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Health Care Spending Control:
The Experience of France, Germany and Japan

Statement of
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Special Committee on Aging and
the Committee on Governmental Affairs
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Chairmen and Members of the Committees:

We are pleased to be here today at this joint hearing of the Senate Committee on Governmental Affairs and the Special Committee on Aging. We are here to discuss the health systems in France, Germany, and Japan and the results of our report just issued.[1]

As you know, there is concern nationally about the twin problems that afflict the health care system in the United States: escalating spending and narrowing access to health insurance. How to address these problems remains under debate in the domestic policy arena, and it was in this context that the late Senator John Heinz asked us to undertake this review. We are reporting on lessons that the United States can draw from other industrialized countries. We are not advocating any one system or feature discussed. I will begin with a brief overview of the three countries' systems, pointing to their similarities and differences, and then summarize what we found to be significant.

HIGHLIGHTS OF THE FOREIGN HEALTH CARE SYSTEMS

We focused our report on France, Germany, and Japan, in part because these countries provide universal access to health

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[1]Health Care Spending Control: The Experience of France, Germany, and Japan, GAO/HRD-92-9, November 15, 1991.

insurance while spending proportionately less on health care than the United States. In 1989 the United States spent 11.8 percent of its national income on health care, whereas France, Germany, and Japan spent 8.7, 8.2, and 6.7 percent, respectively.[2]

Similarities

These countries' better spending records and their similarities to the U.S. system have attracted the attention of health policy experts. They resemble the U.S. system in four ways: First, they provide health insurance using multiple insurers, or payers. Second, people typically get health insurance for themselves and their dependents at their place of employment. A person's employer or occupation determines which insurer provides coverage of health benefits. Third, people in these countries have free choice of physicians that charge on a fee-for-service basis.[3] Last, both private and public hospitals deliver inpatient care.

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[2]National income refers to gross domestic product.

[3]In the United States, the choice of some Americans is limited. In some rural areas and inner cities, alternative providers are few. Moreover, some Americans have opted to limit their choices by enrolling in health maintenance organizations or other forms of organized care, such as preferred provider organizations.

Differences

We do not want to overstate the similarities, however. The French, German, and Japanese systems are notably different in that they are extensively regulated. This regulation has important consequences. The first is that almost all residents are guaranteed access to health insurance. The government achieves this by stipulating which insurers will cover which population groups. The government also mandates a minimum package of health care benefits, compulsory enrollment, and payroll contributions from both employers and employees (for insurance obtained at the workplace).[4]

The second consequence of regulation is that insurers' payments to physicians and hospitals are standardized. All three countries use price controls that place ceilings on physician fees or daily hospital charges. Insurers are required to reimburse providers according to the set rates. This means that a given service gets reimbursed at the same rate, regardless of insurer. The government does not set these payments unilaterally, however. Instead, insurers and providers help develop these rates--negotiating with each other, as in France and Germany, or advising the government, as in Japan.

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[4]In Germany people with incomes over US $36,000 are not required to enroll.

Finally, regulation in these countries also is designed to control the rise in health care spending. Nationwide policies in the three countries set goals for overall health spending increases. In addition, France and Germany set goals for and impose spending budgets on inpatient hospital care. Germany has a budget that caps spending on physician services. As part of our review, we did an econometric analysis of the French and German budget controls to see how effective they were.

In Japan, the government targets a desired growth rate for total health care spending, but does not impose budgets on physician or hospital care. Rather, Japan relies much more on controlling prices in its efforts to restrain spending than do France and Germany.

GAO OBSERVATIONS

We have just identified important features of the French, German, and Japanese health care systems: multiple insurers, near-universal health insurance, regulation of provider payments, and price and budget controls. Taken together, these features suggest four main lessons that bear on the cost and access problems of U.S. health care.

First, these countries achieve universal health coverage using many insurers. To provide this coverage, these countries mandate

that a minimum broad package of health benefits be offered by all insurers. In addition, the government designates an insurer for those people not covered through the insurance offered at the workplace.

Universal health insurance in these countries precludes the need for physicians, hospitals, and insurers to shift the costs of otherwise uncompensated care to people with health insurance. The standard benefit package, moveover, allows providers to make medical decisions without having to be concerned about which services are covered by the patient's insurer.

Second, these countries standardize rates for reimbursing providers without the government setting rates unilaterally. Although there are exceptions, insurers' reimbursements to providers are usually made at a uniform rate. These rates are set with the participation of payers and providers. This arrangement differs greatly from that in the United States where physician fees are largely determined in a market with the interaction of myriad players--physicians, insurers, and consumers.[5]

Because reimbursement rates in these countries are standardized, providers have little reason to shift costs of care

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[5]In 1992, when Medicare introduces a relative value scale for physician services, physician payment rates for a substantial proportion of the population will be determined administratively, not through market interactions.

from less generous payers to more generous ones. In addition, when prices are uniform, providers have less incentive to withdraw their services from people whose payer might otherwise reimburse less generously. In the United States, Medicaid is such a payer. Medicaid beneficiaries encounter difficulty finding physicians willing to accept Medicaid's relatively low reimbursement rates.

The policy of placing a ceiling on reimbursement rates for providers is not universally popular in these countries. Physicians in France and Germany, for example, have sought to undo or soften the effects of this policy on their incomes.

Third, these countries can moderate increases in health spending by putting entire sectors of health care on a budget. Our report details how budget controls worked in France and Germany. For example, budget controls in Germany restrained spending for physician care. In fact, we estimate that, by 1987, spending was 17 percent lower than it would have been without these controls. The story is similar in France: we estimate that French budget controls, by 1987, reduced spending on hospital services by 9 percent compared to the amount that would have been spent otherwise.

Our analysis also found that budget controls with teeth were more effective than those that were simply guidelines. Germany first introduced a target for physician spending that did not have

an enforcement mechanism and later adopted a cap that did. Because the cap had enforcement built in, it was more effective than the earlier target. Targets for hospitals, however, were not effective at reducing expenditure growth in Germany, but were effective in France. Again, we believe that enforcement was the key to effectiveness. That is, the French government enforced the national targets set for hospital care through its participation in budget negotiations with each hospital individually. By contrast, in Germany, no formal mechanism linked the nationwide spending targets set for hospital care to individual hospital budget negotiations.

Fourth, the experience of these countries shows that budget controls are not a panacea--they do not relieve all spending pressures, nor do they assure quality or efficiency. In fact, France and Germany's health expenditures continue to rise. For one thing, some sectors are not subject to budget controls. For another, social pressures on spending, such as the aging of the population or the spread of AIDS, are beyond the reach of budget controls.

In addition, budget controls in France and Germany offer little incentive for physicians or hospitals to deliver care efficiently. For example, fixed budgets for hospitals do not reward administrators or physicians for making cost-saving innovations. Likewise, fixed budgets can keep inefficient

hospitals open that might otherwise suffer losses and shut down. France and Germany have recognized these limitations of budget controls. They are exploring policy proposals and reforms, including a diagnosis-based approach to hospital reimbursement--similar to Medicare's system.

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Consensus on how to address the problems of cost and access in the U.S. health care system has been elusive, and Americans have begun to look abroad for insights. Given the complexity of the U.S. health care system and the diversity of the United States, no foreign model can be imported wholesale. Nonetheless, the debate over divergent approaches to health financing reforms will benefit from assessing the merits and flaws of foreign health care systems.

This concludes my statement. I would be happy to answer any questions.