doctors in France (over 30 percent by 1989) have refused to accept the negotiated fee as full payment, insisting on adding an extra charge. However, most people have private insurance, which pays the patient's share of the cost, so its impact on cost containment is small.

The scope for acceptable cost-sharing targets depends on what health insurance has traditionally covered. Countries find it more acceptable to apply cost sharing to dentistry and glasses because, with the one exception of the urgent need for tooth extraction, such expenditures can be postponed until people have the resources to pay for them. This option is not available in countries that have either never provided these benefits or have offered them only in a token way, as is the case in Spain, Greece, Ireland, Italy, and Portugal. Belgium has never covered provision of dentures.

During the period studied glasses were made nonreimbursable for adults in Belgium except for individuals with very bad sight; children under 12 were entitled to free lenses and a cash grant toward the frames. In 1985, the United Kingdom also removed the right of adults to receive glasses under the National Health Service unless they had special eye problems or were receiving social assistance (welfare in the United States). For persons who were still entitled, a cash grant or voucher replaced provision in kind. In 1988 the right to free dental checkups and sight tests was abolished and dental charges were increased. Higher charges were also imposed in Germany. In Denmark, persons over 30 years of age have had to pay the full cost of dental care since 1983. Dental care is subsidized for those aged 18 to 30 and is free for persons under age 18.

There was an increase in cost sharing for drugs—often taking new forms—in seven countries. Drugs have been selected as a target partly because the share of health expenditure devoted to them is not small, varying from 6 percent to 21 percent (Portugal) of total expenditures. Additionally, in at least seven of the countries drugs have constituted the major expenditure, increasing faster than any other category.

An ingenious system was introduced in Germany in 1989. Not only does the patient pay a low flat-rate charge, in the range of $1.30 (U.S.) per prescribed drug, but also, where cheaper similar products, including generics, are available, a "reference price" has been established, averaging 30 percent below the price of brand-name products. Patients have to pay the amount above the reference price instead of the flat-rate charge. This has had the effect of inducing manufacturers of products selling for more than the reference price to lower them so as to eliminate the extra charge. It is too early to see the effect of this item on expenditures, but economists are projecting that DM 2 billion will be saved when the system is fully developed. In addition, Germany now requires doctors to specify on a prescription when generic substitution is not permissible.

Exclusion from health insurance coverage can be viewed either as a restriction of supply or as a system of 100 percent cost sharing. Ireland extended its list of drugs that cannot be given free to GMS patients in 1982 and is planning a restricted list of what can be covered by the scheme (Republic of Ireland 1989, 314). Germany also removed certain minor drugs from coverage by health insurance in 1983. In 1985, the United Kingdom removed several drugs, mainly those obtainable without prescription, from National Health Service coverage. The list of items not covered by health insurance in Luxembourg was written in 1979, and has not been changed since that date. Limited lists of what may be prescribed under health insurance are to be found in Belgium, Denmark, Italy, the Netherlands, Portugal, and Greece, although Greece does not effectively enforce the restrictions. As yet there is no list of restrictions in Spain, but one is planned.

Charges were introduced in Ireland for inpatient care and specialist visits (but not for the lower-income GMS patients) of about $19 (U.S.) a day or visit, subject to an annual maximum. In Italy a daily charge of $7 (U.S.) to $50 (U.S.) per day for the first ten days of inpatient care was introduced and then withdrawn after a half-day general strike and the fall of the government. A charge of about $7 (U.S.) for a visit to a specialist was introduced instead. A daily charge of about $5 (U.S.) for inpatients was introduced in Luxembourg in 1983, to be increased thereafter with the cost of living. Charges for diagnostic tests were introduced in Italy: 30 percent of the cost up to a maximum of about $14 (U.S.). Subsidies for travel were reduced in Denmark. In contrast, charges for drugs and specialist visits were removed in the Netherlands and fees for all types of visits to doctors and for inpatient care were abolished in Portugal. All of these charges are modest and the main effect has been to transfer costs from the public to the private domain, although there is clear evidence that people who have to pay prescription charges in the United Kingdom reduce their consumption with commensurate increases in the level of the charge (Birch 1986, 163–84).

Health Promotion

No country was able to give complete and separate figures for expenditure on health promotion. It is therefore not possible to show whether the WHO Health for All (HFA) program has led to greater expenditure, although Spain and Ireland have developed their own national HFA

programs following WHO guidelines. Nor is it clear whether the emphasis on AIDS has shifted attention away from other health problems.

Action on Supply

The Quantity of Current Supply

Budget and Manpower Controls. Overall budgets for the public health services in Denmark, Spain, Ireland, Italy, Portugal, and the United Kingdom are not normally increased if prices rise more than the government has projected. In Denmark, overspending is covered by the county budgets and is limited by the central government: 15 percent of any overspending by the counties has to be paid back to the Ministry of Finance in the following year. Denmark reduced the spending limits of the counties in 1983 and again in 1984; the 1982 level of spending was not regained until 1985. As a result, using the local narrow definition of health services, the percentage of the GDP that is devoted to public health services fell from 6.4 percent in 1982 to 5.4 percent in 1988. In Ireland, real expenditure fell almost every year from 1982 to 1988 because of budget restraints reenforced by controls on manpower and public sector pay: using the broad local definition of health services, the proportion of the GDP devoted to public health services fell from 7.5 percent in 1982 to 6.0 percent in 1988.

In Spain, spending on the health services was kept roughly constant in real terms until 1988; the amount was increased once the economic situation improved. In Portugal also total budgets were kept roughly constant in real terms from 1982 to 1984 and then eased. In England, real expenditure on the National Health Service was reduced in 1983–1984 and then slightly increased. The percentage of gross national product spent on health services was slightly lower in 1989 than in 1982. In Italy, budgets are always set unrealistically; regions borrow and permit their bills to fall into arrears until the government pays the outstanding debt with a special appropriation. Expenditure is instead effectively kept in check by controls on personnel. From 1983 to 1986 personnel who left government services were not normally replaced, thereby lowering the proportion of the GDP spent on public health services.

In view of the difficulty of restraining expenditure on primary care, other than by cost sharing, the main burden of economizing in these

countries has fallen on the hospitals. Hospitals have been pressured to rationalize their stock by closing smaller units or converting their use, particularly into facilities for the chronically ill or for the aged. For example, in Denmark, occupied beds fell by 17.5 percent and length of stay by 25 percent between 1983 and 1988, despite an increase in admissions of 9 percent. In Ireland, the number of beds available in public hospitals fell by 22 percent between 1982 and 1988. Neither country experienced any substantial problem of patients waiting for admission. In Portugal, where there have always been long waits, length of stay in the central hospitals was reduced by 14 percent within three years.

Of greater interest to the United States are countries that do not have a national health service, but use multiple insurers instead. Germany targets each main expenditure after discussion every year with all parties concerned, and then introduces special measures, such as greater cost sharing for dentistry or a reference price system for drugs, if the targets are exceeded. To deal with hospital care, Germany, with its mix of public and private hospitals, in 1986 introduced "flexible budgets," which were established by the main "sick funds," the German term for statutory insurers. These rewarded reductions in length of stay beyond what was planned and penalized failures to keep length of stay within the plan's guidelines. Nevertheless, admission rates have continued to increase. In spite of this, Germany has achieved remarkable stability in the proportion of the GDP that is devoted to health expenditure (see table 1). The latest German figures display a 0.4 percent reduction in the proportion of the GDP spent on health services between 1988 and 1989.

Most of the other countries operate budgets for hospital expenditure. Although hospitals in France are paid by insurers per day of care, the government budgets the total amount each public hospital can receive from all insurers. A special local agency has the task of calculating the share of this budget payable by each insurance fund according to patient use of different funds during the year. Total expenditures for private hospitals are also limited and the association of sick funds has to negotiate daily rates for each hospital to keep within this total. Budgets are set for each hospital (most of which are nonprofit) in the Netherlands; an increase in real terms of 0.5 percent was allowed in 1983 over the 1982 figures, no further increase followed in 1984, and a cut in real terms of 1 percent was ordered in 1985, followed by a further cut of 2 percent in 1986. During the next two years budgets were kept constant

in real terms. One effect was a decrease in admissions. Belgium controls its mix of public and private hospitals by setting a quota of bed-days for each hospital. In 1983 the quotas were 3 percent lower than the bed-days used in 1980, with a further reduction of 5 percent occurring in 1984. From 1985 to 1987, the quotas were unchanged; a more complex control system was introduced for the period 1988 to 1990, requiring a hospital that exceeded its quota to pay back the money to the appropriate sick funds. The length of stay in Belgian hospitals fell by 16 percent between 1982 and 1988, but admission rates increased. Luxembourg continues to pay hospitals on a daily rate basis, which encourages long stays, but is likely to change to a pattern of hospital budgets similar to that used in Belgium or Germany.

This budgeting system was effective in restraining expenditure. For example, expenditure on hospital treatment in real terms in Belgium fell by 8 percent between 1982 and 1985. In France hospital expenditure increased by 18 percent in real terms between 1982 and 1989 compared with an increase in total health expenditure of 40 percent. Similarly, hospital expenditure in current prices increased by only 6 percent in the Netherlands, compared with an increase in total expenditure of 14 percent.

Despite tight financial controls in Belgium, Germany, France, and the Netherlands, waiting for appointments with specialists or for admission to the hospital is not a major problem except, in some cases, for transplant surgery, which results mainly from a donor shortage. Fee-for-service payment of specialists seems to guarantee that competition among them cuts waiting time for appointments.

Alternatives to Inpatient Care

Day hospitals and day surgery are well developed in Denmark and the United Kingdom, rapidly increasing in the Netherlands, and encouraged in Ireland. The German insurance system has no fee structure to pay for them. Day surgery exists on a small scale in Belgium, France, and Italy and is in the planning stage for Luxembourg.

In nearly all countries provision of nursing homes and homes for the aged (which do not usually provide professional nursing) comes under a separate budget of local government or social security or is left to the private sector. Only in Ireland does the same budget pay for old-age homes, but, because provision is poorly coordinated with the hospitals,

an old-age home is more expensive than a hospital, although not as expensive as using a facility in the private sector without any subsidy. Nursing-home care appears to be the most fully developed in the Netherlands: there are more occupied beds in nursing homes than in hospitals. Compared with 4 percent in the United Kingdom, 10 percent of the elderly in the Netherlands are in institutions; nursing homes are financed under a separate national insurance scheme and care in old people's homes is financed out of the national budget. Many countries are recognizing the need to make more provision for the elderly by transforming small hospitals into homes for them. It has been estimated in Germany that 17 percent of hospital patients do not need care in a hospital. One county in Denmark made the municipalities reimburse it for each day any patient stayed in the hospital while waiting for a place in an old-age home, with the immediate effect of forcing the municipalities to establish more old-age homes. This system is expected to be duplicated throughout Denmark.

Home nursing is poorly developed in most of the countries I studied, but is provided extensively in the Netherlands by the Cross societies with government subsidy; home help services are available to over 20 percent of the elderly. Home nursing is provided by the health boards in Ireland, but on a limited scale, and it is poorly coordinated with the hospital services. It is more extensive in Belgium and the United Kingdom, although they also do not coordinate these services well with the hospitals in spite of the fact that home care and nursing share the hospital budget in the United Kingdom. The most extensive and dynamic service is provided in Denmark, where home nurses with cars are available to visit patients, even during the night, for injections and supervision. I do not have the data to make quantitative comparisons of the extent of provision in these countries. In Germany, a home care benefit and cash payments to insured persons who make their own arrangements were introduced in 1991.

Changes in Payment Systems for Doctors Performing Outpatient Services

Where doctors are paid on a fee-for-service basis, expenditure is particularly difficult to control. The major change in the period under review occurred in Ireland in 1989 with general practitioners who worked in the GMS scheme accepting replacement of payment per office or home visit

with a capitation system. The goal was to reduce the rate of prescribing for these patients, but the effect is not yet apparent.

A second major change has been the agreement in 1987 by office-based doctors in Germany to a payment system under which any increase in actions for which doctors can claim payment from insurance, even if caused by an increase in doctors, lowers proportionately the final level of payment per act to all office-based doctors. The effect has been to continue the decline in office-based doctors' average earnings, which have fallen relative to average earnings of the general population from 6.5 times the amount in 1971 to 3.5 in 1988. An attempt to apply a similar system to office-based specialists in the Netherlands was abandoned because of lack of cooperation in collecting the requisite information for its operation.

A further change in Germany, also in 1987, occurred in the relative value given to different services provided by doctors so that less was paid for diagnostic tests and more for medical treatment. Extra spending on tests was not allowed to siphon money from the fees for consultations and other services. Belgium recently placed a ceiling on payments for out-of-hospital pathology and lowered the fees for inpatient pathology. A quota of allowable pathology was imposed per day of care as well. A further new rule stipulated that an X ray would be paid for only if it was done in the presence of a radiologist. In France health insurance payments for diagnostic procedures have been proportionately reduced.

Medical Profiles

Medical profiles are used in many countries to attempt to limit excessive medical acts or prescribing by doctors working outside of the hospital. They are used for drugs in Denmark, Germany, Spain (since 1983), France, Ireland, Italy, Portugal, and the United Kingdom and are planned for Belgium and Luxembourg. However, they do not seem to have much of a long-term effect because sanctions are rarely imposed. For example, Germany placed a legal ceiling on expenditure for drugs in 1989, but has not specified how this will be enforced. Similarly, general practitioners in the United Kingdom are to be given "indicative budgets" for prescribing: sanctions probably will be applied over time to doctors who exceed these budgets. An exceptional step taken once only in Portugal was to publish a list of the names of high-prescribing doctors. Portugal also reduced package sizes and required each drug item to

be written on a separate prescription form. This had no effect on prescribing and was withdrawn.

Profiles on doctors' actions are used in Belgium, Germany, and France, and on specialists in the Netherlands. In Belgium and France their value is limited by doctors' refusal to reveal diagnoses to health insurers for reasons of "medical confidentiality." In Germany the 10 percent of doctors whose practice deviates significantly from the average is called to account by regional medical associations before a review board. Sanctions include counseling and advice, warnings, and fines. The special feature of the German system is that, with the advent of lower fee levels for office-based doctors, medical associations have a clear interest in restricting deviant behavior among their members. Recently the sick funds have been empowered to employ doctors to investigate cases of suspected fraud.

Entry of Doctors to Statutory Health Insurance Practice

One way of limiting increases in cost is to restrict the number of doctors. For example, it has been calculated that in Germany a 1 percent increase in doctors leads to a 1.1 percent increase in the reimbursement claimed. The number of doctors allowed to enter compulsory insurance practice in Germany is controlled by the regional doctors' associations. The federal government has recently increased the training required before a doctor is eligible to apply.

Six of the countries have specific restrictions on doctors entering compulsory insurance practice. In Denmark each county is responsible for indicating which regions are open or closed to entry by additional specialists and general practitioners. In Ireland, the health boards limit entry of general practitioners to the GMS service for lower-income patients, and in Italy control is exercised by each of the 673 districts. Entry to GMS general practice in Ireland is highly competitive and requires general in-practice training. As only one such course exists in Ireland, most of this training must be obtained in the United Kingdom. In Spain and Portugal, the number of posts for doctors is also tightly controlled. In Spain entry to health insurance requires in-practice postgraduate qualification. In Portugal, no new posts for doctors were allowed between 1986 and 1989. In the Netherlands an abortive attempt was made to limit the number of working doctors (and physiotherapists). Since the start of the

National Health Service, the United Kingdom has heavily restricted entry to general practice in overdoctored areas, but there has been no attempt to place an overall limit on entry by general practitioners into the National Health Service.

Expensive Medical Equipment

Countries with budget-financed health services are in a strong position to limit the expansion of costly medical equipment in the public hospitals, although in Denmark counties tend to be very responsive to requests from their specialists and in the United Kingdom carefully developed plans have often been frustrated by gifts and public appeals. In Spain, Ireland, and Italy developments in the private sector can limit the effect of restrictions in the public sector. In Germany also a 1985 law governing all hospitals is circumvented by doctors purchasing expensive equipment for their private practices, which nearby hospitals may contract for use. Portugal specifically drafted its law of 1988 to include the private sector, but since 1990 the government has been more lenient in the treatment of requests from private doctors. There are specific expensive medical equipment laws in Belgium, France, and Luxembourg: the permitted ratios have been increased over the years.

Only Denmark has a central body that is specifically responsible for technical assessments of new equipment. Although France and the Netherlands plan to establish such agencies, the occasional reports issued in France are not very influential. Assessment is done ad hoc through the department of health in both Ireland and the United Kingdom, but the other countries have no system at all.

Prices Paid for Goods and Services

Levels of Pay

One effect of budgets is to strengthen the reluctance of service administrators to agree to salary increases. In Belgium the pay of hospital employees has not kept pace with the cost of living. In France agreements on the levels of fees payable by health insurance have slowed the rises in pay of specialists and have caused the pay of general practitioners to decline. In the Netherlands specialists' pay was reduced by 7 percent in

1989, on the grounds that their expenses had been overestimated in earlier settlements, and fee levels were fixed to remain constant for three years.

Drug Prices

Methods of controlling drug prices indirectly or directly operate in all countries in the Community except the Netherlands and Germany and partially in Luxembourg. Germany has a system of indirect control for certain drugs through imposition of the "reference price."

Longer-term Restrictions in Supply

The Capital Stock

All the countries have long had provisions to control the construction of new hospitals and the expansion of existing ones: government-operated "certificates of need." Ireland and the United Kingdom have closed or changed the use of public hospitals judged to be unnecessary; additionally, Ireland has drastically withdrawn subsidies from private nonprofit hospitals. The number of public hospitals in the United Kingdom has decreased by about 30 a year over the past decade. An ambitious plan to close hospitals in the Netherlands in 1982 was thwarted by local opposition and the invidiousness of selecting which hospitals to close in a country with a mix of public and private hospitals, some of them denominational. A more recent plan entailed reducing hospital beds by 8,000 between 1987 and 1991. In Germany, although each sick fund can exclude particular hospitals from its contracts, this seldom occurs because of competition for members among the various funds.

Medical and Dental Education

Medical and dental education is a potentially important issue for the European Community in view of the directive giving rights of free movement among member states. In practice this directive has been relatively little used despite substantial medical unemployment in Spain and Italy. The United Kingdom has carefully developed plans to try to

limit entry to medical schools on the basis of the number of doctors they expect will be needed in the future. Denmark reduced entry by 23 percent between 1982 and 1987. Other countries produce more physicians than they need. Belgium is the only country that allows all qualified entrants to take a full medical course and it is an important supplier of Luxembourg, which has no medical school. Greece finds it difficult to exercise control because so many students go abroad for training. Although France allows all qualified candidates to enter, the numbers are greatly reduced by a difficult examination at the end of the first year. The number of entrants has fallen by 56 percent between 1975 and 1989, partly because of a decline in applications. In Spain, Germany, Italy, the Netherlands, and Portugal, student numbers are fixed according to the universities' capacity to maintain acceptable standards of teaching, not according to estimates of any future need for physicians. Student enrollments have been greatly reduced in Spain and have been kept roughly constant in Ireland, the Netherlands, and Portugal. Italy did not establish a limitation until 1986, but in any case new enrollments have fallen by 62 percent between 1980 and 1989 because of a decline in applicants. Moreover, only about 65 percent complete their degree. In Germany, where there is a surplus of doctors, both the sick funds and the medical associations would like to see a reduction in the number of entrants to medical school, but so far any attempt to impose restrictions has been politically unacceptable.

Higher Priority for Primary Health Care?

How far do the data that I have collected indicate a switch of priorities toward primary health care in line with WHO's HFA principles? No breakdown of total health expenditure over the last few years is available for Greece. In the case of six countries (Denmark, Germany, the Netherlands, England, France, and Italy), there has been a clear transfer of finance from hospitals to primary health care, a trend that is particularly marked in France and Italy. Confirmation that it may also be the pattern in Belgium, Ireland, and Luxembourg would require a more detailed analysis of the figures. The seeming preference for primary care may stem from tough controls on hospital expenditure being more politically acceptable than restraints on doctors and what they authorize

for outpatient care. The trend has taken the reverse direction in both Spain and Portugal.

Major Plans for Reform

Dissatisfaction with the incentives under the present methods of organizing and paying for services is leading the Netherlands and the United Kingdom to plan radical changes. Some of these changes have been inspired by the experience of health maintenance organizations (HMOs) in the United States, although Europe had thousands of similar insurers in the nineteenth and early twentieth centuries. The essential idea is that the same agency should not act as insurer (or purchaser) and provider, but rather each provider should compete for contracts according to the price and the quality of its services. In the United Kingdom, Mrs. Thatcher's reform of the National Health Service was based on three main principles (Department of Health 1989). First, the larger public hospitals, while still being publicly owned, should be freed from the main rules of the National Health Service and, for example, be allowed to determine the pay of their employees rather than being constrained by negotiated national pay scales. Second, each district manager of the National Health Service should become a buyer of services rather than a provider. As such, the manager would seek bids from both public and private hospitals for the provision of particular services and make contracts on the basis of price and quality. Certain "core" hospital services, however, would still have to be provided on the existing budget basis.

Third, larger partnerships of general practitioners with over 9,000 patients on their combined lists should be given budgets on a broader capitation basis out of which they buy the main services their patients require. Any profit can be retained to improve the practice. In other words, the partnership of general practitioners becomes the insurer or HMO that motivates the primary care unit to do two things: first, to consider carefully any expenditures and, second, to purchase the most cost-effective services.

There are three main difficulties with this type of approach. The first is maintenance of quality: general practitioners may be tempted to provide services that are beyond their competence. The second is that low-health-risk patients may be overselected by general practitioners. The

third is physicians' lack of experience in operating a system of this kind and the cost of obtaining the information to do so effectively.

The reform proposed for the Netherlands in 1991, in which all residents will be covered by national health insurance, was even more ambitious (Ham, Robinson, and Benzeval 1990; Wynand 1988). Thus, the Netherlands will be the sixth of the twelve countries to have a national health service. European usage assigns no other meaning to this term than equal health care rights for all citizens.

Every citizen will choose a public or private insurer that will be responsible for securing by contract the provision of defined health services and alternatives to them such as nursing homes, homes for the elderly, and home care services. Insurers will have to practice open enrollment and will be paid capitation payments based on age structure, geographical region covered, and other risk factors of the population that chooses them out of what is, in effect, a tax. This "tax" will pay, on average, 97 percent of the cost of present health services and related social services: 82 percent of this "tax" will be earnings related and 18 percent flat rate. On average, the remaining 3 percent of the cost of the insurance will be paid directly by the insured, who will be able to buy supplementary insurance to cover it. The insurers will be able to enter into contracts directly with hospitals: any savings from obtaining favorable contracts can be passed on to insured persons in the form of lower premiums for the supplementary insurance. The full scheme is expected to be in place by 1995.

At first it may seem that reintroducing some of the magic of market functioning can solve all the problems of efficiency. Although there is little doubt that these mechanisms could obtain services at low cost, the process of contracting is by no means free for the parties to the contract. The major problems with these models involve building in guarantees of quality and preventing discrimination against users who are high health risks.

Summary: Policy Convergence?

The greatest convergence in the policies of the different countries is in the use of the budget as a system of control, reenforced in some cases by manpower controls. The six countries with overall budget control (in-

cluding Denmark, where there are ceilings for expenditures by local government) have used expenditure ceilings, whose cash terms are normally stated in advance as the main method of controlling costs. However, budgets have also been set and enforced for each hospital in Germany, France, and the Netherlands; in Belgium bed-day quotas have the same impact and Luxembourg probably will have such budgets in the future. Thus, hospitals in 11 of the 12 countries either use or will use some type of budget control. The exception is Greece, which has been trying to improve its hospitals.

Budgets have been used in Germany to control payments to doctors practicing outside the hospitals and were tried unsuccessfully in the Netherlands for specialists. Such control is not needed when doctors are paid by salary or some type of capitation system, as is the case in six of the countries. Out-of-hospital prescribing costs are contained by budgets in Germany and the United Kingdom; these costs are controlled within overall budgets, successfully in Ireland, Spain, and Portugal, and unsuccessfully in Italy.

In most countries budget control has had the largest impact on hospitals. This has led to pressure to reduce lengths of stay, rationalize facilities, transform hospitals into other kinds of facilities, or sell them and develop alternatives to hospital care. Day hospital care and day surgery are well developed in only a few countries. Separate financing of nursing homes, old age homes, and home care limits the development of alternatives to hospitals in nearly all countries. In six countries, and possibly three more, a higher proportion of health expenditure has been devoted to primary health care rather than to hospital care, thereby reversing past trends.

All countries, except the Netherlands, use cost sharing for drugs. The trend has been to extend it to dentistry, at least for adults who have had extensive dental coverage in the past. There is also a movement to reduce or remove subsidies for adult glasses, except for persons with very bad sight. Countries differ mainly in whether there are charges for visits to doctors and inpatient stays.

There is also convergence in the attempts to control expensive medical equipment; lack of success, where it occurs, can be traced to exclusion of the private sector. Common to all countries except Belgium are controls on entry to medical education and they all have instituted controls on insurance practice.

Both the United Kingdom and the Netherlands are planning to use market forces as a system of cost control. Once tried and judged it remains to be seen whether these new systems will be retained.

Why Does Europe Differ from the United States?

The main message from the experience of the European Community is that it is technically possible to control health care costs by government regulation of supply rather than demand, particularly by applying budgets to hospitals. Some HMOs and "regulated states" have demonstrated this in the United States as well. Why can these European countries do nationally what the United States can only achieve on a local basis? The key to Europe's success is the use of monopsony power whereby one purchaser dominates the market, and not just the hospital market. Where there are many purchasers, as in Germany, they are forced to act together. Because the insurers are not allowed more revenue, either from tax or contributions, and because what they can charge the insured in copayments is centrally determined, they are forced either to confront providers or to ration their allowable resources. In most countries this does not lead to lines of patients waiting for treatment. The most ingenious control is operated in the Netherlands, where private insurers have 40 percent of the market, although the government controls how much hospital care an insurer can buy. The existence of national health insurance that covers nearly all of the population, while easing the task, is not a prerequisite for cost containment.

Why can European countries introduce and operate regulations that actually bite over most of the market for health care, while the United States is apparently unable to do so? One answer is that there is little or no competition among insurers in Europe, or where there is competition, each insurer is bound by the same restraints on the supply side. The same is true in Canada, which has been successful in containing costs. As Ted Marmor and his colleagues have recently pointed out, in the United States "competition for patients, employees and insurers constrains the degree to which suppliers can police strongly to avoid moral hazard" (Marmor 1990, 167). Are Americans so wedded to choosing their insurer after examining the small print of particular policies that they refuse to have this choice restricted?

It is also true that, in Europe, regulation works. It is acceptable for government to do the regulating and to use career civil servants to settle the details, once principles are established. There is no question of the regulated taking over the regulators. Is this unacceptable in the United States—at least in the case of health care?

At a deeper level one can ask whether in the United States the coalition of interests seeking to retain the status quo is too powerful. Does the federal constitution protect this coalition of insurers, providers, and the growing body of contractors working for them? Each of the European countries has one predominant legislature in which the real power is concentrated and a government that can normally control it, even though that government may be a coalition of different political parties. Is a country with two separate and powerful federal legislative bodies, a lack of party discipline, and a division between the legislature and the executive too open to the pressure of special interests to be able to take united action in this field? The experience of the countries of the European community demonstrates that firm and united governments can achieve what would previously have been regarded in many countries as "undoable."

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Acknowledgments: I wish to thank the Milbank Memorial Fund for the financial support that made this study possible. I would like also to thank experts in the 12 countries of the European Community. Some worked in the statutory health insurance agencies and some were independent researchers. I sent my report for each country to these experts for checking and correction.

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