LABOUR/MANAGEMENT PROGRAMME

HEALTH CARE REFORMS IN LIGHT OF CHANGING FUNDING, INCENTIVES AND PRODUCTION PATTERNS

Report on a meeting of management experts held under the OECD Labour/Management Programme

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(Paris, 4-5 May 1995)

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FOREWORD

Under the OECD Labour/Management Programme for 1995, a meeting of management experts on "Health care reforms in light of changing funding, incentives and production patterns" was held in Paris on 4-5 May 1995. The meeting was prepared in collaboration with the Business and Industry Advisory Committee to the OECD (BIAC).

Below is an overall report of the discussions of the meeting of experts, prepared by Mr. William Looney who was designated as General Rapporteur for this activity.

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EXECUTIVE SUMMARY

The meeting was designed to bring representatives of provider groups together to discuss the implications of expenditure restraint initiatives for the structural reform of health systems in the 25 member countries. It was divided into two parts:

- a review of the progress of expenditure restraint programs in various member countries and an analysis of their likely short- and long-term effects;
- a discussion of possible new approaches to structural reform that combine a commitment to expenditure restraint with wider use of market-type instruments designed to preserve access to care and enhance the measurement of quality and outcomes.

Participants agreed that traditional methods of expenditure restraint like price controls and global budgets are unlikely to remain effective in controlling costs over the long-term, and that wider use of competitive incentives and other market-type instruments is feasible due to the slowness of member countries to take advantage of the opportunities that remain to increase system efficiency. While "incentives can work wonderfully," attention must also be paid to preserving the commitment to social equity in the delivery of health services. This is because the reform issue must be resolved in the context of a democratic political process that is a shared institutional characteristic of all OECD countries.
I. INTRODUCTION

The need to assert greater control over health care costs is emerging as a dominant theme of macroeconomic policy in OECD countries. Health spending not only accounts for a sizeable share of GDP, it also has significant distributional effects by extending the public sector's claim on economic resources and diverting productive investment through the indirect wage burden assumed by employers. The 1994 OECD Jobs Study established a link between the rising cost of social benefits like health coverage and the capacity of member country economies to generate new jobs, reverse the trend toward stagnant or declining real wages, and boost international competitiveness in manufacturing and other labour-intensive sectors. Thus, from a management point of view, health costs are no longer a human resources issue but a key strategic factor affecting the overall business climate.

Economics is also driving the pressure on governments to devise new spending restraint strategies suitable for an era where the dispersal of market power and political authority makes the traditional public interventionist approach to regulation less effective. The systems member countries have employed to finance continuous improvements in health coverage rest on an increasingly precarious fiscal foundation, with the post-war commitment to universal access at subsidised rates threatened by a new budgetary environment marked by scarcity and shortage. At the same time, the spread of structural unemployment as well as a demographic shift that has spawned a rise in the pensioner population is pushing up demand for health care and other social benefits -- just as the liberalisation of global capital flows effectively prevents governments from underwriting the added costs through higher taxes or larger public deficits.

As a result, health policy-makers have little choice but to work to apply existing resources more efficiently: the strategy favoured by an increasing number of member countries is to promote the use of incentives and other market-oriented management tools designed to stimulate competition among health providers and thus approximate the manner in which private markets find the optimal balance between price and demand.

The most important area of consensus in recent OECD research on health care costs is the substantial opportunity that member countries have to capture additional savings through greater efficiency in the delivery of services. Conventional techniques used to save money -- such as caps on provider rates and product prices -- have not proved sufficient in removing the underlying sources of pressure on spending, which range from the explosion of new medical technologies to increased life expectancy and a surge in the number of elderly people. The reluctance of governments to take a comprehensive multisectoral approach to controls has simply redistributed the burden of spending to the weakest constituencies in the health system rather than allowing for a reduction in outlays overall.

The result is that while most OECD countries appear to have made progress in slowing the growth rate of health spending during the 1980s, the pace of the reduction has slowed since 1990. Current expectations are that health costs will probably increase as a percentage of GDP for the remainder of the decade.

Moreover, the success of a market-based approach to expenditure restraint is far from guaranteed. Ambitious reform targets have been introduced despite a lag in the capacity of either the public or the private sector to collect and evaluate information so that outcomes in the health system can be measured accurately, on a comparative basis. Co-operation between public payers and private
providers remains sporadic at best, and few OECD governments have been willing to extend market disciplines to politically sensitive areas like insurance coverage and drug reimbursement.

Questions have also been raised as to the readiness of public agencies to compete with private entities on the basis of quality and to accede to a new "performance measurement culture" that acknowledges the erosion of their monopoly position in the contracting of health services. It is equally unclear whether use of a rigorous market test of efficiency can work so long as governments continue to make pursuit of social equity the central organising principle of their health care systems.

Ultimately, the reform of health care -- and at what cost -- is a political issue that must be resolved in the context of the democratic process that is a shared institutional characteristic of all OECD member countries. The business community expects to participate in this process by virtue of its position as one of the two social partners as well as the crucial role it plays in funding health benefits through payroll taxes and other mandated wage-based contributions.

II. RATIONALE FOR THE MEETING

The Business and Industry Advisory Committee (BIAC), in a discussion paper submitted to the OECD High-Level Conference of National Experts on Health Care Reform held in November 1994, stressed that the objective of expenditure restraint should be to preserve the integrity of national health systems as a source of social solidarity and stability without inhibiting investment in innovation, a practice which is "fundamental to continuous quality improvement and cost reduction." There was general support for the BIAC approach among member country delegations attending the Conference, but no real discussion took place concerning specific strategies that might best accomplish these objectives.

Soon after, BIAC proposed to the OECD that an informal exchange between OECD staff and management experts take place to build on the results of the High-Level Conference and to complement similar discussions held in October 1994 under the joint sponsorship of the OECD Labour/Management Programme and the Trade Union Advisory Committee (TUAC). This resulted in agreement between BIAC and the Secretariat to organise a meeting of Management Experts on 4-5 May, with the participation of key OECD health policy staff. Specific objectives of the meeting included:

- examination of the effects of conventional demand-side controls on the pattern of health spending, with particular reference to the impact of these reforms on key health sectors as well as industry in general;

- discussion of new expenditure restraint strategies based on competition and market-driven incentives, including the potential benefits and liabilities of this approach;

- exploring the feasibility of other expenditure restraint strategies that might be pursued by governments and/or the private sector as part of a comprehensive reform initiative.
III. AGENDA ITEM ONE: HEALTH CARE OBJECTIVES AND THE NATURE OF HEALTH CARE MARKETS

The Chairman opened the meeting by stressing the vital commercial stake that industry has in the health reform debate. Spiralling health care costs have been identified as a principal source behind the deteriorating fiscal condition of member countries. Industry has suffered serious adverse effects from this trend due to the tendency of many governments to transfer the additional financing costs to employers through higher payroll taxes. Numerous studies and BIAC surveys have concluded that government policies like price controls and declining drug reimbursement rates have helped to erode support for innovation.

Such tactics are self-defeating in the long-term because they can no longer obscure the fact that demand for health care now exceeds governments’ funding capacity. However, the growing signs of system overload have failed to mobilise the health bureaucracies behind a meaningful program of comprehensive reform: OECD surveys of the health reform process in the member countries reveal that governments are suffused with a short-term mentality that eschews broad policy strokes in favour of a patchwork of incremental changes. This approach, by shifting costs from one part of the system to another, distorts the normal pattern of care for patients as providers react to a new mix of incentives and disincentives. The public response to such reforms sometimes results in stepped up pressure for more spending, not less -- a trend that may explain why savings targets in many countries have fallen short of expectations.

The Chairman cited the background paper [SG/RE/LMP/(95)6] prepared by the meeting Rapporteur in proposing a number of general themes to guide the discussions. These are:

- how the solidarity aspects of health policy can be reconciled with the fiscal policy imperative to rein in costs;
- the role of patients and providers in the health care system, with particular emphasis on the need for all parties to assume a larger degree of individual and collective responsibility in the management of costs; and
- how to ensure that the push to eliminate waste and encourage more competition among providers does not result in a decline in quality and destruction of health systems innovative capacities.

The Chairman’s remarks were followed by two presentations highlighting the results of recent OECD staff research on trends in health policy reform in the member countries. Mr. Jean-Pierre Poullier stressed that after more than a decade of reform there is no firm consensus among the member countries on how best to ensure that national health systems can go on meeting the needs of patients at a cost that societies are willing to pay. There are many subjective and unquantifiable factors at work as the environment for health care moves toward the 21st century, not the least of which is the constraints that high levels of public debt will impose on the process of policy innovation. The OECD Secretariat thus has an important role to play in helping member countries identify and implement restructuring strategies that appear to work best.

Health research within the OECD is a collective effort, involving experts in statistics and economic analysis, industry structures, and public enterprise management. One of the most important components of the OECD program is the Health Data File, which consists of 700 sets of...
indicators incorporating more than 300,000 statistics covering the period from 1960 to the present. The data base has many broad applications to the process of policy formulation, not the least of which is its potential in helping governments to identify treatment patterns and measure health outcomes on a cross-sectoral and comparative national basis.

The OECD also publishes a broad range of studies that centre on health care. Analytical surveys of the status of reform efforts have now been published in three volumes covering 24 of the 25 member countries [a paper on Mexico is being completed]. The Economics Department has produced chapters on health policy for inclusion in the series of OECD economic surveys of the member countries, while the OECD's Industry Division is studying the pace of innovation in large-scale enterprises, with special emphasis on biotechnology. The Public Management Service (PUMA) has also conducted important research on how health bureaucracies respond to service quality initiatives and the success of market-type reform mechanisms in public hospital settings.

Mr. Poullier stated that OECD contacts with the member countries had produced a number of basic themes regarding the manner in which governments approach health care reform. These "ten commandments of reform" are as follows:

- separation of financing from the delivery of health care so that payers have more autonomy in determining how monies are spent;
- acceptance of the idea that health care dollars should follow the patient, through DRG-like structures that link provider payments to a ranking of specific services;
- promotion of contracting between purchasers and suppliers of health care;
- introducing principles of a market system into the provision of health care through "regulated competition;"
- strengthening the role of primary care physicians as "gatekeepers" to the health system;
- empowerment of patients in the relationship with other participants in the system;
- enhancement of the commitment to quality assurance in the delivery of health services;
- placing more emphasis on research in medical outcomes as a barometer of cost-effectiveness and patient satisfaction;
- integration of health planning with broader social and environmental priorities, with an emphasis on prevention and health promotion; and
- support for greater accountability through the endorsement of formal health planning targets, with specific goals and deadlines.

Underlining each of these reform themes is the evidence that market-based incentives have played a key role in guaranteeing the success of any initiative. If a single conclusion can be fairly derived from the past decade of member countries’ experience with reform, it is the idea that "incentives work wonderfully."
Mr. Howard Oxley continued the discussion by raising issues outlined in a recent report, *Health Care Reform: Controlling Spending and Increasing Efficiency*. The key problem confronting the member countries is how to address a conflicting set of circumstances, in which pressure is growing to deliver more and better quality health care at a time of unprecedented fiscal restraint. As a result, member countries need to know precisely what reform will yield the biggest "bang for the buck."

Government is the primary instrument for reform in the health care system. With the exception of the United States, all OECD countries are committed to provide citizens with adequate health care insurance. In most countries, the government share of total health spending is also growing at the fastest rate, placing more pressure on the public sector deficit. It is impossible to discuss health care reform without accepting the principle that government has to be deeply involved in the process.

Another factor influencing the climate for health reform is the capacity of member countries to make significant gains in microeconomic efficiency, particularly on the supply side. Probably less than one-half of the increases in health spending since the 1960s can be attributed to demand-driven influences such as rising personal incomes, an ageing population, or expanded insurance coverage. Much of the run-up in costs is instead accountable to the manner in which health services are funded and supplied, including a pervasive lack of information on practice patterns and the most cost-effective treatments, provider and patient responses to the incentives rooted in the delivery system, the absence of strategies to manage the impact of technological changes, and a failure to prudently apportion the supply of personnel and physical plant.

In addition, there are substantial differences among the member countries in the structure of health systems. While some of these differences may be due to the influence of cultural and social antecedents, the dynamics of the institutional arrangements among physicians, hospitals, pharmacists and other providers are also a factor. This suggests in turn that reforms aimed at transforming the institutional setting for health care delivery can have an important impact on system efficiency.

Experience in the member countries has shown that price controls and other mandated top-down forms of budgetary constraints are less useful as a strategy to increase microeconomic efficiency. They tend to work best in single-funder systems, where government has the dominant role in financing and delivery, and are least effective in social security-based systems, where control is dispersed. The problem with this approach is simply that it is not sustainable over time: eventually top-down controls that coerce compliance lead to poor service, a decline in quality and a sharp overall loss in efficiency.

A more constructive path to reform is one based on the use of incentives that clearly delineate responsibilities and rewards to the participants. A separation of tasks between the purchaser and the provider provides the patient with an assurance of better quality care because the practitioner is held accountable to the consumer. In the hospital sector, the contracting of services also ensures that more control can be exercised over the consumption of services, with control defined as that which is the best quality for the money that is being spent. On the ambulatory side, the evidence appears to indicate that a capitated payment system that requires primary care physicians to control patient access to care is a powerful instrument for increasing efficiency while holding costs down.
Mr. Oxley emphasised that the kind of cost-containment that leads to better health requires a primary focus on supply-side issues. For example, there are substantial savings to be made by limiting the number of physicians eligible to practice. Demand constraints are less effective; it is popular to cite the savings produced by patient co-payments but the evidence shows that co-payments actually increase overall spending and shift the burden from the public to the private sector.

Prevention measures also have untapped potential in the effort to improve microefficiency. In most OECD countries, prevention efforts are centred within the ministries of health and tend not to be well-funded. There is a need for an integrated approach to prevention so that activities designed to stop medical problems before they occur are made part of the individual relationship between the physician and his patients.

Ultimately, the goal of microeconomic efficiency should not be to reduce overall spending on health care but rather to ensure that governments spend that which is necessary to achieve better health. It is unfortunate that the slowness of OECD governments to embrace formal planning targets to measure progress in areas like disease control and prevention has made it more difficult to identify what level of spending will deliver better health.

There is also scant understanding of the likely long-term impact of the health reform process on both the rate of spending and quality of service. This is a question that needs to be discussed in detail and made a key focus of future health policy research.

1. Discussion and Comments

Several participants stressed that aggregate measures of health spending should not be used as a performance benchmark in the cost containment reform process. The real yardstick is the level of efficiency: if a country's delivery system is efficient, then it does not matter that health costs comprise 14% of GDP. Statistical comparisons are also misleading if they are not placed in the proper context. For example, Germany is reputed to spend upwards of 9% of GDP on health care, which apparently makes it a more efficient provider than the United States, which spends more than 14% of GDP. Yet when the cost of worker's compensation and sick leave charges are added to the German total -- which is only fair as these are constituent elements in the German health security system -- its costs are actually as high as those of the United States.

In addition, the debate on expenditure restraint is presaged on the notion that cost is always a negative factor. The fact that health care costs are increasing is not reprehensible: such costs allow health-related industries to devise new technologies, introduce useful new products and research cures to many diseases, yielding enormous savings over time. The cost issue must take account of the long-term benefits.

Another participant echoed this position, noting that in Germany the cost of supporting the telecommunications sector is not perceived as a social burden even though spending is much higher today than only ten years ago. The difference is that, unlike the health care sector, unit costs have declined in telecommunications because of the efficiencies realised through privatisation. This shows the futility of attempting to measure efficiency by relying on aggregate costs.

The Chairman also stated that the most persistent theme in the debate on the direction of health reforms was the control of expenditures. Perhaps it is time to change the emphasis to what
governments are doing to preserve and enhance quality. He stressed the value attached to increasing patient choice but asked how this could be done without also requiring patients to make some contribution in respect to the cost of treatment. The argument in favour of co-payments is that the provision of greater choice for the patient requires the patient to bear a greater measure of responsibility as well.

Many participants underlined the need to build expertise in outcomes research to improve understanding of the value relationships between costs, quality and efficiency. Economists must move closer to the physician to see what is actually going on in the field rather than calculate standard reference points like variations in the pricing and use of medical treatments. For example, instead of compiling statistics on how many appendectomy's are performed, economists might better concentrate on field evaluations on whether the procedure results in an improved level of health. The essence of the argument is that outcomes research has to focus on what is important, which is health status.

Used in this manner, such research can point out serious failings in the status quo that will prod policy-makers to take action. In Sweden, some 10% of the workforce on any given day is off on disability leave. Viewed as an outcomes measure, that statistic alone tells us that the Swedish health system is failing miserably.

A second issue posed by participants was the impact that a capitated payment system supervised by physician "gatekeepers" has on patient choice. The sentiment was that a capitated system gives the patient fewer options and thus deviates from one of the central precepts of a market-based approach to reform.

A third point raised in discussion was the adverse impact that rising health costs have on worker's wages. It has major implications for the labour market by discouraging new employment and depressing real wage increases as employers seek to compensate for higher social security charges. Governments have failed to assess the effect of their reforms on the average working man and woman as well as employers, large and small.

This perspective was countered by another discussant who avowed that employers do not distinguish between benefits and wages in deciding what a particular worker will cost them. The sole determinant used in deciding to add to employment is whether a particular annual wage will produce at least an equivalent amount of monetary value to the company; other factors like health benefit costs are extraneous.

A fourth issue in the discussion centred on the insufficient attention paid by policy-makers to the "perverse effects" of the reform process. In Belgium, the government's drive to cut costs and enhance efficiency by reducing the number of hospital beds has merely shifted expenditures to other areas like welfare and unemployment insurance because thousands of workers lost their jobs during the transition. Likewise, a "gatekeeper" system puts tremendous pressure on the physician to see more patients, prompting the physician to save time by referring the patient to more expensive specialist care. It is important to recognise that in many cases the "savings" realised through reform are simply a transfer of costs from the public to the private sector.

This view was supported by several other participants, who affirmed that "gatekeeping" runs counter to the goal of patient satisfaction and hence carries adverse implications for the quality of care. In many countries, use of a primary physician to control access to the system is
mandatory only for the poorest part of the population; the more affluent can always spend what they want to retain their right of choice. How can reform pretend to promote the concept of mutual responsibility when some people are allowed to be exempted?

IV. AGENDA ITEM TWO: COMPETITION AND REGULATION IN HEALTH SYSTEMS REFORM -- EXPERIENCE WITH PHARMACEUTICALS

Mr. W. Brian Healey surveyed the climate on expenditure restraint from the special perspective of the research-based pharmaceutical industry. He noted that cost containment and health systems reform is presently a key strategic priority for all the major pharmaceutical firms. Despite the breadth of experience supplied by its broad multinational reach, the industry only recently has taken a strong interest in reform; there was great reluctance to engage governments on the issue in the past because of the presumption that the bureaucracy knew best how to manage systems that were largely publicly financed.

The fact is that the pharmaceutical industry can claim enormous expertise derived from operating in virtually every health care market in the world. The major industry associations like the European Federation of Pharmaceutical Industry Associations (EFPIA), as well as groups like Pharmaceutical Partners for Better Health Care, can marshall this knowledge to contribute to all aspects of the debate on health reform, not just those that relate directly to the pricing and sale of drugs.

Unfortunately, the crisis in health care funding has "imploded" on the industry, with an impact that is more profound than that experienced by any other sector. There is a growing gap between demand for health care and the capacity of cash-strapped systems to supply it. Demand-side expectations are fuelled by demographic changes, income gains, and the arrival of new technologies. At the same time, the supply of health care is being squeezed by the need to reduce public spending deficits and the unwillingness of voters to contemplate higher taxes and benefit contributions.

Pharmaceuticals are a major target in the drive to contain costs, which is surprising in light of the fact that the sector comprises a modest share of health spending, ranging from 10% to 20% of per country outlays in Europe [on a regional basis, Germany ranks highest, with 21% of total spending allocated to prescription drug purchases]. The average European spends only about $300.00 per year on drugs.

However small it appears in the aggregate, the cost of drugs is a highly visible part of the health spending ledger. As a stand alone item, drug purchases can be scaled back with relative ease. But it has also been shown that pharmaceutical therapy is extremely cost-effective, reducing the need for expensive surgeries and hospitalisation. Significant savings have been achieved with the arrival of new drug therapies for treatment of asthma, heart disease, schizophrenia, many cancers, and hepatitis B.

The key question for policy-makers is deciding whether drugs are part of the problem, or part of the solution. The answer depends on how wisely the national drugs budget is spent. It would be imprudent and probably politically costly if governments maintained funding for drug reimbursements without also considering the need for significant structural reforms that would improve the operating environment for producers of innovative medicines over the long-term.
Appropriate interventions by government is crucial to the outcome of this question, because in nearly all OECD member countries it is the public sector that is the leading payer for drugs. In Europe, anywhere from 75% to 90% of health costs are underwritten by governments, while about two-thirds of the cost of drugs are provided from the public purse.

The task is more of a challenge than first appears, as health systems suffer from serious gaps in information. It is unique in public policy that we have an industry that comprises a sizeable chunk of GDP -- one-seventh in the United States -- yet there is very little awareness of what this economic activity actually contributes to in terms of levels of public health. Is health improving? We do not really know. Speakers at the earlier session were right in stressing that OECD governments have an obligation to focus not just on achieving budgetary targets but on ensuring that their policies deliver acceptable medical outcomes as well.

This perspective is vital to the pharmaceutical industry because it is the chief victim of the fiscal mentality that says cut first and evaluate the consequences later. In many countries, the savings obtained from targeted patented "monopoly" medicines have proven to be illusory. In Germany, for example, if all patented drugs were removed from reimbursement lists, total health spending would drop by only 2%. Unfortunately, the industry remains vulnerable to a range of counterproductive strategies to squeeze drug costs -- caps on drug expenditures has become a particularly popular option in the past few years -- and as a result the long-term profitability outlook for the industry is bleak throughout the industrialised markets of North America, Europe and Japan.

Any rational strategy to contain drug costs should concentrate on the wide variations among OECD member countries in the quality and type of medicines eligible for reimbursement. Long established medicines --including many of dubious efficacy -- are being overconsumed, while access to important "breakthrough" drugs languishes due to the cost of keeping the older drugs on the reimbursement lists. A recent survey of lists in nine European countries found that on average patented products account for only 25% of total reimbursed expenditures for pharmaceuticals. A surprising 43% of the total consisted of off-patent, single-source drugs that are usually found only in one country or a particular region and are homeopathic remedies and tonics that are simply not up to current standards of therapeutic value and efficacy. Moreover, most European countries have failed to develop a supportive regulatory regime for generic products.

The result is an environment where it is possible to make a solid case that not only are governments failing to cover the best range of products, they may be paying too much for them. The current reimbursement structure in Europe rewards older products at the expense of new ones and inhibits the generic competition that experience in the United States has shown will allow only those products with unique therapeutic characteristics to command a premium price.

Another problem with the current reimbursement system in Europe is the high costs of distribution and dispensing. Only politics can explain why in some European countries the manufacturer of the drug is presently receiving less than 50% of the price that is reimbursed. Margins for wholesalers and pharmacists should not be legislated, but left to the market.

The presence of too many incentives in some areas but too little in others has to affect the prescription habits of patients. More government support for rational prescribing initiatives might reverse this trend so that more resources are available for the treatment of chronic conditions, where drug therapy is still an under-utilised option.
The inevitable conclusion is that all participants in the health system should be encouraged to change their behaviour if cost-containment reform is to fulfil its intended aim of boosting efficiency and controlling spending at a level that society can afford.

Governments must focus on the goal of improving health as well as saving money, and the best way to do this is to establish health planning targets to measure performance, create delivery systems based on competition rather than "command and control" regulation, and remove outdated products from reimbursement to free up resources for innovative drugs.

Industry needs to continue its commitment to the discovery of new drugs, through collaborative pre-competitive research, if necessary. It also has an obligation to provide top-quality information to physicians and the consumer, enforced through tough, self-regulating practice standards.

Physicians should alter drug prescribing patterns to ensure that patients receive better value for money. Practice standards should take account of the obligation of the physician to gear his advice to what is the most cost-effective therapeutic alternative.

Patients are required to assume more responsibility in determining the best course of treatment, chiefly by making a contribution to the cost in the form of co-payments at the point of service. A co-payment policy need not be socially regressive if it is designed to be both income-adjusted and outcomes oriented. Lifestyle changes should be encouraged as part of a co-operative effort with providers.

Wholesalers must push to consolidate in order to exploit the benefits of a wider market for medicines. This is particularly true in Europe, where wholesalers have been slow to address the arrival of a single market for medicines. Lower margins will result and the savings can be passed back to governments, manufacturers and the patient.

Pharmacists should build up their therapeutic relationship with physicians and the patient in the interest of more rational prescribing. Pharmacists have a right to receive fair compensation for follow-up contacts with patients, but the cost of dispensing should always reflect the level of service rendered rather than simply being fixed at a percentage of the retail price of medicines.

The research-based industry believes that the dimensions of the crisis in health care expenditures requires that participants in the system cooperate in the development of new models of health care financing, where the principal role for government is to set overall objectives and priorities rather than to finance and deliver health services directly. The ultimate objective of the drug industry is to increase the rational use of medicines. To accomplish this it will be necessary to accelerate the break-up of the many service and provider "cartels" that have been created as a consequence of years of government regulation.
1. **Discussion and Comments**

Participants suggested that a basic premise of this presentation is that what the consumer is willing to pay for care is the ultimate determinant of how much a society spends on health. It was pointed out that this premise poses a conflict to another key theme of the presentation, which proposed that governments should do more to set public health targets and help "fix" medical outcomes. What happens when a stupid and uninformed consumer wants to pay for a procedure that outcomes measures show to be of dubious efficacy?

The Chairman affirmed that it was very important to distinguish between the role of government in setting public health targets and the considerably more multi-faceted task of measuring medical outcomes. He also emphasised that sponsored research has shown that a patient co-payment requirement is the best way to address the issue of wasteful patterns of consumption in the health system.

A representative of PUMA noted that an additional challenge posed by the focus on using targets and outcomes to induce changes in the health system is the absence of a "performance measurement culture" in the public agencies and professional provider groups that dominate the delivery process. The simple question to ask is whether these people are really prepared to have objectives set for them.

Many participants agreed that some drugs are being overconsumed due to institutional factors such as the incentives that physicians have to write a prescription and the culturally ingrained expectation of the patient that he will do so. It was proposed that this issue could be addressed by bypassing the physician and allowing more drugs to be sold over-the-counter. Switching from prescription-only status to over-the-counter sale produces real savings to the health system because of the reduced necessity to visit a physician. However, to minimise any potential adverse public health effects, the pharmaceutical industry must be allowed to participate more directly in the crucial tasks of building consumer awareness and educating patients.

Participants from other segments of the health sector also stressed the desirability of dialogue with the pharmaceutical industry on cost containment issues. All providers have a stake in minimising waste and over-consumption of services because failure to address the problem will simply lead to government-imposed rationing.

V. **AGENDA ITEM THREE: COMPETITIVE MECHANISMS IN INSURANCE -- PAST EXPERIENCE AND NEW SOLUTIONS**

Mr. Peter Zweifel emphasised the role of insurance as a key factor influencing the effectiveness of a demand-side approach to expenditure restraint. Insurance is a beautiful social invention for managing the prevalence of uncertainty in human affairs, but it has a number of challenging side-effects. The most important of these is the problem of moral hazard, which tends to raise demand for health care and causes the individual to respond differently to a medical event than would be the case if he were without coverage. This has been proven in numerous studies like the 1976 analysis by Professors Newhouse and Feldt.
Health policy-makers have addressed the stimulative effect of moral hazard on demand through a variety of cost-sharing measures such as co-insurance or co-payments. A 1993 study by Newhouse and the Insurance Experiment Group concluded that imposition of a 20% co-insurance requirement is sufficient to minimise the extent of moral hazard. A fixed or experience-rated bonus system geared to providers has the approximate effect as well when applied to ambulatory care.

However, there is evidence that these conventional solutions to moral hazard are becoming less effective. The problem is that the success of improved health care coverage and new technologies in adding years to the average lifespan has spiked the demand for medical services even further. This "Sisyphus Syndrome," in which continuous improvements in quality and access to care results in an increasing number of aged patients requiring the most expensive types of medical services, has created a new and more persistent form of moral hazard -- one that is "dynamic" rather than "static."

The impact of "dynamic" moral hazard on the health system is pernicious. The combination of new medical technologies and comprehensive insurance coverage raises the proportion of the aged in the total population; their clout in turn forces the politicians to agree to spend more money, resulting in a new cycle of benefits that puts still more people in a position to receive them. The situation is made even worse by the tendency of physicians to compensate for bureaucratic controls on their fees by encouraging patients to consume even more services underwritten by insurance.

"Dynamic" moral hazard thus represents a serious threat to the long-term financial sustainability of all insurance-based health care systems. The solution is to break the cost spiral forged through the Sisyphus Syndrome by changing the behaviour of the insured population. The idea is to provide them with a financial incentive to limit their consumption of covered services.

A useful and practical approach to achieving this objective is the establishment of a Bonus Option system that, combined with co-insurance and co-payment mechanisms, would actually reward recipients for limiting their insurance claims. The basic thrust of the scheme is that covered recipients that submit no claims over a period of time [i.e. three years] would be eligible to receive a payment from the insurer equal to several months [i.e. five] premium -- a considerable sum of money. The actual amount would vary according to the structure of deductibles as well as the system's actuarial profile.

An attractive feature of the Bonus Option is that, in contrast to standard deductible mechanisms, it can have a restraining impact on supply as well as demand. In a co-payment based system, physicians are able to price their services knowing that patients have a set out-of-pocket cost per procedure, with the remainder eligible for subsidisation by the third party insurer. The Bonus Option makes it much harder for the physician to determine in advance the patient's reaction to prices, or whether the patient will choose to avoid care entirely or to seek it through an alternative provider whose fee is lower.

Conversely, there is concern that reliance on the competitive mechanisms built in to a Bonus Option scheme would exacerbate risk selection and "cream skimming" practices on the part of insurers. But this problem can be dealt with easily in the form of a Risk Equalisation Fund that penalises insurers seeking only prime healthy candidates while rewarding those that accept some additional risk in their recipient pool. Insurers would also be discouraged from attempting to reduce the quality of covered services through a stronger public commitment to oversight through
appropriate research on medical outcomes. This strategy is hardly a novelty: both the Netherlands and Switzerland have opted to introduce risk equalisation funds as part of reforms that each has made to encourage more competition in the operation of their respective social insurance systems.

1. **Discussion and Comments**

Several participants suggested that adoption of competitively-based insurance schemes like the Bonus Option would be harmful to the poor. There is too much economy built into the idea and not enough equity. It was pointed out that a key factor that persuades patients to avoid using the medical system has nothing to do with incentives -- it is the long wait that patients must undergo to even see a physician.

A contrasting opinion stated that poor as well as rich people have the native capacity to make informed choices about coverage that best suits their needs. Rank and file workers and the labour unions that represent them are not afraid of incentives as long as they provide real choices and retain the basic right to quality care. The major source of opposition to an incentives-based approach is the health bureaucracy, which persists in the idea that the average man or woman is too dumb to make the decision on insurance coverage themselves.

Another participant noted that experience with this type of reform in the Netherlands indicates that governments tend to stop short of allowing real competition in the insurance system, creating instead a patchwork policy that confuses the consumer. This view was contrasted by a participant who said that smaller initiatives that are based on competitive incentives are vastly preferable to large structural reforms that take years to implement. Incentives can rapidly alter the way a system functions because they are founded on basic human nature.

Several other speakers stated that a central problem raised by the Bonus Option as a solution to "dynamic" moral hazard is that it gives people too little incentive to seek vital preventive and prophylactic care. Prevention cannot be left entirely to the discretion of the patient as would appear to be the case in the Bonus Option scheme.

It was also noted by some observers that the arguments in favour of the Bonus Option are ultimately unconvincing as they relate to expenditure restraint because the real driver on costs is the problem of excess supply. The challenge is to place incentives on the supply side of the equation -- experience over the past 20 years shows that there will be no real savings unless governments attack the waste produced by too many hospital beds and specialist physicians.

A final point was the cost of administering a Risk Equalisation Fund, a task that was potentially very complicated and could lead to far smaller gains in savings and efficiency than predicted.

VI. **AGENDA ITEM FOUR: PRIORITY SETTING -- CAN COST CONTROL AND INNOVATION CO-EXIST?**

Ms. Patricia Danzon focused on the role of innovation in health reform. Innovation is useful in two ways. It can produce real cost savings and/or it can enhance the quality of services. However, it should not be assumed that these two are always complementary: an improvement in quality can sometimes push costs higher. Finding the optimal balance between innovation that
simply costs more and innovation that produces more for society at a price that the innovator and society find acceptable is one of the most difficult challenges facing health policy.

Achieving an appropriate balance is harder still because of the nature of the innovative process. The innovator must bear the fixed costs associated with a new technology's discovery and development up front, even though many thousands of individual patients may benefit from the technology in the long-term. In the case of pharmaceuticals, a manufacturer may spend several hundred million dollars on developing a drug only to obtain a government mandated price that carries no recognition of the fact that its development costs need to be shared with the beneficiaries if the total investment is to be recouped.

The ability of consumers [and countries] to access new technologies without contributing anything to the fixed cost of developing them creates a serious problem in funding R&D. The recipients do benefit in a myriad of ways, ranging from cures for chronic diseases to fewer physician visits and less waiting time in physicians' offices, but this is not reflected in the incentives available to the investor.

Two conditions are necessary to encourage an optimal level of innovation. First, the health care system must be flexible and efficient enough to allow for the substitution of innovative medical services, including pharmaceuticals, in the treatment of particular health conditions. Second, consumers need to have a way in which they can directly express their individual preferences, if necessary by paying a higher insurance cost in return for access to new technologies and higher quality care. In this regard, the most common forms of expenditure control measures -- such as global budgets -- are likely to be counterproductive to the process of innovation because of the restraints they impose on consumer choice.

Far less antagonistic to the process of innovation is the current United States trend toward integrated HMO-based delivery systems, which rely on a capitated payment structure in providing a comprehensive range of services. An integrated system combined with capitation provides for greater efficiencies in the design and operation of basic health services; facilitates the integration of new technologies in a manner that ensures prompt access to them for the widest possible pool of patients; and enhances efficiencies on the supply side by creating incentives to eliminate under-utilised hospital beds, control wasteful capital expenditures and prevent an oversupply of physicians -- all without recourse to government controls.

The chief attribute of an integrated system that fosters support for innovation is the ability of insurance plans to compete on the basis of benefit design and price, and where the rules that plans adopt are constrained by markets rather than the actions of a single monolithic provider or payer. Conversely, in systems that define a uniform set of services and then impose it on everyone, decisions on access to medical services affect the entire market and thus carry the potential to eliminate the customer base needed to make a new technology commercially viable.

These systems also are highly effective vehicles for the processing and evaluation of information. The integration of patient, payer and provider relationships means that data bases can be shared more, while the size of the patient pool enhances the capacity to introduce statistically meaningful disease management and medical outcomes programs. In addition, the inclusive nature of the systems makes the monitoring of quality indicators a vital part of the process due to the extra costs associated with a decision by a patient to seek medical care outside the integrated network.
It is important to note that it is the basic incentives established through capitation -- not the methodological tools -- that help bring down health costs and improve system efficiency. Technology assessment procedures are a case in point: this tool should be used only as an adjunct to an efficient incentive structure, rather than as a substitute.

A key issue concerning the relationship between an integrated capitation system and medical innovation is how the system permits consumers to express their own preferences concerning new technologies. It is clear that when given the opportunity patients will respond differently in terms of their willingness to exploit new technologies and alternative modes of treatment. The diversity of responses can be addressed by permitting patients to pay extra to command access to a wider range of innovative services, through higher co-payments or by purchasing a supplementary insurance plan that improves coverage for procedures involving new medical technologies.

This is not intended to promote the establishment of a "two tier' health system that condemns the poor to second rate care and eliminates government as a force for social solidarity. The public sector must continue to have a role in the management of the system, but only as an enforcer of basic standards of access and coverage.

The point of allowing patients to purchase the right to access the latest technologies through expanded insurance coverage is that new technologies have to be used if they are to be priced competitively. The more that new technologies are used, the lower the price of access will drop. Government policies that bar access to new technologies until such access is universal fail to recognise that this makes everyone worse off in the long-run. A "trickle down" approach to the utilisation of new technologies is the only practical response because it guarantees that the innovative process will at least find a market.

The pricing of innovative technologies like pharmaceuticals is a sensitive issue for governments. Many are reluctant to permit or to recognise differences in drug price within their own countries but conversely tend to welcome such differences when these are between countries. In the latter case, the aim of public policy is to be the market with the lowest prices.

The fact that in some countries the commitment to low pricing is an element of official government policy represents a serious threat to the future funding of pharmaceutical research. A simple examination of the costs involved in developing a new chemical entity (NCE) to formal market launch shows why: some 50% of the total cost consists of charges for use of working capital and administrative overhead as well as the direct expenses for the research itself; these fixed costs are higher than the marginal costs associated with manufacture and must be incurred regardless of the size of the NCE's eventual market. They cannot be assigned to any particular set of users or, for that matter, to any country.

Pricing policies biased in favour of older products rather than new products that should command a premium for cost-effective applications against conventional treatment are evident throughout the OECD, with the notable exception of the United States. This is reflected in statistics on pharmaceutical R&D per industry employee, which demonstrate that expenditures in the other OECD countries are lower relative to the United States and in decline. The fact that the United States appears to place greater value on the opportunity to utilise new technologies than other OECD countries suggests in turn that there is little merit to the argument that the prices of new technologies must be set in a uniform manner.
1. Discussion and Comments

A certain amount of scepticism was expressed concerning the overall merits of a capitated payment and integrated delivery system as a tool for cost containment. One of the oldest such systems, administered by Kaiser Permanente in the US state of California, has failed to realise the benefits of integrated delivery by continuing the practice of managing pharmaceutical care separately from the hospital budget. There was strong agreement on the proposition that the health sector invests too little money in information technology and fails to exploit it effectively in the management of costs.

Several participants contended that a reform plan that encourages innovation by allowing for some degree of patient choice in accessing new technology fails to address a fundamental question: just how much new technology is enough? There is a need for some form of regulation to avoid a possible rise in health care inflation. It was noted, however, that this scenario could be minimised by moving the purchasers of technology into an integrated delivery system, where every participant must compete on the basis of price.

Another participant stressed that limits on new technology were far more damaging when introduced as a consequence of government edicts. Experience in the United States market has shown that public sector programs like Medicaid follow the European lead in seeking to restrict access to new drug technologies through formularies, which gives the patient absolutely no choice in the decision on what is listed or not. In a private-sector system, the patient has the option of switching plans to get the coverage that best suits his needs. So whether there is an optimum environment for the dissemination and acceptance of new technologies depends very much on who picks up the bill.

VII. AGENDA ITEM FIVE: IMPACT OF HEALTH POLICIES ON ECONOMIC DEVELOPMENT AND GROWTH

Mr. Wilfried Prewo presented an analysis of the German health care system, where high quality health care is being delivered at too high a price. The health system is wasteful as measured against the benchmark of efficiency, or the best quality care at the least cost. And governmental "liposuction" in the form of reference prices or budget caps doesn't reduce the fiscal waistline, but, like many diets, leads to perverse results in the long run.

A major difficulty in implementing economically efficient social policy reforms is that, in the political arena, equity considerations always take precedence. Too often, sensible reform steps are blocked because this or that group's distributive status quo is threatened, even though the overall gain might far outweigh such partial losses.

Despite the recovery from the recession, Western Europe is suffering from record-high unemployment. It is apparent that the current economic growth cycle will produce few new jobs. This is in stark contrast to the United States, where the number of jobs nearly doubled from 1960 to 1993. In Germany, the increase over the same period was less than 10 percent.

The main cause of sluggish job growth is the high cost of labour, especially indirect wage costs. In German industry, these indirect costs amount to 80% of gross wages, or about double the United States proportion. Indirect labour cost in Germany has increased twice as fast as gross
wages, and this increase is closely correlated with the rise in unemployment rates. Thus, while employment creation depends on total labour cost, the most promising avenue to lower the latter will be on the indirect part.

Up to 1989, European labour costs were bearable, as the competition for labour was mainly restricted to the triad of Western Europe, Japan, and North America. Here labour cost differences of up to 35% could be partially compensated by productivity and other locational advantages and were not the deciding factor for investment decisions.

However, the benchmark for labour costs is now set by the emerging markets in South East Asia and Eastern Europe. These countries not only offer low wages, in the magnitude of one tenth of European labour costs, but also a productive work force. For West European firms, countries such as the Czech Republic are the "Hong Kong around the corner"; they are particularly attractive for mid-size companies that, in the past, did not consider going to far-away countries as the multinationals did. As a result of this transition, it is hard to see how employment growth in Western Europe can be anything but stagnant -- or even negative -- for the remainder of the decade.

This brings us to the related issue of the financing of the welfare state: in the "Bismarckian" variety of social security systems, like Germany, financing is linked to employment and becomes a part of labour costs. In the "Beveridgean" systems, of which the NHS in the United Kingdom is the prime example, social security is financed via government revenues and hence the effect on jobs is somewhat more indirect. But eventually both systems come full circle to the same conclusion: in the former case, the higher payroll taxes needed to finance social security make jobs too expensive to create. In the latter case, jobs are eliminated as the total tax burden induced by social security make industrial production too expensive on world markets.

On the investment side, the welfare state's consumption spending drains resources needed for capital spending. The resources that normally supply the seeds of growth for future welfare are eaten up today. In 1970, Germany's welfare expenditures equalled investment outlays; today, they are twice as large.

The welfare financing problem is exacerbated by demographic trends: in 1960, Western Europe still had a population pyramid with a broad base of young and few old people; in 1995, the "age tree" is a cucumber with few young people, many mid-lifers (still in the active labour force) and a growing, though not yet dominant, number of retirees. By 2020, we will have a mushroom: very few young, few mid-lifers, and many old people.

Such a system cannot be financed by a pay-as-you-go system where the actively employed pay the cost of providing pensions, hospital and nursing care for the elderly. The "generational contract" underlying this system has become an immoral, albeit legal, "chain-letter." It impoverishes the current generation, deprives future generations of growth opportunities, and even shifts liabilities onto this economically weakened future generation.

The major fault of the national health plans in Europe is that each is a uniform plan that disenfranchises the individual. Benefits are standardised into a "one size fits all" package. Through the institutional tools of either the payroll tax or outright socialisation in financing health care, individual consumption is unrelated to individual expenditure. Consumer responsibility and choice have no material place; the individual is bestowed with an entitlement determined by the government -- he is not an enlightened consumer/buyer of social insurance products.
It is important to note that government health plans in Europe are not insurance systems. The individual contribution or premium is not actuarially calculated, there is no incentive for prudent use, no penalty for abuse, and hence a moral hazard problem is rampant. The insured individual exploits the system by extracting as many benefits as the system allows; the costs that he inflicts on the community of the insured are only marginally borne by himself as premiums increase for everybody. As more and more people respond rationally to the incentives built into the system, the system becomes grossly wasteful; worse yet, as prudent behaviour is ridiculed, solidarity loses its moral base.

In attempting to control costs, the social security systems have become increasingly politicised. Even in the many countries where the health systems are not run outright by the government, but rather were conceived as friendly workers' societies or as self-managed employer-employee partnerships, the increasing level of bureaucratic intrusion has converted them into de facto government plans.

The systemic fault of European health care systems -- disenfranchisement of the individual -- can be rectified. To do this, the top-down, social engineering approach of government-run systems must be discarded and health care reorganised in a bottom-up, incentive-driven and customer-friendly way. This is the "consumer model" for health care: it allows for the empowerment of the individual to make his own decisions regarding the scope of his health coverage. Such a reform requires five elements:

1. Empowering the individual first means enabling him to finance his choice. In the Bismarckian systems, our proposal is that all current employer contributions to social security systems (with the possible exception of workmen's compensation), together with the employee's payroll tax -- which combined total 13.2% of gross wages -- should be deposited in a new Social Savings Account (SSA) established in the employee's name. This transfer must be tax-free, to the extent that current employer contributions are also tax-deductible. In the Beveridgean countries where social systems are financed from general tax revenues, the government would transfer the corresponding monies into the SSA of the taxpayer.

2. The individual is in turn obliged to buy mandatory coverage against such risks which, if uninsured, would make him a welfare case. That implies, for example, mandatory coverage for most hospital care or chronic illness and ambulatory care beyond a sizeable annual deductible.

3. The novelty of this approach is that beyond this mandatory coverage, all other types of coverage are optional. The individual owner of the SSA would have free choice to select among providers of insurance or managed care (HMO/PPO). Free choice among providers of insurance or care applies first and foremost to the mandatory coverage -- mandatory coverage does not mean that government acts as the provider.

4. Savings obtained from selecting coverage at a lower premium than current coverage would be transferred and remain in the SSA. The individual can draw on it for expenses not covered and other social security purposes, such as nursing care or life insurance.

5. As current European health care systems typically contain implicit cross-subsidy elements -- from high- to low-income earners, from small to large families, or from the young to the old
it will be necessary to finance such subsidies, if the no-loss rule is to be preserved. This requires no fresh money. We must merely take steps to reveal currently hidden transfers and make them explicit. Those that currently finance the implicit transfers (e.g., young high-income earners or those without families) will have a corresponding amount deducted from their SSA; that amount is transferred to the SSA of the recipients (e.g., old, large families, low income). After the transfer, both sides will have an amount in their SSA that is sufficient to pay for the current coverage at full actuarial value. Both would reap analogous savings from their individual economising behaviour.

The consequences of such a simple, albeit politically radical, change would be as follows:

**Health Costs.** On the demand side, consumer choice would bring a decrease in spending, as waste related to the phenomenon of moral hazard is eliminated. On the supply side, consumer choice would bring about an efficient and competitive structure: the health system will no longer be managed on the basis of medieval, guild-like professional or corporatist rules. There will be a variety of plans fitting a variety of individual needs. HMO's or PPO's will be offered to the individual, who can reject them or accept them according to his preferences. The solo physician practice will not disappear altogether, but will have to carry its price tag. The SSA approach does not prescribe, but lets the individual choose his preferred option and pay or save accordingly. Overall, costs may or may not decrease, as ageing and technology advances are unpredictable and tend to push costs up. But whatever total costs we will have, they will be at the minimum for the level of care desired by society.

**Quality of Care.** The quality of coverage increases, as perceived by the consumer. The individual will spend the money where he needs it (i.e. for eyeglasses or dental fixtures), not where a one-size-fits-all government plan offers or restricts coverage.

**Social Equity.** The no-loss rule is preserved. The insured have the same amount of money at their disposal as currently spent for them. Current hidden transfers are made explicit. Employers and government do not lose, either. No new money is required. An important side effect of such reform is that subsidies become transparent; information is a precondition for a sound democratic debate on social policy.

**Labour Costs.** This reform may not result in an immediate, dramatic drop in labour cost, because employers pay out what they have paid out before, unless employees would be willing to share some of the savings that they expect. This is an issue that can be settled in the labour markets, between employers and employees. Far more important than short-run gains, however, are the medium and long-run effects on the trends of health costs and, consequently, labour cost and employment. First, we believe that a SSA-based consumer model will begin to check the increase in health expenditure. Everybody will try to beef up his SSA and avoid unnecessary expenses. Second, sick leave will decline. Third, the consumer model will bring sizeable real labour cost decreases in the medium run, as it will evoke structural change on the supply side.

**Employment.** As the labour cost trend is reversed, unemployment rates will decline. This would be enhanced if the SSA concept could be applied to other social security areas as well, such as sick leave, unemployment, pension insurance.
1. Discussion and Comments

A number of participants expressed concern that the Social Savings Account would destroy the commitment to social solidarity and replace it with an individualistic calculation of economic self-interest that would leave some people worse off. The long-term unemployed, patients with disabling chronic illnesses, and the handicapped were cited in particular: what happens when a cancer patient depletes the Account and has to fall back on the solidarity system? Will society still be as willing to pay for their care with this new approach?

It was also suggested that the Social Savings Account might serve as a pretext for employers to lobby for a scaling back of their contribution to health system financing as the amount of money held in the Accounts increased. The key assumption behind the proposal is that the current social security system is an economic handicap. It might be more appropriate to say that the system constitutes a protection against risk. It recognises that health risks are unequal and that only society can intervene to soften the blow of illness for the individual and absorb the shock. This has to be recognised as an economic benefit in itself.

VIII. CONCLUSIONS

In concluding remarks, the Rapporteur noted that there was strong support for the thesis that an overt regulatory approach to cost containment, as exemplified by price controls and global budgets, has failed to solve the financial problems of national health systems. More important, such tools are hindering the future innovative capacity of OECD countries in cutting-edge industries like pharmaceuticals and biotechnology research.

The introduction of new cost containment strategies founded on competitive market principles show promise of being far more effective in containing costs without a commensurate drop in quality. Nevertheless, endorsement of these new mechanisms must be accompanied by a reaffirmation of the commitment to social equity to avoid having their merits challenged on grounds of bias towards the affluent.

The Chairman ended the meeting by stressing the complexity of health policy issues in an uncertain fiscal and social environment marked by the absence of a "single truth" to guide decision-makers. Continued dialogue among the social partners as well as health services providers is therefore critical in order to ensure that the effects of alternative reform options can be accurately assessed. The OECD has an important role to play in this regard due to its status as an intermediary between governments and industry. It will be particularly useful in marshalling its considerable quantitative and analytical expertise to highlight those practices which produce cost savings while preserving quality and nurturing the innovative capacities of member countries’ economies.

It was agreed that continuation of the dialogue process between BIAC and the Secretariat is desirable, and that a follow-up session covering more specific issues be convened on the technical level in 1996.
## ANNEX -- LIST OF PARTICIPANTS

**Management experts**

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