The impact of cost-containment policies on health expenditure: evidence from recent OECD experiences

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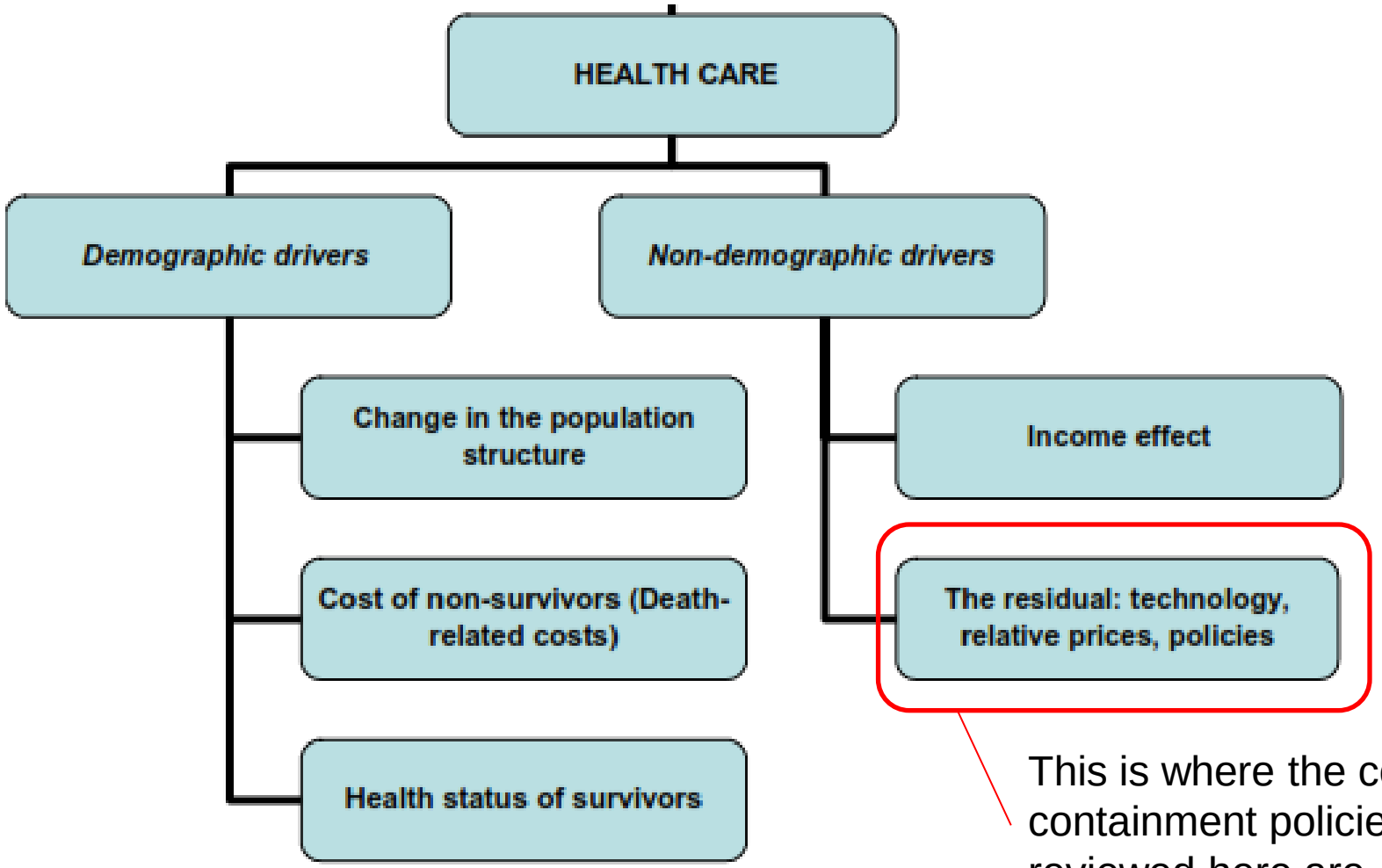
Aims

- Review the most robust empirical evidence on health spending impacts of cost-containment policies (OECD, recent decades)
- Assist policy-makers: informed decisions on reform paths based on country experiences
- Health policy alternatives to contain *excess cost growth*

Background: expenditure drivers



Source: Oliveira Martins et al. (2006)

A stylised economic framework

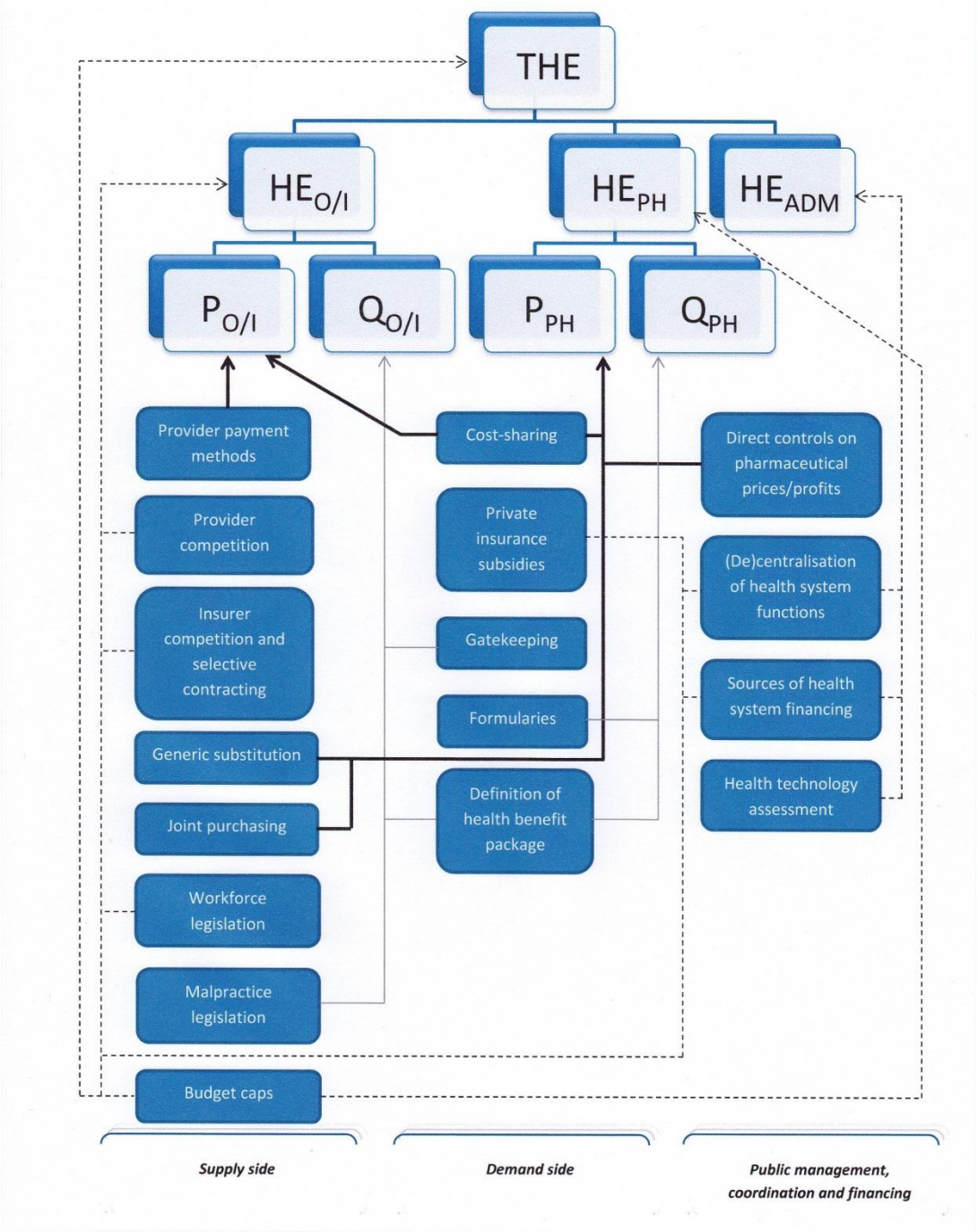
THE: total health expenditure

Health expenditure (HE) components:

- O/I: outpatient & inpatient care
- PH: pharmaceutical sector
- ADM: public administration

Policies may influence HE <u>primarily</u> via:

- Service prices (P): black lines
- Service quantities (Q): light grey lines
- P & Q (indirectly): dotted lines



Supply-side reforms: what do we know?

Cost-containment policy	Category	Primary effect on	Empirical evidence of cost-containment?	Main empirical evidence from	Notes
Fee-for-service reduction	Supply-side	Price	Yes	United States	Cost-containment effect partly mitigated by increase in service demand
Capitation payment	Supply-side	Price	Yes	United Kingdom	Combined with GP fundholding and gatekeeping No evidence of cost-shifting
DRG-based payment	Supply-side	Price	Yes	Several OECD countries	May affect quality of services
Hospital competition	Supply-side	Mixed price and quantity	Yes	United Kingdom, United States	Price-based competition linked to lower care quality
Insurer competition and selective contracting	Supply-side	Mixed price and quantity	Mixed	Netherlands, United States	Successful in the United States (combined with payment-for-performance) Less successful in the Netherlands (limited selective contracting and payment-for-performance)
Mandated generic substitution	Supply-side	Price	Yes	Canada, Sweden	
Joint purchasing of pharmaceuticals	Supply-side	Price	Yes	United States	Most evidence methodologically limited
Budget caps (sector and global)	Supply-side	Mixed price and quantity	Yes	Germany, United Kingdom	Most evidence methodologically limited Some evidence of cost-shifting due to sector budget
Workforce supply and wage controls	Supply-side	Mixed price and quantity	No	Canada, United States	Evidence of cost increases due to stricter entry legislation
Malpractice award limitation	Supply-side	Quantity	Yes	United States	Magnitude of cost-savings controversial

Demand-side reforms: what do we know?

Cost-containment policy	Category	Primary effect on	Empirical evidence of cost-containment?	Main empirical evidence from	Notes
Cost-sharing extension	Demand-side	Price	Yes	Several OECD countries	Extended cost-sharing linked to reduced access to necessary and quality care Consequential deleterious impacts on inequalities and health outcomes
Private insurance subsidisation	Demand-side	Mixed price and quantity	No	Australia, Spain, United Kingdom	Subsidy removal probably cost-saving
Gatekeeping role for physicians	Demand-side	Quantity	Mixed	Several OECD countries	Most evidence methodologically limited
Pharmaceutical formularies	Demand-side	Quantity	Yes	Canada, United States	Most evidence methodologically limited
Definition of publicly funded benefit package	Demand-side	Quantity	Evidence unavailable		Direct restriction to services offered within the public health system Link to use of health technology assessment (see below)

Public management, coordination and financing reforms: what do we know?

Cost-containment policy	Category	Primary effect on	Empirical evidence of cost-containment?	Main empirical evidence from	Notes
Direct price control of pharmaceuticals	Public management, coordination and financing	Price	Yes	Several OECD countries	Magnitude of cost-savings from reference pricing schemes heavily context-dependent Long-run effects on costs controversial
Decentralisation of health system functions	Public management, coordination and financing	Mixed price and quantity	Mixed	Several OECD countries	Centralised funding associated with higher sub-national expenditures Evidence of aggravation of inter-regional spending inequalities
Recentralisation of health system functions	Public management, coordination and financing	Mixed price and quantity	No	Norway	Only one country-case, with concurrent change to provider reimbursement
Reforms to the mix of health financing sources	Public management, coordination and financing	Mixed price and quantity	Yes	Several OECD countries	Evidence of cost-savings from move away from social insurance contributions towards general taxes
Use of health technology assessment	Public management, coordination and financing	Mixed price and quantity	Evidence unavailable		Cost-containment impacts likely to arise from combination with other reforms, including definition of basic benefit package

Concluding remarks

- There is *robust* evidence on the cost-containment effects of many OECD reforms
- Spoiler alert: no magic bullet!
  - Many examples of context-dependency, policy interactions
  - Evidence offers valuable insights about cost-containment potential (and risks) in alternative contexts