

The European Experience: Basis for U.S. Reform?

**Many Countries Offer Models, but Everywhere
the Key is Controlling Costs**

Reform of the American health care system might be likened to caring for a chronically ill patient with multi-organ failure, one who has continued to indulge in the kind of unhealthy behavior that made him sick in the first place. The chronic disease is equivalent to the continued downward drift of U.S. health care, due mostly to ideological differences that have thwarted substantial reform for decades. The multi-organ failure consists of the 45 million uninsured, the steady decline of employer-based health insurance, and the constant rise in out-of-pocket expenses for insured people and Medicare recipients alike. The unhealthy behavior consists of the excessive consumption of ever more expensive medical technologies — many of them with only marginal benefits.

What makes a solution especially daunting is that each of this country's systemic pathologies not only needs to be cured for its own sake; all must be cured together. Health care costs are rising at an annual average of 7 percent,¹ with a projected bankruptcy of Medicare in a decade or so,² and a doubling of overall expenditures in the same time frame, from \$2.1 trillion to \$4 trillion.³ Costs cannot be controlled without universal care, which cannot be achieved without a successful ideological *rapprochement* between government-inclined and private sector-inclined advocates. Neither can be achieved without a different vision of medical progress, one based on appropriate goals and limits of health care. Nothing,

I believe, is more noxious than the combination of an excessive drive for medical progress and technological innovation — unlimited in its aspirations to cure all diseases and relieve all suffering — and an organization of health care that aims for economic profit in the pursuit of health, as if these were perfectly compatible aims.

Are there some different organizational models and visions of health care we might look to for answers? The most obvious are those in European countries and Canada. Most have devised ways of dealing with the organ collapse that afflicts the U.S. system. Yet, a longstanding resistance toward reform based on other countries' programs continues in this country. Some on the conservative side see in these programs the ogre of "socialized medicine," a term politically designed to appeal to the anti-government, anti-socialist thread that has long run through our nation's culture (though, notably, no one has ever referred to the government-run Department of Defense as "socialized defense.>"). Some others have difficulty imagining how systems devised in countries with cultures, politics and histories different from our own could be transferred to the United States. Still others regard the successes of other cultures and traditions with indifference, as if nothing but a native-grown system would be suitable for the United States.

The time for that kind of resistance and indifference has passed. Experiences of other countries can offer us much of what our present system lacks. I am thinking not only of universal access, but also of coherence, by which I mean



**BY DANIEL CALLAHAN,
Ph.D.**

Dr. Callahan is senior scholar and president emeritus, The Hastings Center, Garrison, N.Y.

ABOUT THE AUTHOR

Daniel Callahan is the author or editor of 41 books, including the forthcoming book *Taming the Beloved Beast: Medical Technology and Health Care Costs* by Princeton University Press.

The European Experience: Basis for U.S. Reform?

ways of reconciling the kinds of conflicting values and traditions that give us fits. Universal access is a common and bedrock goal for European countries — every European country has some form of universal health care — and all understand the value of modern medical technology. But all likewise grasp the need to limit its creation and diffusion to make it efficacious and affordable. All understand the need to control costs, but most pursue that goal by means of global or institutional budgets and by government regulations rather than private sector dominance. Most have long understood that an appeal to the value of solidarity, rooted in the recognition that we are all threatened by illness and death and must support one another in responding to them, is a more effective way of making the case for universal care than appeals to rights and justice, the most common way of making the argument in the United States. European nations put different amounts of resources into their systems, but the baseline is that everyone is to be covered.

LOOKING TOWARD EUROPE

Two distinctions are useful when looking at health care systems in Europe. The first is to note European systems are different from one another and thus offer us the possibility of picking and choosing among features to seek a mix that would work for the United States. The other distinction is that two types of systems exist:

- 1) Tax-based systems, which offer financing by direct taxation and, in some cases, direct government management (e.g., the United Kingdom, Italy and Sweden)
- 2) Social health insurance systems, which offer care financed by employer- and employee-mandated contributions using private insurance companies, combined with additional government support for the elderly and the poor (e.g., Holland, Switzerland and France).

By and large, the social health insurance systems offer the most likely models for the United States. They have been the most successful, both in terms of quality and public satisfaction (most notably with an absence of the waiting lists that are a central complaint against health care systems in Canada and the U.K.). They make use of a strong private sector, and they are willing to use some market ideas, such as competition among private providers and insurers, but always

in the service of universality rather than pitted against it.

EXAMINING COST ISSUES

For the European countries, as for our own, the main problem is how to pay for steadily increased costs of care. Europeans see rising costs as the main threat to universal care (just as we should in this country). While this country's problem is how to climb the mountain to universal care, Europe's concern is how to keep it. But how do the European countries manage to control costs? It is here the European systems show their greatest strength, but also display the most vivid clashes with American health care values. Europeans control costs with expenditure ceilings for health care systems as a whole, or for regions and provinces. They also put restrictions on the number of physicians and medical students, negotiate physician salaries with physician associations, implement prospective global budgeting for hospitals, and establish budgets based on mandated benefit packages.

Control of technology expenditures (drugs and medical devices) is one of the most striking features of the European systems. Expensive technologies are licensed and their diffusion regulated. Fixed budgets for pharmaceutical expenditures are in place as well as price controls and enforced price cuts, prohibitions against direct-to-consumer advertising, and ceilings on drug promotions. The net result of these restrictions is that there are far fewer MRI and CT scanners than in the United States, far fewer cardiac bypass and angioplasty procedures, half the rate of kidney dialysis per 1,000 people, and a much slower adoption of expensive new drugs. Those methods of controlling costs are open, and public policies are put in place by government.

But the European countries have two other advantages, neither of which has anything to do with policy, but much to do with culture. One of them is a far less intense interest in health, much less of an obsession with it when compared to the United States. Europeans understand that death is a part of life, that some physical pain and suffering is unavoidable, and that health care, though important, is not necessarily the most important social problem.

I recently participated in a symposium in The Netherlands titled, "The Contingent Nature of Life: Bioethics and the Limits of Human Existence." It is hard to imagine a topic like that

getting much traction in the United States. Limits, contingency and finitude are well out of the American bioethics and health care mainstream.

The other European cultural advantage is that its media pay far less attention to medicine and health care than in the United States. Our media celebrate medical breakthroughs and seem to enjoy pointing out the seemingly endless stream of new health hazards. Many years ago, I took a trip to Europe on a day when the U.S. media gave major attention to the introduction of Viagra into the health care market. It was a lead story. By contrast, European reports on Viagra were brief, as if it were a topic of only minor interest. Further, it had not been advertised to the public. The absence of pharmaceutical advertising in European media, where it is forbidden by law, is striking, and there has been little effort to put it in place, even under the guise of “medical education” — the way pharmaceutical advertising started here. Even weeks later, many people I met in Europe had yet to hear of Viagra.

In short, costs in Europe are controlled by what American conservatives call the “heavy hand of government.” Such controls are acceptable in cultures where people are not fearful of government and not nearly as obsessed with health as people in this country. And they work. An important result is that the annual cost increase for European health care is in the 3 to 4 percent range, compared to 7 percent in the United States. Despite spending significantly less per capita on health care, providing less access to medical technology, and paying health care workers less, the European systems get better health outcomes than we do in this country and with greater patient satisfaction.⁴

The obvious significance is that we Americans spend far more than we need to on health care, and receive far less value for the money we spend, than our European counterparts. In the United States, health care serves many ends other than health: jobs, profit and prestige. That is far less so in Europe. America’s unworkable marriage of the profit motive and altruism in health care guarantees an unhappy and inefficient relationship — but one where, so far, divorce has been forbidden and, worse, where far too few even understand why it should be allowed. Doing good and doing well in health care are as American as apple pie.

MOVING FROM IDEOLOGIES TO AGENCIES

As noted above, ideological differences in this



Illustration by Chuck Groth

country through the years have been an obstacle to achieving universal care and controlling costs. Conservatives want greater consumer choice and increased competition, both thought to be values far more compatible with American history and culture than government-run or highly regulated systems. The health care proposal by Republican presidential candidate Sen. John McCain, R-Ariz., moved strongly in that direction with hardly a nod toward equitable access. Conversely, President-elect Barack Obama has moved gingerly in the direction of universal care, but has so far not directly offered a plan. The two candidates shared a belief in competition as the royal road to cost control. They also embraced information technology, some form of technology assessment and improved prevention efforts.

Neither candidate broke any new ground with ideas related to cost controls, and some that were floated, particularly those invoking competition, fly in the face of the available evidence. Although competition has controlled costs in some limited

The European Experience: Basis for U.S. Reform?

contexts, it has nowhere proved to be superior in national health care systems to government-run programs. Through the years, Medicare costs have been consistently lower by an average margin of 10 percent to 20 percent than costs of private health care, and the European systems have always done better with costs than American private care.

Since an embrace of competition seems to be the compromise via media of ideological clashes in the United States, it is important to review such proposals with skepticism. Belief in competition has not been based on health care data or

experiments in health care. Instead, it has been the experience of a competitive American business community that has been repeatedly held up as the pertinent model, as if what works to reduce the price of cell phones, TV screens and automobiles will work equally well with health care. That is a sheer act of faith. While it may pass some ideological test, it cannot pass the empirical one.

A technology assessment agency is another favorite idea for both liberals and conservatives. Every European country has one, and it makes good sense: patients and physicians need to know what treatments, drugs and devices are efficacious

WORDS MATTER: THREE DILEMMAS FACING HEALTH CARE REFORM

Three dilemmas need to be addressed in advancing meaningful health care reforms, all of which turn on how Americans talk about the problem.

1) What words do we use to describe the need for equitable and universal access?

One reason (among many) for the failure of the Clinton plan in the mid-1990s was that it appeared to threaten the adequate health care of 85 percent of the population to meet the needs of the 15 percent uninsured. Everything had to change to help a comparative few, or so it seemed. Arguments based on fairness, justice or equity were all but powerless against that perception, which appeared to turn justice on its head. Today, the problems with our health care system go well beyond the numbers of uninsured. Instead of simply invoking justice for the uninsured, invoking empathy, solidarity and common sense would strengthen the case for reform.

2) How can advocates for reform persuade the public that the greatest threat to American health care is not the growing number of uninsured?

People need to know that rising costs are a main reason for the increase of

the uninsured. However, surveys show the public tends to have mistaken ideas about rising costs, attributing them mainly to waste and fraud, not to needless CT scans or marginally beneficial and expensive cancer treatments. Nor does the public understand that rising costs will mean forgoing services and benefits they may desire and sometimes need. Even if universal care is achieved, it would not endure if costs are not controlled.

Unlike arguments to provide good care for the uninsured — which hardly anyone objects to as an abstract ideal — the control of costs is an unpleasant, even nasty, idea. It connotes rationing. That's why politicians and presidential candidates evade the problem, substituting vagueness and pious hopes for tough realities.

Although some might argue that it would be better to get reform in place and then take on the problem of costs, candor would save us from putting in place a reform that could not endure. Even with the merits of health care in Europe, its countries are anxiously trying to deal with cost increases as well, though more successfully than we do. Some countries, such as Italy, are even now struggling to hold on to universality. Even so, it will be necessary to make the case that nothing less than a coherent universal care system

will be able to control costs, and that only a strong coordinating government hand can make this work. The American private sector in health care has decisively demonstrated for more than 40 years that it cannot do so.

Although hybrid solutions are politically attractive, they would have to be exceedingly clever, with a strong government bias, to have any chance of managing the cost problem (e.g., not disbanding the insurance industry, but firmly regulating premium increases).

3) How do Americans justify the drive for endless medical progress and technological innovation while striving to bring good care to everyone in an affordable way?

This is the deepest issue facing American health care and all developed countries. No value is so deeply embedded in American medical culture than that of progress, of taking on that long and ever-growing list of diseases and pathologies that bring suffering and death. The healthier this country's people get, the more society spends on health, driven by rising standards of what is adequate.

— Daniel Callahan

and which are not. But care is needed here. Twice in recent decades, Congress established such an agency, but both were shot down after a short life span by hostile medical industries and opposing physicians. This time around, some added features would be necessary if a meaningful agency were to exist. For openers, it would need the authority to command, not just to commend, acting on its findings. That feature is the strength of the British assessment agency, the National Center for Clinical Excellence, which examines new and old technologies, and, barring extenuating circumstances, makes recommendations that are considered mandatory for the National Health Service.

No less important, a technology agency would have to be granted a long life span by Congress, 10 years at the least. An effective agency, sure to step on the toes of people in industrial and medical sectors, would need a guaranteed term to protect it against critics and give it time to develop meaningful evidence. Last, it would need a substantial research and dissemination budget and the power to subpoena information from the private sector.

A second agency will be needed: a powerful government office to provide information and oversight on health care costs and access. The office would be charged to make an annual report to Congress assessing the following:

- Access to care based on the needs of different age and economic groups
- The cost of care and an identification of the main drivers of cost increases
- The overall health status of the population and an identification of particularly urgent health needs

Much of this information is already available from federal and private sources, but it is a full-time job to find it and put it all together. A more or less authoritative office could be a great help in galvanizing Congress and the public and in giving its director an important bully pulpit.

Most Americans and most legislators treat the health care system as one suffering from waste and bad management, open to reform by organizational change. There is surely something to that view, and the success of the European sys-

tems is heavily due to their being organized in a way that combines the value of solidarity and the managerial modes needed to support it. But the Europeans have something else of importance: a built-in respect for human finitude. They do not put the pursuit of health care on a pedestal, as we do, and they much better understand that more technology does not equal better health. That is something we need to learn. No possibility exists that any organizational scheme can find a way to support unlimited medical progress.

CONCLUSION

Americans should now be able to understand why the current health care structure in this country is unsustainable. Deciding to pursue unlimited progress regardless of cost suggests that all-out warfare is the only morally acceptable response to human finitude. Alternatively, society can set some different, more finite goals for health care by deciding to live within its economic means, as various European health care systems have shown it is possible to do. That would require taking the cost problem with far greater seriousness. It would mean recognizing that an affordable and sustainable health care system is simply not going to be possible in the long run without a fundamental change in some of this country's deepest values. Without that change, it is folly to think that better organization and management is the answer. No affordable system can be built on a foundation of infinite expectations and demands. ■



**Comment on this article
at www.chausa.org/hp.**

NOTES

1. Agency for Healthcare Research and Quality, "Reducing Costs in the Health Care System: Learning From What Has Been Done," www.ahrq.gov.
2. Ceci Connolly and Mike Allen, "Medicare Drug Benefit May Cost \$1.2 Trillion," *Washington Post*, Feb. 9, 2005.
3. Associated Press, "Health Care Costs Might Top \$4 Trillion by 2017," *USA Today*, Feb. 26, 2008.
4. The Commonwealth Fund, "Learning from High Performance Health Systems Around the Globe," www.commonwealthfund.org.