Private Financing and High-level Functioning: Some International Approaches to Health Reform
Alliance for Health Reform and Commonwealth Fund
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ED HOWARD, J.D. – help us to shape these programs in the future to your better utility. I do want to welcome you to this briefing on behalf of the congressional leadership of the alliance, Senator Rockefeller and Senator Collins and our board of directors. This briefing is all about exploring what lessons America might learn from others about how to extend coverage and contain costs in a system in which private entities, particularly insurers and providers, play a major role.

Normally it's a pretty tough sell to get a Washington audience to sit still long enough to hear what makes other countries' health systems tick where we might be able to learn a little bit, where we might see where others have made some missteps that we can also profit by, but frankly our turnout today gives me some heart that the possibility of serious health reform debate here in the coming months has made it a little more respectable to discuss what you might call comparative systems right out in the open here.

So, thank you for being here. And if it is true, then our partner in today's program, that is to say the Commonwealth Fund, deserves a lot of the credit. The fund is one of America's clearest voices on health policy issues and frankly they have focused as much or more on international policy

questions for many years as anyone in America so you will be hearing from the fund vice president Robin Osborn in just a few moments, but we want to thank them for their support and cosponsorship of this event.

A couple of logistical notes, by Tuesday morning for sure, maybe even Monday afternoon, you'll be able to view a webcast of this briefing on kaisernetwork.org. There are materials, the ones that are in your packets and actually a few more that we couldn't fit in your packets on both that website and on ours at allhealth.org. Eventually you'll be able to read a transcript, download a pod cast, who knows, we might have an I-tune to the melody of what you hear today.

[Laughter]

I do want to encourage you to fill out your evaluation at the appropriate time and point out the availability of those green question cards that you can use to raise points that need clarification or amplification at the appropriate time and there are also microphones that you can use to ask your questions in your own voice.

We have a very impressive list of speakers today from both sides of the pond to help us grapple and see where we might learn from one another so let's get started. If you have cell phone or a pager, you ought to put it on vibrate. That would be very courteous of you, if you would, and I want to

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turn now to Robin Osborn. You will get full biographical information on the sheets in your kits, so I can't do justice to Robin or our other speakers. I did mention that the Commonwealth Fund is a cosponsor of this event and Robin is serving both as the fund representative and as our lead off speaker. She is the vice president and director of their international programs and somebody who oversees a broad portfolio of internationally oriented activity at the fund. She has an extensive background in health policy, private sector experience as well. Welcome, I should say welcome back, Robin. Thanks very much for being here.

ROBIN OSBORN: Thanks so much and I want to join Ed in welcoming all of you on behalf of The Commonwealth Fund to this afternoon's event and to thank the Alliance, Ed and his staff, for their collaboration organizing this program.

As many of you know, the Commonwealth Fund was established in 1918 by Anna Hartness with the broad charge to enhance the common good, and the mission of the fund is to promote a high performing health care system that achieves better access, improve quality and greater efficiency and in doing that we have a particular concern for access of care and quality of care for vulnerable populations.

The fund's international program as Ed mentioned is actually quite unique. Out of 67,000 foundations in America,

we are the only one that supports a program in international health policy focused on industrialized countries, so sometimes that's a lonely position to be in and sometimes it's an advantageous position to be in.

But the program is premised on the belief that the differences, despite the differences in the way health care systems are financed and organized, the differences in culture or political context, that there is a lot to be learned for policy makers, for researchers, for journalists, in looking beyond our own borders and so we are especially pleased today and privileged today to have the distinguished panel that we do, Dr. Busse from German, Professor van de Ven from the Netherlands, and then to have leading experts from the U.S., Professor Danzon and Dr. Butler to help distill what you are going to hear about the other country health care systems.

Surely ensuring access, improving quality of care, and increasing efficiency are driving concerns for policy makers and the public across all industrialized countries and similarly they are concerned with getting value from money and particularly in the U.S. I think that theme resonates now in this election year and recognizing that the U.S. health care system is the most costly health care system.

And U.S. per capita spending on health care is more than twice the OECD average but while we outspend other

countries, our system often fails to deliver superior value for the money that's spent so by way of setting the stage for this afternoon's panel, I just want to share very quickly, I'm going to breeze through it but it's available and your packs are outside on the registration table, some data from the OECD and from the Fund's recent international surveys. I'll just start off here.

In 2006, the Fund issued a national score card and looking at 37 indicators which reflect dimensions of a high performing health care system, the U.S. was benchmarked to best practice and we got an overall score I think of 66. As you can see the U.S. compared to other industrialized countries, outstrips them in terms of spending on health care, 16-percent of GDP and certainly you can see the trend on per capita spending on health.

And the interesting thing that I'm not sure everyone is that aware of is if you look at the stack bar chart here and you look across the blue on the bottom that is the public spending for health care. U.S. public spending for health care is really comparable to what other OECD countries spend. The difference then occurs when you see what we stack on top in private spending and then in out of pocket spending. One further difference is that the U.S. is basically the only industrialized country that doesn't have some form of universal

coverage so with comparable public spending levels, we still have 47 million uninsured.

Looking at utilization of health care, the U.S. actually has compared to other countries, very low rates for admissions to hospitals. Average length of stay and throughout these charts you will see the U.S. is the yellow bar and Germany and the Netherlands, you just get a quick picture of how we compare to the other countries we are going to hear about so we have short lengths of stay. We also have low rates for seeing physicians, fewer physician visits than most of the other countries. One place where we do stand out in utilization is on high tech procedures. We tend to be an early adopter of expensive high tech procedures.

But another area where we stand out and some of you may have seen those *Health Affairs* articles by Uva Reinhardt, Jerry Anderson, 2003, it's the price that's stupid. We also tend to pay more and one other area that is worth noting is on administration and the U.S. system is far more fragmented than most other health care systems and you can see administrative costs for health insurance, again the U.S. is somewhat of an outlier compared to other countries.

How do we do what we get, value for money, the quality, looking at, this is mortality amenable to health care, so these are deaths that could have been prevented with timely effective

appropriate health care. The U.S. ranks 19 out of these 19 countries so here and this is around diabetes, it's around cancers that can be treatable, it's complications from common surgeries, so it's pretty clear here that there are opportunities for doing better.

Just referring to some of our data that we get from our surveys, we do population surveys across seven countries and each year the U.S. is the country is where people face the greatest barriers to getting care, so here we have more than one in three saying in the last year they didn't see a doctor, didn't fill a prescription, didn't get needed tests because of cost, financial barriers.

Another sort of difference that stands out in terms of the U.S. health care system has to do with primary care and having a regular doctor, so compared to most other countries, certainly in the six and seven that we will be looking at, the U.S. doesn't have as strong a primary care infrastructure in general and if you look, you can see people in the U.S. .

And these are sicker adults in this survey, are far more likely not to have a regular doctor and they are also the column five years or more if you compare the U.S. to Germany, much less likely to have this long term relationship with their doctor and we know from work, Barbara Starfield's work in

particular, how important primary care is to having comprehensive continuous care, preventive care.

Access, one of the areas, the U.S., we often assume that we have easiest access to care and when it comes to elective surgery we often do. Countries like the U.K. and Canada may have much longer waits to get in for elective surgery but again going back to the primary care. If you look at the U.S. on the left side of the chart compared to Germany and the Netherlands, people are much less likely to be able to get in on the same day to see their doctor when they are sick.

And the U.S., two-thirds of people in the U.S. report that they have a lot of difficulty getting after hours care, evenings, weekends, much more so that Germany or the Netherlands, and you can see how that plays out on the right side of the chart in terms of much higher rates of using an emergency room, which is not very efficient for the health care system. It's a costly way to get your care your primary care doctor could have provided. It's also in terms of quality, continuity of care, a lot of problems.

We asked people about deficiencies in care, and again here you see the fragmentation of the U.S. health care system, higher rates of people reporting when they showed up for a visit with their doctor, the medical records weren't there, their test results weren't there, the doctor had to order

duplicate results. It's partly fragmentation. It's also lower uptake in the U.S. of electronic medical records we think.

Again, some of these issues, fragmentation has, plays out on medical errors. These are patient reports of a medical error, a medication error, or a lab test error, that means getting the wrong test result or delaying getting an abnormal result, and again the fragmentation of the system, the handoffs, the lack of interactive, interoperable medical records comes into play here.

We asked doctors, primary care doctors across countries whether they had medical records. The U.S. and Canada are lagging in this area. You can see that. We also asked primary care doctors, this was in 2006, about financial incentives and the extent to, which this is pay for performance. People had incentives to do some of the things that really take more time are harder to do in primary care practice.

The U.K. stands out, which has a GP contract that has 147 indicators that can result in incentive payments doctors get, about 25-percent of compensation can be based on incentives. But even just looking at the third row down, you can see that in the U.S. doctors are not really given the same kind of financial incentives to manage these patients with complex chronic diseases, patients that take a lot of time to manage their care, and I think we'll hear, the other countries,

they are addressing that in different ways that are interesting.

This is the last slide, and this is just to give you an overview. It's a trend question. We asked people whether they, how they feel about their health care system so this is one of the few questions of their views. Most of them have more to do with their experiences, actual care they've gotten, and these numbers, the top is people thinking that the system works pretty well, only needs minor changes, tinkering around the edges.

The bottom row, rebuild completely, a striking contrast if you look particularly at the U.S. compared to the Netherlands and that U.S. number is actually held fast for the last ten years. It hasn't moved at all so we know this is sort of real core group of people using the health care system who are looking for improved experiences.

And just very quickly, you will hear from our speakers from Germany and the Netherlands, country patterns and policy choices make a difference. Universal coverage also makes a difference. You can see that in the barriers to care. National policies and have a national health care system make a difference. They really do matter in terms of improving quality of care and performance.

Financial incentives can be used to enhance quality and value and one of the things we are learning from our surveys is primary care redesign is just key, giving people, equipping them with something the equivalent of a medical home really makes a difference in their experiences and the quality of care that they report. So, I thank you.

ED HOWARD, J.D.: Thanks very much, Robin. As Robin said, we are going to sort of divide this up. Forgive me. I mean nothing sinister by this into “us” and “them” [laughter], that is to say we will have presentations from our two European health policy experts about their respective countries’ systems and then we will hear comments from a couple of leading United States experts and then we will open it up for your comments, so let’s get started on that.

Our lead off speaker is Dr. Reinhardt Busse, who heads the department of health care management at Berlin University of Technology. He is also the dean of their faculty of economics and management. On the side, he is consultant to every international health and economic organization you can think of and we are very appreciative of you opening with us this afternoon, Dr. Busse.

REINHARD BUSSE: Yes thank you for inviting me over here, over the Atlantic, to share with you the German experience and you will see that clearly this is not the model

simply to copy but we have learned over the last 125 years since our system was originally designed and many of the issues are relatively similar because people in Germany also don't want one state run system, like when you ask Germans, usually the U.K. is a better example, besides the U.S., and so we try to combine various aspects in our system.

I usually not only for teaching but I think to understand a health care system, it's useful to have a framework. I use this triangle where we have the population that provide us and the third party payer which we should usefully separate into the collector role and the actual payer role, and then clearly we have a regulator which is the ministry or in Germany rather the parliament which sets out the legal framework but relatively stays out of the system.

So when we look at the German system the first thing that we see is that much of the actual running of the system is delegated to act as inside the system and the government is not controlling it but steering it, otherwise just simply using this framework.

And we have two systems as you will see in a second, in the statutory social health insurance system, we have about 240 sickness funds as payers and they insure roughly 90-percent of the population but besides that we have a private health

insurance system which takes care of the other 10-percent and they are dealt with by 50 private health insurers.

The people in the statutory system have a choice of their sickness fund, they pay a wage related contribution share between their employer and the employee while the people in private health insurance pay a risk related premium, then to make up for the differences in what is collected by the 240 sickness funds, we have a so called risk structure compensation which redistributes the money between the sickness funds in their collector roles and the sickness funds in their payer role.

The providers are a mix and if we say public in Germany, we also mean that okay, local governments might own hospitals but they are totally separated from the payers, so there is a clear payer provider separation and they come public, private, mixed, or organized also in associations. They are contracts, mainly collective, but in private health insurance there are no contracts and there is choice for people in both systems and I must emphasize there is also basically no waiting time as you have seen just in the international comparative figures.

This is just, you have the data in your printout, it will compare the two systems which together have ensured almost universal coverage and has now become mandatory as I'll show in

the end. We see the two big differences is really on the financing side that people in the statutory system pay a percentage on income and people in the private system pay a risk related premium.

The interesting thing is that we leave it to high income earners to choose the system, which you would say is a stupid way because we need the high income earners in the public system to pay their percentage but it has been the tradition over a long time and this is like the like most test of the system because most people with choice, about 75-percent of those people was choice go to the statutory system and not to the private system and so everybody in the country has to be aware that the public, the statutory system needs to be attractive and so to keep these voluntarily people in who could go out.

Care coordinator, quality and cost effectiveness have been problematic and I think similar to the U.S. the public notion was that we had the best system in the world for a long time but then we learned that this is not the case by various publications, WHO and others. We had introduced quality assurance relatively early but focused originally only on structural parameter that has changed as I will show in a minute, and we see that especially the chronically ill were disadvantaged.

One big thing I must say is already going on now for seven years is that all hospitals in Germany whether they are private, for profit, public, or whatever are required for a certain set of indicators, currently 170 indicators covering about one in six inpatients in Germany, they have to report data and then they receive a feedback and you see that the data collected of those on the indications or on the appropriateness, on the process, is it done correctly?

And also on the outcome, clearly only on short term outcomes during the inpatient stay and then all hospitals receive a feedback and they see how they compare to other hospitals and if they are doing badly then they are called and they have a so called structured dialog.

The interesting this is that even on indicators which we thought every hospital would at least achieve some good quality, we always see that there are bad ones and certain indicators will now be made public. So far for the first seven years, only the hospital got the individual feedbacks and the public only sees the overall results like this but now certain indicators will be made public.

Then we have the disease management programs, partly copied the original idea from the states but this is a new approach in Germany based on the idea that the sickness funds under this risk structure compensation actually only got age

sex related compensation and that the chronically ill were always under financed under this system and that sickness funds were not incentivized to provide good care.

Originally we didn't really know which diseases to cover separately so we came up with this clever trick and said okay people who inscribe in a disease management program, they voluntarily show that they are chronically ill. They have to meet a certain threshold and then so we have this double trick, the sickness funds get better compensation under the risk structure, scheme, and have an incentive to do something and if it works then they might even save money by providing better care.

The mandatory evaluation is a bit methodologically weak because it does not have the control group but the first publications came out where people are using control groups of people not enrolled in the disease management programs and these are people enrolled in the diabetes program and so 100-percent of those not enrolled but still are being diabetes and you see that the incidence of stroke for example is between 30- and 35-percent lower and the incidence of foot and leg amputations is even only about half of those people not enrolled in the programs.

The other thing, as I said, we delegate the decision making on the benefit basket which I skipped over is very

broad. It includes all kinds of inpatient care, outpatient care, pharmaceuticals, medical technology, dental care, rehabilitation.

The decisions of what is actually covered are done by the federal joint committee with equal representation of the providers and the sickness funds, managed, chaired by neutral members, and the federal joint committee is assisted by the Institute for Quality and Efficiency since 2004 and that assesses the comparative benefits of new technologies, especially drugs, and this year we will change that it also can be asked to compare the cost effectiveness of drugs in the same indication group versus other drugs.

If I stay within the triangle and look at the latest reform which has been passed last year, pretty much one year ago it went into effect and then the changes which are happening currently in the German system, the one thing is, this is on the very lower left hand side here, that we could not solve the problem clearly with this unequal system of the statutory and the public health insurance system where the rich can basically opt out and pay smaller premiums than they would do on a contribution based system but we make health insurance now mandatory so people cannot lose their coverage and it’s mandatory for next year to have coverage.

The self employed and the civil servants will be required to go to the private system and the employed people to the statutory system. There will be in the statutory system a uniform contribution rate which is a new thing. Currently the sickness funds are determining their uniform rates. The money is put in a big health fund which will still be virtual because the sickness funds will act as the collect does. The money is then reallocated to the sickness funds on a new formula which is not only taking age and sex into account but also if people fall into one of up to 80 disease categories and we have just came out with a proposal for that.

And that is important I jump over this, but from as same as in the U.S., we see that 5-percent of the population make up 50-percent of expenditure, 10-percent make up 70-percent, and so it's very important that our sickness criteria, these 80 disease categories, actually pick up who these 5- or 10-percent are and the model we have designed and which has been given to the ministry looks very promising in that respect.

Then if the sickness funds cannot cover their costs based on this new allocation which takes sickness into account, they have to ask for extra money from their insured above the uniform contribution rate. If they have leftovers, they pay the money back to their insured, then I'll leave this out, the

sickness funds will be reorganized which might be of less concern for you. They are still in several associations.

We make one big association now and lastly the contracts will remain mainly collective but under this so called act of strengths and competition as the law was called, we allow them to have in certain areas so called selective contracts where they can offer additional services to their members above the uniform benefit basket agreed upon by the Federal Joint Committee. Thank you.

ED HOWARD, J.D.: Thank you very much, Dr. Busse. By the way, a few years ago the competing trade associations of health insurers in the United States consolidated so we are familiar with that phenomenon.

Next we hear from Professor Wynand P.M.M. van de Ven, who is a professor of health insurance at Erasmus University in Rotterdam. By any measure, he is an insurance expert. He has been a board member and an advisor to private insurance companies. He too has consulted with the World Bank, the WHO, the governments of several countries, and from him we will learn about the recent reforms in the Netherlands' health care system. Thank you very much professor for being with us.

WYNAND P.M.M. VAN DE VEN: Thank you, chairman. Many people in Europe think that United States is a champion when it comes to market competition as free choice, but for health

insurance this is not the case. In the Netherlands, consumers have much more free choice of health plan than in United States. Your country, many employs people do not have any choice of health plan at all because simply the employer does not offer any choice and those employees who do have a choice often have a very restricted choice and in addition they have a financial incentive not to choose the most efficient plan and that is because of the employer subsidy and the tech subsidies.

In the Netherlands, every individual has a free choice of health plan for premium that everyone can afford and the subsidies are organized in such a way that everyone has a financial incentive to choose the most efficient health plan and I will explain to you how we have managed that.

First let's look at some characteristics. We spend about 10-percent of our income on health care. There is much private initiative, much private enterprise, so it's not a public national health service system but there is much government regulation with respects to prices, capacity, licensing and that started in the 1970's and the 80's with the goal to contain cost.

We have the general practitioner who acts as the gatekeeper and assumes, coordinates and pre-authorizes follow-up care. Our health insurance before 2006 was a mixture, two-thirds of the population had mandatory public health insurance,

one-third primarily the higher incomes they had voluntary private insurance system and now there is a mandate for everybody to buy private health insurance. And you can understand that is the reflection of a political compromise.

The new health insurance system is part of the reform that started about 15 years ago and the core of that reform is that no longer government is responsible for cost containment and efficiency but it is the insurer's, risk bearing, competing insurers, are assumed to be a prudent buyer of care on behalf of their members. Governments will gradually take away existing price and capacity controls and governments will step back and will set the rules of the game to achieve public goals.

As part of the reforms since 2006, it's mandatory for everybody in the Netherlands to buy individual private health insurance from a private company so it is individual insurance, no group insurance, no family insurance, individual insurance. The benefit package is standardized in the sense that the law prescribes which services should be covered but there is much flexibility for the insurers to manage care. And there is much consumer choice.

Each year consumers can choose another insurer or another insurance contract in kind or reimbursements the preferred provider organization or free choice. Voluntarily

they can choose a higher deductible and they can buy voluntary supplementary insurance for benefits that are not included in the mandatory basic package.

So the key elements of the reforms and of the Health Insurance Act is that individual insurers are assumed to be the prudent buyer of care. They have many tools to do so and also there is much flexibility for them in defining the consumers' concrete entitlements.

For instance, which panel of selected preferred providers has open enrollment and community rating, there are income related allowances and we have risk equalization system which is to create a level playing field for insurers. The risk equalization fund, the ref is a key element of the Dutch health system. All individuals, the insured, have to pay an income related contribution to the ref, and in addition all adults have to pay a premium directly to the chosen insurer on average debts around 1100 Euro per year. Each insurer sets its own community rate premium.

Of the high risk people, the insurers receive a high risk adjusted equalization payment from the ref for the low risk insurers have to pay the payments towards the ref. The Netherlands is the first country in the world that is to our knowledge that is consistently implementing the managed

competition model as proposed by Professor Alan Anthoven [misspelled?].

It's competition among insurers, we have about 15, and its competition among providers of care. It is not a free market. Government manages to market to achieve socially desired outcomes and this requires that many preconditions have to be fulfilled. We need good risk equalization because otherwise we have risk selection with a lot of adverse affects. We need effective competition policy because otherwise we have cartels and that is no competition. We need transparent consumer information because otherwise it does not make sense to give the consumer a free choice. We need a product classification system because otherwise insurers do not know what they are buying, et cetera, et cetera.

So it is not a free market. You need a visible hand to let the invisible hands work well. And therefore government has set up the Dutch health care authority. It weighs our governmental organization at arm's length of government which is responsible for managing the competition, the insurance market and the provider market. They can interfere in the market if necessary. They closely cooperate with the Dutch competition authority who is very active in health care market.

This authority is responsible for transparency and for consumer information. The government has set up a website, you

can see there, and consumers can compare on that website all insurers and providers of relevant aspects. The Dutch health care reform is work in progress. So far, the emphasis has been on health insurance markets. A major challenge for us now is to reform the market for provision of health care.

And major questions are, are the insurers in the Netherlands really able to manage the care? Which forms of managed care will be acceptable for the public? And will government be prepared to give up its traditional tools for cost containment by really reducing supply site regulation? So far, the jury is still out.

Looking at health care systems of the Netherlands and the United States, complementary strengths and challenges can be observed. In the Netherlands, we have implemented universal access, a free consumer choice of health plan. Our challenge is now to create integrated delivery systems that provide high quality care. Here in the United States you have several excellent examples of these integrated delivery systems while the reform debate is dominated by the lack of universal access to health insurance coverage. What are the best elements of both systems can be combined in the coming decade is a major challenge for health policy makers in both countries. Thank you.

ED HOWARD, J.D.: That's terrific, thank you very much Professor van de Ven. Now we turn to our first American commenter. He is Stewart Butler, the vice president of domestic and economic policy studies at the Heritage Foundation. Don't let that trace of an accent fool you. He may have been educated at St. Andrews in Scotland, but Stewart has been at the Heritage Foundation since 1979. And by the way in that time he has graced the number of alliance programs, so Stewart thanks very much for being here and we are looking forward to your comments.

STEWART BUTLER: Thank you. I know that Patricia and myself are supposed to be the "us" commenting on the "them" [laughter] but as you've said if you listen to both of our accents you'll discover that we are probably more in line with the "them" than the "us" in many respects, [laughter] at least in terms of our background.

I'm delighted to be asked to take part in this very important discussion. And I think very much that these kinds of international comparisons in looking at different countries is critically important for us in the United States to think through how we get from where we are, where I think we all agree is not the right place to be, to where we want to be, so we do have in these foreign examples the opportunity to what

you might call quasi social science experiments to actually look at to kind of draw some conclusions from.

I think it's also very important though as we do that to apply some caveats in terms of how we respond to these kinds of foreign examples because they have to be seen through the lens of our institutions and values and so on that very much shape how we would take the lessons and apply them here. I think there is a tendency very often from what I would call love at first sight or the grass is always greener on the other side, to sort of think immediately this is the answer and I think it is important not to do that.

I could probably make a very nice case if given a little time to the British National Health Service which I wouldn't wish on my worst enemy, but anyway. [Laughter] I think it is very important to avoid that. I think it's important to recognize that there are very important different values that have to be taken into account when one thinks of translating these kinds of alternative systems to our country.

It's often said that when the British see a line, they get in it [laughter] and only after they've been in it for 10 or 15 minutes do they ask what it is for. So, I think that our attitudes to waiting and to equality and so on are very different and that's very important.

I think our attitudes in this country to mandates, for example, is rather different from the Europeans in general. We have mandatory auto insurance in this country as they do in most of Europe. In somewhere like Switzerland it's about 100-percent of people that comply. Here it is about 80-percent. That tells you something about making and requiring people to do things which at least you've got to take into account when you think about the politics here.

We also have different political institutions that affect and other institutional factors that affect how we would apply lessons from abroad. We have a federalist system here which is very, very critical in terms of thinking about the organization of insurance and how you would do that and what debates would take place and tensions would take place if you tried to organize things in a kind of national system that we see to a large extent in both of these countries.

Our traditions with employment based insurance is quite different from the German system and actually also the Dutch system or many other countries. We have a more individualized employment based system as opposed to collectivized employment based system and too as we think about moving forward we have to think in terms of how would you change that to move in the direction we would want to go?

That is an institutional factor, as is things like the level of doctors' pay in the European countries generally compared with this country, so when we start thinking about how can we get costs under control, that forces you to start thinking about the relative payments and salaries of doctors in the U.S. compared with other professionals but that poses enormous issues and difficulties as we think about moving down that road.

All that said, I think that these particular examples give us a lot of very interesting clues and lessons as to how we might grope forward. Americans always do these things of course in a gradual way, like a lot of Europeans, that change things rather dramatically rather quickly sometimes as we did in the U.K. and I think some things come out of that. One is I think this combination of looking at risk adjustment mechanisms, looking at subsidies that really are more designed to more calibrated to incomes, allows you to look at ways of giving people options where the price differential is not dramatically wide.

We could edge towards the idea of more similar premiums for people that they can understand and work with a little bit more by learning some of these lessons, particularly from the Dutch system I think of how we can use risk adjustment and directed subsidies in a way that allows us to be less necessary

than we are today in America of having big price differences in order to have stable insurance coverage. I think that is something first to look at very, very carefully.

I think also the issue of benefits and the degree to which they should be standardized is a very, very important issue, which has still not been resolved really in both of these systems in terms of the long run implications of cost.

Both countries, again similar to most of Europe, actually have two tiers of systems, two tiers of coverage and two types of benefits. I think that is instructive in terms of how we would think about the future. I think there is a tendency now and we see this very much in the presidential debate right now to talk about what we might call the lake woebegone effect of everybody should be on average or above.

I'll explain this to our colleagues from abroad a little bit after the panel what this means exactly but this sort of notion that well if we have this great benefit system for federal employees, everybody should have that or more and so when you start thinking about reaching our objectives of cost control, and yet widening the base that everybody can count on, that is a dilemma that we still have to struggle to deal with in this country as they have done in Europe.

I think in addition the idea of negotiation, of payment levels and benefits as we see in the German system especially,

and that general approach of collective negotiation is really almost unthinkable in the United States in terms of the idea of negotiating in broad terms what payment levels should be for doctors.

Obviously we do it to an extent in medicare but just then think about every time there is an attempt to really ratchet that down, what does congress do? It rolls it back. It's very difficult to envision exactly how we would see that which leads me to be very interested in the consumer choice cost control that we heard particularly from the Dutch example.

As to how that might in fact be a much better track for us to look at and to examine and to experiment with than the idea of collective negotiation in terms of payment levels so when I started looking at these examples and we could obviously talk a lot more about very specific lessons from, it leads me to think about what if we were to try to move in the direction of these countries, how might we do that in an American context? And I'll just leave a few ideas or a few elements of that to think about.

It does seem to me that these lessons from these two countries should encourage to look even more at the idea of disaggregating or divorcing the organization of benefits for working people from their place of work and to explore much more ideas like exchanges and so on which of course is also

from Anthoven and others, in other words to de-link what you actually get in terms of coverage and how you organize insurance from the place of work per say.

We are seeing that of course now in some of the state experiments, particularly in Massachusetts. We have it essentially to all intents and purposes in the fellow employee system that you have here where you can go from one place of work to another and it doesn't affect your choices and availability of coverage.

I think we've got a lot of opportunities to move forward on that and it will in fact then allow us to get the kinds of levels of choice that in a sense we only dream about in America, as has been said, land of free markets and yet we don't actually have the kinds of range of choices that the Dutch have in reality. I think moving towards and exchange kind of model and exploring that further helps us in that way.

I think also recognizing that we've got to make some fundamental changes in the subsidy system as they have done in these countries. It is critical. We have a tax system which I think, Mr. van de Ven mentioned that is really very hard to understand as a method of trying to enable people to afford coverage. Our tax treatment of health care in this country is linked with the place of work and it's the exact opposite of

what you would do if you were trying to give subsidies related to income.

The higher income you have in the United States, the bigger subsidy you get. We have got to get to grips with our tax subsidy system, $200 billion a year we subsidize people in this way, completely perverse and we have to deal with it and I think many people recognize that and I think when we think about insurance organization, moving towards exchanges and so on, I think one of the big Americanizations of these ideas and lessons that we have to look at is the idea of doing that at the state level rather than the national level.

It may seem messy. It may seem like not what some people would want to do, but A, it is the system we have, the federal system is integral to the United States and it allows us and requires us to move forward in that way, and also it allows us to experiment in ways that you can't do at the national level, given the scale and the differences and the history of the United States.

So I think when we look at these experiments, these examples from abroad, they really do I think give us a lot of very, very interesting lessons, a lot of caution, a lot of things to look at in an American context of how we would take these basic ideas and these basis lessons and revise them and

alter them to fit our experience, our political system, and our values. Thank you.

ED HOWARD, J.D.: Great thank you very much, Stewart. Finally, we will hear from Patricia Danzon from the Working School at the University of Pennsylvania where she chairs the health systems department. She is a professor of insurance and risk management. She is an internationally known expert in insurance and other topics, in health economics. She holds degrees on both sides of the pond, a B.A. first class through Oxford, a Ph.D. from the University of Chicago, Patricia thank you for joining us this afternoon.

PATRICIA DANZON: Thanks very much and let me just say that while I agree with a lot of what my colleague Stewart said, I'm willing to be a little bit more defensive about the U.K. health system than he was. [Laughter] But that is not the subject of today's discussion so let me say that as I look at the systems in Germany and the Netherlands, I think there are some tremendously useful lessons for the U.S. as we think about reforming our system.

The three key messages I would take from these talks is that if we want to move to a system that is operated through competing private insurance plans but nevertheless yields universal coverage, then the three essential ingredients are we need an individual mandate that everybody obtain coverage, we

need to make sure that coverage is available, that insurers are available to provide it, and we need to make sure that the coverage is affordable to individuals and that the plans can afford to take all individuals.

Let me elaborate on each of those. First, the individual mandate, we've talked a lot in the U.S. about an employer mandate and essentially Germany had an employer mandate until the recent reforms and the Netherlands has only recently adopted the individual mandate. I think both countries, experience shows that in today's labor markets where people are moving between employments, where many people are self employed in small firms, an employer mandate just doesn't bring everybody in and one needs to move towards an individual mandate and move away from employment as being sort of the basis of the source of insurance as Stewart was mentioning and both of these countries show ways in which it can be enforced using the tax system, using systems with penalties and carats, et cetera.

I think in the U.S. we tried doing it in Massachusetts but it is much tougher to do it at the state level than it would be at the federal level and if we were to do it at the federal level using the IRS or the tax system to enforce it, it would be easier to do, and having an individual mandate immediately solves some of the problems of insurance markets

because once everybody has to be buying insurance, the risks of adverse selection that individual insurers face are somewhat reduced. It is not just the sick people who are out looking for coverage.

The second point I mentioned, to make a competing private system universal is that insurance has to be available and both of these countries require that health plans take all comers and open enrollment requirement and something like that I think is necessary. One could also have a backup system of a state operated fall back insurer for people who can't get coverage through private plans but something that makes insurance available is necessary and then most importantly affordability issue.

In both of the comparison countries, premiums are basically based on a percentage of income, a payroll tax in Germany and more of an income based tax in the Netherlands, which is very different from our approach where basically we have a payroll tax for medicare but for private insurance everybody is paying roughly their own costs so it's more like a head tax and I think there would be a lot of reluctance in the U.S. to move towards a payroll tax based or an income tax based system of contribution that would be massive redistribution.

And so the middle ground I think we can reasonably aim for is a revision of the current tax treatment which as Stewart

outlined gives higher income people in fact greater tax subsidies, moving away from that to a system that gives everybody a tax credit for purchasing health insurance but where the value of that credit is higher for lower income people so it pays the full cost of coverage for low income people but then it phases out the higher income people and where you phase it out is a matter of judgement.

But we could without too much trouble revise our system to do that and that would help make coverage affordable for individuals and in the fourth, pardon the third issue is to make it affordable for health plans to accept all comers because once there is an open enrollment requirement then health plans have an incentive to try to select the healthier individuals unless they are going to get higher payment for taking sicker individuals and both Germany and the Netherlands have developed very sophisticated systems of risk equalization, redistribution between plans that has at least mitigated the incentives of health plans to cream scheme and go after the low risk individuals.

There is a lot to be learned and I think very promising lessons from these countries because just five or ten years ago the systems they used were very rudimentary. Now they've become very sophisticated and I think there is great opportunity for us there.

Moving on now to the cost control size of things, as was sort of briefly mentioned in both Germany and the Netherlands they have been systems that basically allow the system as a whole to set payments for providers collectively and in the U.S. I think that would rapidly fall afoul of antitrust requirements, the idea of us allowing the alliance or the association of health insurance plans to get together with the American Medical Association to set doctors' fees. It is not going to happen and I don't think it should happen.

I think that is one area where the experience in the U.S. has been perhaps better than in other countries where health plans have a lot of experience of trying to selectively contract with providers, design payment systems that induce more efficiency, and so I think that is an area where we do perhaps have a head start but I think it will be very interesting to see how these comparison countries perform once they relax some of the controls that have been in place and have been controlling spending in those countries.

Moving now briefly to pharmaceuticals, which wasn't mentioned specifically but I think is obviously a very important area for rising costs. Both of these countries have mechanisms for evaluating cost effectiveness or relative effectiveness of drugs and other technologies and clearly it seems to me that is an area where we need to move forward where

there is a lot to learn both from what the private sector is doing in the U.S. already and also what other countries are doing in the design of these systems.

Whether they are helpful or antithetical to efficient care really depends on how well they are designed and how the benefits are measured and again I think there is growing expertise and sophistication in measuring the outcomes of new health technologies in ways that can take into account improved quality and not just focus on reduced costs.

So I think there are definitely some lessons to be learned there. The one area where I wouldn't, I probably would not choose to learn from these countries is in adopting reference pricing for pharmaceuticals. Both Germany and the Netherlands have systems of therapeutic referencing which basically groups together drugs with similar indications into one group and then the third party payer pays the same price for all drugs in that group, regardless of their patent status and regardless of their relative efficacy.

Now how Draconian that is depends on how broadly the groups are defined but the concern with that is that it really, if broadly defined groups are used, it undermines the incentives for drug companies to develop improved formulations and improved drugs within the therapeutic class so if the U.S. does choose to adopt that sort of therapeutic referencing it

seems to me it would be better done at the level of the health plan as an option rather than something that is done at a national level.

More generally, I think that we do have a system where individual health plans contract the pharmaceuticals designing their own formularies within broad guidelines and that is a system that at least the Netherlands is moving towards I think and it is a system that can work reasonably well.

So finally let me just close in saying I think there are some really important lessons to be learned from these countries in terms of the individual mandates in making payments affordable to individuals by if not having contributions proportional to income then at least having bigger subsidies for lower income people.

The risk adjustments systems for equalizing payments between plans, there is a lot of expertise there that we could learn from. Technology assessment, if done in a sensible way, open enrollment and community rating within bands may be ways that we want to modify the risk equalization approach.

And then finally I think they can probably learn from us something about trying to encourage competition between providers in terms of having PPOs, HMO arrangement, exclusive contracting, all those sorts of variations where we are

allowing plans to experiment and that is teaching us something I think in gaining efficiencies in delivery. Thanks.

ED HOWARD, J.D.: All right, thank you very much Patricia. This has been an incredibly rich set of presentations and you have been incredibly patient, waiting your turn to be part of this conversation. Let me remind you that you have green cards that you can fill out a question and hold up. Someone will take it from you. There are microphones right here where you can stand and ask your questions. Let me also invite our panelists and Robin especially to ask each other questions or comment on what they have heard.

I am happy to take a chairman's prerogative as long as I've got the microphone in front of me and I'd be delighted to hear from both Dr. Busse and Professor van de Ven. You mentioned explicitly the availability of quality information to consumers so that they could make the individual choice, that is a matter of great controversy in the United States, particularly as to the availability of that kind of information, I wonder if you would characterize how well you think that information is presented to consumers?

WYNAND P.M.M. VAN DE VEN: In the Netherlands, only in the very early states but as I said it does not make sense to give the consumer a choice if there is no transparent consumer information because that would be at risk of only having price

competition which might reduce quality but it's a very controversial issue of course and hospitals are not eager to give that information. It is government who has to enforce the hospitals to provide the information and then the government puts it on the website but it is in a very early stage and I'm sure we can learn a lot from the quality indicators in the United States.

REINHARD BUSSE: Maybe I should say something similarly, we also proved necessary that there was regulation for all hospitals which have a contract with the sickness funds which are by the way basically all hospitals. We really have only like 1-percent of hospitals which only treat for out of pocket money.

All the other 99-percent of beds are contracted beds and so they have to produce this information initially as I said, it's only published in an aggregate way and there was big discussion of which of the indicators, where they failed the methodological development or furthest advanced and which now will be given to the public and so out of the 170, it is 30 indicators become mandatory now. It's another roughly 10 may be published by the hospitals and the other one still remain on this aggregate level but clearly the development is there to make more information available over time once everybody feels that these are appropriate and valid indicators.

ED HOWARD, J.D.: Could I just add a follow-up and maybe Robin is appropriate to answer this question, there is a lot of talk in the United States as we try to develop quality indicators about there not needing to be 100 countries looking at the same kinds of quality developments, but rather individual use of commonly developed kinds of indicators and I wonder how far along that process is, either with the countries we have here or others?

ROBIN OSBORN: Actually it's work that the Commonwealth Fund itself has been involved in on a small scale starting 1999 to bring, it brought together five countries: U.S., U.K. Canada, Australia, New Zealand, to develop a set of common quality indicators and it is pretty hard to work to do that across countries and make sure you're measuring the same things.

That work has transitioned over to the OECD and the fascinating thing because the OECD data which has generally been available in terms of health care spending and utilization, technology, manpower, that has been quite well developed on the quality side. There wasn't a lot available and the OECD countries themselves have really, there has been a groundswell of support to develop indictors and there are 30 countries participating right now, ongoing active expert groups

to develop indicators for primary care, patient safety, diabetes, cardiac care.

There are about 16 or 18 indicators on the OECD website at this point in time. They would like to get that list up to about 50 and so they are working on that fairly intensively but harmonizing the data between the countries is very difficult. It is collected in different ways and it's very expensive for a country to change the way that they collect it and for various reasons in terms of their own agendas in health care policy, they don't necessarily want to change the way they collect it so working within that and there is a lot of collaboration and cooperation, it's just a slow process but little by little the indicators are coming out and come of them need further refinements but I guess it's only by getting them out there that they'll get better.

ED HOWARD, J.D.: Thank you. Yes sir? Do you want to identify yourself?

MATTHEW GILBERT: Matthew Gilbert, National Conference of State Legislatures. I want to say thank you for the very informative presentations. My question kind of stands on what you were just talking about since in Ms. Osborn's presentation a lot of the data from OECD comes from [inaudible] before the Dutch reforms were in place, so I was just wondering if there is possibly any anecdotal [inaudible] evidence or something

that shows satisfaction with the new system and also another question is if you could talk, Dr. van de Ven, about some of the enforcement mechanisms for the individual mandate?

WYNAND P.M.M. VAN DE VEN: Consumer satisfaction, consumers are very satisfied with the low premiums because it appears that the last two years, insurance markets are very, very competitive and the premiums are 2-percent below what was predicted. Insurers are making losses and so consumers are very happy with their consumer choice, with low premium. The other point about how to enforce the mandates, that is a critical issue.

Currently we have about 1.5-percent of the population who still is uninsured so they don't buy their insurance. Governments are really willing to find an effective way to solve that problem and the intent to do that currently, we don't know who are the uninsured so the government is preparing that situation so that they are allowed to compare the files of the insurance company with the files of the civil registration, then they know exactly who are the uninsured. They will send a letter again and if in the end they will not voluntarily ensure even although they had all kinds of sanctions and fines, then governments will enforce them in an insurance one way or the other.

The other problem is will they pay premium? We have another problem. That is another 1.5-percent of the population during the last six months did not pay their premium so we have a default problem. Governments also want to resolve that problem by new legislation which gives the power to governments, to authority, to deduct the premium from the wages of the social security payments, just like to withhold taxes, and then we have a system where everybody will have insurance and will pay the premium.

ED HOWARD, J.D.: By the way, there is another question that came in while you were answering it, asking how do you deal with people who have lower reading levels and limited aces to information? Has that arisen yet?

WYNAND P.M.M. VAN DE VEN: Not yet. I think currently the website that the government set up is addressed to maybe the average person, but right some consumers are handicapped one way or the other so that certainly will be the next stage in the Netherlands to help them to get transparent consumer information so to enable them to make a good choice.

ED HOWARD, J.D.: Dr. Busse?

REINHARD BUSSE: Well maybe I can add something there from Germany, it was rightly said, I mean it’s also an individual mandate but in real terms the employers pay in Germany and so the enforcement is mainly on the employers as

most people are still employed. When you count their dependents, we already have a large chunk of the population covered. The same with the pensioners and the unemployed because those people who receive pension benefits or unemployment benefits, we also have an agency which is responsible for the payments and so then the number of people in the population who would really have to pay individually becomes relatively small.

ED HOWARD, J.D.: Thank you. A series of questions addressed to either Stewart or Patricia, which actually are requests for comment on what the questioner lists as facts, and you can quarrel with that first and then comment. One, this is U.S. adoption of innovations that we have heard discussed in the context of our international speakers, medicare already uses a sophisticated risk adjustment system for paying medicare advantage plans.

Second, there are very good consumer information systems for federal employers and medicare enrollees. Third, medicare advantage already uses plan based formularies, and fourth, original medicare is moving now to "pay for performance." Now, do you consider all of those positive developments? Are they as robust as might be implied by the way they are cataloged there? And are they really significant in terms of the comparisons with the German and Dutch systems?

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

STEWART BUTLER: Well I think we are seeing movement here, attempts to incorporate particularly risk adjustment, the experiment with that, and the consumer information and I think that's all good and we are seeing it not just in medicare but in other plans as well, in some large corporate plans and so on and I think that is one of the lessons that comes out of this that you are not going to see a stable insurance system combined with choice unless you have some way of adjusting risk selection in the system.

And so I think that is very, very good incidence of what we have seen in this country. It is a step forward and I think we do need to experiment even further, and but I also as I pointed out that I think when you look at what will be a stable, affordable system, it is a combination of choice and competition, of subsidies that are more accurately designed to hit the people who really need them which we don't have in this country, and I think it involves risk adjustments that are still primitive in terms of how they are used in this country. We have just got to make a lot more progress.

If I can just take five seconds to just make the observation that on another matter that Dr. van de Ven mentioned, what they do to enforce the mandate in the Netherlands in terms of the sharing of information, what kind of penalties, what the government can obtain in terms of that,

it's hard to imagine many Americans putting up, we live of course in a city here where even getting the ability of the government to share the information from security cameras on capital hill is considered a massive invasion of privacy, the idea that people can find out what insurance you have and share it with the government and then come and knock on your door if you haven't signed up is something that all Americans are a little, a little bit of push back here probably on that one.

ED HOWARD, J.D.: All we need to do really is to put it on the laptop and it will be leaked. [Laughter] Not a problem. Patricia?

PATRICIA DANZON: I would agree with the question that medicare is doing something in trying to risk rate the medicare advantage plans. It seems to me the critical difference between the medicare experience and what is happening in Germany and the Netherlands is that medicare is basically trying to risk adjust medicare advantage by benchmarking it to traditional medicare which is the fee for service plan and that is a very different and more limited operation than what is happening in Germany and the Netherlands where basically they are pooling all the experience from all the insurance and they are not sort of just gearing a little bit of it to a basically uncontrolled, unmanaged medicare traditional, that is one thing.

On the question of the enforcement of the individual mandate, way back when in the 1990's when Mark Culien's [misspelled?] [inaudible] and I proposed an individual mandate. The way we proposed it be enforced in the U.S. would be partly through the tax system so when you reported your tax system to the IRS, you simply had to report what your health insurance coverage was and then between obviously that only happens hopefully once a year, but in between if you go to a provider whether it's a hospital or a physician and you don't have insurance coverage, they would simply refer you to whatever the relevant office was and then they would follow up so as soon as you had contact with the health care system, the fact that you didn't have insurance becomes evident and then the system begins to roll to collect whatever the premium is.

ED HOWARD, J.D.: A question for Professor van de Ven and Dr. Busse, could you discuss the political challenges that your countries faced in enacting these health care reforms? There are a lot of people who think that the real problem with the United States is not that we don't have lots of ways we could get a better system, but no way to get past the political encumbrances that prevent us from enacting it.

REINHARD BUSSE: Could I start maybe?

ED HOWARD, J.D.: Sure.

REINHARD BUSSE: That's a good question. I mean, you have seen that our system has evolved over 125 years and the question of universal coverage actually never became very pertinent until a few years ago and maybe we could now solve it because we had the grand coalition which brought very different views of the two big parties and they had to govern together.

And so it was a compromise that one party which might still the separation of some people being able to buy no longer voluntary because now it's mandatory private insurance even though clearly the risk rated system which is advantage for the high income people is still good for them but this was kept, the universal coverage is included and again on those people's side who would have liked to combine the two systems like in the Netherlands.

Clearly now that the private health insurers also have a mandate to accept everybody that they also will have to have their internal risk equalization scheme, and so in a sense I think we are following the Netherlands which 20 years earlier put more regulation on the private health insurance and it simply takes time. We see that at least step by step you somehow prepare the next step but it's not easy.

I mean they are big defenders always of the status quo but that step by step, I mean we also by looking to other countries in the Netherlands is very widely looked upon from

the German perspective because it also was in a very similar situation as was explained with the two-thirds/one third split, so if we move further with combining our two systems, probably we will have to have a look. We will not copy it but we will learn from the process there which was also very long as will be explained to us.

WYNAND P.M.M. VAN DE VEN: The reforms in the Netherlands started in the late ‘80s with the Dacca Report and were implemented in the early ‘90s. At that time we could not have that [inaudible] overnight because of all these preconditions that had to be fulfilled, none of them were fulfilled at that time so technically it was impossible. We did not have any risky possession system at all.

Secondly at that time, the sense of urgency for change was not as high, a lot of politicians had the idea well, we can continue with our system. And thirdly one of the political issues was that it changed the insurance system, you can immediately see, but you can change the law and the incentives and to say we want more competition, but then you have to change the behavior and that’s a very long process so it was political problem that change of the insurance system was done by the then minister and there was opposition because that was too much public insurance and not enough market.

In the early ‘90s, we saw a sharp increase of cost and that was the sense of urgency for change, a major political issue was should it be a mandate for public or mandate for private insurance? And I’m sure that it would be and in the public system we would not have national health insurance now because of the opposition of the commercial insurance who in our opinion are very powerful, but because it was a mandate for prior insurance, they agreed, and accepted and they were previously opposed to a lot of the risky possession but they said okay, it’s more sophisticated now and let’s do it.

ED HOWARD, J.D.: Very good, thank you.

STEWART BUTLER: I think it’s clear from what the two speakers just said that political circumstance and timing is critical for any of these kinds of big changes and that has been true I think throughout European changes, like including the national health system after the Second World War and so on. That is very, very important. And I think it’s important for us to recall that.

I think when you look at the American system, as I tried to say I do think we have a useful card if you like in our system of federalism because that does allow us to try things and to demonstrate their effectiveness at the state level where you would not be able to cast the same thing at the national level. And there are certainly a lot of people who

were looking at legislation proposals to make it easier for states to experiment even further than they currently can do within some broad parameters of some kind of national objective and to internation goals, and I think that is very, very important.

I think also when you look at something like the mandate issue, as I said I think there are powerful reasons to believe in America that it's going to take a long time for there to be an agreement to move forward on that if you think it's just an essential part but when you've got ideas like automatic enrollment proposals, which basically is to say well you are enrolled unless you actively decide not to, we have a lot of evidence in this country that people just go along with that and so the same person who would fight tooth and nail not to be forced to enroll in something, actually just allows themselves to be enrolled by default.

So that, I think, tells you something about how to amend a strategy to take into account both the political structure that we have here and also just our attitudes to kind of get to the same place rather than going in the most obvious, sort of in the front door approach, which you can do sometimes if political circumstances are right, which is demonstrated in these European cases.

PATRICIA DANZON: Just to pick up and expand on this point about the state versus federal issues in the U.S., while it's true that the states give us a ground for experimentation, I think it's also true that in particular if you are doing an individual mandate it is very difficult for the states to do that, both legally they are not permitted to do that and in terms of enforcement they don't have the IRS there to enforce it and state income tax is not as far reaching as system generally and if one looks at what is happening in Massachusetts they cannot actually mandate it. They just have some rather weak penalties for people who don't obtain insurance coverage, so that's a tough one to do at the state level.

Where I think the state versus federal issue would be very difficult in the U.S. if we were to try to implement a Dutch or German system would be in the risk equalization component. Whether or not we would try to do that at a completely national level which would be the ideal in terms of risk distribution because we would be basically pooling the costs across the entire country or whether if we were to do that the differences that exist across regions just simply because of regional differences in health care costs that are not due to inefficiencies but more due to differences in cost of living and other things, would make such a single one size

fits all REF system, in fact very unequal and inefficient incentives so that is a tough one and I could see us doing that at the state level.

ED HOWARD, J.D.: May I ask and this is exposing my own ignorance, in the German and Dutch experiences, were there the kind of huge variations in the cost of care from one part of the country to the other that we have here?

REINHARD BUSSE: Well, they are not as huge as I have seen the data from the U.S. but there are clearly there and depending how your states, the boundaries are, are designed. Like I come from Berlin. Berlin is a state land of its own so if there is no rural area which clearly then has a different cost structure than certain other states and as we are also a very federal country where many of these negotiations, which I have briefly mentioned it, being the physicians and the sickness funds are on the state level.

That means that physician reiteration as developed differently and so there is also discussion how uniform the allocations from the new health fund to the sickness funds can be and where they are, especially Bavaria where people have a higher income, the physicians have higher income, whether they would lose another new reform so we have the same debates. And we try to balance that because we also needed the state's vote in our second chamber of parliament where the states are much

more directly involved as here in the U.S. because we don't have senators, we have the state governors voting in the second chamber, and they are clearly interested that it is hopefully a win-win situation for them.

WYNAND P.M.M. VAN DE VEN: You have to realize that risk adjustments, equalization payments, are affordable core subsidies from one group to another group. We started in the Netherlands with risk adjustment for age, gender, and region, and that was accepted by everybody.

In health insurance act, one of the bylaws, there is an interesting statement that only the following risk adjusters should be used, age, gender, and health status, but not region but we did calculations and region, while we are a very small country, it's plus or minus 10-percent but if we have only members in one region, [inaudible] can make a large decision but it's a political decision whether or not regions should be included as a risk adjuster.

Our Belgian neighbors also have risky possession, made the exquisite decision, North, South Belgium, not to adjust for region. That was a political decision. In the Netherlands in fact it should be logical that the community rating requirement should be replaced by community rates and by region. If the political decision is that you don't want to have redistribution among regions but only age, gender, and health

sets but it's a pure political decision. It's a subsidy system, the risky possessions.

ED HOWARD, J.D.: Okay we've got a couple of quick questions. We have about ten minutes left since we got a later start than normal in these we are running a little past our usual 2 o'clock end time, and two questions I particularly wanted to get to, one of them for Dr. Busse, can you explain and I have to say this occurred to me as well as you were speaking why civil servants are in the private insurance system in Germany?

REINHARD BUSSE: Well, because when health insurance started it was a coverage for people who needed it because it was basically today you would say it was insurance for the working poor, for the blue collar workers, initially only 10-percent of the population on who the government and acted regulation, it was then expanded to higher income employees, white collar workers, dependents.

And so on while the civil servants and we are only talking about the civil servants, the permanent public employees, were already pretty well covered when they started, because until today and as a professor at a public university I am also a civil servant, we get like 50-percent of our health care bills directly paid by our employer, the state, and we

need voluntary so far insurance we can take out for the remainder for the other half.

And so we have really the perverse situation that much of the private health insurance expenditure is actually text financed because it is for the civil servants and we have clearly the perverse situation that the people in the Ministry of Health which right legislation that they are not affected when it comes to statutory health insurance, the same by the professor sitting in expert committees and giving advice to the government, we are also not covered by this legislation so I mean it is a default. We see that around the world. Either you take the civil servants in first or they never get in.

[Laughter]

STEWART BUTLER: We have a similar pattern here and civil servants can be quite well under the system.

ED HOWARD, J.D.: And this also was originally directed to you, Dr. Busse, but Professor van de Ven, feel free to chime in. What role does the government play in deciding what is included in the benefits package, given that the decisions are going to effect government expenditures fairly substantially?

REINHARD BUSSE: Well maybe I start. The government intervention is really low. The law is social health. The social code book defines that all necessary treatment things are in. It is a bit more specific in certain prevention things

but it leaves it to the self governing actors and it's not government spending. We don't have the view in Germany that health care expenditure is government spending.

I know it is internationally classified, same as in the Netherlands, statutory health insurance is public money but we see it separately. It is not government money which deals with the sickness funds, the money is no where every under governmental control. Our Ministry of Health has the smallest budget from all ministerial budgets. Our Ministry of Health is a totally small thing. They have 400 employees in total of the German Federal Ministry of Health. The system is run outside the ministry.

ED HOWARD, J.D.: I think we have more than that at HHS. [Laughter]

WYNAND P.M.M. VAN DE VEN: In the Netherlands, government and parliament together decides what should be the benefits that should be included in that pre insurance contract but that's very rough. It's much more what kinds of cost effectiveness and quality? Twenty years ago we had a committee, the Darning [misspelled?] committee on priorities on health care and they said the criteria should be to be necessary care, efficient care, cost effective care, which cannot be left to the responsibility of the consumer. So we

have had much discussion and the Dutch population realizes we have to make choices and priorities.

There is a very subtle element in the new health insurance act that says that insurers are allowed to compete on price and quality but if you really think about what that means, that could mean that the certain procedure with the certain cost effectiveness is not covered by one insurance company but it is covered by another one. We do not see that yet but in the law that clause is included and over the next decade we will see that but that will give a lot of public discussion I can assure you.

ROBIN OSBORN: I would love to pick up on that and Professor Danzon had actually raised this before in terms of compared with effectiveness and cost effectiveness review and would really value the types here, a few comments of how IHCQE has operated in Germany and this is the Institute for Health Care Quality and Efficiency in terms of comparative effectiveness in their cost effectiveness would be what kind of impact has it had, what kind of challenges?

REINHARD BUSSE: Well in two sentences, the thing it's clearly doing is the assessment, IHCQE can not make any decision in the German system so they are commissioned by the federal joint committee and IHCQE is a foundation which is also sort of the founders of that are the sickness funds, the

physicians, the hospital federation and so they do the assessment based on the available evidence.

The Federal Joint Committee might come to a different conclusion for example if there is not enough scientific evidence then they might say okay but we still basically included in the benefit package or we demand further trials and so on so IHCQE is not deciding, it has fostered the debate on the whole effectiveness and cost effectiveness side which we previously did not have.

I mean, when you look at all the figures in the German system, we have even though it's stable we have a relatively high expenditure, almost 11-percent of GDP, but we have no rating list so it's efficient in producing the individual service but it is inefficient in a way that we produce unnecessary services and so the second idea is now brought forward by really all the services which we pay for on a necessary, appropriate and cost effective and the debate is fostered but it's not leading yet and probably not for the foreseeable future to hard rationing decisions because the federal joint committee still says that all necessary care should be paid for and cost effectiveness I think in our debate is still runged lower than in other countries.

TED CURER: Yes, Ted Curer [misspelled?], Senator Prior's office. And I'm just going to say that Stewart Butler's

comments made a lot of sense about the employer tax subsidy and I've also heard a lot of those same comments in reference to the home mortgage tax deduction.

And I guess my question is to what extent and how do you think you would start to move our policy in that direction and then to kind of tie this into an international aspect in the Netherlands and Germany, to what extent was part of the population giving something up in order to get the health reforms that went through and what made those people willing to make that sacrifice?

ED HOWARD, J.D.: Thank you. Good questions. And while you are preparing your responses, I just want to suggest to you that as many of you have, pull out those blue evaluation forms and start filling them out. [Laughter]

STEWART BUTLER: Well maybe just to comment directly on your question I guess about the tax treatment, you're actually right of course and it's true we need more reduction and so on, if we think of the tax system as a subsidy system to help people afford coverage, we are doing it completely wrong in the way we do it so a simple deduction system or tax exclusion in the case of health, how you get from A to B of course is a strictly political question.

My own feeling is that probably the best way to do that is to put some kind of high cap somewhat as the president has

proposed awhile ago and others have, too, and allow over time that to sort of ratchet down at the same time as you gradually expand more direct subsidy for lower income people through a credit, I think that's probably the only way you could do it in this country in the foreseeable future but it's a big problem. I mean we just have enormous amounts of money that we such "spend" through that tax treatment that takes away from what we are really trying to do.

PATRICIA DANZON: I would just add to that I think it's a huge problem that is relatively poorly understood. I mean, the notion and it's sort of reinforced in the OECD numbers, the massive text have to be to private insurance is not in the official OECD number for public spending on health care in the U.S.

STEWART BUTLER: Or anybody's paycheck, you just don't see it, or W2, there's just no item.

PATRICIA DANZON: It's not part of the public debate and raising the awareness of that I think is a precondition for there being the political will to change it.

ED HOWARD, J.D.: Yes and gentlemen would you like to talk about the winners and losers in your reforms that were put in place, or were there winners and losers?

WYNAND P.M.M. VAN DE VEN: Well the winners were clearly those who had a private insurance and were married with

your insured because they were not accepted by the other ones. They were happy with their consumer choice because nearly the whole population had some form of insurance. It was not that major.

The major change was the redistribution of income because the two-thirds mandatory public system the premium was way too late, up to a certain ceiling and in the one-third, the higher income, they had the risk rated premium so bringing these two groups under one regime there was a huge amount of redistribution of income but it was not only health care reforms, there were other types of reforms in the tax system, in the social security system, and nobody knew what was going on. [Laughter]

And there were new income related allowances and we have a central planning bureau and they make a lot of calculations about the redistribution for all thinkable subgroups and it was all plus or minus 1-percent, well after six months there were some small groups who were unhappy but that was repaired.

ED HOWARD, J.D.: We call that reconciliation. [Laughter]

REINHARD BUSSE: Maybe I should say I've been cleaning the privately insured but financially advanced, they had an advantage before, though as Wynand also just said as in the

Netherlands they have the disadvantaged, they have practically no choice. Once you sign up with a private health insurer, it's like I'm underwriting everybody's starts with calculating your premium upon entrance, there is basically no choice. Once you are 40 or something you cannot change.

This time they had to pay a bit more because for the mandate to private insurers to accept everybody, which means that the chronically ill and poor people who now also have a right to go to private insurance, there will be a capped premium for them which will be subsidized by the other privately insured. We don't really know yet how much that will increase the premiums but basically the costs of the universal coverage are put only on the privately insured which I think is fair because they pay a relatively small premium so far.

The insurers clearly lobbied against the reform by saying oh they would go up by 30-percent and clearly counting on the fact that the civil servants writing the law are all privately insured [laughter] but they didn't make it because also the calculations were not really convincing that premiums would go up that much and so in the end I think people have forgotten that they might from next year on would pay a bit more.

ED HOWARD, J.D.: Thank you. Robin, any final comments?

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ROBIN OSBORN: I really just want to thank our panel for what has been a fascinating, provocative and really thoughtful conversation and to thank the audience for your participation and your contribution. Great questions!

ED HOWARD, J.D.: It has been a very good experience. Thanks for filling out the evaluation forms. Let me thank the Commonwealth Fund, Karen Davis, and Robin and all of our friends from Commonwealth who have helped put this together. We will learn from this and it wasn't painful at all, was it? [Laughter] Thank you all for coming. [Applause]

[END RECORDING]