

# Observations on “Cost Containment and New Priorities in the European Community” by Brian Abel-Smith

LAWRENCE H. THOMPSON

*U.S. General Accounting Office*

PERSONS FAMILIAR WITH CURRENT TRENDS IN American health care financing will find an interesting mixture of striking similarities and stark contrasts between the European developments described by Brian Abel-Smith and recent U.S. developments. On both sides of the Atlantic, governments and those charged with paying for health care (to the extent that they are different institutions) are struggling to slow the rate of growth of health spending. Where a national goal has been articulated, it has usually involved holding health-spending increases to the same rate as national income is rising.

Some of the European developments have close parallels in the United States; others—including some of the more promising—do not. In particular, most of the demand-side reforms discussed by Abel-Smith, such as greater use of copayments and promotion of healthier lifestyles, have been tried in the United States. However, the European strategies that involve systemwide budget controls have not been tried—or at least not as extensively. In the rare cases where such approaches

---

The views expressed in this article belong to the author and are not necessarily those of the General Accounting Office.

---

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

have been attempted, their scope has been limited to a particular state or region.

Had Abel-Smith included the United States in his health expenditure table, he would have shown spending growing from 7.4 percent of the gross domestic product (GDP) in 1970, to 9.3 percent in 1980, and 11.8 percent in 1989 (Schieber and Poullier 1991). Thus, during the 1970s the fraction of national output devoted to health care grew more rapidly (though from a lower starting point) in many of the Northern European countries (e.g., Germany, Sweden, and the Netherlands) than in the United States. However, the trends then reversed. In the 1980s, many of these European countries were successful in keeping health-spending increases in line with increases in national income, whereas spending growth accelerated in the United States. Apparently, the expenditure control strategies adopted by the European countries during the 1980s were more effective than the strategies adopted in the United States.

In a study published in 1991, for example, the U.S. General Accounting Office (GAO) estimated that, between 1984 and 1987, the enforceable global budgets for French public hospitals reduced spending by about 9 percent, but found no statistical evidence that hospital spending targets adopted in Germany had influenced spending totals. Similarly, the GAO found that, over the period from 1978 through 1987, German controls had reduced ambulatory physician expenditures by as much as 17 percent by first introducing spending targets and subsequently imposing binding spending caps. Each approach appeared to be effective, but the latter approach seemed far more effective. The GAO study thus confirmed that systemwide budget controls can slow health care spending growth, especially when institutional arrangements allow the budget to be enforced.

If these European strategies have been effective, why have they not found widespread favor in the United States? I suggest adding three factors to the list of possible explanations offered by Abel-Smith. First, the particular institutions used to finance health care in the United States obscured the importance of the escalation of health spending, at least until recently. Second, the initial American response to rising health spending was to introduce greater competition as a mechanism for cost control. Thus far, this strategy does not appear to have been effective at controlling aggregate spending, but it does seem to have led to other desirable institutional reforms. Finally, the United States currently lacks the institutional structures necessary to manage systemwide budgets so

that the European-style budgeting approaches could not be introduced here easily, even if a majority agreed that they were desirable.

Differences in the way health care is financed may in part explain why European governments have been more active than the United States government in trying to contain spending. In the United States, the cost of health insurance for working-aged persons is paid primarily by employers in the form, more or less, of a charge per covered employee. In contrast, health expenditures in European countries are financed either by general taxes (e.g., the United Kingdom) or by wage-related contributions (e.g., France and Germany).

For many years, health cost increases in the United States were simply a problem with which the business sector had to contend. They were not particularly visible to the average worker because they were not financed from payroll deductions. Nor were they visible to those debating government budget priorities because they were not competing for scarce budget resources with education, highways, and other socially desirable government activities. They have emerged as a problem only recently, as workers begin to realize that rising health costs may mean smaller wage increases in collective bargaining and as governments discover that health-spending increases are undermining attempts to balance budgets. The German government has articulated a goal that each worker's health insurance contribution rate should remain constant and has introduced major reforms designed to achieve this goal. Even today such a goal would have little meaning to the average American worker because Americans cannot see the connection between health care spending and their net wages, even when they realize such a connection exists.

Financing health insurance from payroll deductions has probably also made achieving universal health insurance more difficult in the United States. Employed persons who do not now receive health insurance as part of their employment package tend to work for smaller establishments and to earn lower wages than persons who are insured. Expressed as a percent of their current pay, the costs of health insurance are, on average, greater for these people than for workers making higher wages who are employed by larger firms. Thus, mandating that all employers provide health insurance imposes a disproportionate burden on smaller firms.

Second, the strategy adopted in the 1980s in the United States (implicitly, if not explicitly) was to let competition among private sector in-

surers and providers act as a brake on health spending. Presumably, insurers who created the most efficient delivery system could quote employers the lowest insurance rate and increase their share of the market. Although its effect on aggregate spending has been disappointing, this approach has led to major changes in the structure and management of health care providers. These changes may well have improved the quality of much of the health care delivered as well as the efficiency of many of the delivery mechanisms.

Finally, even if the United States wanted to introduce some form of systemwide budgeting, such an institutional change would be more difficult than in Europe because of the decentralized nature of both the health care financing system and the governmental structure. The responsibility for financing health care is divided among a large number of independent entities, each following its own set of payment policies. In the past, each payer—including the major governmental units—has pursued cost containment independently of the other payers. Unfortunately, the lack of coordination among payers has meant that policies adopted in the 1980s by each to control costs too often simply shifted the costs from one payer to another without actually reducing total health care spending.

The division of government responsibilities presents yet another challenge to systemwide budgeting approaches. In the American federal system, primary responsibility for promoting health and regulating health care providers has traditionally rested with the states. The states also are responsible for regulating private insurance companies. Because they already have these responsibilities, some state governments have recently shown themselves willing to assume a greater role in managing their health care finance and delivery systems along lines similar to those found abroad. Yet state governments do not now have all of the authorities needed to achieve these reforms. The federal government limits the states' authority by prohibiting state regulation of employers who self-insure, by retaining total control over the payment policies of the Medicare program, and by limiting state control over Medicaid payment policies. The distribution of responsibilities among the different levels of government may have to be adjusted before government could play a more active role in managing the American health care system.

Although the Europeans have been more effective in controlling aggregate health care spending during the 1980s, the budgeting approaches that account for this achievement have other limitations. For

example, lump sum global hospital budgets do not necessarily encourage efficiency in the delivery of health care services and, in some instances, have led to waiting lists. Also, budgeting total spending on a sector-by-sector basis can inhibit the natural evolution of the structure of the health care delivery system in response to technological, scientific, and management breakthroughs. Health service delivery mechanisms have not evolved nearly as dramatically over the past several decades in Europe as they have in the United States. In particular, the European systems have not developed the kind of managed care structures that have become common in this country.

Recognizing these shortcomings, several of the European countries are now trying to incorporate certain features of the American system into their own. Many are exploring ways to encourage more managed care. The French and the Germans are developing prospective hospital payment methodologies (similar to, but not identical with, the system used here in Medicare) in order to increase the incentive for efficient handling of individual cases without sacrificing aggregate spending controls. As Abel-Smith reports, governments in both the United Kingdom and the Netherlands are introducing a greater degree of competition into the system. In part, they hope competition will encourage greater efficiencies in their delivery systems. The Dutch at least hope also to introduce greater structural flexibility.

In summary, since 1980, the United States has been far less effective in stemming the increase in health care spending than have most of the European countries visited by Brian Abel-Smith. This may reflect, in part, the fact that the cost of health insurance has been more effectively hidden from American workers and political leaders, at least until recently. It may also reflect the preference of many Americans to try first to use competition as a cost control strategy and the fact that responsibility for regulating health financing policies is split between the federal and state levels of government. At the same time, governments and private insurers in the United States have developed new health delivery structures and reimbursement mechanisms, which may prove useful additions to the European systems.

It is hard to dispute Professor Abel-Smith's observation about the importance of some form of central budgeting and/or management in achieving meaningful control of health care spending. The United States will have to develop mechanisms of its own that can achieve the results obtained by these European structures. Some European systems,

however, are also experimenting with greater competition among providers or insurers as a complement to central management of the health care system. One possibility, therefore, is a convergence toward policies relying on some form of managed competition to encourage efficiency, introduce flexibility, and control aggregate spending. In the United States, this would be accomplished by introducing greater management into the existing competitive system. In Europe, it would be accomplished by introducing greater competition into the currently managed systems.

## References

- Schieber, G.J., and J-P. Poullier. 1991. International Health Spending: Issues and Trends. *Health Affairs* 10(1):106-16.
- U.S. General Accounting Office. 1991. *Health Care Spending Control: The Experience of France, Germany, and Japan*. GAO/HRD-92-9, November 15. Washington.

---

*Address correspondence to:* Lawrence H. Thompson, Human Resources Division, U.S. General Accounting Office, NGB/ACG, 441 G Street, NW, Washington, DC 20548.