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—From cost containment to effect assessment

In pre-industrial societies, agriculture frequently had the highest share of gross national product; why should the health sector not rank high in post-industrial societies? A structural shift of the economy in favour of health care could be justified in four ways. Firstly, in terms of the quality of growth, this sector produces health, a basic need-oriented item. Secondly, because health care is labour-intensive it creates and secures jobs—and indirectly health—in times of mass unemployment. Thirdly, there are essential forward and backward linkages to other sectors, like the equipment and chemical industries. Finally, the market for health care expands quite strongly with the supply. Many other economic sectors do not have comparable advantages. Why should we not allow the health sector to expand? Why should the health sector not be one of those leading economic recovery after recession? To force cost-containment policies on the health sector could be misguided from the economic point of view as well as inhumane.

But do we really produce health through health care? Is there not room here for scepticism? Nearly all statements on the efficacy of health care are hypothetical rather than factual, or relate only to isolated topics. There are few comprehensive evaluations of health care covering both context (e.g., availability, quality) and effects, especially side-effects (e.g., iatrogenic diseases) and after-effects (e.g., cost increase because of higher life expectancy). On the other hand, some factors seem to affect health more than the health care sector itself, viz., nutrition, sanitation, and real income. Without contrasting the economic and health impacts of health care against those of other sectors, a plea for containment of expenditures or costs in health care seems to be at least premature, and certainly inhumane, since health care undoubtedly produces more health and well-being than most other social and economic sectors do. So, if cost containment is nothing but expenditure containment, let us contain it, even if we do not fully understand whether health care prevents illness or produces health and well-being. A similar situation

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is presented by many economic and social sectors: we know the outputs but seldom the outcomes in terms of satisfaction of basic needs.

In all economic and social sectors, inefficiency is unethical because it involves the wastage of resources that could have been put to better use (*1*). There seems to be a variety of inefficiencies within the health care sector: misallocations, surplus of specialists and beds, shortage of general practitioners, double diagnoses, overtreatment, extremely high use of technologies, unnecessary hospitalization, and excessive utilization and wastage of drugs.

To force cost containment on the health sector could be both inhumane and economically misguided.

If there are no policies of primary prevention, where can we best use measures to decrease costs and increase efficiency within the health care sector?

Let us consider cost containment in the Federal Republic of Germany. Assuming that supply creates demand in health care and that the most important resource allocations are made by providers, then, given that over 80% of health insurance expenditure in the country is induced by practice-based physicians, it is clear that cost containment requires persuasion or incentives directed towards these physicians. This was done, in fact, in Bavaria. The Federal Republic, however, has chosen a comprehensive procyclical approach (instead of alleviating health problems caused by recession anticyclically) based on macroeconomic data. About 60 representatives from government and industry meet twice a year (in what is called a "concerted action") to analyse the background and to discuss strategies and measures for cost containment, such as ceilings on expenditure increases. So far it is not clear whether such policies strengthen efficiency rather than merely reduce expenditure or transfer it to the weakest parties involved. It is also uncertain whether people do not inadvertently undercut such policies and vitiate any long-term containment effects.

In spite of all the uncertainties, there is an explosion of ideas (salvation doctrines) about how to achieve cost containment and efficiency in the Federal Republic of Germany. Most proposals try to combine market intervention with bureaucratic regulation, as with the closing of the market for new physicians and the opening of that for practising doctors. Proposals are made for reducing welfare policies, for rationalization, for the introduction of markets and competition, and for co-payment. Bureaucratic planning is now often disregarded, and what might be called the health underground economy often bears costs that had been contained elsewhere.

Greater freedom for market forces in health care should lead, via competition, to the emergence of cost-effective providers (physicians and insurance companies), since consumers would be able to exercise choice. Proposals regarding supply — alternative delivery systems, consumer choice health plans, health maintenance organizations, workers' cooperatives — have not yet found favour in the Federal Republic. Demand-oriented proposals are predominant: co-payment for minor diseases, drugs, dental care, and hospitalization have been implemented for the 90% of the population with statutory insurance rights. As in other highly developed countries, only embryonic measures for competitive supply have so far been taken; demand management measures are more likely to be effective. Consequently, we do not have valid answers in respect of such matters as risk selection, preferential pricing, unjustified demand decreases, cost shifting, monopolization, consumer sovereignty, consumer preferences, and distributional equity. At present we can only speculate about them.

Throughout the cost-containment discussion the federal authorities are said to have increased their power. Professional medical organizations and the administrations of sickness funds have tried to strengthen their positions too. But there is no strong evidence, either empirical or theoretical, on their effectiveness and efficiency in overcoming problems arising from lack of consumer sovereignty, high transaction costs, and inadequate information. Such features usually call for state intervention (*2*). It is uncertain whether the state and the bureaucracy fulfil their *raison d'être* by defining need and demand and by producing merit goods. The belief that effectiveness can be strengthened by state intervention is a matter of social theory or political preference. There is an absence of empirical knowledge based on thorough evaluation.

There are other uncertainties. For example, to what extent do lay people themselves contribute to health and well-being, independently of the health market and health plans, through participation, self-help, and life-style? It is not clear how mem-

bers of the public, using their own common sense, react to cost-containment policies, which are shifting the costs in terms of time, pain, and money to the private sector, nor how this is to be avoided or reversed. The only certainty is that strong provider interests compete with weak consumer interests. According to the extent to which costs are contained by the market or by health plans, the third sector—the lay system or the shadow economy—expands. Costs contained elsewhere are paid here.

Various of these doctrines of salvation have been implemented in the world: full competition in many Third World countries, models of competition with only slight state intervention in the developed countries, comprehensive planning of health care in widely diverse countries, many forms of payment such as capitation reimbursement or fee-for-service occuring in one and the same country and, all over the world, alternative delivery models of every kind. Before starting to implement one of the modern doctrines of salvation on a large scale, one should try to evaluate the effects, side-effects, and after-effects of intended policies, checking them against comparable policies carried out at other times and in other areas and creating scenarios to assess which policies are likely to work.

As regards evaluation, a direct transfer of theories or results from other sectors to the health sector is impossible; health care is not a commodity like soap. Doctrines of salvation should be open to verification. We need independent, rigorous health systems research rather than mere belief.

To summarize, we do not know whether expenditure or cost containment in health care is relevant from a macroeconomic point of view. It is conceivable that containment policies are abolishing the most effective measures. It is unclear whether cost containment has the effect of increasing efficiency or of decreasing expenditure; shifting expenditure to other areas might prove even more inefficient. We simply do not know which of the usual doctrines of salvation—competition, planning, and/or self-help—can do most to improve effectiveness and efficiency. In the absence of concrete information, we should not try excessively to curb costs and expenditure in health care but should invest in the rigorous evaluation of the effects and side-effects of actual and alternative measures within and outside the health sector, even if this means increasing health care costs. Expenditure on health care seems to be more useful in terms of health and economics than expenditure on arms and many other items in the economy, and this should be our main hypothesis. □

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