Curbing U.S. Health Care Costs: Lessons From Europe?

By Bryan Keogh

The U.S. health care system is the world’s most expensive, consuming almost 20% of the economy and forecast to swallow half within decades if current trends continue. Yet despite the hefty cost, the U.S. lags behind many countries in Europe and other developed nations for health outcomes and quality of services, according to metrics from the Organisation for Economic Co-operation and Development (OECD), such as life expectancy, mortality, and safety.

“No one would sensibly argue that we don’t have a health care spending problem,” said Peter Bach, M.D., associate attending physician at Memorial Sloan–Kettering Cancer Center in New York. Yet “there is no evidence that we provide better health care to our population as a whole than these other countries.”

Although some solutions to bending the health care cost curve, long the norm elsewhere, remain anathema to most Americans (most notably nationalized health care with a single-payer system better able to negotiate lower prices), other options with a view to offering long-term savings are gaining support. These alternatives include establishing panels that assess cost- and clinical-effectiveness in determining which drugs and treatments Medicare covers, emphasizing patient-oriented primary care, and boosting preventive care.

“Many countries have better-functioning, lower-cost health care systems that outperform the United States. We must learn from them,” concluded the American College of Physicians (ACP), which represents 130,000 physicians and medical students, in a report comparing the U.S. with other nations such as Denmark, the UK, and Germany. “The high cost of health care in the U.S. is not correlated with high quality and efficiency in the delivery of services or improved health outcomes,” the group noted the next year in another report on affordable care.

A September 2011 Lancet Oncology Commission report, “Delivering Affordable Cancer Care in High-Income Countries,” called particular attention to the high costs of cancer care. The 37 experts in the author group wrote, “Cancer care in the USA is fast becoming unaffordable except for the well insured and most affluent,” while some expenses are “unwarranted and contribute to the high cost.”

Calls for Change

The National Academies earlier this year lent its weight to calls from other organizations such as the ACP in pushing the U.S. to explicitly consider cost as a factor in determining what health benefits should be covered. In an October 2011 report, an 18-member panel set up by the Academies’ Institute of Medicine said the U.S. should create a national entity that establishes a Patient-Centered Outcomes Research Institute to develop evidence-based analyses to guide decisions on coverage and access, it won’t be able to consider cost as a factor.

“Cost-effectiveness analysis might be an option, but politically people don’t want to talk about [it],” said Ya-Chen Tina Shih, Ph.D., an associate professor of medicine at the University of Chicago and director of its program on the economics of cancer.

Donald Berwick, M.D., who managed Medicare and Medicaid until late last year, said that 20%-30% of health spending is waste that yields no benefit to patients, according to an interview in the New York Times. Others have put the waste at closer to 50%. The reasons beyond the wasteful spending include over-treatment, the failure to coordinate care, and the administrative complexity of the health care system, said Berwick, who left his post as administrator of the Centers for Medicare and Medicaid Services in December 2011. “Much is done that does not help patients at all,” he said, “and many physicians know it.”
Overtreatment and Overdiagnosis

Studies assessing the key drivers behind U.S. health care spending typically point to overtreatment and overdiagnosis—ranging from unnecessary surgeries to ineffective, yet expensive, drugs—as among the primary culprits than can be curbed to achieve a more affordable system without sacrificing quality. The Congressional Budget Office (CBO) estimated in 2008 that 5% of the nation’s gross domestic product (GDP), $700 billion, is lost just on tests or procedures that don’t improve health outcomes.

“You’re over the tipping point,” said Richard Sullivan, Ph.D., lead author of the Lancet Commission report and a professor at King’s College in London. “You can’t keep on spending at this rate. It’s just not possible while getting diminishing returns.”

Some studies make clear that without substantial changes, health care spending in the U.S. will become unsustainable within decades. Controlling the skyrocketing costs of health care is also essential to the ability of the U.S. to tame its $15 trillion debt, according to Peter Orszag, Ph.D., a former director of both the CBO and the White House’s Office of Management and Budget.

At about 17.4% of GDP as of December 2008, health care is expected to consume 25% of the U.S. economy by 2025 and 49% by 2082, the CBO said in a report. The cost of cancer care alone could jump to $173 billion in 2020, from an estimated $124 billion in 2010. Among developed countries, France and the Netherlands come closest to the U.S., each at about 12% of GDP, with Germany at 11.6% and the UK at 9.8%, according to the OECD. Americans spend about $8,000 per capita, at least about 50% higher than each of the other 33 OECD members.

Price is a key driver behind the surging spending in relation to that of other countries. People in the U.S. simply pay more for the same drugs and MRIs, Bach said.

“If you look across the board, you really can’t find a type of health care service where we don’t pay more in real terms than most other countries for that same service,” he said. “Our doctors make more. Our nurses make more. The average fully loaded hospital bed day costs more than twice the OECD average.”

Dissatisfaction With Services

The most expensive system in the world gets poor marks from its users. In a 2010 international survey by the Commonwealth Fund, 68% of Americans polled said the U.S. health system needs “fundamental changes” or should be “completely rebuilt,” with just 29% saying the system works well. Among the 11 developed countries the fund analyzed, only Australia had a larger percentage of respondents expressing such dissatisfaction with their health care system.

OECD data show that, in a reversal from several decades ago, citizens of every Western European country live longer than Americans and have lower infant mortality rates, whereas the U.S. has among the fewest physicians, hospital beds, and doctor consultations per capita. According to the Commonwealth Fund, among 11 high-income countries, Americans report the highest rates of obesity and mortality amenable to health care, as well as the largest percentage of the population experiencing access barriers due to cost. The U.S. also has the second-highest percentage of incidents of medical, medication, or lab test errors over a 2-year period, at 18%.

The Commonwealth Fund’s latest national health scorecard gave the U.S. 64 out of 100, on the basis of the fund’s 42 indicators of health care performance comparing national averages with benchmarks of best performance achieved internationally and within the U.S. In 2000, the World Health Organization ranked the U.S. 37th among 191 member states assessed. France topped the list.

Also, almost 50 million, or 16% of the U.S. population, are uninsured, and another 29 million are underinsured, with high out-of-pocket expenses in relation to their income, according to the Commonwealth Fund. That finding contrasts with universal coverage throughout Europe. Out-of-pocket spending here comes to about $976 per capita annually, second only to Switzerland among OECD countries.

The lack of benefit from the extra spending shows why it’s worth looking at other countries with the same or better quality at much more affordable costs, considering best practices that can restrain the unsustainable climb without worsening outcomes or denying care to those who need it simply because of cost.

“We are still in a situation where we’re putting off the hard choices is the least noxious option,” said Bach, who wrote an article titled “How Medicare Could Use Comparative Effectiveness Research in Deciding on New Coverage and Reimbursement” in the October 2010 Health Affairs. “Right now it’s less noxious to just pretend in a sense that this isn’t happening.”

LESSONS FROM EUROPE

Cost-Effectiveness: UK

In most health systems outside the U.S., factoring cost-effectiveness into decisions about what drugs and treatments are covered is more common; the centrally planned systems simplify the task. The UK is a leader in this practice, with NICE, its National Institute for Health and Clinical Excellence, which since 1999 has balanced the financial costs and clinical benefits of health treatments to evaluate their cost-effectiveness. NICE offers advice to other countries through an international division, making it the de facto expert institution for nations such as the U.S. looking to make cost-effectiveness a part of the process, the Lancet Oncology Commission wrote.

Primary Care: The Netherlands

The Netherlands’ recently restructured health care system “provides virtually everybody with high-quality and convenient medical care, and at a much cheaper price than the U.S. system,” and its reliance on private insurance to achieve those goals made it a template Obama Administration officials looked at when developing the Affordable Care Act, Jonathan Cohn, author of Sick: The Untold Story of America’s Health Care Crisis—and the People Who Pay the Price, wrote in October for the Commonwealth Fund. Cohn, also a senior editor at the New Republic, credits the close relationship the Dutch have with their primary care physicians in explaining why the Netherlands ranks high on quality, such as measures of chronic care. The ACP argues that health
Care systems with accessible primary care as the point of entry for all individuals may offer the best guarantee for clinically effective care and greater value. "As Americans move from debating health care reform to implementing it, they would be wise to keep studying the Dutch system," Cohn wrote.

**Technology and Clinical Benefit: Germany**

Although new technology is improving physicians' ability to diagnose cancer, make prognoses, and select therapy, the costs of tools such as computed tomography, positron-emission tomography, and magnetic resonance imaging are soaring at twice the cost of cancer care, according to the Lancet Commission. The U.S. often adopts new technologies quickly, before conclusive evidence shows they're more effective than current or previous tools and worth the expense, Shih said. "The system is not designed to try to cut costs," she said. Germany's health care system, the world's oldest, founded in 1883, finances only technology that has proven, relevant benefits and for which no similar or clinically beneficial alternative is less costly exists, according to the ACP. While considering cost as a secondary factor in technology use, as well as other types of treatments, Germany places a priority on clinical benefit to patients.

**Electronic Medical Records**

Better use of electronic records is another way the U.S. could curb costs fairly quickly. About 46% of primary care physicians use electronic medical records, compared with 96% in the UK, 99% in the Netherlands, and 97% in Norway, according to the Commonwealth Fund. The main problem is the cost of adopting the system. Requiring hospitals and physicians who participate in Medicare to use electronic records, for example, would reduce federal deficits by about $34 billion over 10 years, according to the CBO. The Affordable Care Act includes provisions to encourage more use of such records in the U.S.

**Palliative Care**

The economic burden of metastatic breast cancer amounts to $9,788 per month per patient on average, and as high as $30,000, for a total estimated cost of $250,000 over a typical 2.2-year life duration, according to an analysis of 7,698 patients aged 18–64 years written by Alberto Montero, M.D., assistant professor of medicine at the University of Miami's Sylvester Comprehensive Cancer Center. End-of-life costs for breast cancer patients could be lowered if doctors incorporated palliative care earlier in the treatment, as they commonly do in Europe, he said. A May article in the New England Journal of Medicine on making cancer treatment more affordable suggested that better-integrated palliative care could prolong patient survival while cutting costs, citing two trials that showed a savings of more than $4,800 per patient. In a 2010 report, the Economist Intelligence Unit published a "quality of death" index that ranked the UK as having the best end-of-life health care services. The U.S. ranked ninth, behind Ireland, Belgium, and Austria. "One of the important ways we could bend the cost curve is to integrate palliative care early on and not give patients costly chemotherapy in the last years of life," Montero said. In the European model, he said, "they integrate palliative care a lot earlier."

**Universal Health Care With Private Opt-Outs: France**

France's two-tiered health care system, which covers all residents while encouraging use of private insurers offers a useful example for how the U.S. could achieve universal coverage while "maintaining the principles of our capitalistic society," according to the ACP. France, which spends 11.8% of its GDP on health care, mixes public and private financing, helping maintain competition while not restricting patient choices. Up-front payments when services are used help discourage overuse, and private insurance bridges gaps as needed. France's health care system scores high marks from its users and boasted the lowest mortality rates among 16 high-income countries in a Commonwealth Fund report. The U.S. ranked worst.

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PDQ (Physician Data Query) is the National Cancer Institute’s source of comprehensive cancer information. It contains peer-reviewed, evidence-based cancer information summaries on treatment, supportive care, screening, prevention, genetics, and complementary and alternative medicine. The summaries are regularly updated by six editorial boards. The following PDQ summaries were recently updated:

The PDQ Genetics of Prostate Cancer summary was recently updated to include an expanded section on genome-wide association studies (GWAS). The section includes an overview of GWAS and a description of candidate genes and susceptibility loci that have been identified through GWAS. The clinical applicability of these findings and potential insight into the mechanism of prostate cancer risk are also discussed. To review the summary, please use the following link:

http://www.cancer.gov/cancertopics/pdq/genetics/prostate/healthprofessional/allpages#Section_513

The PDQ Cancer Prevention Overview was recently updated to include a section on immunosuppression stating that medications that suppress the immune system, such as in patients undergoing organ transplantation, are associated with an increased cancer risk. To review the section, please use the following link:

http://www.cancer.gov/cancertopics/pdq/prevention/overview/HealthProfessional#Section_97

The PDQ Cervical Cancer Screening summary was recently updated to include