The Role of Independent Commissions in Controlling Costs and Enhancing Value: International Lessons
Alliance for Health Reform
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ED HOWARD: My name is Ed Howard, I'm with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Collins, our Board of Directors, thanks for being here for what I think is going to be an excellent session to examine the quasi-governmental authorities that a number of countries, particularly Germany, the Netherlands, and France, have established in their health care systems.

Now, in the reform legislation that Congress is considering, there are a number of new organizational entities, some governmental, some sort-of governmental, and some not to handle a bunch of very important tasks. So we had a radical thought in light of, especially radical in light of what some call American exceptionalism, that is, the belief that we have nothing to learn from anyone else.

That is why we look at some of the governing or advisory structures in place in other countries in areas like quality and cost containment and payment regulation. How do they work? How well do they work? How are they held accountable?

Fortunately, our colleagues at the Commonwealth Fund were convening a three-day meeting that ended just moments ago, which is why we're just a couple minutes late, bringing to town representatives of many countries involved in this area of

endeavor. So we drafted several of the articulate members of that group, convinced them to stay a few more hours, add in a thoughtful American commentator and voila, a great panel.

Now that leads me not too subtly to the fact that our partner and cosponsor in this briefing is the Commonwealth Fund, which has done more good in comparative analysis among countries' health systems than anybody else I know of. With us today representing the Fund and co-moderating the discussion is Robin Osborn. Robin is the Vice President and Director of the Fund's international program in health policy and practice and has been so since 1997, a record for longevity. Robin, thank you for helping us put this together and for making sure that our panel is intact.

ROBIN OSBORN: Great. Thanks so much Ed. On behalf of the Commonwealth Fund, I'm delighted to join Ed and welcome you here and to thank you for joining us for this briefing. I know that I'm speaking on behalf of Karen Davis, President of the Commonwealth Fund, and Steve Schoenbaum, Executive Vice President when I say how pleased we are to be able to conduct this afternoon's international session here on Capitol Hill and to be able to share with this broad audience of Washington policy makers a look at three industrialized countries and their approaches to policy making and governance in their systems.

We're particularly grateful to the Alliance, to Ed Howard, Nancy Peavey, and Deanna Okrent for their collaboration in organizing this program.

As many of you probably know, the Commonwealth Fund is a private foundation established in 1918 by Anna Harkness with the broad charge to enhance the common good. The mission of the Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency. In doing so, we are particularly committed to improving care for society's most vulnerable populations, the poor, the uninsured, minority Americans, young children, and the elderly.

Since 1918, the Fund has conducted research and sponsored service delivery innovations aimed at helping to address many of the most urgent health policy problems in the United States, recognizing, however, that many of the issues of greatest concern to the Fund, are access to adequate primary and preventive care, quality of care, responsiveness to patients' concerns, reducing barriers to health care for vulnerable populations, long-term care, and ensuring value for money, are matters of equal concern in other industrialized countries.

The Fund established an international program in health policy and practice. The core countries of the Fund's program

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are Australia, Canada, France, Germany, the Netherlands, Norway, New Zealand, Sweden, Switzerland, and the U.K.

The program is very much premised on the belief that despite the differences in the ways health care systems are organized and financed, the cultures and the political context in which they operate, there are valuable lessons to be learned and drawn when policy makers, researchers, and journalists look beyond their own borders at the experience of other countries.

I think instinctively, there's a conventional wisdom and it operates similarly in other countries for each of us to believe that we have the best health care system in the world. Unpeeling that, however, what the data shows and what we've learned is that no country really is the best or the worst. Each performs well on some measures and shows room for improvement on others.

What the Fund hopes to do through cross-national comparative research and exchanges such as today's is share country policy innovations that may be relevant to the United States ensuring access, improving quality of health care inefficiency are driving concerns in each of the countries that are represented here today. Similarly they're concerned with the parallel theme of getting value for money.

For the U.S., these themes as we stand on the threshold of health reform really resonate. U.S. per capita spending on

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health care is more than twice the OECD median but despite outspending every other country, we often deliver poor performance. In a recent study by Nolte and McKee published in *Health Affairs*, the U.S. ranked 19th, last of the 19 countries on mortality amenable to health care. These are the deaths that could have been prevented: bacterial infections, treatable cancers, diabetes before the age of 50.

On an annual basis, the Fund produces cross-national data for benchmarking and comparing U.S. health care system performance with other countries. In an eight-country study of chronically ill patients, and these findings are in the packs that you have and have been published in *Health Affairs,* patients report their health care experiences, the U.S. performance was at the bottom of the eight-country ranking of our 2008 study of chronically ill adults when it came to patients not being able to get needed care because of costs, inefficiency, poor coordination of care, medical errors, and hospital readmissions.

Yesterday, the Fund published its 2009 international survey of primary doctors in 11 countries. Key findings where the U.S. was an outlier were that the majority, 58-percent of U.S. doctors reported their patients have difficulty paying for medications and paying for out-of-pocket costs compared to five-percent to 37-percent in the other countries.

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One half of U.S. doctors said that the amount of time they have to spend getting patients needed medications or treatments because of insurance restrictions is a major problem. Only 10-percent of primary care doctors in the Netherlands, where everyone in the health care system has private insurance, said this was a problem for them. The U.S. also lagged behind on after-hours care, electronic medical records, and financial incentives to improve quality. This too, is in your packet.

This afternoon, we have the opportunity to look at three high-performing OECD countries, Germany, the Netherlands, and France, and their respective approaches to policy making and to governance. Each has undergone sweeping health reforms in the last few years that have impacted health insurance coverage and financing. Each has implemented bold provider payment reforms including blended payments and made increasingly innovative use of financial incentives to try and drive quality and performance.

Each has tried new approaches to controlling costs and encouraging competition. Each is concerned with paying only for what works and has established entities to do comparative effective research and to use the findings to inform coverage decisions.

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Today's briefing will showcase the kinds of quasi-governmental authorities that Germany, the Netherlands, and France have established. These operate within broad legislative frameworks with relative independence from their respective health ministries. These entities are designed to help control costs, oversee quality, regulate insurance, and provider payments, and insure competition.

Some of them are advisories. Sometimes they're regulatory authorities that can be public or private. Nonetheless, they should be the aims of trying to support more evidence-based and transparent decision making in health care that is at arms' length from the political process.

We're privileged today to have with us three outstanding speakers each of whom occupy senior positions in their country and can talk from very firsthand experience about these entities. I'd like to introduce them. Dr. Karl Lauterbach is an elected member of the German Parliament, the Bundestag, where he has also served as advisor to the Federal Minister of Health and Social Security.

He is, as well, Director of the Institute of Health Economics and Clinical Epidemiology at the University of Cologne and adjunct professor at Harvard School of Public Health. He's a health economist, an expert on evidence-based medicine, managed care, and cost effectiveness analysis.

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Dominique Polton is Director of Strategy and Research at CNAMTS, the French National Health Insurance Fund for Salaried Workers, the public health insurer covering 85-percent of the population. It also has responsibilities for the regulation of health care system. Prior to working at CNAMTS, she was Director of the Institute for Research and Information in Health Economics and is a member of the French National Council for the Future of Health Insurance.

Cathy van Beek is Action Chair of the Executive Board of the Dutch Health Care Authority, the NCA. Her responsibilities include health markets, innovation, and quality of care. Cathy van Beek has extensive managerial experience in the Dutch hospital sector and her last position before joining NCA was Chair of the Executive Board of the Specialized Hospital and Center of Excellence for Orthopedic Surgery, Rheumatology, and Rehabilitation.

Lastly, we're delighted to have John Rother here as reactor on this panel to provide a U.S. perspective. John is Executive Vice President of Policy and Strategy for AARP. He's responsible for federal and state public policy and for formulating AARP's overall direction.

He is a, I think almost everyone in the room would know, nationally known authority on Medicare, managed care, and social security who had served as staff for Former Senator

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Jacob Javitz and Staff Director and Chief Council for the Special Committee on Aging under Senator John Hart prior to joining AARP. So with that, I'll turn it over to Ed. Thank you.

ED HOWARD: Great. Thanks very much Robin. I should add with respect to Mr. Rother that in the interest of full disclosure and I'm happy to be able to say this for the first time, as introducing him as a panelist, John now serves on the Board of the Alliance for Health Reform. So we're happy to have him both helping us carry out our program and helping to shape our program.

The other thing before we get started is I wonder if I could ask Atul to turn our timer right side up so we wouldn't confuse our speakers quite as much as we would otherwise. You don't have 0001 minutes to speak Karl.

Now, a couple of logistical questions to be answered: you have the materials, as Robin said, that relate to this discussion including most of the PowerPoints, one we received late and you'll get it on our website, allhealth.org, as soon as we get back to the office. We'll have a webcast and a podcast available on Monday through kaisernetwork.org or through our website and a transcript available a few days after that on our website.

We'd love to have you ask questions at the conclusion of the presentations. You can do that either by going to one of the microphones or by filling out the green question card in your packets. At the appropriate time, please fill out the blue evaluation form to help us improve these programs as we go along. So without further delay, let me turn to Karl Lauterbach, whom I think of as the German equivalent of Mark McClellan except that Mark has never been elected to Congress. Karl thanks for being with us.

DR. KARL LAUTERBACH, M.D. Ph.D.: Thank you so much. It's never too late for Mark to be elected [laughter]. Thank you so much for the invitation. I will, first of all, introduce very briefly the German system. The German health care system is actually a system that serves 82 million inhabitants, 72 million are covered by the public system, which we also call the statutory health insurance system, and 20-percent are covered by private insurance.

The higher income groups and the upper middle class can pick between the private and the public system but the private system is not open for everyone. It is not open for very low-income people and it is not open for the unemployed. So in that sense, we do have competition between the private and the public system but the private system is by and large only open for civil servants and for high income people.

So, statutory health insurance or the public system dates back to 1883. It was originally only open to blue collar workers. It had a minimum benefit catalog and different types of sickness funds were open to different professional groups. Nowadays, the system is open for everyone.

It is operating through the so-called solidarity principle. The solidarity principle means there is mandatory contracting, so contracts are available for everyone. There's no surcharge for age or risk. There is a dependency of what you pay according to what you earn. So low salary, low payment.

The payments are income-related; dependents of members are free and enjoy the same benefits. There are contributions for unemployed and welfare recipients paid by public funds. So it's a system that covers, by and large, everyone other than those that are in the private system where you can opt out from the public system into the private system.

It does have a highly developed infrastructure. There are no waiting lists in Germany for major services. The system does have the common problems of all European societies: we have aging societies, low-birth weights. We have very expensive innovations and therefore, we have spiraling costs. What I'm going to present today is what I consider to be the heart of the German system.

The heart of the German system is the self-administration of the public system and in the self-administration, the decisions are made, what is reimbursed, on what evidence, and for what prices.

So what we are basically looking at here is what is the benefit package and at what cost is the benefit package for societies available, and what are the prices that are reimbursed to providers? So again the three major decisions we focus on, what is in the benefit package, why is it in the benefit package, and at what prices is it in the benefit package.

There are three institutions that make these decisions on behalf of the government. The government is not involved in this decision making process directly but it's only supervising the decision making process. The decision making process is made by the self-administration but most important, the decision, what is actually covered is made by the GBA, the federal joint committees.

This is a committee represented by patients, physicians, sickness funds, so basically by the payers, the providers, and the patients. This is the most important body in our set of government. This body determines what is in the basic benefit package.

The services that are to be covered all have to be effective, efficient, and they have to be provided in a cost-effective way. So therefore, the system can only include services that are shown to be effective, they work. They have to be efficient so the cost effectiveness may not be too bad. The services must be provided in an efficient way.

So for example, the service that can easily be provided in outpatient settings will not be covered in an in-patient setting if it's way more expensive in certain settings. These are the decision rules for which the federal joint committee is responsible. The IQWiG, which is compared to the U.K. NICE System to which you may be more familiar, is a federal research institute which you value its' medical service with regard to their effectiveness and cost effectiveness and makes recommendations to the joint committee.

What you see here is a Center, Federal Association of the Health Insurance Fund. This is the institution that then determines the prices in particular, whether there are reference prices or not, whether there are price ceilings, yes or no but this institution only determines at what rate a service is covered. It does not determine whether a service is covered yes or no.

So in Germany, the sickness funds have to cover all services that were determined to be effective and efficient by

this federal joint committee. It is not possible for a sickness fund, for example, to say we are not going to cover this or that service if the service passed this body. So this is the reason why this is basically the body that determines what services are covered or not.

So going back to the federal joint committees or the GBA, the federal joint committee's a main decision making body in the German health care system. It is authorized by law to issue legally binding directives. So once a decision by this body has been made, this does have legally the status of a law and if you, for example as a sickness fund, do not want to cover such a service, you must legally claim against this body and this, by and large, never is successful. So the directives are equivalent to laws. So it's a kind of a law making body.

It was established in 2004 but its' predecessor goes back to the 1920s. It represents physicians, hospitals, sickness funds, and patients. It does include evidence-based coverage decisions regarding innovation, outpatient care- apologize for the spelling mistake- hospital care. It does cover evidence-based patient information.

It covers pharmaceuticals, for example, exclusion of prescription drugs, reference by setting, therapeutical advice, second opinions. It can, for example, determine that particular innovations can only be provided after second

opinions and very expensive services. It can perform cost effectiveness analysis but it doesn't have to perform cost effectiveness analysis.

Also it does include quality assurance. So it, for example can give rules, what type of services can be provided by specialists only and what services will also be provided by primary care physicians. It is involved in disease management program.

Disease management programs in Germany have been used to improve the quality of care for diabetes and heart disease and pulmonary disease treatments, very successful programs which I cannot explain to you at that occasion but those programs are based on evidence-based guidelines. So the way these guidelines are drafted is very much influenced by the GBA. The GBA also determines what rare diseases are covered by hospitals, what outpatient treatments are covered including psychotherapy, dentistry, orthodontics, maternal, and perinatal care, prevention screening, and many more issues.

Here you see the structure of the GBA. There's an impartial chairman and two co-chairs. Then there's the sickness funds, the health care providers, in particular, the physicians, the hospitals, and the patient representatives and most of the decisions ultimately made by the body in what you would call a bipartisan fashion. It is very unlikely that a

position goes through, which is let's say supported by all sickness funds but rejected by all providers, typically the negotiations go on and on until there is a kind of a bipartisan, there's a strong bipartisan tradition in the GBA because the structure of the GBA depends on the bipartisan position to be held up.

The GBA works in the following way. If a service is new, for example, a new way of radiation therapy, think about proton radiation therapy or something like that. Then there is an application to the GBA whether this should be covered or not. This application can come from the government or from the sickness funds or from the providers.

Then what typically happens is that the IQWiG, the NICE type of institution sums up the literature, the evidence involved the providers of the service at that point early on so not only published data are included but also data on record studies, on record by the providers and so forth, all available evidence is basically included.

Then a report is given to the GBA. The GBA makes an appraisal and then comes obviously a directive. The directive is then turned into law by the Ministry of Health and is then published. In very rare occasions, the Minster of Health can veto a decision by the GBA but this is rarely done and the GBA

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immediately responds by taking legal veto opportunities against the Ministry.

On the last two occasions we had, I think the Ministry as a matter of fact, lost. So this is a very complicated process. By and large, the decisions by the GBA are upheld by the social lawmakers in Germany. So don't underestimate the legal importance of the directives by the GBA at that point.

The important criteria effectiveness is whether a service is necessary or not and whether it's efficient or not. Necessary or not means that directives can also specify for whom the service is covered.

So it's not, let's say, put on therapy yes or no but for example, put on therapy for eye tumors yes and for solid tumors at the base of the scar yes but not for prostate cancer and so forth. If a service is necessary, if it is efficient and effective then it is covered but then on the other hand but at the end of the table, all sickness funds have to cover the service and have to pay for the service.

The institute, which provides a lot of the evidence for the appraisals of the joint committee of the GBA, the IQWiG is basically a research institute roughly employing, at the moment, 100 full-time employees and the IQWiG works only on assignment.

So the IQWiG does not do independent research and so forth but it only looks into the issues that are bought through the IQWiG either by the sickness funds or by the government so that resources of the IQWiG are not wasted.

So the ways the question is phrased for the IQWiG is very important. So for example, if the assignment is to look [inaudible] on therapy is effective and efficient for scar tumors; that is a completely different question as in, for example, look at the same issue for prostate cancer.

So the assignments are very specific and the IQWiG is only permitted to work on the various assignments in the ways the assignments are all done. There's a whole process that's very transparent.

For example, there are public hearings about the issues. The data that are made available are immediately published. There's a long written justification of individual decisions and there's standard operating procedures for almost every step in the process of making the decision.

So every desk in the IQWiG is more or less governed by standard operating procedure because so much depends on the recommendations to the GBA of the IQWiG. The IQWiG is obviously also a target of major legal battles and so far, the IQWiG and the GBA have survived all legal attacks by all providers including all American drug companies that have

provided, that have tested their best attorneys on German ground on this one. I'm not going to name examples here. Maybe some representatives are sitting in the room and I do not want to wear out my welcome so early.

So in that sense, what you have seen here is this is the center of the German solidarity principle because the solidarity principle only will continue to work if it continues to be available, if it is too expensive or if there is arbiter within the system, it will lose its' financial stability and also its' support by the public and the public support is only there because there's a fairly transparent evidence-based decision making process in place in which the government does not have a direct role.

If all of this was done by the government, there would not be enough acceptance of support by the population or the providers. If it was done in a bizarre fashion, market type fashions, then it would never get the support by the scientists and the medical community that want to make sure that the care that is supported is also effective.

So if you want to have a working compromise, something that is accepted by the population because it is government away and at the same time is supported by the medical community because the decisions are evidence-based. Then this is a

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compromise we worked on in earlier reforms and the processes that you now see is in place from 2004.

It was a bipartisan decision by the social Democrats, the party that I represent, and the Christian Democrats are middle Conservatives. So it was a political bipartisan decision to come up with this process at that point. It has been stable so far. I do finish here in confirming rumors that our social Democrats lost the recent election but it was not because of this decision making process in health [laughter].

ED HOWARD: I know there are some people just a few hundred yards away who feel great comfort in that [laughter]. Now we turn to Cathy van Beek.

CATHY VAN BEEK: Okay. Thank you so much to be invited here. I'm very honored especially on this day to tell you something about the health care authority. I would like to give you an overview of what I'm going to say. I will first speak about the need for reforming the Netherlands, which can be summarized as a combination of rising costs and market failure.

Next I will set out the basic elements of reform, the idea behind a competitive health care market, and the role of our health care authority as a market regulator. In conclusion, I would like to offer you two friendly pieces of

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advice. First of all, a short overview of the Dutch system summarized in seven key characteristics.

It's essentially a market-based system with fully private health insurance and fully private health provisions. There are, however, two important remarks to make. There is an overriding general consumer interest objective in the system. This is an activity pursued within the regulatory framework. This framework is characterized by full coverage of the population and a gradual or step-by-step process of price liberalization that will soon reach 50-percent of hospital prices.

In this context, it's worth noting that in the liberalized segment, prices have so far not increased out of line with inflation. Moreover, the number of treatments has grown. Finally, we have an independent regulator that's also a sector-specific competition authority and a comprehensive system of largely [inaudible] risk adjustments executed by the health care insurance authority. I will get back to these last two points in detail later.

I will now elaborate health care reform and the reasons for it. Harvard health care economist, Dave Cutler, has identified three successive waves of health care reform that tend to occur in developed countries. I skipped them because of the time. The increasing dissatisfaction of consumers with

rationing leads to the third wave. It's a movement away to more incentive-based systems including competition.

Promoting effective competition is not a goal in itself but regarded as the best way to deliver the three key public policy objectives, accessibility, affordability, and quality of care. These three dimensions of the general consumer interest are our key objectives.

As you can see, if you follow the blue graph, the cost of health care in the Netherlands is increasingly fairly rapidly and is now around 40-percent of the GDP, although [inaudible] is not aimed at controlling costs. It is expected that increased competition will have these effects by more efficiency, more innovation, and more added value. At the same time, we shouldn't forget the benefits of health care. Largely, it has been money well spent at least if you go by the associated increase by large expectancy, the pink graph.

Apart from rising costs, health care markets are also burdened by a range of market failures. On this slide, you can see the so-called health care triangle between consumers, insurers, and health care providers and between the markets for insurance, the markets of health care contracting and health care provision. Next to these relevant markets, you see the main forms of market failure listed. I will not go into these in detail but I will mention the three important aspects.

First, the effect of the third party pays principle, which means that patients are not sensitive to costs whereas providers have obvious incentive to provide more care. There's, therefore, a problem, a moral hazard, and the expense of insurers and of the taxpayer.

Second is the risk of the adverse selection, which means that insurers would prefer to insure healthy patients who never need care whereas healthy patients have no incentive to take out insurance. This could lead to a race to the bottom with insurers, both weeding out costly consumers on the one hand and baring them at the gates on the other.

Finally, I want to point out the strong position of health care providers both in terms of information, there's an information asymmetry and in the form of market power. There's reason to believe that market power of health care providers is pervasive in many health care markets. All three risks are serious ones that regulation must address.

What are the characteristics of the Dutch health care reform that was designed to counter these problems I mentioned earlier? The reform took place in 2006. It was introduced as a new legal framework that provides, in the first place, for mandatory health insurance for all Dutch citizens and a tax subsidy for those on low-incomes.

The counterpoint to this is universal coverage, an obligation for all health insurers to provide services to all consumers who demand them without either risk selection or premium differentiation, the so-called crown jewels of the Dutch health care reform. The funding regime comes in two parts. Fifty-percent of the premium is a nominal premium that's differentiated by insurer in the competitive process but isn't different per consumer of a particular insurer. It is collected by the insurers themselves.

The other 50-percent of the premium is income-dependent and collected by the state. This part of the premium is redistributed to insurers based on the risk adjustment system. One of the main elements of the reform was this risk adjustment system. This helps avoid adverse selection and moral hazard and promotes competition on the merits. It removes the incentives to select consumers based on their health status, which is also illegal. It promotes competition on things like quality and prevention.

As you can see in this picture, the idea behind competitive health care markets is based on competitive insurers' markets. If consumers can choose freely between competing insurers, these insurers will have incentives to put pressure on providers to improve their performance at

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competitive prices, competitive quality indicators, etc. And in the end, the consumer benefits.

So again, the economic characteristics of the model of health care competition in the Netherlands are as follows. Consumers have free choice of health insurance company. There's neither risk selection nor lock in. Switching costs are low. Competition between health insurance companies leads downward pressure on costs. We expect the development of selective contracting with health care providers and directing consumers toward more efficient choices.

Next we would expect utilization review by insurers. This means cross-checking the need for treatment received as well as best practice benchmarking. So far, however, these developments are still in their infancy. Apart from the NZA, a number of other authorities are involved in health care regulation. For instance, there is an agency, the Health Care Insurance Authority, which is responsible for advisor or whether specific forms of care should be covered by basic insurance or not. That is also responsible for the administration of that risk adjustment system.

As I told you before, we also have a health care quality regulator, the inspectorate. The inspectorate is in charge of the quality of health care provision and of developing and approving health care standards and indicators.

Apart from these health care-specific agencies, there are a number of other regulators that are responsible for the entire economy. I will skip that also to come to the role of the NZA, as an independent regulator.

First of all, we are responsible for the supervision and the development of three markets in health care triangle that I showed earlier. Secondly, we are in charge of tariff performance regulation. This means setting prices or rates and defining standard product categories, which has to be used by the market participants as part of their negotiation language.

Third, we supervised execution of the Health Insurance Act of which I've already listed the key elements. Fourth and fifth, we are in charge of supervising long-term care and responsible for advising the Minister of Health, both on request and at our own initiative.

I will now briefly discuss our role as a sector-specific competition authority for health care. So far, I found few comparable authorities in other countries with exception of the Cooperation and Competition Panel in the U.K. This demonstrates that you can police competition even within the context of a national health service. Hopefully this will provide inspiration for others. The objective for our supervision is the public interest, the elements I mentioned before, accessibility, affordability, and quality.

In the first place, we have our own specific powers to promote effective competition. This involves notably our power on significant market power, in markets with dominant players. Here we can impose proportionate obligations that range from transparency and nondiscrimination to accounting separation and individual price control. A prior finding of abuse is not necessary. The rationale is the protection of emerging markets as opposed to policing established markets.

We can also intervene in conditions of agreement and the manner in which they are concluded in the event of structural problems and in order to promote competition and the transparency in health care markets. For example, we can mandate excess or strike out exclusivity clauses or impose an option requirement for particular services.

Secondly, we also cooperate closely with the General Competition Authority. This is necessary because based on what I have just said; we have concurrent powers relating to market power and anti-competitive agreements. One important aspect of this cooperation is that the Dutch Health Care Authority advises the Competition Authority on mergers in the health care sector. We are also jointly involved in the development of competition policy instruments such as on efforts of market definition, merger simulation with significant input, I should add, from leading U.S. health care and competition economists.

Finally, we have the powers to grant state aid to struggle health care providers. It's clear that aid may distort competition between providers and that distorting market exits can distort market entry.

At the same time, there are public interest issues of continuity of care. The legal framework in this important area is still under construction. We are currently in process of developing our policy toward principles of minimal intervention and consistency with the IU law requirements on this regard.

With this, I come to the end of my talk. I hope to have given you some idea of the Dutch health care system and especially of the role of the Dutch Health Care Authority in that context. However, I still owe you the advice that I promised at the outset. Our own practice shows that health care reform is highly complex.

It takes a great amount of time and efforts to get things at least partly right some of the time [laughter]. So it is not because I believe that our system is flawless but in the hope of sparing you unnecessary problems and complications, I offer advice for your own health care reforms.

First, the need for an independent sectoral regulator with competition powers especially in relation to providers with market power but as an acting chair of the Dutch Health Care Authority, I should say that shouldn't I? Second, the

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even greater need for a comprehensive system of risk adjustment as a necessary condition for both competitive private insurance markets with full coverage and competitive markets including the public option.

You could even say if you get this wrong, public option is likely to fail as it will be burdened by all the risk that private insurers are seeking to avoid but if you get it right, private insurers, by themselves, will compete to provide full coverage of the population. In a word, I wish you a real health care authority. Thank you for your attention.

ED HOWARD: Thank you [applause]. Thanks Cathy. Let's move to Dominique Polton. I should say that Ms. Polton's slides are the ones that you do not have in your materials. We will have them posted on our website presently. Please?

DOMINIQUE POLTON, Ph.D.: Thank you. Yes, maybe a few words to begin with, if that's okay, on the French health care system just in order to make sure you have the main features. We are an insurance-based system, social insurance system but with universal coverage. So we don't have a choice of insurers.

We have affiliations according to our occupational status but we, unlike, for instance Germany, we've always had a concentrated system. We have three insurers, three public insurers, covering 96-percent of the population and the first

one, the fund for salaried workers and their families alone account for 85-percent of the population.

So we have a delivery of care, which is a mix of public and private. We have mainly private independent physicians and other professionals in ambulatory care. Hospital care is provided both by public hospitals and private hospitals, private non-profit and private for-profit hospitals. Private for-profit hospitals have a rather large area in France of surgery especially elective surgery.

We have a general principle of cost sharing but we have a lot of exemptions and the role is that if you are facing high expenditures, you will be better reimbursed and this is the case, for instance, for maternity, for work injury, for occupational diseases, and also for chronic and severe illnesses. There was a list of 30 diseases with exemptions of copayments.

In addition, it’s important because it has to do with what I’ll say afterwards with, 92-percent of the population has supplementary insurance to cover copayments basically. The long-term trends in our system have been the following ones. It’s important to state that all sickness funds have never had the same responsibility the German sickness funds. They have never been really responsible financially. That means if we had to raise federal contribution, it has always been the

state, which has decided to do that and not the sickness fund themselves.

In fact, over time, what has happened has been that we've gotten more and more universal. We've replaced some of the federal contribution by taxes, earmarked taxes and with all this, the legitimacy of sickness funds to manage the system has been challenged and the state has taken over more and more responsibilities. Also we had a sort of division between sectors. The sickness funds have always been much more involved in ambulatory care and the hospital care and drug regulation have always been on the state side.

The last is the fact that we have been more and more strengthening the regional level. It began in 1996 with the creation of regional agencies for hospitals and also regional unions of sickness funds but then in 2009, we had a big step towards regional health agencies. We had two main reforms, rather important reforms in terms of governance in the last five years. Probably these reforms don't go exactly the same way but I'll talk about the one on which we have some insight, which was the 2004 reform.

The second one has been just passed in parliament. So we'll see what it gives afterwards. So the 2004 reform created three new institutions. First, a union of all the sickness funds or at least the main sickness funds that you've seen.

They account for almost the whole population, then union of private additional insurance and third, national health authority for health, which is the equivalent but not exactly with the same orientations, maybe the same missions but not exactly the same way of doing them as the IQWiG in Germany.

What was major in this reform is that the government decided to give some autonomy to these union of sickness funds to manage the system and there was a rather broad delegation given to, for instance, negotiate with the providers, before that the sickness funds negotiated with the providers but the state was always intervening afterwards to see that, it didn't want the tariffs to be set like that and it was always interfering with the negotiations.

So now the income negotiates with all the providers in private practice and also it has a very strong executive, the Director General of Income who has been nominated for five years and cannot be fired for five years, which is rather important to be independent from the government, really is the one to negotiate with a mandate of the three sickness funds and of the board of course in the framework of orientations of the government.

We don't have the legitimacy to set our own strategy. We have to be oriented by the government but then this is his responsibility to negotiate with providers. We have other

levels such as we now manage the fee schedule, which is not quite a success because it hasn't… it was supposed to redistribute the money between the specialties but it hasn't done that so far but still, what is true is that this is the first time that the radiologists have seen their income lowered by the sickness fund.

We have decreased the tariffs over a certain number of procedures for radiologists and other specialties who are very, very, very, were very high incomes. Again, I think that this wouldn't have been totally possible probably directly by the government. So this idea of putting this institution at arm's length with some powers, with some formula given by the government, with some autonomy and with this sort of mid-term vision that it had to be efficient and meet the financial targets. I think it has had some impetus on the system and too, I think that if you discuss with people and friends, everybody will say that during the four last years, they have not achieved in that respect.

If we look at the results, I mean I will skip the list of innovation but it's true that we've been through a lot of innovative programs during the last four years but moreover between 2004 and the economic downturn, which has of course changed things because we are again in deficit. But we have the growth rate of health expenditures as being the same as the

growth rate of the GDP. There we have achieved a lot of efficiency programs and some of them have been very successful, some of them less of course but we are trying a lot of things and it's a rather innovative institution.

Now the two other institutions that have been created are the National Authority for Health. So I won't talk too much about it but basically this is the same idea than IQWiG. We need an authority, which is independent from the government but from all stakeholders, and gives advice on what should be in the benefit package, what is effective and efficient enough to be in the benefit package and also has a responsibility for quality in the system.

So the National Authority for Health has merged different institutions who had responsibilities and it's really a very broad agency with very broad responsibilities. While it's probably a little different but this is the French culture from Germany and especially from the U.K., with NICE, with the National Institute for Clinical Excellence, is that in France we don't like very much cost effectiveness but it's not the only National Authority for Health. It's the fact that we really believe that we can put everything in the benefit package and it could be possible and sustainable.

So we really are very reluctant to have these cost effectiveness methodologies, which say that such and such kinds

of drugs should be only for some types of patients. We are not still ready for that but we are making progress. I am an economist also which, of course, explains the way I think but in 2007, the annual act on social security has given the National Authority for Health a new responsibility, which was really to develop this cost effective analysis more than they had done before and to give its advice on this basis and not only on the basis of effectiveness as it was before.

So the last maybe element is a few words on the new reform because in France, we believe a lot in institutional reform so we're doing reforms from time to time to see whether it will get better but what is true with this one is that we had a real problem at the regional level. We had a lot of layers of administrative bodies, which had been created to do this, to do that and everybody thought that one day we should jump to the point in merging all of these and saying that there would be somebody strong in the region to do a lot of things. That's what we've been doing in the last law that has been passed last July.

So we now have regional health agencies and they will be rather powerful, the people that have been, just been nominated and some of them were Minister of Health before so it's sort of rather a higher level of responsibilities given and the only problem. So I think it's very good because really

they will have a lot of levels at the regional level and probably it will enhance innovation. Maybe we'll test some things in the region, in some regions and see whether it can be extended to other regions.

The only problem is that the link with the sickness fund, which remains a rather national organization with a network of local offices are still to be built. I mean obviously these are two directions. They're not contradictory but they're not really consistent in a very simple way. So we still have to build this articulation. Thank you [applause].

ED HOWARD: Thank you. Let's move to John. John, have you picked out enough that you can help those folks preparing for the vote on Saturday?

JOHN ROTHER: I think we've already said what we want them to do on Saturday [laughter] but what should we do about a commission? I'm sure that you are impressed as I am by the diversity of experience and how different European systems are from the United States. You can't help get the feeling that maybe they're slightly ahead of us on the ability to have sophisticated regulatory guidance.

I guess the first question is why have a commission in the United States if we have CMS and we're about to have exchanges. I think the perception, which I share, is that Congress isn't always the best place to make decisions that

require saying no or decisions that require a high level of complexity. I think those are the two key justifications for something like independent Medicare Advisory Commission.

So I think what I'll do with my time is just raise five questions that I think that the excellent presentations from our colleagues from Europe have presented us. The first one is how broad, assuming we have a commission, that's the first question I raise so that the next part is how broad should that commission's scope of authority be? Of course what's amazing is that what's being proposed is something limited just to provider reimbursement but what we're hearing from our European colleagues in a much broader, much broader range including benefit design, quality metrics, risk adjustments, really impressive range of regulatory oversight. It does kind of make you think that maybe we need to think about who's going to make which decisions, all of which are necessary to have a successful system. So that's the first question I would raise.

The second one is will a commission that's limited only to Medicare be successful because I think in each of these cases, the regulatory authority de facto extends to the entire health care system. Medicare alone raises the prospect of cost shifting and dysfunction. I think that's something that we have to really think about.

The third question is who makes up this commission? Karl mentioned, in Germany, that all stakeholders are represented but the commission, as being described in the Senate Finance Bill, is a commission of experts. So which is it? Do we want this to be expertise-based or do we want stakeholders sitting around the table working out the deal? I thought it was extremely interesting, again just to repeat a point that Karl made, that there are two audiences that have to accept the work of the commission, the public and transparency is the key to that and providers and evidence-base is scientific-base is key to that. So I think that's very helpful guidance to us.

Fourth point is the last point, I guess, I'll make is the experience in Europe, it seems to me is that each regulatory system started smaller and evolved over time. You can see a kind of step by step evolution. It feels, to me, like we're just at the very beginning of that process and whether or not something like an IMAC would evolve into something more robust or not, I think depends very much on how successful we are in designing it, in leading it, and implementing it over time. Those are questions that we can't answer here. Thank you.

ED HOWARD: Terrific. Thank you John. We have some time for questions. I remind you, we have a different starting

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time and we're going to 2:15. So we don't have to rush out of here except for John since this is his panel day unfortunately. We're very pleased that he squeezed us in. Let me just offer, remind you that you have the opportunity to ask questions, to write questions, and to hear questions from our co-moderator. Robin, you want to start us off?

ROBIN OSBORN: I just want to ask both Karl and Cathy if they wouldn't mind saying a few words in their systems about the role of whether it's the Federal Joint Committee or the Dutch Health Care Authority in terms of overseeing and regulating provider payment, hospital and physician payment, and to what extent is there a cost containment role in what they're doing.

KARL LAUTERBACH, M.D. Ph.D.: Thank you for the question. There is indirect cost containment in the joint committee because obviously if services that are not effective or vastly inefficient are not covered then in the long run, it reduces the cost of the total system and makes the system sustainable. If these decisions are made in a wise fashion, that not only cuts costs but also is a benefit for the public. So it is like consumer protection.

This is one of the reasons why the institutes are well accepted by the population because it also protects the public against ineffective care, of care that is highly inefficient

but the committee's not involved in setting prices because I was actually involved in the law making process many years ago when this was done. One of the ideas that we had was we did not want to contaminate the work about effectiveness and the question for whom a service does work with the question of what prices should be offered.

So therefore, all pricing decisions are made by what I called the [Speaks in foreign language]. This is the Association of the Sickness Funds. If you merge these two questions then there will always be a suspicion by the public that a service, which is effective, is deemed, or is called to be ineffective because the public should be spared the financial burden. So you want to make sure that it is quite clear who's responsible for what, who determines on effectiveness of care and efficiency and who determines prices. We separated this quite categorically.

ED HOWARD: Cathy?

CATHY VAN BEEK: Okay. Thank you for the question. As I mentioned also in my speech, the targets of the health care authority is not to contain costs but we expect that competition will have its' effects on reducing costs. That's the one thing I like to say about it. The other is that we do set prices or rates. We do that kind of regulation regularly periodically. So when the prices are not free in the hospitals

in the near future, we have 50-percent of the prices free but the other prices we have to sustain.

We do very large cost research. So when a provider can do the work much more efficient then he has a profit for his own benefits. That's not the target of the government. So we do some activities in the frame of cost containment.

ED HOWARD: Could I just clarify something? You referred to freeing up prices in your presentation. By that you mean moving away from regulated or set prices into a competitive mode. Is that right?

CATHY VAN BEEK: Yes, yes, yes.

ED HOWARD: Okay. Thank you.

CATHY VAN BEEK: That's a movement we make and we also, perhaps I can also address some of the questions of the other person, I don't know his name exactly, I'm sorry, about how the stakeholders are involved. We make the decisions but we have a couple of advisory committees. There the stakeholders are represented and so we don't do anything without them but we decide after consultation.

ED HOWARD: Actually if I can pick up on Karl's use of the example of comparative effectiveness. In the United States, some of the stakeholders have pointed out that when you're comparing A to B, sometimes A works better for 80-percent of the population and B works better for 20-percent.

How does your system deal with subgroups that may benefit from treatments or pharmaceuticals or any other kind of intervention that are of value to some smaller subset of population?

KARL LAUTERBACH, M.D. Ph.D.: So there's decisions that are made by the GBA, by the Federal Joint Committee, takes this into consideration. For example when, to use again the example, radiation therapy, radiation therapy may have long-term consequences and may cause cancer in younger cancer survivors later on because some of the radiation again kills one tumor but causes secondary tumors many years later. This is at least true for some forms of radiation. This will not make a difference for very old patients but it definitely will make a difference for very young patients.

So if therefore radiation requirements for children are quite different from radiation requirements in, let's say, 85-year old patients and the recommendations by the IQWiG towards the Federal Joint Committee do takes this into consideration and may therefore say, for example, this is covered for younger patients but it is not covered for older patients because there you do not need this extra precaution or it may actually say it is covered by both but the recommendations are quite specific to patient groups and take into consideration all the available evidence.

When new studies are out then the directives are changed taken into consideration the new evidence. Coming up to what John Rother was saying, I think we originally thought if this very complicated and scientifically rigorous assessment is done, you want to make it available to as many people and for as many purposes as possible. So therefore, we decided to make the decisions public and to develop the patient information that forms these assessments because as you all know, there's so much information now available on the Internet but most of the information is fairly low quality.

This information, from a scientific perspective, is fairly high quality and is supported by most of the associations for also physicians. For example, physician association specialty groups are early on involved in the process of generating the evidence. So therefore, why would you not use this information for informing patients or the public at the same time?

This answers the question, which you said before, but you ask why do we bring this information to bare on so many issues, what patient groups, I mean reimbursement decisions and so forth, even quality control, because in order to make a good decision at the core of the question, you need to gather information on all different aspects. If you have this information, you want to use it as long as it is fresh because

you can be sure that in a couple of months, sometimes two years or so, you need a full reassessment. So therefore, we make available the information for as many purposes as possible and do the process of assessment as rigorously as possible.

ED HOWARD: Yes, do you want to identify yourself?

GEORGE RAINBURG: I'm George Rainburg from HHS. I had a question for Cathy. It is my understanding in the Dutch system that there's, since the enactment of the Health Insurance Act in 2006, there's been a great consolidation of the number of insurers and that 80-percent of the population is now insured with four or five insurers only when previously, there were as many as 30.

I'm just wondering if either your authority or the more general competition authority is concerned about that consolidation and the potential threat it has for the general model of competition that you're trying to make work and whether any specific concerns or discussions within the authority or within the government as to what the future direction should be in terms of insurance consolidation in the market.

CATHY VAN BEEK: Okay. I shall give him, try to give him an answer. We are not as concerned as you probably think because we have big four insurance companies but there are seven to 10 smaller ones. From the perspective of the

consumer, there is enough choice. On the other hand, the pharmacists, which are very much at discussion at the moment, are complaining about market power of the insurance companies because of the insurance companies say that they don't like to make a contract to negotiate with every pharmacist on the corner. The pharmacists are asking for negotiation about price and quality. This complaint is, nowadays, in research with our health care authority.

The population in the Netherlands is a bit concerned and the providers, the big providers, have the feeling that the mergers between them has to stop. We also think that it's enough, so does this answer your question?

ED HOWARD: Thank you. Yes, go ahead.

BOB BERENSON: Bob Berenson from the Urban Institute. I guess I want to ask Karl and Dominique, it sounds like in both of your systems, you now have an association of sickness funds negotiating with providers. In France, it's more recent. How is the representation of the physicians and the hospitals determined? How do they come to the table and how is that accepted by the diverse set of physicians and hospitals that would be affected?

KARL LAUTERBACH, M.D. Ph.D.: In Germany, the hospital association basically determines who represents the hospital. Therefore, they send typically the leading four or five experts

to the table and they can exchange experts depending on question. For example, to come up again with the radiation issue, if radiation is the issue then they will typically come up with two hospital managers that will present at the board and two radiation experts.

They have seats but they are not seats that are linked to a particular person so they can exchange the people representing. We want to make sure that the people coming represent their organizations but bring to the table is the best available expertise. So therefore, we permit the tables to exchange their representatives depending on the issue, which is to be negotiated. It's the same with physicians. For example, if there's an issue with dental care then dentists will come and not GPs. If we're speaking an issue about GPs then GPs will come and not specialists. So the physicians have their own associations and the associations determine who are the best people representing them on the table for this particular issue in the joint committee.

DOMINIQUE POLTON, Ph.D.: First, we do not negotiate with hospital physicians because public hospital physicians are salaried and they are… basically they are not exactly civil servants but almost civil servants. As I said, one of the problems of our system is that the older hospital part is much more shared between the insurance funds and the state. So

basically, we negotiate with private providers who are either in ambulatory care or in private for-profit hospitals.

The unions of these providers, physicians, dentists, nurses, the therapies because we have all these professionals are in independent practice in France. We have processes and rules in order to ensure that the unions, unlike Germany again, we have a very fragmented representation of providers, very fragmented. It's amazing, for nurses we're discussing with four or five different unions of nurses with different views of what should be done and for physicians, we've now got a lot of people who have been, because there have been unions at the beginning and then they didn't agree with each other.

They created a separate union and basically the rules to being at the table are set by the government. There is a survey to see whether there are enough representatives of the professionals; they have enough mandates in order to be negotiating.

So basically, this is the way they are selected. Some of the unions have been declared not representative anymore because they had too few enrollees. So this is… the government is setting both the rules and the processes to ensure that the unions are representative of the entire professionals.

Once this is done, some of them may sign and others may not sign the agreement. So we are not obliged to have all the

physician unions or hopefully because otherwise it would be very difficult but we have had some success. Nurses for the first time, we have an agreement with nurses about, in France, physicians and other professionals can set their practice wherever they want. There is no regulation, territory regulation.

So we had the first agreement with nurses saying that we would regulate the nurses because we have very huge discrepancies between territories and they agreed all together that it was a real problem in France and we had to do something together. So we did that by contract and not by regulatory measures but this we did with all the unions. Sometimes we cannot negotiate with all the unions. So we have only part of them with us.

ED HOWARD: Yes? Go right ahead.

DIANA DENNETT: Yes. Thank you. Diana Dennett with America's Health Insurance Plans. We represent private health insurers here in the U.S. Thank you very, very much for a very informative panel today. My question is really for particularly Germany is it's very expensive to do the kind of really in-depth work that you're doing. I'm wondering how, if there are opportunities for collaboration across the EU, or how close do you work with the UK in their efforts? Is there any

consistency with some of the rulings that you make relative to NICE or other countries? Thank you.

KARL LAUTERBACH, M.D. Ph.D.: Thank you for the question. From the experience we have, the type of work that I'll describe to you is we're actually very inexpensive because if you consider, I mean we have 150,000 physicians and we have 2,000 hospitals. These regulations we are speaking about hold for all of them. So if 50 or 100 people are working on these simple decisions, this is not a large administrative body. I don't know of a single private insurance company not employing more people despite the fact that this company has no influence on the general scheme to begin with.

So the cost effectiveness of this investment is obviously, I mean the return on investment is tremendous. Even a single decision, which avoids a test to be used, which isn't helpful or so, already repays the whole investment. We are sometimes speaking about major investments here. So I think the costs are not an issue here.

On the other hand for, let's say, there's all these good reasons to collaborate with other institutions doing the same work and this is actually going on. I mean the researchers working in this field in IQWiG are in touch with the people doing the same work in the Netherlands, in very close collaboration as a matter of fact, with the Netherlands,

and as they are working together with people in France and with NICE and with a group in New Zealand and so forth but this is professional collaboration and professional reassurance. This is not meant as a measure of cost containment.

I would also warn everyone to do this because otherwise, the public will feel that the decisions about the German health care system and what is reimbursed are some were made in England or wherever or in the U.S., yes, unthinkable. Don't you think so? Yes [laughter], you're absolutely right. So don't spoil the process in making a strategic mistake here and trying to save a couple of thousand dollars.

ED HOWARD: Yes, I see people lining up back there. Go right ahead.

ELIZABETH ORLEN: Hi, my name is Elizabeth Orlen and I'm a student at the George Washington University. I'm actually writing a paper on the Dutch Health Care System and how we could use their lessons to reform the U.S. health care system. One of the questions that I had for you was before 2006, one of the big complaints and problems that the Dutch system had was the fact that the government was competing with private insurers.

So I was wondering what you thought about the idea for a public option and how the U.S. Senate and House of Representatives are pushing for this public option especially

in the Democratic party and if you think that this sort of government competition will interfere with the prices, make prices of health care go up or if you think that it would be positive.

CATHY VAN BEEK: It's a very good question. I would like to invite you to the Netherlands [laughter]. The Health Care Authority is not a political body so I'm not supposed to do any political statements. So I don't think it's wise to answer your question [laughter] but as a person [laughter] I do think the public option is a possibility in the health care competition because of the public option can set prices in the neighborhood, not in the far distance of the cost prices. Then the competition can go on. So I do think it's a very wise option but as a person [laughter].

ED HOWARD: Any other persons like to [laughter] comment on that? Alright, go ahead.

SID GOSAR: Hi, I'm Sid Gosar [misspelled?]. I work with McKenzie and Company. I just wanted to ask about how… I can't get a clear sense from you about whether you use negotiation to set prices or do you use regulation to set prices and whether or not if you've had experience with both, which one has worked better for you in terms of keeping costs low or keeping the cost trend good because here, in the States, we have a mix of both and it's unclear whether or not costs

plus in Medicare is actually working to control prices or if we should have negotiations that—

DOMINIQUE POLTON, Ph.D.: Was the question for me or yes?

ED HOWARD: If you'd like. Please.

DOMINIQUE POLTON, Ph.D.: Yes, I would like yes. We do believe and that's also our experience that not every market, not every part of the health care market is going to be liberated because of the interests, the very huge interests of some markets for the general well being, for instance, very complicated health care for the elderly people, fragile elderly people.

For instance, the severe health care for mental health care population, some parts of its can be liberated, some parts not. The parts we selected to liberate, we would suggest to do the regulation but also always in cooperation and communication with the stakeholders.

So both are possible and both are indicated. It depends on which kind of market it is. So for instance, we are going to liberate the market of the pharmacy and the primary health care. We have liberated the physical therapist care in primary health care but we don't think it's now an option to liberate the GPs because of the general interest for a good

functioning system and also we expect that we haven't enough GPs. That's also a very important factor.

ED HOWARD: Let me just ask Dominique, I just finished reading T.R. Reid's book and he has this image of a French physician with a price list on his office wall and he asserts that that price list is the same in every doctor's office in France. That sounds like regulation. Is it and does it work? Is it accurate?

DOMINIQUE POLTON, Ph.D.: Oh well we have a very strong tradition of regulation of prices in France. I mean we've been regulating prices for a very long time and we're still doing that for drugs, which is not the case in most countries and also for physicians. I think that our prices are low, that's quite clear, but when you look at the income of our physicians compared to other countries, they're rather low especially for GPs but for also part of our specialties.

The drug prices have been low for a very long time. The question is that low prices do not exactly ensure efficiency. I mean it's a little bit different. It has [inaudible] because it's true that it in the French health care expenditures, you have very high volumes and rather low prices obviously compared to your country but at the same time, it's not a solution to the challenges that we're facing now.

The challenges are to have efficient processes, better quality of care, better cost efficiency in the way we use care, and it's not only a question of prices. So I don't know what to answer to your question. Our prices are reasonably low. If it's the objective then regulation is not so bad after all but the problem is that beyond that, we have a lot of other problems to solve.

ED HOWARD: Karl?

KARL LAUTERBACH, M.D. Ph.D.: Just for clarification because I know from my discussions with the American citizens that the German system, in one way, is often misunderstood. We basically have two systems, the public system and the private system as I just mentioned. Twenty-percent are in the private system, 80-percent in the public system. There's a group of about a third of the population, which can choose between the two systems and two-thirds of those who can choose go for the public system and one-third go into the private system. So it's a kind of an opting out system.

In one way or another, it's comparable to some of the proposals that you are currently debating in the House and in the Senate. What many people misunderstand is that in the private system and Germany's prices are actually regulated because there was a state government set price list.

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In the public system, the prices are negotiated so it's not the same. I only say this because I'm very often confronted with a very important misconception. If the prices were not regulated in the private systems then the private system would be bankrupt very soon in Germany.

So the total costs in the private system are going at twice the speed of the public system. So we have way more dynamics to put it carefully [laughter] in the total costs in the private system than in the public system. The private system is not trying to get the new price list regulated by the government in order to have price control because they are not in a position to negotiate prices in the way a public system does.

If the prices are fixed in a regulated way then the providers typically increase volume. This is why the private system is becoming so expensive in Germany because if the prices are regulated, physicians very easily can increase volume and there is no way for the private system to renegotiate the prices because the prices are fixed. So there is no good volume control. Volume control is way more difficult to implement than price control. Whoever thinks that price control is difficult should first think of volume control.

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Volume control is really difficult. I mean it's next to impossible. So the private system in Germany suffers from the problems that volume control is next to impossible. We have vast overuse in some of the private sector. This, combined with the price regulation leads, to put it literally, to the cost dynamics and price dynamics in the private system.

ED HOWARD: Very good. We have just a couple of minutes left. Yes, go ahead?

JOANN LAN: I'll be very quick. I'm Joann Lan. I'm with the Department of Health here in the city of Washington. We don't have naturally occurring regions that govern health care. It's very intriguing that most of every other country does, has some locus that you can point to as the locus of authority for some geography. In your experience in making these things work in regions, what helps make for better, as opposed to worst, regional governance of health care? What kind of data do we need? How big do they need to be?

Can you do it for Washington, D.C. or do you need to have the whole metro area? It could be the size of states or does it need to be smaller? What's the accumulated wisdom of how a region could integrate its' health care system? Of course now Ed's only going to give you two minutes to answer [laughter].

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CATHY VAN BEEK: I don't think I'm the person now who can answer this question because the Netherlands are very, very small, perhaps a province of Germany and we don't have the regional level. So we don't have experience with that. So I can't answer your question.

ED HOWARD: How about Dominique? You talked about regionalization.

DOMINIQUE POLTON, Ph.D.: We think that some things are better done at the national level and some things are really better done at the regional or local level because there's not only one territory that could do everything. We have chosen the region as the, well the second level of management of the system because we think that given the size of the French regions, we have 22 regions, we have 64 million inhabitants, they have the full spectrum of supply.

They are responsible, what the region can do that the national level cannot do is to be sure that on each point of the territory, there is the supply available for people, that there is the access, geographical access to care, that there is a hospital in, as we you were saying this morning Karl how the hospital A and the hospital B, are they doing the same thing then trying to compete with the same activities or shouldn't they try to cooperate and maybe do the surgery in one place and do the medicine in another place. Wouldn't that be more

efficient? Of course all of these are stakeholders, which are independent from each other.

The role of the region in that area is to try to organize care in the best possible way and to, especially since our medical demography is declining now, we're beginning to have some holes in the territory with some places where we like GPs. So we have to have specific policies to try to retain people and so on. This has to be done at the regional or local level.

Regional doesn't mean that there is no local level. They might also work with smaller offices in the region but this cannot be done at the national level. So basically this is the idea. Now what is more debatable is should they be responsible for everything? This is, more or less, what has been done in the last legislation. They have a lot of levels. So the idea would be probably that they would be really the one to regulate the system within each region with a national framework. This could be either regional or the national level. I think that both would be, this is more debatable but for the geography of care, obviously we need some territorial level.

ED HOWARD: Robin, you want to just?

ROBIN OSBORN: I just wanted to pick up on a question that John had raised in talking about an independent Medicare

Advisory Commission and it being discussed in terms of experts and compare that to the models in your countries and particularly in terms of public involvement. So the Federal Joint Committee, as I understand it, includes patients, providers, and payers and to get a sense of what the patient public role is and similarly in terms of some of the other structures in the Netherlands and France, what role is there for public representation and how effectively does that really work?

CATHY VAN BEEK: We regularly have contact and meetings with several patients' organizations. We always try to think from their perspective and we also test that with them. They are very content until now because they have the feeling that we are really doing a good job for them but ultimately, they have to participate on the advisory commissions but they don't like it. It's very technical and most of the time, they don't understand what the issues are about what their added value should be. So we are searching for a modus that is satisfactory to both of the parties, in three of the parties. So we have not a final solution but it's continuously on the agenda. Is that an answer to your question?

ROBIN OSBORN: Great.

ED HOWARD: Dominique, did you want to respond to that?

DOMINIQUE POLTON, Ph.D.: Well in France, the National Authority for Health is, I mean has a scientific basis but works a lot with providers on one hand and patient associations on the other hand. So they are gathering commissions to discuss the different aspect for, let me give you an example. We have these 30 diseases for which people are exempted for copayments and we had asked the National Health Authority to tell us what the kind of protocols of care could be delivered to these patients and with both the idea of having better quality but also limiting the 100-percent reimbursement to these needed care and that's it.

So they had, four commissions for examining the data on these diseases and they invited patient associations, invited the different professional associations to debate on each of these diseases. So they involved them a lot in the debate. Then afterwards, they've given advice on the basis of expertise but also on the basis of the testimony of these different stakeholders.

ED HOWARD: And let me turn to Karl for the last comment on the last question and as I do, ask you to take this opportunity while you're listening to his wonderful answer, to fill out that blue evaluation form. Thank you. Go ahead Karl.

KARL LAUTERBACH, M.D. Ph.D.: Well I think that the patient evaluation or participation is incredibly important for

the credibility of the whole process because in medicine, many decisions or many medical beliefs are plausible but false. Whenever something is plausible but false, there is a risk that people believe that what is not done is not done for cost containment reason while the truth is it doesn't work.

I'll give you one example: breast cancer screening for women younger than 50 is very plausible, that it should work for those younger than 50. if it works for those women older than 50, it's plausible it works for older women, it should definitely work for younger women but it's unfortunately false because the studies do not show a survival benefit for younger women.

We made this decision not to cover screening on a routine basis. This is not speaking about women with extra risk factors and so forth but on a routine basis, we made this decision with the involvement of the patient groups and the credibility of the whole process was much higher than if it would have done exactly the same without their involvement. So without involving the patients in the process of the decision making process. In the process of the decision making it is very difficult to get the acceptability and the credibility of the decisions that are made, in particular, in the large subgroup of issues where something is plausible but false.

ED HOWARD: Well we've come, oh go ahead Dominique.

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DOMINIQUE POLTON, Ph.D.: Because I'm a little bit charged by what you are saying because in France it looks as if everybody could agree on what to choose and what not to choose but in France, I mean if you do cost effectiveness then you will have for some treatments the fact that yes, they may add some small benefit but at such a cost that it's effective but not efficient.

It seemed to me that you had both on your slide but then in France, it's very difficult for patient associations to admit that something could not be done on the basis of efficiency. They would admit if it was totally, totally non-effective but a lot of things are more complicated than that. I mean they're effective for very marginal benefits and then they're not really efficient. It seems that you had only white or black things in your decisions and it surprised me.

KARL LAUTERBACH, M.D. Ph.D.: Well so far, I'll respond to this directly. So far we have not turned down a single service for cost effectiveness reasons. We have only looked at effectiveness because I think—

DOMINIQUE POLTON, Ph.D.: We do the same then. We do the same.

KARL LAUTERBACH, M.D. Ph.D.: —Because typically what happens is that a service for the right group is effective and if it is effective then typically it's also cost effective. I

mean there's a very small segment of services that are effective but clearly not cost effective. If you focus, for example, the breast cancer screening issue, here the issue is not the cost effectiveness but simply that there's no studies showing a survival benefit for women without risk factors at these younger age groups.

I'm not sure that in the long run, cost effectiveness will not become a more important issue. If it becomes a more important issue, I think then it is even more important to have patients involved in order to defend the credibility of the process because if the patients are no longer in the process at the very moment when cost considerations come in to play a role, the credibility of the process will not be defensible.

ED HOWARD: Alright. Thank you so much. As you're filling out those blue evaluation forms, listen to me say that I want to thank the Commonwealth Fund, Robin Osborn and her colleagues, for making this event possible and supporting and providing us with much of our grist for the discussion.

Thank you for being with us and thank our panelists, in which I would hope you'd join me, for enlightening a number of U.S. domestic situations in light of international experience. Thank you all [applause].

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