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Report to the Chairman, Committee on Ways and Means, House of Representatives

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U.S. HEALTH CARE SPENDING

Trends, Contributing Factors, and Proposals for Reform

GAO/HRD-91-102

GAO

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Comptroller General
of the United States

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The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

This report contains testimony presented to your Committee on April 17, 1991. (See app. I.) We are publishing the statement as a report to make the information more widely available. The testimony responds to your request for information on health care costs in the United States as well as on long-term strategies for reform of the U.S. health care system. In short, we discuss U.S. health spending trends; their effects on business, government, and individuals; factors contributing to rising expenditures; and a comprehensive approach to reform.

In 1990, the United States devoted 12.3 percent of its national income to health care spending. If present trends continue, in 10 years health care's share of national income will climb to nearly 15 percent. This growth will add $300 billion to national health spending in the year 2000, an amount equivalent to the current defense budget.

The chronic rise in health care spending affects businesses, all levels of government, and individuals. For example, in 1987 U.S. corporations spent on their employees' health care an amount equivalent to roughly 94 percent of their after-tax profits. Similarly, state government spending on the Medicaid program—which pays for health care for some low-income citizens—has grown faster than all other components of state budgets.

The persistent increases in health spending have many causes. The aging of the population and the rise in family incomes have led people over the past two decades to both want and buy more health care. Likewise, technological advances in treatments and in diagnostic procedures have stimulated the demand for more care, while often raising the cost of such care. These demand- and cost-increasing factors, undergirded by the ready source of funding provided by public and private insurance benefits, have fueled the escalation in health spending.

Businesses, state governments, and the federal government have tried a wide range of piecemeal cost-containment strategies over the past decade. Some efforts failed; others achieved limited success that

restrained expenditures for only one payer (for example, a business or a state). This experience suggests that, if the United States is to slow the rapid pace of health care spending by all payers—public and private—the nation must develop a comprehensive strategy that affects the entire spectrum of health care payers and services.

Policies to constrain health care spending have been relatively successful in several other industrialized nations, and these policies suggest an approach to reform that the United States should consider. The health care systems of countries that have restrained spending share three elements: insurance coverage of all citizens, uniform policies governing payments to providers, and enforceable spending targets.

We have several studies underway that may be helpful to the Congress as it considers proposals to reform the U.S. health care system. We will be issuing two reports this year on foreign health systems, and we will continue to work with the Congress as it seeks to solve the pressing problems of U.S. health care access and spending.

This report was prepared under the direction of Janet L. Shikles, Director of Health Financing and Policy Issues, who may be reached at (202) 275-5451 if you or your staff have any questions. Other major contributors are listed in appendix II.

Sincerely yours,

Charles A. Bowsher
Comptroller General
of the United States

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Abbreviations

FASB	Financial Accounting Standards Board
GAO	General Accounting Office
GNP	Gross National Product
HMO	health maintenance organization
MRI	magnetic resonance imaging
PPS	Prospective Payment System

Statement of Charles A. Bowsher, Comptroller General of the United States, Before the House Committee on Ways and Means, April 17, 1991

I am pleased to be here today as you examine health care financing from the standpoint of the federal government and the nation. I believe that, in the 1990s, problems of our health care system and the need for its reform will be among the most serious issues facing the Congress.

You have asked me to discuss U.S. health care spending and what makes it such a significant matter of national concern. I want to review the dimensions of the problem, its implications for payers and patients, and the avenues our nation might explore to solve it.

GAO's analysis of this issue leads me to conclude that piecemeal reforms, whether undertaken by business or government, are unlikely to reduce the growth of national health spending substantially. No individual sector can solve its spending growth problem on its own. I believe that if the United States is to succeed in slowing the spending spiral in health care, its reform must be comprehensive. In designing our reform, we should consider three elements of the approaches used in several countries that have been relatively successful in restraining health care spending. These elements include: (1) insuring each individual, (2) instituting uniform payment rules for health care services, and (3) setting caps on total expenditures for major provider categories, such as hospitals, physicians, and technology.

Background—The Rapid Rise in U.S. Health Care Spending

The United States has a serious problem with health care spending, but that problem coexists with the notable achievements of U.S. medicine. Because these achievements provide a backdrop to the spending issue, they are worth enumerating. American medicine is a magnet for the rest of the world: physicians and medical students are drawn to our teaching hospitals and medical schools to learn the most advanced medical procedures; patients seek out state-of-the-art treatment from our premier medical centers and specialists; and policymakers travel across our country, learning about innovative methods of delivering care. Americans often share foreigners' admiration for the technological prowess and clinical skill of U.S. physicians and hospitals. Not only are Americans grateful for CAT scans and other high-tech marvels, when surveyed

they typically express satisfaction with the care they themselves receive.[1]

With such perceived medical achievements and such patient satisfaction with care, how can so many observers view our health care system as flawed or even in crisis? I believe that they consider the flaws in U.S. health care to be less medical than financial: it is the costs of medical services—weighed against their value and the number of people denied ready access to care—that cause concern.

The problem with the U.S. system of health care financing begins (though it does not end) with one fact: The United States leads the world in health care spending. In 1990 we spent on health care $671 billion, or $2,660 per person. By contrast, Canada—the second highest spender on health care—spent less than $2,000 per person. In 1970, U.S. health care absorbed only about 7.4 cents of each dollar of national income.[2] In the same year, Canada's health care took about the same share of its income. By 1989, though, U.S. health care required about 11.6 cents of each dollar of national income, whereas Canadian health care absorbed only about 9 cents. If U.S. spending on health care, relative to our national income, had increased only as fast as Canada's, the United States could be devoting today over $140 billion to other uses. This sum is equivalent, for example, to over 40 percent of all national outlays on education.

All signs point to our continuing to have the highest level of health spending. In 1990, over 12 cents out of each dollar of U.S. national income was used to buy health care services—and this fraction is growing. Every 40 months, the health care portion of each dollar of GNP goes up by a penny. In 10 years—120 months—the United States will spend, the Department of Health and Human Services projects, nearly 15 cents of each dollar of GNP on health care. This growth will add $300 billion to national health spending in the year 2000, an amount equivalent to the current defense budget.

[1]In a recent survey by the Employee Benefits Research Institute and the Gallup Organization, 56 percent of the respondents characterized the U.S. health care system as "fair" or "poor." Their view of the care provided by their own family physicians was dramatically more favorable: 92 percent of those with family physicians—an important proviso—said the care they receive is "excellent" or "good." "Health Costs," Wall Street Journal, March 27, 1991. See also Robert J. Blendon, Robert Leitman, Ian Morrison, and Karen Donelan, "Satisfaction with Health Systems in Ten Nations," Health Affairs, Summer 1990, pp. 185-192, and Cindy Jajich-Toth and Burns W. Roper, "Americans' Views on Health Care: A Study in Contradictions," Health Affairs, Winter 1990, pp. 149-157.

[2]The measure of national income is Gross National Product (GNP).

Rising Health Care Outlays Are a Major Problem for Business

Those trends strongly affect the financial condition of all participants in the system. Individual households are affected, as well as the large institutions (businesses, governments, insurers) that pay for individuals' insurance and reimburse providers.

For businesses, rapid increases in health care spending overall have meant that their outlays on health insurance have risen quickly, too.[3] Over the past two decades, this fringe benefit has been the most rapidly growing component of labor compensation. A Foster Higgins survey of larger businesses found that, between 1989 and 1990, average health care outlays rose 21.6 percent; these businesses, whose health plans cover 11 million employees, had medical plan costs averaging $3,161 per employee.[4] (General Motors alone spends over $3 billion per year on health care.) In 1987, employee health care costs paid by U.S. corporations were the equivalent of more than 94 percent of total after-tax corporate profits.

Employers have responded to large and rising outlays by trying to shift more of the explicit cost of health insurance and health care to their employees: the share of employees holding policies that require deductibles of $100 or more rose more than fivefold between 1980 and 1988.[5] Many businesses have decreased their insurance coverage for employees' spouses and children. Increasingly, firms do not offer health benefits to workers who are part-time or temporary. Not surprisingly, labor disputes in the past decade have often centered on health care benefits and insurance premiums. Of all labor disputes in 1989, for example, 78 percent involved health benefits.[6] Highly publicized disputes include the Communications Workers' strike in response to NYNEX's attempt to raise employee contributions for their health coverage.

[3]Health outlays have more than doubled as a share of total labor compensation (i.e., wages, salaries, and fringe benefits): from 3.1 percent in 1970 to 7.0 percent in 1989. Note, though, that the business share of total health spending has scarcely changed during the past decade. See Congressional Budget Office, Trends in Health Expenditures by Medicare and the Nation, January 1991. The increase in health's share of labor compensation reflects rising health care costs, but not a larger role for business in health care financing.

[4]A survey by the Health Insurance Association of America found a lower rate of increase—on the order of 15 percent annually.

[5]From 8 percent in 1980 to 44 percent in 1988. See Employee Benefit Research Institute, Issue Brief, Number 100, March 1990, p. 6. Our report, Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 22, 1990), discusses responses by insurers and employers to cost increases.

[6]This figure applies to the first 10 months of 1989. Employee Benefit Research Institute, pp. 16-17.

Businesses have also felt the pressure of health spending increases on their ability to pay for the benefits due their retired employees. A business that, 15 or 20 years ago, promised its employees health benefits when they retired is surprised now by the heavy financial burden that it must shoulder to keep its promise. In a recent example that triggered a protracted labor dispute, the Pittston Coal Company canceled health and pension benefits for disabled and retired miners and their dependents. Moreover, business financial statements will contain next year a dramatic sign of health spending's impact: Under a recent ruling of the Financial Accounting Standards Board (FASB), employers will be required, after 1992, to report the estimated future cost of retirees' health benefits. That is, the unfunded liability of benefits already promised to retired employees but previously unrecorded on financial statements will suddenly be put on the books. GAO has estimated this liability at $227 billion (in 1988 prices).[7]

Faced with this information, some firms have sought to extricate themselves from past promises—that is, to cut benefits. For example, AT&T recently has imposed caps on retirees' health care bills. Other businesses in shaky financial condition may find that, after this FASB rule, bankruptcy is a more likely option than before.

Most large and medium-sized firms continue to offer health benefits to their permanent, full-time employees. For small businesses, though, the situation is changing markedly. Health insurance coverage of small businesses' employees has suffered, as individual insurance companies have responded vigorously to the growth in health care spending.

This spending growth increased the average size of patients' claims that insurers had to pay and spurred insurers to change their methods of doing business. Until the 1950s, insurers established premiums based on "community rating." That is, when an entire community's claims experience was used to set rates, insurers could rely on the law of averages: Claims of high-cost patients would usually be offset by those of low-cost patients. Today, many medium and large employers are "self-insuring"—in effect becoming their own insurance company. As bigger employers self-insure, smaller businesses increase as a proportion of the private insurance market.

[7]Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (GAO/HRD-89-51, June 14, 1989).

As insurers have competed for the better health risks in the population, risk pools have narrowed. In some cases, the employees in an entire industry (e.g., foundries, barber and beauty shops) are denied coverage by a particular insurer, because the workers' current or future health status is judged too costly. In other cases, a specific business may drop insurance coverage for its employees because one worker incurs unusually high medical bills, which in turn drives up premiums beyond a level that the business can afford. Finally, even in small businesses that receive insurance coverage, insurers' exclusion of payment for preexisting medical conditions can lead individuals with costly claims to be denied coverage. These changes for industries, specific firms, and individuals contributed to the growing population of individuals lacking privately provided health insurance. (Between 1980 and 1988, the number of individuals covered by private insurance fell by about 5 million.)

Large Increases in Federal and State Health Care Outlays Squeeze Health and Other Programs

Rapid health spending increases are also aggravating the budget difficulties of both state and federal governments. For example, state government budgets have been squeezed by rising expenditures on Medicaid—the fastest growing component of state budgets. The Medicaid program, which pays for acute and long-term care for the eligible poor, has increased by about half, relative to state finances, in recent years. The National Governors' Association reports that Medicaid, which in 1980 took 9 percent of state budgets, now absorbs 14 percent.[8] A number of states have continued to pay for rising Medicaid expenses, but have financed part of the increases by reducing spending on other health services. In addition, various states have tried to reduce the rate of increase in Medicaid spending by cutting benefits, tightening eligibility, and reducing reimbursements to providers.

Federal outlays account for almost 30 percent of all U.S. health expenditures, and increases in these outlays have aggravated the severe budgetary difficulties facing the U.S. government.[9] Since 1980, health spending has been the second fastest growing component of the federal budget—only the interest costs of our mounting public debt have risen more quickly. As a result, health spending now accounts for 14.4 percent of the federal budget, up from 10.7 percent in 1980.[10] The extra

[8]Rising national health spending is not the only source of rising Medicaid expenditures. An increase in federally mandated benefits has also led the states to increase spending.

[9]Our report, The Budget Deficit: Outlook, Implications, and Choices (GAO/OCG-90-5, Sept. 12, 1990), discusses the role played by the health care sector in the federal fiscal situation.

[10]7.6 percent in 1970.

$55 billion reflects both an increase in beneficiaries and an increase in costs per beneficiary.

As federal health outlays have risen, Medicare—the largest federal health program—has increased its budgetary importance.[11] In 1980, Medicare outlays represented 54 cents of each federal health dollar; in 1990, Medicare took 61 cents. Continuation of this trend in Medicare outlays endangers the Medicare Hospital Insurance Trust Fund. Looking to the future, the Advisory Council on Social Security projects that the trust fund will go bankrupt in the year 2006.[12]

The pace of increases in federal health spending serves as yet another warning of the pressures that work against a long-term resolution of the federal budget dilemma. Total federal spending in 1990 would have been about $50 billion less if health spending during the 1980s had grown only at the average rate of increase for all federal outlays.

Growth in Numbers of Uninsured—Persistence of Inadequate Health Outcomes

From almost any perspective, our health care expenditures are large, but what do we get for this level of expenditure? Although the quality of services delivered is considered to be generally good to excellent, many of those services are unnecessary or not worth their cost. In addition, millions of Americans lack adequate care.

As I suggested at the outset of my testimony, the quality of medical services delivered today in the United States is in many respects high, and higher than, say, 20 years ago. For example, compared to earlier treatments for glaucoma, laser microsurgery offers better results, while sparing the patient much discomfort and inconvenience. Advances in diagnostic technology, such as magnetic resonance imaging (MRI), often free patients from the need to undergo invasive surgery simply to obtain an accurate diagnosis.

Nonetheless, Americans who are insured probably also are "overserved": they receive some procedures and tests that are unnecessary or of marginal benefit. For example, recent studies—in the Journal of the

[11]See our report, Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

As for Medicaid, its share of the federal health dollar has also been rising, although more slowly than Medicare's. Other federal health programs have shrunk in relative importance in the budget.

[12]Advisory Council on Social Security, Press Release, Thursday, March 14, 1991, p. 3. The projection was issued by the Advisory Council's Health Technical Panel.

American Medical Association and elsewhere—report that, for various procedures, many of those performed are inappropriate: 14 percent of coronary artery bypasses, 20 percent of pacemaker implants, and 32 percent of carotid endarterectomies.[13]

By contrast, many of the 31 million-plus Americans who are uninsured have the opposite problem: lack of insurance means receiving less care, less timely care, and lower quality care than received by the insured.[14] For example, a low birthweight baby, even if born to an uninsured mother, may get good or even superb neonatal care. But the need for such sophisticated care might have been avoided if the mother had received timely (and relatively inexpensive) prenatal care. More generally, the problems with care for the uninsured point to a more general, critical deficiency in converting our huge health care resources into top-quality health outcomes for everyone: our record on infant mortality does not meet expectations set by our own history (improvement in infant mortality has slowed significantly in the past decade, compared to the 1970s) nor those set by the record of other industrialized countries (in terms of infant mortality rates, the United States ranks 22nd).

Factors Contributing to Rising Health Care Expenditures

The prospect of health care consuming an ever-rising fraction of U.S. national income raises two questions: Why does health care spending increase so rapidly? And why is that spending increase unlikely to stop of its own accord?

Health care spending has grown faster than national income for the past two decades (indeed, for the past four decades), but no single factor explains why. Moreover, no one can provide a precise accounting of the

[13]A carotid endarterectomy is a surgical procedure performed on the principal artery in the neck.

Studies of inappropriate procedures include C. Winslow and others, "The Appropriateness of Performing Coronary Artery Bypass Surgery," Journal of the American Medical Association, 260(4), July 22/29, 1988, pp. 505-509. A. C. Enthoven, "What Can Europeans Learn From Americans?" Health Care Financing Review, 1989 Annual Supplement, pp. 49-63, provides additional citations.

[14]A recent study by Georgetown and Johns Hopkins University researchers found that "the actual in-hospital death rate was 1.2 to 3.2 times higher among uninsured patients" for 11 of 16 demographic categories. Jack Hadley and others, "Comparison of Uninsured and Privately Insured Hospital Patients," Journal of the American Medical Association, 265(3), January 16, 1991, p. 374.

many, often hard-to-quantify factors at play.[15] In any case, for understanding spending increases overall, it is helpful to separate the major influences into two groups:

First, several factors push on the health care sector from the outside: Increases in income, for example, lead people to want and buy more health care, as they seek longer and healthier lives. Similarly, the aging of the population adds to health spending; older people tend to incur double the health expenses per person of the young and middle-aged.[16]

Second, processes at work within the health care sector give health spending an additional momentum.

- Medical care prices increased 44 percent faster than consumer prices over the past two decades. One reason is that wages increase more quickly in the health care sector than in the rest of the economy. Shortages of nurses exemplify the market conditions pushing up wages. Physicians' net incomes have also risen, between 1977 and 1987, about 27 percent faster than the average earnings of private, nonfarm workers. Another reason for rising medical care prices is the slower increase of productivity in health care than elsewhere. Health care, like other service industries, is relatively labor-intensive, and new medical technologies often do not reduce labor requirements. Sometimes, in fact, new technologies call for more labor, or more expensive labor.
- Rapid advances in medical technology often improve quality, but may require equipment that carries a big price tag as well. Examples include advanced diagnostic equipment and radiation therapy equipment. The steady stream of new procedures and services tends to add, year by year, to health care spending.
- Technological advances have sometimes led hospitals to participate in a medical "arms race," as they seek to keep patients and doctors from shifting to rival hospitals. A recent example of high-tech escalation has been reported in the county containing Altoona, Pennsylvania: a hospital and a group of radiologists each have acquired MRI machines.[17]

[15]Nonetheless, researchers are continuing to investigate sources of health spending growth. For example, GAO is analyzing the reasons for the increase in costs of hospital care, and expects to issue a report to the Committee later this year.

[16]The typical household headed by someone over 65 spent $2,099 on health care in 1988, while the typical household headed by someone under 65 spent half that amount ($1,089).

[17]The Philadelphia Inquirer, July 30, 1990, and The Washington Post, November 16, 1990. In conversations with state officials and others, GAO has been able to check on key facts in these news reports.

Another MRI also serving Altoona residents is nearby in the next county. As a result, a small area has three sophisticated diagnostic machines, each costing $1.5 million or more. With these machines, physicians apparently performed more MRI scans per resident than were done in Philadelphia and many other hospitals in the state.

These technological advances and other cost-increasing factors propel spending upward—because for each new service, somebody pays. In recent years, that somebody is the third-party payer—business, government, and private insurers. Private and public health insurance provide deep pockets that surely have facilitated the escalation of health care spending in the United States.

Past Incremental Initiatives Had Little Success—Piecemeal Reform Is Unpromising

The medical marketplace is unusual and complex. The many facets of health spending increases, and the chronic nature of the problem, have led businesses, state governments, and the federal government to undertake numerous initiatives. Many of these efforts have failed; some have had success in restraining spending growth for an individual payer—a business, a state government, or the federal government. No private effort, no state initiative, no federal policy—nor the sum of all these piecemeal initiatives—has slowed the growth of overall national health spending substantially and over the long haul.

Based on this experience, I believe that further piecemeal reforms will also be disappointing; that is, they are unlikely to reduce the growth of overall health spending significantly. Furthermore, no individual sector can solve its spending growth problem on its own. In particular, the federal government cannot restrain increases in its own health spending permanently—and yet maintain benefits and access—if the rise in health spending by other payers continues unabated.

Several examples make the point:

- Businesses have reduced or eliminated health benefits to employees, thereby cutting the businesses' own expenses. Such benefit reductions do not reduce overall health spending, because they tend to shift the burden to employees or to governments, who then must pay for the uncompensated care of uninsured workers or extend coverage to them through public programs.
- Since the 1970s, businesses have sought to contain their health care outlays by turning to managed care approaches, including health maintenance organizations (HMOs). In theory, managed care reduces

unnecessary and uneconomical services by having an organization "manage," or regulate, all the care a patient receives—from specialists as well as a family physician. Businesses' use of managed care is unlikely to contain overall health care spending in the future, for three reasons: First, managed care has sometimes achieved one-time savings, but whether it moderates the upward trend of spending is debatable.[18] Second, managed care seems unlikely to cover a large enough proportion of Americans during the next decade to moderate the upward trend of health care spending overall. Currently, HMOs cover only 8 percent of Americans.[19] Third, managed care does not seem to restrain those forces that increase overall health care spending but that originate outside the managed care population—e.g., medical "arms races."

- States' reductions in Medicaid reimbursement rates cannot slow the increase in national health spending over the long run. A sustained policy of Medicaid rate reductions would shift low-income, acute care patients out of Medicaid and into charity care that other payers must subsidize.[20] Consequently, Medicaid rate reductions would not reduce overall health spending commensurately. Moreover, this Medicaid rate policy would not significantly alter the trend increase in overall health spending.
- Medicare, since soon after its inception, has struggled to contain spending increases. Compared to federal cost-containment initiatives in the 1970s, recent reforms of Medicare reimbursement seem to have been more successful. In particular, the Prospective Payment System (PPS) for hospitals—instituted in 1983—revamped Medicare's method of setting reimbursement rates and has slowed the increases in Medicare's hospital spending. PPS may have restrained overall hospital spending growth as well.

[18]William Custer, "Health Care Costs and the Quality of Health Care," Employee Benefit Research Institute, Sept. 28, 1989, p. 13. Karen Davis and others, Health Care Cost Containment (Baltimore: The Johns Hopkins Press, 1990), p. 223.

[19]Karen Davis and others, p. 222, estimates that an upper bound for HMO enrollment in the population is 25 percent.

Managed care is sometimes defined more broadly to include any effort at providing oversight by third-party payers over the delivery of medical services. For example, utilization review, which involves insurers challenging providers' decisions to undertake specific procedures (e.g., coronary bypass surgery), has become increasingly prevalent. The effectiveness of utilization review has not been extensively researched, but the current evidence is at best mixed. See Custer, pp. 9-10.

[20]The level of Medicaid reimbursement rates (relative to the prevailing rates of Medicare and private insurers) has been low, historically. See Physician Payment Review Commission, Annual Report to Congress, 1991, April 1, 1991, for current data. As a result of these low relative rates, provider participation in Medicaid has been limited. This limited participation has reduced beneficiaries' access to acute care—in settings other than emergency rooms and clinics.

Even these achievements, though, have not brought about a major moderation in the trend of national health spending. The reasons are by now familiar: first, hospitals appear to have shifted costs from Medicare to private payers willing to reimburse them at higher rates. Second, PPS seems to have spurred the movement of procedures—and hence spending—from hospitals (inpatient care) to other medical facilities (e.g., outpatient surgery centers). The impact of the PPS reform on the trend of overall hospital spending is almost inevitably limited, because of PPS's restricted scope—the Medicare system and spending on hospital inpatient care.

These experiences of business and government payers demonstrate that pressing the balloon of health care spending in one spot results in the balloon bulging out elsewhere. Spending control initiatives that are limited to one payer (or subset of payers) or to one category of services (e.g., inpatient care) will have limited effect on overall spending. Providers can shift costs from less generous payers to the more generous ones; payers themselves can seek to avoid covering people who are bad health risks, thereby unloading the burden of uncompensated care onto the rest of society. Finally, piecemeal initiatives tend to leave untouched the full set of forces that give health care spending its momentum.

The U.S. Health Care System Needs Comprehensive Reform

This record suggests to me that if the United States is to be successful in slowing the spending spiral in health care, it needs to develop a comprehensive set of reforms to its health care system. As part of this effort, the United States should consider strategies that other industrialized countries have employed.

Other industrialized countries differ in whether they rely on a single public insurer or a mix of public and private insurers, and all have struggled to contain health spending. The more successful examples of cost containment appear to be where countries have employed a framework with three common elements:

- First, all citizens are covered by insurance. No one in these countries lacks insurance.
- Second, where more than one insurer is involved, all payers, whether public or private, play by essentially the same rules. That is, uniform policies are established for: who is eligible for insurance coverage; what services are included in the benefits package; what rates of payment are allowed for providers; and which procedures are used to file claims.

Consequently, from the perspective of physicians and hospitals, it typically makes little difference which payer covers a particular patient.

- Third, some of these countries make explicit decisions about the amount they will spend in major health care sectors. That is, these countries often set a target for all spending on a specific category of services. For example, in Canada, the provincial governments negotiate a fixed budget for each hospital. The hospital has to determine how best to provide care while living within this budget. As another example, Germany has controlled expenditures on physicians by establishing a schedule of fees for each type of physician service, and by setting a target for overall spending on physician care. If physicians increase the number of services they provide, and expenditures threaten to exceed the target, the fees are reduced so that actual spending stays within the target.

In each case, the country has been able to offer a broad range of health care services to all of its citizens while spending substantially less per capita than the United States does.

I believe that if the United States is going to be serious about broadening access and containing health care spending, we must adopt a framework that allows us to pursue strategies like those now in place in these other countries. The particular approach best suited to achieving these goals in our country will be developed through debate and must be consistent with American culture, political traditions and institutions. Nonetheless, in designing our reform, we should consider the three elements just discussed:

- insure everyone;
- establish policies and procedures for provider reimbursement so that all payers—public and private—follow uniform rules; and
- cap total expenditures for major categories of providers and services (including physicians, hospitals, and new technology).

In the United States, such an approach could help restrain the escalation in health care spending and free resources for other important uses. If this approach slowed the annual growth rate of federal health care spending by one-third, we have estimated that more than $125 billion would be saved over the next 5 years for the federal government alone.[21]

[21]This calculation of cumulative savings assumed that, without effective restraint, federal spending on health care would continue to grow at its average rate between 1980 and 1990—that is, at 10.5 percent per year.

GAO has underway several studies on spending control strategies that the Congress will be able to use as it considers proposals to reform our health care system. Two reports will focus on foreign countries that employ frameworks similar to the one I described earlier. One report will examine health care in Canada, which provides universal insurance through a system managed by the provincial governments. A second report will analyze the recent spending control efforts in the German and French systems. In addition, we will be reporting on U.S. experiments at the state level with policies (for expanding access and restraining hospital rates) that resemble some of the foreign approaches.

I believe that health care is at the forefront of the domestic agenda. I look forward to working with the Congress to address these important challenges successfully.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

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