

creased by 232% before taxes (284% after taxes), adjusted for inflation.⁵ The belief that employer contributions to health insurance come out of corporate profits rather than workers' real wages reflects the triumph of hope over experience — and represents a tremendous obstacle to gaining public support for a more efficient, more equitable way to pay for health insurance.

The confusion about employers' role is paralleled by confusion about government's role. Politicians often claim that the government is "giving" people health insurance. In fact, every dollar the government spends on health insurance must come out of the public's pocket. If the government is acting responsibly, the money will come in the form of taxes. If irresponsibly, it will be borrowed, creating debts for which

future generations will have to tax themselves in order to pay interest and principal.

The most efficient, equitable way to achieve universal coverage is to make basic health insurance available to everyone regardless of income, employment status, family circumstances, or other characteristics and to pay for it with a tax roughly proportional to income or consumption. In such a system, the wealthy and the healthy would subsidize insurance for the poor and the sick. Persons of average income and average health would pay enough to cover the cost of their own insurance.

The long-running debate about health insurance and health care that is continuing this fall will be more constructive, and possibly more fruitful, if all the participants would take these "incon-

venient truths" as a starting point.

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ELECTION 2008

Slowing the Growth of Health Care Costs — Learning from International Experience

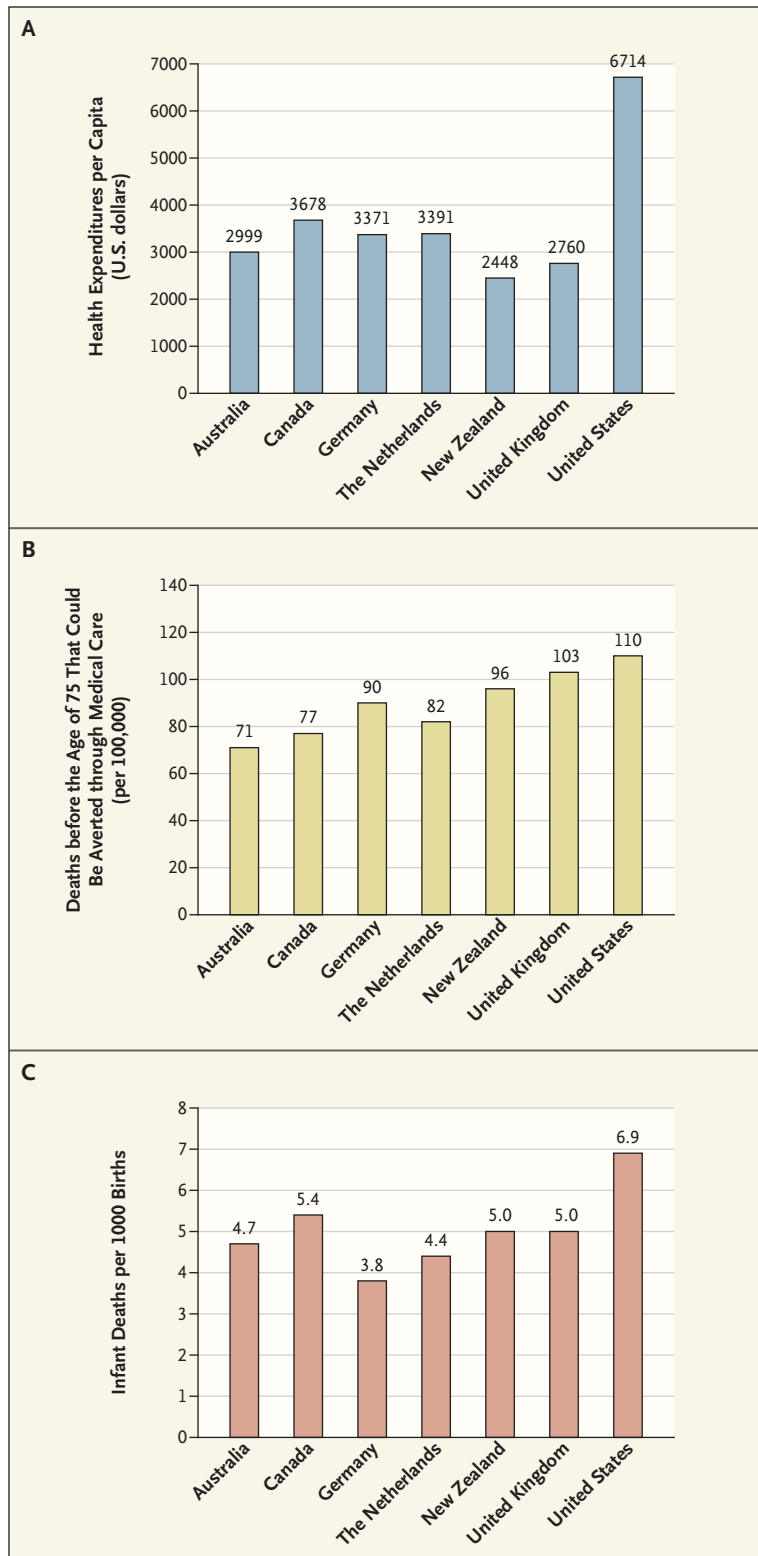
Karen Davis, Ph.D.

High health care expenditures and the growing number of people without health insurance set the United States apart from all other industrialized countries. The United States spends twice per capita what other major industrialized countries spend on health care^{1,2} but is the only one that fails to provide near-universal health insurance coverage. We also fail to achieve health outcomes as good, or value for

health spending as high, as what is achieved in other countries (see graphs).

The United States has been slow to learn from countries that have systematically adopted policies that curtail spending and enhance value. Chief among these are mechanisms for assessing the comparative cost-effectiveness of drugs, devices, diagnostic tests, and treatment procedures; implementation of information tech-

nology, including electronic repositories of patient medical information, across sites of care; easy access to primary care, including organized systems of off-hours care; a strong role for government in negotiating payment for care; and payment systems that reward preventive care, management of chronic conditions, care coordination, and health outcomes rather than volume of services.



Health Expenditures per Capita (Panel A), Rates of Deaths That Could Be Averted through Medical Care (Panel B), and Rates of Infant Deaths (Panel C) in Selected Industrialized Countries.

The figures in Panel A were converted to U.S. dollars with the use of values for purchasing-power parity. Data on health expenditures and infant deaths are from the Organisation for Economic Co-operation and Development. Data on death before the age of 75 years are from Nolte and McKee.³

No single silver bullet will transform the U.S. health care system, but a series of coordinated policy changes has the potential to substantially bend the curve of projected health care spending.⁴ Recent estimates prepared for the Commonwealth Fund Commission on a High Performance Health System indicate that \$1.5 trillion could be saved over a 10-year period if a combination of options, including universal health insurance, was adopted. These options were specifically designed for the U.S. health care system and would preserve its mixed private–public system of financing rather than being contingent on the adoption of a single-payer system.

The option currently receiving the most attention is a system for generating more information about the effectiveness of medical treatments, weighing it against that of other diagnostic or treatment options, and assessing cost relative to benefits to determine whether more expensive therapies warrant their additional cost.⁵ In this effort, the United States can learn from the cost-effectiveness review systems in Britain and Australia.¹ Britain's National Institute for Health and Clinical Excellence makes a judgment

about the effectiveness of new drugs, devices, and diagnostic tools relative to existing technology and provides advice on clinical guidelines and management of individual medical conditions that is grounded in a systematic review of available evidence. It evaluates the incremental cost of a new technology per quality-adjusted life year and recommends that the National Health Service cover new technologies whose cost per unit of health benefit is below a certain threshold, such as \$50,000 per quality-adjusted life-year.

We have no comparable process.⁵ Even a recent legislative proposal calling for a private organization funded by public and private sources to undertake effectiveness research stops short of recommending assessment of the cost-effectiveness of technologies or systematically basing insurance coverage decisions on such evidence. We need to ensure that new technology yields value over and above existing technologies, commensurate with its incremental cost. Investing in the knowledge needed to improve decision making and incorporating information about relative clinical value and cost-effectiveness into the design of insurance benefits would yield an estimated 10-year savings of \$368 billion for our health care system (see table).³

We also lag behind other industrialized countries in the adoption of information technology.^{1,2} Only about one fourth of U.S. primary care physicians have electronic medical records, as compared with 90% in countries such as Britain, the Netherlands, and New Zealand.¹ Denmark has a

national health information exchange that contains all of a patient's relevant clinical information in a repository that is accessible to patients and all the providers caring for them. In the United States, accelerating providers' adoption of health information technology with the capacity to support decision making and share patient health information across sites of care could be financed through an assessment of 1% on insurance premiums and Medicare outlays. Estimates are that the initial investment could be recouped after 7 years, and the estimated net savings to the health care system could reach \$88 billion over 10 years (see table).

The third area in which the United States differs markedly from other industrialized countries is the financing and organization of primary care.² Patients in many other countries are required to enroll with a primary care physician. In Britain, general practitioners receive bonuses accounting for up to 25% of their compensation in exchange for meeting quality targets in preventive care, managing chronic conditions, organizing care, and collecting patient feedback. In addition, primary care in Britain is easily accessible. The Netherlands and Denmark have excellent organized systems of off-hours care. The Netherlands funds the salaries of nurses placed in private physicians' practices to work with patients with selected chronic conditions. Analysis of the cost-savings potential of developing a system of "patient-centered medical homes" for primary care in the United States

indicates that Medicare alone could save \$194 billion over 10 years (see table).

Other countries control high-cost services through payment practices and patient incentives. France, among other countries, negotiates prices for pharmaceuticals and eliminates cost sharing for highly effective medications. Germany uses a reference-pricing approach, whereby the insurance system pays the lowest price for comparably effective drugs, with patients paying any difference between the reference price and the actual price. Negotiating pharmaceutical prices would generate savings of \$43 billion over 10 years in the United States. Japan, though it uses a fee-for-service system of payment, tightly controls rates of payments and, as a matter of deliberate policy, reduces the price of new technologies over time to encourage improved efficiency and productivity.

In some countries, specialist physicians are typically salaried hospital employees. Germany has also set aside a portion of its payments for contracts with providers delivering integrated care, such as cancer care. Moving to a bundled episode-of-care payment system that combines hospital and physician services for episodes of acute care in the United States would generate 10-year savings of \$229 billion (see table).

The issue, therefore, is not so much whether we know how to slow down the escalation of health care costs. Abundant international evidence, and even examples in the United States, demonstrate that higher quality, better access, and lower costs can be

Policy Options and Their Projected 10-Year Impact on Spending.*					
Policy Option	Spending				
	Total National	Federal Government	State and Local Government	Private Payer	Household
	<i>billions of \$</i>				
Producing and using better information					
Promoting health information technology	-88	-41	-19	0	-27
Establishing a Center for Medical Effectiveness and Health Care Decision Making	-368	-114	-49	-98	-107
Instituting patient-shared decision making	-9	-8	0	0	-1
Promoting health and disease prevention					
Promoting public health: reducing tobacco use (through new taxes invested in prevention programs)	-191	-68	-35	-39	-49
Promoting public health: reducing obesity (through new taxes invested in prevention programs)	-283	-101	-52	-57	-73
Instituting positive incentives for healthy behavior (through federally funded wellness programs)	-19	2	-12	-4	-5
Aligning incentives with quality and efficiency					
Instituting Medicare hospital pay-for-performance	-34	-27	-1	-2	-4
Instituting Medicare episode-of-care payment	-229	-377	18	90	40
Strengthening primary care and care coordination in Medicare	-194	-157	-4	-9	-23
Limiting federal tax exemptions for premium contributions	-131	-186	-19	-55	130
Correcting price signals in the health care market					
Resetting benchmark rates for Medicare Advantage plans	-50	-124	0	0	74
Instituting competitive bidding between traditional Medicare and private plans	-104	-283	0	0	178
Instituting negotiated prescription-drug prices	-43	-72	4	17	8
Applying Medicare provider-payment methods and rates to all payers	-122	0	0	-105	-18
Limiting payment updates in high-cost areas	-158	-260	13	62	27

* A negative number indicates a decrease in spending as compared with projected expenditures (i.e., savings); a positive number indicates an increase in spending. In some cases, because of rounding, the sum of the effects on spending by the various payers does not add up to the total effect on national health expenditures. Data are from Schoen et al.² and are based on modeling by the Lewin Group.

achieved simultaneously. Rather, the United States has been paralyzed by partisan divisions at the level of the federal government and by organized opposition from those who benefit from the status quo. The key to progress may lie in both a presidential admin-

istration committed to transformation of the health care system and a new policy process that is better insulated from special-interest political pressures. At a recent summit sponsored by the Senate Finance Committee, both Chairman Max Baucus and Fed-

eral Reserve Board Chairman Ben Bernanke raised the possibility of a "Health Fed" or a "MedPAC [Medicare Payment Advisory Commission] with teeth," which would be delegated by Congress to make specific payment and policy decisions under a broad

policy framework established by Congress. This approach, applied first to Medicare, could accelerate the diffusion of policy innovations throughout the country and provide a testing ground for broader application to Medicaid and commercial insurers.

The status quo is unacceptable. Without serious commitment to change, health spending as a percentage of the gross domestic product will rise from 16% currently to 20% by 2017; and Americans without adequate insurance and access to essential

services will continue to suffer avoidable health consequences. American resources and ingenuity are adequate for the challenge. What is required is national leadership and commitment to moving toward a high-performance health care system.

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Dr. Davis is the president of the Commonwealth Fund, New York.

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