THE BROOKINGS INSTITUTION

LESSONS FROM INTERNATIONAL EXPERIENCE IN DETERMINING HEALTH CARE PRICES

Part 3 of a Panel Series on Health Care Price Regulation Honoring Uwe E. Reinhardt (1937-2017)

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P R O C E E D I N G S

MR. GINSBURG: Hello, I'm Paul Ginsburg. I want to welcome you to this event, sponsored by the USC-Brookings Schaeffer Initiative for Health Policy and co-sponsored by Brookings Center for Regulation and Markets.

This is the third and last webinar, of our series on regulating health care prices, created to honor the late Uwe Reinhardt. Our first panel focused on whether the U.S. health care prices are, indeed, higher than they should be. The second was on potential policy approaches, that either have been, or could be pursued in the United States, including caps on prices for out-of-network care, rate setting, and a public option.

Today's panel focuses on lessons from the international experience, in constraining prices through regulation. This panel would have been a particular interest, to Uwe Reinhardt, who wrote extensively on how other countries have addressed these issues. As many of you know, Uwe was born and grew up in Germany, but immigrated at the age of 19, first to Canada, and then to the United States.

I had the privilege of traveling with Uwe, twice, to Germany, first to attend a small conference on healthcare costs, convened by a German Foundation, and later as part of a joint delegation, from the Physician Payment Review Commission, and the American Medical Association, to meet with leaders of Germany Physician Associations, and sickness funds, as well as Government Officials, to learn about physician payments in Germany. I was the executive director of the Commission at the time and Uwe was a commissioner. We were at the Commission together for eight years.

At the conference, a number of Germans, who knew Uwe well, joked to me about Uwe, now speaking German, with an American accent. The delegation to discuss physician payment was a follow-up to Congress's enactment of the reform that included the Medicare physician fee schedule. At the time, some older Germans were not that comfortable with their English skills, so, Uwe did a lot of translating for our group.

We have four excellent panelists, today, and I'm pleased to introduce them. First to speak will be Reggie Williams, Vice President for International Health Policy and Practice Innovations, at the Commonwealth Fund. He will help set the context for today's discussion. Miriam Laugesen, Associate Professor, at the Mailman School of Public Health, at Columbia University, will discuss the

experience of three countries, France, Germany, and Japan, with regulation of prices. Adam Elshaug, who is Professor of Health Policy at the University of Melbourne, in Australia, and a visiting Fellow at the USC-Brookings Schaeffer Initiative for Health Policy, will focus on the Australian experience, and, finally, Chris Pope, Senior Fellow with the Manhattan Institute, in New York City, will present some very interesting perspectives on the landscape of experience with price regulation abroad.

After the four panelists speak, they will have an opportunity to comment or ask questions on other panelists' presentations. Then, I will pose some questions of my own, and turn to questions from the audience. Viewers with questions, can use either Twitter, and that would be #healthcareprices, or send an email to events@brookings.edu, and those questions will be funneled to me. So, we'll begin with Reggie now.

MR. WILLIAMS: Hi, Paul, thank you for the invitation. I am excited to speak with everyone here today.

My goal is level set on the different approaches to determining the healthcare prices from around the world, but before I get started, I want acknowledge Uwe Reinhardt. I met him about 20 years ago, when I first came to Washington, D.C., and worked at the National Academy of Social Insurance. To say his wit and insights were profound is a major understatement. He is also a grantee of the Commonwealth Fund, and we cherish the insights he shared with us over the years.

Now, to today's presentation. I'm going to share a little bit about the Commonwealth Fund International Program, what we have learned about international spending and costs, share a high-level overview of price setting approaches, and considerations for going forward.

First, on the Commonwealth Fund. We seek to promote a high preforming healthcare system for all, with a focus on low-income people, the uninsured, and people of color. We have five major areas of focus, and I am the leader of our International Program. The International Program does a couple of different activities. The key thing that I want to focus on, today, are some of the research programs, that we have led for over 20 years. We have an Annual International Survey of the general population, those over 65, and primary care physicians in annual -- in 11 different countries.

Through our Miramar, every three years, we conduct benchmarking, key indicators of access, administrative efficiency, equity, and healthcare outcomes. We also evaluate OECD data, and

distill implications for the United States, and maintain a detailed set of International Healthcare System Profiles, to show how other systems in the world are structured. So, as it relates to our work, looking at healthcare spending, we see that there are -- that the United States stands as a leader here, in healthcare spending. When you compare us to other countries, the amount spent per GDP is obviously much higher.

If we look at this a level deeper, when we conduct our Miramar, and we look at health system performance and spending at the same time, and, unfortunately, United States stands as an outlier, when you look at both the higher spending and lower healthcare system performance.

So, on to spending, and how it looks different across the various countries. This slide highlights hospital spending per discharge across a number of countries, that we focus on in our analysis, and you see here, again, the United States is a leader in healthcare spending, and you can see the dramatic differences across many of the high-income countries that we focus on, as a part of our analysis. As far as where is money being spent? The money is being spent in hospital services. We see it as a predominant place, where care is delivered, and where expenditures are focused.

This chart highlights differences between hospital, physicians, and medical practices, and prescription drugs. So, when you look at that hospital spending, you can see how the United States fairs across a wide variety of different services that are delivered. This slide highlights just a few. You can see the relative magnitude of difference in the United States, around hip replacements and angioplasty.

But, now, I would like to turn my attention to talking a little bit more about price setting, and the different approaches we see. To start, there are many different approaches to defining the unit of activity on which prices are set. Common base payments are a fee-for-service, Diagnosed Related Groups, or DRG's, per diem or capitation. Budget based line item, in global payments, are typical in many low- and middle-income settings. These are gradually being replaced by other methods. Payment of Americans directly linked to activities, like, fee-for-service, per diem and DRG's, require a well-defined planned episode of care, and strong evidence that such care will achieve desired outcomes.

We know that the fee-for-service methodology rewards activity. It tends the result in the overprovision of services because of the incentives per volume, regardless of patient need. Capitation is a population-based payment, whereby a fixed payment is made prospectively for a defined benefit

package, or for a person, for a certain period, regardless of the services provided, and a growing number of provider payment mechanisms are being deployed, that explicitly seek to align payment incentives in healthcare system objectives. So, we see the introduction of things, like bundled episodes, global capitation, pay for performance, a wide variety of different settings.

When you look at primary care across different countries, the most common means of purchasing from a healthcare service is through capitation and fee-for-service, and out-patient services are commonly purchased through fee-for-service. To counter the disadvantages of fee-for-service, such as the lack of incentives for quality, and the incentive towards volume, you often see it combine with other mechanisms to promote efficiency and cost control. For example, fee-for-service has been combined with pay performance in France, in Korea. Decapitation has been combined with fee-for-services in Australia, France, and England. I'll be speaking a little bit more about those later.

It's also interesting to see the mix in England, where capitation is used for primary care, but fee-for-service is the focus for out-patient specialists. So, you still get a mixing of these different types of bases for payment, in different care services. So, turning to hospitals, here, you see the dominance of DRGs. The financial incentive or DRG payments have provide strong incentives for changing provider and hospital behavior. France has an interesting model of DRGs and bundled payments for public health services and utilizing pay performance, which is of particular note.

Japan uses an interesting combination of diagnosis procedure combinations, and a weighted care per diems for non-acute services, in both public and private hospitals, which can also be combined with fee-for-services, and bundling together, and creating one unit. We'll be speaking a little bit more about the Japanese experience, later, but it is an interesting approach worth noting.

So, once you think about that -- establishing that overall, kind of, base for payment, there are an administrative process, or some sort of negotiation that takes place on those services that are being provided. These processes are grouped into three major methods, individual negotiations between providers and payers, negotiation between associations of providers and payers, and unilateral administrative policy, and that's where you see a lot of variation across countries.

In this slide, you'll notice that under individual negotiations, prices are agreed upon through negotiations between individual health insurers or self-paying patients, and individual providers of

healthcare services. Transaction prices are the result of many discrete negotiations and they're often unknown to the final consumers and to the public, and the results may be treated as commercially sensitive. In the Netherlands, you see healthcare insurers negotiating contracts with individual hospitals for many services. Some insurers negotiate a lump sum budget, while others negotiate a price and/or volume, for individual treatments.

Furthermore, health insurers will then negotiate with multi-disciplinary groups or single bundled payments to deliver care for, say, diabetes, or COPD, or asthma. In turn, care groups, then, negotiate with general practitioners for the delivery of primary care services. So, this is a kind of a complex multi-layered system, that you see applied in the Netherlands. Under collective negotiation and associate, you see an association of payers, you know, health insurers, negotiate with the association of hospitals, or doctors, or other healthcare providers. The outcomes of these negotiations are typically displayed in the Uniform B Schedule.

We're going to speak a little bit more about Germany, later, but it has a really kind of interesting approach, where cost weights for Federal Base Prices are negotiated centrally. The DRG base rates for those states are negotiated between sickness funds and hospitals, within a given range of set prices, and, subsequently, at the local level, budget negotiations take place between individual hospitals, and larger sickness funds. So, again, you see this multi-layered approach taking place, under collective negotiations.

The third method of determining price is unilateral administrative price setting by a regulator. In the U.S., this is known in the -- as the Medicare approach, that we see in fee-for-service, and it's also important to note Maryland's all-payer system, where both in-patient and out-patient services at hospitals are determined by a commission of stakeholders, but it has a global budget. So, you can see how you can mix the different approaches, different bases of payment.

Some of our other speakers are going to detail the Australian approach, and so, I won't steal their thunder, but the Independent Hospital Pricing Authority demonstrates a clear approach to doing so. So, ultimately, when I think about the lessons of other countries' systems, and what they have for policymakers in the United States, and others that are focused on this topic, I think there are, really, a set of objectives associated with price setting. You have accuracy, fairness, and the ability of the prices

to ultimately support overall healthcare systems goals, and there are ways to ensure price setting approaches meet those overall policy objectives.

You have the ability to make adjustments as needed, controlling overall expenditure, managing, balanced billing, and patient protections, ensuring efficiency and quality in activities, like bundle payments and quality incentives, and there's really a feedback loop that can constantly take place between these objectives and approaches. There are, at times, in constant tension, and policy solutions have an opportunity to balance them, and so, I hope this give you a little bit of an overview of how we can approach price settings in different countries, and please reach out to me, if you have any questions about our work, or how we pull together this information to distill insights for the United States. And, now, I'm going to pass the baton to Miriam to talk a little bit more about some countries.

MS. ELSHAUG: Thanks. Thanks, Reggie. Thanks, Reggie. Okay. Just a second. Thanks, that was a great setup for what I'm going to talk about now, and I'm delighted to be here. Thanks so much to Paul, for the invitation, and Brianna, for technical assistance.

So, my talk is a brief overview of a book that we're working on. My colleagues at Columbia, Rutgers, and NYU, we are working on a comparative book, and I'd also like to acknowledge the help of research assistants and funding from the Tao Foundation.

So, I'm going to talk a little about the goals of the project, but primarily discuss sort of three main findings that we have, that are relevant. So, the start of this project really began from looking at the work by some colleagues, Ted Malmo, John Overlander, and Joe White, and they had asked the question of whether fee-for-service is the fundamental cause of our malaise in the U.S.

And I think the key point from that work was we need to think about the sort of multifactorial causes of higher health expenditure. So, we developed a project, which uses a sort of most similar design. So, what we're doing in this project is trying to find and look at fee-for-service systems. We chose three, France, Germany, and Japan. These systems are -- offer a lot of lessons for the U.S.

We wanted to develop a really deep understanding of how these systems work, and, in particular, eliminate the institutional structures that underlie the fee negotiations. Finally, I think it's really important, when you're doing comparative work, to be conscious of the differences and the, you know, the applicability of foreign lessons. However, we also want to come up with proposals that could be

acceptable, and also counter this idea that the U.S. is two different for cross-national lessons. So, I think, that's really important.

We've basically been engaging in a study of the policy processes and the stakeholders in these countries. So, we -- we've been doing key informant interviews and document review, in both the languages of the country and English. So, let me just move to some of the key lessons. I think this heading would probably make Uwe proud. He appeared to be an enthusiast of puns and memorable titles. So, one of the messages of our book is that fee-for-service is not necessarily the major problem that we have to address. What we need to address is a lack of standardization of prices, and so, our book talks about the co-existence of fee-for-service and standardized prices.

Other systems seem to make it work. So, let's look at what realistic alternatives exist for making this arrangement work in the United States. Absolute values, absolute prices are a really important thing to keep in mind, and something that, you know, we're aware of, the higher prices in the U.S., but we lack the institutional mechanisms to really address those prices. The good thing about a generalized approach or a generalized prescription, that you could allow co-existence of fee-for-service and standardized prices is that they're sufficiently general, that you can adapt them to a variety of different payers and systems.

It's not -- it's not a one size fits all, depending on the level that you adopt it at. In any case, some of the most successful policies that we've had in the U.S. have been fairly blunt. Now, I don't want to get into a debate about the readmission penalties, but I think that everybody agrees that, for good or bad, they certainly have an impact. That's an example of a very straightforward policy that seemed to alter the incentives, simply by changing the payment levels.

I think simplicity is underrated in the debates around payment reform, and we should prioritize that, and have greater transparency, and standardization would allow that. This would bring a lot of order to the chaos of the U.S. Healthcare System, but, most importantly, and this is where we touch on U.S. values, which are actually pretty consistent throughout the world. People, everywhere, want to be able to choose their doctor, where, you know, as much as possible, and that certainly is something that fee-for-service does, offer that, that choice, and I think that's important to consider as part of any sort of policy change.

Our second lesson relates to stakeholder power, and any payment or form that doesn't address the fundamentals of stakeholder power is deemed to fail, in the United States, and I'll just speak about Medicare briefly. The rulemaking process is how we set prices. This puts the CMS and other -- and the agencies under the rubric of the Administrative Procedure Act. Instead of it being about sort of shared governance, what we have in the United States is a rulemaking process, and, for some reason, payers don't really seem to participate in that process, or exert a strong voice on those prices, even though they actually use those, you know, those relative values.

What we need is an approach that reinforces, rather than works against, what some people call civil society, and, in some ways, the sort of paradigm of civil society is somewhat applicable, given that what we're talking about is the people's health. We want to prioritize and make sure everyone has access to quality healthcare, and so, the use of the term civil society seems quite appropriate.

Fundamentally, though, payment is not always a civil process. It puts one stakeholder against another, often, and the answer to that is not accentuating that power, but to make sure that everyone has a strong basis, that everyone has an equal basis in that discussion. So, I think the most important thing, and the thing that we're being really impressed by, are the system, is how they get everybody moving in the same direction, and that seems to be a key thing that we have failed at, in the United States.

The third lesson is that we have -- we talk about how we may need to think differently about prices and coverage. There's always been a sort of a dichotomy in our Healthcare Policy environment up around these two sort of separate issues, and yet other countries see them as unified. So, our argument is that you need to have affordable coverage, you need to have good networks, wide networks, and until you do that, you can't put the coverage before the prices, priority. We have to address both, and, maybe, what you need to do is address prices first, as a way of lowering costs and increasing affordability, in such a way that will improve coverage and affordability.

I've been brief, and I look forward to answering questions, but a pleasure to be here, and I'd like to introduce, next, Adam. So, I'll just stop my screen share.

MR. ELSHAUG: Miriam, thank you very much, and I'd like to say thank you to the Brookings Institution for inviting me to participate today. I, too, want to share -- excuse me, one moment.

Okay, here we go.

So, look, I'm -- in my eight minutes, I'm going to do what I call a shallow dive into Australia, and really just provide, I think, two examples, one where we seem to be struggling a little bit, to our prices under control, and another example where, I think, we're doing a very, very good job, and before I get to that, I know Reggie has a quick overview of some of the Commonwealth Fund Data, but just to place Australia within context, in terms of its performs, the Miramar Data does show Australia performing quite well, against its peer countries. I will point you down the Australian column to equity, which at -- it scores a little poorly on, and I'll -- and I'll be picking up that point in some slides down the road.

And because we're talking about mortality amendable to healthcare, I think it's also noting that Australia is performing both within the country, over time, but also between peer countries quite well, on mortality amendable to healthcare. So, the takeaway point from these two brief slides is that I think it can be considered a high performing Healthcare System, by any standard. This paper from Pepper Nicholas, which is also drawing on OAC data, much like the Miramar work, gives us a little bit more information about some of the similarities and differences between the U.S. and Australia. So, at the top there, we seem to be achieving these outcomes, with around about the same, slightly more physicians per capita, or nurses per capita.

If you drop down to that middle green circle, we have more hospital beds, more long-term care beds, and, most importantly, down at the bottom here, which is the healthcare spending, we're managing to achieve all this, at just over half of what the U.S. is spending in healthcare. So, these data are a little old, it's suggesting 9.6 percent GDP, we've recently ticked over to 10.3 percent GDP, but the point is, that it's still quite a long cry off the U.S. Healthcare spend. Okay, so, some high-level points. So, Australia has a Universal Healthcare System.

So, all of our 26 million population are covered, but we are not a single payer, as some other examples that have been spoken about already today, and so, there are actually three main areas of contribution, the Commonwealth government, or the federal government, as you would recognize it, and there is quite a large private contribution. That's both through out-of-pocket costs, but also there is a supplemental private health insurance option in Australia, and then the states contribute quite a lot to

healthcare.

I'm going to focus on just a couple of these inputs, and you can see from the chart, there, that there's actually quite a lot of complexity into the funding flows. I want to talk a little bit about the ambulatory and out-patient care setting. This is effectively our Medicare fee-for-service system, and with a degree of out-of-pocket cost sharing as well. The large bulk of our healthcare funding actually goes to our Public Hospital System. So, these are state administered public hospitals. They're free. They're point of care. So, there is zero out-of-pocket costs or co-pays associated with care. They're funded through a combination of block and DRG activity-based funding, to a Nationally efficient price and a Nationally efficient cost, and I think that's something that the U.S. could take away some lessons from. It's also worth noting, although I won't speak about in my eight minutes, although we may come back to it in the presentation, is that we also have quite a degree of private hospital activity, of course, through our private insurance option, as well.

So, first of all, to the -- to our ambulatory and out-patient care. So, our Medicare Benefits Schedule has over 5,500 items on it. The way doctors are, and these are doctors, primary care physicians, or specialists working the out-patient setting, clinics and the like. The providers, there, can either bulk bill, which they -- it means that they except the NBS fee as full payment for their service, or they can charge a co-payment, in addition to that. There is safety nets in place, which, interestingly, has actually drawn out some perversities and some gaming of the payment system, which we can talk about later, but there is a safety net there.

If we had time, I'd take a quiz on what people think of the bulk billing rights for primary care physicians, and also specialists, but we don't have time. So, I'm going to jump to the answer. You can see the top red line there, this is our non-referrals, this is our primary care doctors, or our GPs as we call them, General Practitioners. Currently, the proportion or percentage of consultations that are bulk billed are sitting at around 86 percent. So, 86 percent of those consultations, the primary care physicians accepting the Medicare Benefits Schedule Fee are not charging a co-payment.

For other specialists, it's sitting around 43 percent, at the moment, which you wouldn't be surprised at, and if we break down further, between specialties, you can see that, for some, they're very low, so, as low as sort of 15 percent of bulk billing, others are much higher, at around 60 percent.

Now, in this graph, we aren't showing Ophthalmologists or Dermatologists, and they tend to be much lower bulk billers as well, but you can see that this is, perhaps, not so surprising, and this is where our equity issue starts to come into to play. So, there are access barriers here, around cost, and if we jump to some work, all of this, by the way, is work that is published by Gary Freed, who is actually an American. He had done some work in Australia. So, if you think about what sorts of costs we're talking about. I've drawn out just the main columns, but feel free to peruse the other ones. So, for the cardiology, at the top there, the overall fee, that's been charged for an initial consultation, in the out-patient setting, is 202 Australian dollars, or, as of yesterday's exchange rate, that's 144 U.S. dollars.

And there is an out-of-pocket charge of 52 U.S. dollars, on average, for cardiology, and that's the initial out-patient setting, and if you cast your eye down there, you can see how that varies. So, this is where Australia is starting to -- to lose out on equity of access, hence our lower score on the Miramar findings there, and it's a problem. So, Australia's now struggling with idea of runaway out-of-pocket costs. It's been quite a problem in the ambulatory and out-patient setting.

Turning our attention, now, to the good news story, and that is our public hospital systems. So, these are our large tertiary care facilities, teaching hospitals. They carry most bed days, within the country. Interestingly, our private hospitals are performing just over 50 percent of the elected procedures, but actually most of the sick patients are spending most of the time in public hospitals. So, as I mentioned earlier, they're funded through a combination of block grants and DRG activity-based funding to a nationally efficient price. The group that does this is the group called the Independent Hospital Pricing Authority, that Reggie inter-niter earlier, and their website is quite worth a look, and they do a lot of things.

One of things that they do is they set the Nationally Efficient Price, and it's set annually. It has two key purposes. One is to determine the amount of Commonwealth Government Funding, for public hospital services, and so, the Commonwealth government wants predictability about their allocations going forward. So, the National Efficient Price does that. As, or perhaps more importantly, it provides the price signal or a benchmark about the efficient cost of providing public hospital services, and you'll notice the word has changed to cost there. So, all hospitals here are required to contribute to a minimum national data set, which is the cost inputs for providing care for certain services, and it's those

inputs that help the effort to define what the nationally efficient price is for -- for the country.

So, it's based on an average cost of an admitted acute episode of care. Each episode is allocated a national weighted activity unit, or an N-WAU as we call them, and that's a major hospital activity, expressed as a common unit against which the NEP is paid. That's really the point of relativity for the pricing of hospital services, weighted by complexity and there are other adjustments to them as well. So, an average hospital services is worth one N-WAU, if it's more intensive or expensive, it's a multiple N-WAU, or if it's less expensive or simpler, the it's a fraction of an N-WAU.

So, the National Efficient Price for 2021, is Australian, $5,320 dollars, or USD, $3,808 N-WAU. Just to give you an indication of what that looks like through a set of examples of services. So, a regular tonsillectomy is equivalent to .7398 N-WAUs, which equates to almost $4,000 Australian dollars, or almost $3,000 USD. So, yesterday, I looked up the HCCI and the Florida Health Provider finder website, and they said that the U.S. National average price is almost $5,000 dollars, compared to Australia's US $2,819. Coronary bypass, with minor complexity, I couldn't actually find this in the HCCI, or the Florida Health finder website. So, I searched the number of sources, and saw a range of between 44 and 248, but given this is for minor complexity, again, even if you had to look at lower bound of that, Australia is coming quite a long way underneath that.

And for hip replacement, you can also see, and the note that I'll make there is that the U.S. National Average, here, actually is a bundled price, that includes 10 rehabilitation sessions, and the Australian price does not include that, but still -- but still a multiple off that fee. The most important takeaway from the National Efficient Price, I think, from the U.S. perspective, is the rate of growth. So, since the introduction of our Nationally Efficient Price, in 2012-13, that -- the N-WAU rate of growth is reduced, to a sustained growth rate of 1.9 percent annually, in that time. So, it's been a normally enormously successful, and it's really down to that benchmarking exercise that I spoke about, where states are incentivized to ensure that hospitals that are performing above the Nationally efficient price, can manage to bring their -- any cost structures down, to meet that, and so on. And we haven't at all about pharmaceuticals today, as per the previous sessions, but I'd be happy to do so, in the discussion. It's another area where Australia is performing very well, in controlling its prices, and I'd also, if time allows, if people are interested, I'd to touch on our private hospital system and our private health

insurance. That is an area, again, where we're struggling to keep our prices under control. So, with that, I will hand over to our last speaker, Chris Pope. Thank you all.

MR. POPE: Thank you, everybody for joining us today. Thank you, Brookings, for inviting us all to speak, and thank you everyone who's tuned in.

So, I'm going to do basically some comments and thoughts on really what characterizes the nature of approaches between countries, and really to try and bring out some of the commonalities. I think there's generally a desire to see American exceptionalism everywhere in healthcare, which I think, at some level, is sort of motivated by the desire that there's an easy fix out there, that if only we could copy, like, this one kind of mechanism that another country's offering, then we could quickly solve that, and move ahead.

But, I think we -- or at least what I've noticed from studying a whole variety of different payment systems across the world, is that every -- if you don't see a tradeoff in one place, the exact same trade off tends to rise somewhere else, and every -- every single country's healthcare system is perpetually dealing with the tradeoff between quality of care, access to care, breadth of people who can afford care, and then the cost of care, and who bears the cost, who is able to have access, and how quality varies between different patients and the care that they are able to access.

And this is -- there's really no getting away from this. No country really ever gets away from this. Regulated prices, market prices, and attempts to sort of constrain or engineer market prices, or nudge market prices are all ultimately constrained by this sort of same fundamental underlying dynamic. Regulated prices are really constrained by the same supply and demands, concerns and considerations that market prices are, and when we think about the regulatory process, in various countries, the -- is trying to constrain prices, in it's attempt to reduce cost, it has quality in access concerns. They're, again, they're constrained by some of the same drivers that we think of as driving market prices.

The regulatory process is not, in anyway, exogenous. It's very much part of the healthcare system, and to sort of, think about the regulatory process might come into fixed prices, or manipulate prices. It's quite likely the way -- when you have regulatory process, or regulatory intervention, the regulation will end up replicating many of the same features that have emerged with -- well isn't a regulatory tabular browser, but ultimately the whole host of accumulated regulations, certainly

in the United States, we've seen 70 years regulations, trying to do indirectly, while other countries have done more directly, and, so, I think, if there's a theme of my quick overview, it will be that every road leads to Rome, in a sense.

Things that might look like American exceptionalism, are actually pretty similar to things that other countries are doing. I think one of the -- the one key driving dynamics about healthcare systems, and we talk about private systems and public systems, where pretty much healthcare systems in the developed world, are mixed systems. This is sadly true in the United States where about 50 percent of spending is public, and 50 percent is private. But it's true, certainly in Australia, we just heard. It's true in Britain to some extent. It's certainly true in France, Germany, Holland, every country is essentially trying to balance public and private resources, and trying to set prices with an eye, to basically maximizing the returns to both.

There is everywhere, I think, the desire to have private revenues relief train on the public system. If people could pay for their own care, that means that public resources can be used elsewhere. But then, that kind of runs into the opposite concern, that if you have a very high public -- private wiliness to pay, that's quite likely to drive up costs, not just physician fees, not just payments for -- for kind of discrete services that are inelastic in supply, but also the intensity of care. We think that there's a wiliness to pay on the private side of more affluent consumers, and insurers that have a high willingness to attract -- to attract them.

That will tend to drive up costs, it will encourage hospitals to increase capacity, it will encourage hospitals to upgrade their capital services, and that can kind of be -- create a cost pressure that feeds down to the -- to the public system as well. That's only a feature that we notice in the United States, and I think is the dynamic that's present everywhere. The flip side of that, I think, is a similar dynamic that we see in the United States, which is a deliberate desire to harness price discrimination between payers, you know, I mean the United States we certainly think of -- we certainly think that we've become accustomed to private insurers paying more, essentially for the same hospital services, then Medicare, and certainly Medicaid would.

And, there's similar dynamics happen in other countries as well. We see certainly in Germany, there is a private and public fee schedule, but the private fee schedule is higher, and that's

quite characteristic. The desire to spread overhead costs and have private payers, pick up the disproportionate share of overhead costs, I think is pretty common around the world, and, again, the flip side, is sort of the danger of a public private interaction, that constantly arises, is really almost moral hazard, or sort of like this --this danger of cost shifting, danger that providers or entities or even payers in some circumstances, will seek to privatize profits and socialize losses. That's always a big concern with any kind of mixed public private payment system, and any kind of healthcare arrangement, payment arrangement around the world.

This is essentially trying to deal with that dynamic and avoid what can obviously be a -- quite a dysfunctional arrangement. So when we think about rate setting arrangements around the world, it's easy to sort of think about the dichotomy of market pricing and sort of administered pricing, and in a few cases, that's actually the case, I mean, if you think about every healthcare system, or certainly most outcast systems as mixed economies, certainly, in the United States, we see fixed pricing in Medicare or Medicaid, alongside market pricing. That's true of several other countries, as well, have similar arrangements. Fixed pricing with balance spending is an arrangement that we suddenly see in France, the public hospitals, and there will be a public fee schedule as well, for physicians, but they're allowed to balance bill with private insurance allowed to reimburse for fees that are balance billed above the fixed reimbursement from the public's fee schedule, and so, again, there, you have a complex interaction between a public fee schedule and a more unregulated private reimbursement arrangement.

We have market pricing that's up to fixed ceilings, to some extent. That happens, obviously, in various countries, Holland, in some cases, that is the arrangement. In the United States, we see market prices with strings of various sorts. If you think about how they're -- we have network adequacy rules that are designed almost, in some ways, to influence the pricing power of hospitals. If you think about the way that -- the way that we have -- that we have, like, charity care requirements for the tax exemption of hospitals. That, again, influences market pricing. It influences barriers to inferences, entry into the marketplace, and so, there are a lot of indirect tools that countries use to influence market prices, while, on the surface, it might appear to be a market price. It might be the sort of the end result of an indirect regulatory approach.

What we see, also, is, quite commonly, it is what appears to be a market price, really

being a fixed price that's generated through indirect regulation. Now, the -- there are certainly -- there are cases in which one thinks maybe of Canada, where, like, the private healthcare or private insurance isn't completely in every province, made illegal, but through a systems of regulation, it's very much constrained out of existence, and that's quite typical of healthcare systems as well, and then we would have -- you can sort of think about different types of fixed pricing arrangements.

I've already spoken about Germany, where there are multiple tiers of fixed prices for different payers. In a sense, one could think about France similarly, and then just the ideal of sort of all-payer fixed prices, where you might have, across the board, prices that are the same, regardless of payer. So, there's a -- there's an enormous diversity of payment arrangements, in terms of the underlying politics and the underlying mechanisms, even -- it's something that might overtly seem to be just a fixed fee. It's actually not quite -- not quite so simple under the hood.

Now, physician payment arrangements, to sort of enumerate the types of arrangements we talked about, or Miriam, earlier, talked about fee-for-service and capitation, and Reggie touched about -- on this as well, and when you sort of think about the diversity of these kind of payment arrangements, the diversity that exists within other countries is very similar to the diversity that exists within the United States. We have fee-for-service payers. We have payers that manage care providers, that have salary, physicians, and that's quite common.

Again, a big battle ground that I think that we see, politically, in other countries is the issue of dual practice rights, and these are often tied in the payment arrangements. So, if you think about the way that France sets its public payment schedule for physician fees, that's very much tied to sort of trying to optimize the incentive for physicians to participate in the public payment -- the public healthcare system, and dual payment rights are calibrated and restricted, to an extent that they will encourage physicians to cater to the public system at lower costs than they might otherwise do so, and so, the interaction of these regulations with payment -- with payment rates is often an important battleground and a key consideration.

Similarly, hospital admitting privileges and gatekeeping rights are often tied into physician reimbursement in quite complex ways, and so, you look at the fees. You might not necessarily be getting the real picture. Volume incentives are often also tied into, like, physician contracts, and you see from a

look at countries that are doing this, but, to some extent, we have utilization management, under managed care, that does much the same thing, and so, whatever control we see, politically, you might think that there might be with increasing cost controls within managed care. One might likely run into a similar kind of control, obviously, if I was effectively trying to do the same thing through a regulatory approach.

Now, I think it's also sort of worth bearing in mind, obviously, quite commonly, people in a cross-national healthcare talk will compare costs, and, obviously, the United States costs are off the charts, but it's also worth sort of going to compare like with like, and if you sort of -- the most important thing here is that healthcare is fundamentally very intensive in high-skilled labor, and when you compare like wage rates for a very similar -- for equivalent medical providers, in the United States and in Canada, the wage rates aren't actually that different.

There is a disparity. The disparity tends to be the more that the United States has more expensive physicians, more expensive specialists, and that will tend to drive up the aggregate costs. There's more gatekeeping, and so, if you bundle all physician costs together and get an aggregate, you have a more -- a higher intensity of mix in the United States than you might in Canada, but comparing like with like, it is ultimately the same labor market with NAFTA, and so, there is not the huge price disparity that really is the case, if you were to compare North American labor costs with labor costs for physicians in France, where we were talking about an order of magnitude lower.

A similar situation is the case with hospital payment arrangements, if we think about how -- different types of rules that exist. All -- again, it's very hard to sort of pinpoint one variable, one lever that you can tweak. In all kinds of different countries, you find a web of different instruments that are used in sort of interacting ways to constrain costs, to create leverage against providers, to sort of almost increase the price -- the ability of regulators to drive down the price by kind of restricting volumes.

Again, thinking from a supply and demand perspective, if a regulator's trying to drive down the price, it almost always has to start by driving down the quantity, which is in a -- certainly a (inaudible) doing that in the United States, quite a political challenge, to say the least. That's why I think, when sort of thinking about the potential of the regulatory approach, it's probably most instructive to look within the United States, what regulatory approaches have been able to do, at the state level, and if you

use -- and the best example of this, certainly from a payment regulation point of view, is the case of Maryland.

If you were to look at -- you know, Maryland's hospital payment regulation system has existed since the 1970s, and if you were to look at the cost trajectory of hospital care, hospital spending, per capita, in Maryland, relative to neighboring states, relative to the United States as a whole, it's certainly not the case that Maryland has had a very high level -- from a high level has had a significantly lower cost trajectory than the rest of the United States. If anything, it's been slightly higher. If you're thinking about states that have had a good cost control experience, you might think of other states in the Mid-Atlantic region. Maryland wouldn't really be the one that you would pick out as a good cost controlling type system, and if you think about it, this is -- this has something to do with why is Maryland the only hospital payment regulation system that's survived.

Massachusetts and New Jersey, New York, a whole host of blue states had hospital all-payer rate setting arrangements back in the '80s and '90s, and Maryland is basically the one that survived, and the reason that it survived is that it was basically the softest on cost, and, really, to a large extent, it's probably helped drive up hospital sending because it entitles the state's hospitals to a big revenue boost from the Federal government for Medicare patients.

So, why are hospital costs so phenomenally high in the United States, compared to other countries? I think the fundamental dynamic is probably the one that we sort of think about as the medical arms race. Now, I cite the cost of MRI scans in the United States, just because the numbers line up in a pretty kind of intuitive way. So, you probably think about this as a stylized fact, more than anything else, but I think it is characteristic of, really, the dynamic that's out there. We have more MRI machines, three times more than France, but about the same amount of MRI scans. So, they're getting more out of the same amount of equipment, and that means that they can essentially have an average price that is lower, and an average cost that's lower, and the price is low. We don't really have a mechanism to eliminate this kind of excess capacity or to discourage the development of this capacity, and, in fact, we actually sort of have incentives that are aligned in the opposite direction. Most people get their healthcare from their employers. Your employer has staff that covers -- like, your employer has maybe 100 staff, a couple of hundred staff, in all different neighborhoods, and so, they need to have all of the local hospitals in their

network. That means that all hospitals are covered and most patients are well-insured, and so, patients are shopping on quality and convenience, not price. Price is not what gets hospitals nice reimbursements, and so, the incentive is if -- for them to always upgrade their facilities, and upgrade their equipment, and to try and be the best kind of cutting edge facility. That's a dynamic that drives up costs kind of constantly, and so, it's a little deeper. The prices tend to be an outcome. It's more a dysfunction that we have that's unique, I would say, to the payer being dominated by group -- group payment for care, that is ultimately pretty price insensitive.

A good -- as a sort of final part of the landscape, I just kind of wanted to sort of quickly touch on the issue of drugs because when you sort of think about the what are called regulated prices in other countries, there's a lot of rhetoric about value and assessing, like, optimal value, but when it comes down to it, what are the actual levers that other countries have?

Overwhelmingly, it's just to leave a drug off a formulary. It's just not -- it is to not refuse to cover a drug that is a high cost drug. Other countries maybe have -- they have reference pricing, they say we'll cover drugs up to this price, and then people are on their own for marginal costs above that, incremental costs above that, for drugs in a class, the costs an incrementally large amount, and it obviously creates leverage.

Now, we could do this, if we allowed drug plans to be more aggressive with formularies. We could allow drug plans to do reference pricing, certainly to an extent that they're not permitted to do under Part D, but it's, essentially, a lot of the tools the private insurers already have. Now, we're deliberately choosing to not allow them to employ these cost control tools, which means that, on some levels, the United States has more generous access to drugs than most other countries, more generous coverage of drugs because, if you think about the share of household consumption that's out-of-pocket on drugs, the United States is way down there because our drug benefits are structured to be very generous.

The flipside of this, as everyone knows, is that the cost of prescription drugs are, at least through the cost of the plans for prescription drugs, aggregate spending on prescription drugs, and prices for prescription drugs and also physician administered drugs, in the United States, are much higher than they are in other countries, but, at the end of the day, it kind of comes back to the same fundamental tradeoff that underlies everything between quality, access, and cost.

MR. GINSBURG: Thank you very much. All four of you had a lot of interesting things to say. Let me ask if there are -- any of you would like to offer comments, elaborations, or anything else on the -- on what your panelists have said?

MR. ELSHAUG: Paul, if I may, given there's a pause, I guess, just to start off, on Chris's last point about the drug coverage. When we were planning this session, there was some discussion between the group around whether there -- we ought to jump into myth busting in some areas. The pharmaceutical prescription medicine area is one that is really rife with myths about how other countries do it, and it's quite a shame because, in fact, many of the other countries that do have quite novel purchasing policies are really relying more on market mechanisms.

So, there's a real irony there, that it's sort of market -- basic market purchasing mechanisms that are allowing them to achieve the lower prices, so, the idea that they're just sort of missing out on drugs. So, for Australia, you know, there's simply no evidence that Australia's missing out on any, any drugs that are valuable, of value, and that's the point, and within a class, you can say, well, you know, you need access to six or seven drugs. Well, why? If they're -- if they only need two drugs that are doing the same thing, why do you need access to six or seven drugs, when two or three might be all you need?

In fact, what tends to happen in countries, like Australia, through our reference pricing and our cost minimization analyses, is that we actually find that drug companies are coming in to actively compete with one another to reduce the prices for us. So, we are not demanding low prices. They are coming in because they want market, and they're coming in and undercutting their competitor to lower the prices.

So, it's actually quite a functioning element, there, and I pointed to a paper that we wrote in Health Affairs a few years. You can see some of the charts that we provide. There's clear evidence that every -- any time a drug is rejected, it's rejected on a value basis, and what happens is what happens in a market. The manufacturer tends to come back with a new price, and if it's still not cost effective, they get rejected again, and then guess what? They come back with a lower price again, until they reach a willingness to pay a threshold, and then it's added to the formulary.

So, it's actually quite a functioning system, and it's a myth, I think, that has crept into the

United States, that, somehow, countries are losing access, and the ultimate, the ultimate dividend there, is it's playing out in our health outcomes. You've seen the -- you've seen the data, so.

MR. GINSBURG: Exactly, yeah. Let me turn to Miriam and -- because I was hoping that we could focus on services --

MR. ELSHAUG: Sure.

MR. GINSBURG: -- and I don't want to go too far into prescription drugs. Miriam, was your comment about something other than prescription drugs?

MS. LAUGESEN: Yeah, no, it wasn't. Quick question, or I mean comment for Chris. I really enjoyed hearing about your comparison of MRIs, and the quantity, and the -- I think the point you were making was related to productivity, and I think that's something that, you know, maybe there's more to be squeezed out of our system, if we can focus more on productivity. That might be where we find savings. That's all.

MR. GINSBURG: Yes. Thanks. Actually, I had a perspective on -- from Chris's finding because I was, you know, part of a McKinsey Global Institute study, a number of years back, that tried to understand the differences in spending between OECD countries and the United States, and one thing they really focused on was the outpatient sector, and the perspective I got there, which I think comes through very well in Chris's slide, is that if you happen to set the price very high, as the United States has done for MRIs, what happens is a lot more capacity comes in, a lot of people do it inefficiently because there's no price discipline.

In fact, you know, even in the Medicare program, which tries to have an administered price system, you know, they look around at the capacity utilization, and they allow a high price in Medicare, not as high as private insurers. So, in a sense, it's something where it goes, you know, once your prices are high, you invite a lot of entry. It's kind of like monopolistic competition. You invite entry, the productivity goes down because people are doing it not at scale, and it perpetuates the high prices.

MR. POPE: I think something that's interesting with the -- when you think about productivity, in a sense, is that that's, I think, quite often linked with the concern about rationing, at some level. So, if you think about the most efficient hospital is one, from a cost perspective, is the one where there's a shortage of beds because there are no missed appointments. Like, say, you got 100 percent --

110 percent of the capacity, like, you can have people in beds, like, in the end, and you can schedule very tightly, and that's very, very efficient from a spreading overheads perspective, when you think about hospital care.

Like, so much of hospital care is suddenly in the short-run overhead costs. Even the labor cost, in the short-run, is overhead cost, and so, when we think about the United States, you sort of -- you look at, like, the average hospital capacity in the United States is, like, in the low 70s percent, 73-75 percent. In Europe, it's like maybe 80-85, but in rural areas in the United States, what we see, that it's -- it can be 30, in the 30s, and quite often lower, and so, this question of, like, is there efficiency to be squeezed out of the system by getting the capacity up, or kind of it shrinking down, or like what we're willing to tolerate, in terms of access to facilities.

That's a really challenging one, politically, if you think about, like, rural hospitals, rural access to care. There's an enormous amount of inefficiency that comes from that, but you very quickly run into a lot of political constraints, and the political constraints that you thought were driving up -- or what you thought was a market system driving up costs, it turned out there was a lot of politics behind those market prices, and you run into the same politics if you try and set administered prices that are any lower. So, I think that that is my greatest concern, with the notion that the administered prices or kind of any kind of regulated prices, that it would make much difference for things, other than setting a payment floor. Every hospital is happy with the floor, rather than the ceiling, obviously.

MR. GINSBURG: Thanks.

MR. WILLIAMS: Yeah. In -- yeah, I wanted to build upon that a little bit, and really talk about kind of the data infrastructure that underlies this, and the transparency associated with that. Miriam, I would love to kind of hear, from your analysis and work with stakeholder engagement, how you actually use the data and information, those inputs about costs and output, to balance some of those tradeoffs that Chris was talking about.

MS. LAUGESEN: I think they -- the payers in other countries, traditionally, have somewhat lagged the United States, in terms of availability of data, traditionally. I think they're catching up, but I think the data's used for very different purposes, and I think that the challenge that we have, in this country, is we have a lot of access to data, but it's so bifurcated between different payers and

different payment systems, and, you know, there's no sort of standardization, so.

I think other countries are developing. I know Germany's developing its capacity, in terms of health outcomes and looking at quality and issues like that. I think there -- there's definitely a lot of movement in that area.

MR. GINSBURG: Thanks. Let me turn to a question I've prepared, which is, considering the various high-income countries mentioned in these discussions, I presume that some might be better candidates than others for the United States to learn from, given the differences in financing delivery systems. In other words, particular price restraint policies in some countries have more potential to fit into the United States system. What characteristics make a country more suitable for us to learn from?

MR. POPE: Without directly answer the question, I think the most helpful thing to think about, which are the countries to learn from, is which of the countries started out in -- with similar sets of problems, and faced similar sets of problems in the past. Rather, I think there is this game in health policy, that you kind of pick your utopian healthcare system, that they would like to leap over, and have this kind of arrangement, but looking at a country that has faced a similar set of challenges in the past, and attempted to address them, and done so successfully, hopefully, that's probably the best way to go.

I think in terms of our problems with -- if you think -- and I kind of agree with Miriam's point that, like, the what she called, like, lack of standardization, or what I think often get referred to as fragmentation between payers, and that's a problem that the Netherlands had, really, for many years, and then about 20 years ago, for a number of years, they worked on really consolidating their payers, aligning them with individuals, moving away from an employer to employ a fragmented system, and then you could a more systematic concern about price determination.

And the fact is they're determining prices, whereas I think a great vulnerability that we have in the United States because we don't just have different payers, we have entirely differently types of payers. Any conversation can quickly get nipped in the bud, quite often quite far down the process, by saying, yeah, but what about this strange circumstance, where, like, a proposed reform is going to be completely inappropriate, and obviously interest groups pretty good at finding those kind of excuses to torpedo cost controls.

MR. GINSBURG: Thank you. Any other thoughts?

MR. ELSHAUG: Paul, I would just add that I think there's been a myriad of reforms over the last decade, through a number of countries, if you think about Germany, who we've spoken about, and the Netherlands. One of the things that I think that is a great takeaway is that these countries who have been so willing to go down the path of reform, and I think from that there could be learnings, both of things that have worked well and things that have not worked so well, and being open to that, and having the data to demonstrate those strengths and weaknesses is important.

I think, from the Australian example that I gave around the (inaudible) and the simple, I think, step of collecting input data, so, you know, cost input data, from across the country, from all, you know, public hospitals, at least, allows you to get a handle on what are the input costs to provide these services, from which you can start to benchmark pricing. That alone, I think, is quite a novel and very important insight, that I think most countries would gain from.

MR. GINSBURG: Oh, thanks. A question came in on Twitter, and I'll read it. We can't learn from other countries until we get past American exceptionalism, and the blind that we have the best results in the world. The question is: are we approaching that acceptance?

MR. WILLIAMS: You know, I would say, you know, from the working analysis that we've been doing at The Commonwealth Fund, that there is an increased desire to look at international comparisons. I think the recent experience we've had around COVID-19 and looking at how different countries have approached managing the pandemic has really opened up many people's eyes to looking at other countries for insights, and we've seen a dramatic uptick in policymakers, and the media, and other professionals kind of seeking those insights.

MR. GINSBURG: Thanks. I've got a question. Actually, in general, to what extents have other countries become enthusiastic pursuers of alternative payment models, like the United States seem to, at the moment, or -- I remember Miriam started out as if you like your fee-for-service, you can keep it. Has the rest of the world, for the most part, said, you know, we can manage fee-for-service?

MS. LAUGESEN: I think -- I think there's certainly been a lot of controversy. There would be a lot of controversy around that, the statement that fee-for-service is, you know, great, but it's sort of what a lot of countries use. I know from New Zealand, where I'm from, that it was also -- you know, it's been much more aligned, and I think that has driven interest in other funding arrangements. I

think the question is whether -- how changeable a system is, and I think, like, France, Germany, Japan, they're less likely to fundamentally reform all of their payment structures.

MR. GINSBURG: Yeah, you know --

MR. ELSHAUG: And --

MR. GINSBURG: Oh, go ahead, Adam.

MR. ELSHAUG: Well, and Australia's similar, I mean, to Chris's point that he made, a very good point about the blended payment models. I mean, Australia is actually looking to the U.S., in some ways. As I showed you in my chart, there is quite siloed funding structures in Australia, between commonwealth and state governments, which, you know, really doesn't lend very well to integrated care across the systems. So, we're really trying to think more towards blended models, and I don't think we'll ever do away with fee-for-service, but it's about the complementarities that we can meet.

MR. WILLIAMS: Yeah, and when you look at the high-income countries, I think there is a great amount of interest in looking at bundled payments, pay performance, the use of quality incentives, and other approaches that are very common in America, and one of the things that we have seen, particularly with our research partners that come to the United States from other countries, there's a real desire to understand how do we introduce those types of innovations? They look at things, like The Medicare Innovation Center, as a potential model for ways that they can introduce these types of innovations from bundled payment, pay for performance, and others in our countries.

MR. GINSBURG: Yeah. You know, one thing I'm struck by is that, you know, some time ago, how many countries adopted DRGs for their hospital payments, and it wasn't just because of the technical because DR -- going to DRGs for them must have meant either getting away from cost reimbursements, or getting away from, you know, much more -- a fee-for-service approach, so. Was that kind of -- I guess, do you see anything like that, as Reggie was mentioning, happening today, as far as great interest in what we're doing?

MR. ELSHAUG: Yes, in Australia, so, bundles, indeed, even sort of mixed capitation, blended capitation fee-for-service models. It's all -- no one quite knows where to introduce these innovations and on what scale, but they're certainly happening. Usually, the state levels are quite similar to the U.S., as well. There have been some innovative hotspots at the state level. So, it's moving in that

direction.

MR. GINSBURG: Okay. A question for, actually, for Adam. What's your assessment of how successful the structure of public and private coverage has been in Australia, in the ongoing challenges?

MS. LAUGESEN: Yeah, so, it's really reaching a bit of a point, now, where the country's starting to reassess that blended model. So, for history, it was over 20 years ago, a right-leaning government introduced some policies that really incentivized people to take out private health insurance who would not have otherwise. There were tax penalties, and the like, and it took the coverage from about 33 percent to almost 50 percent of the population, but, as Chris pointed out, sometimes, when you have these mixed systems, what that does is it drives the higher prices in the private system, and that has occurred. There have been six percent, year on year, private health insurance premium rises.

So, there is talk in Australia, now, of a potential death spiral of private insurance because younger people are dropping out, and there's questions around the role of a commonwealth or a Federal government that subsidizes private health insurance, to quite a large figure, now, almost eight billion dollars per year, to subsidize people taking up private insurance. So, there are questions around whether that money would be just better off going back into a public system to cover everybody, particularly with these inequities that are starting to appear in access to services across the system.

So, I watch this space. I'm actually writing a paper with Bruce Landon on this very issue, around these tensions that are occurring, and I think if the government were to remove some of those incentive payments and subsidy payments, I almost think private health insurance might almost fall over, or get to a point where it's no longer viable, yeah.

MR. GINSBURG: Oh, thanks. You know, Chris mentioned, in his remarks, that many countries allow their salaried physicians to devote a portion of their time to private practice, where I presume wealthier patients pay high fee-for-service prices. What are the consequences of this practice, which we see in a number of countries, for overall spending and access to care?

MS. LAUGESEN: I can speak about that. I think this is one of the -- it's sort of a myth, I think, that if you have that sort of private sector, it's going to totally undercut the public sector. I think that, in some cases, that it acts as a sort of a bit of a valve for pressure from very wealthy people. The

question is would it work in the U.S.? We have a lot, you know, we have a lot of very wealthy people, and it's a much more unequal society. So, perhaps, you know, that sort of arrangement would be more challenging in the U.S. than in, say, Germany or Australia, where they do it, or France, you know, where they allow some of that sort of buildup of demand for, you know, private care.

MR. GINSBURG: You know, I guess --

MR. POPE: It --

MR. GINSBURG: Oh, go ahead, Chris.

MR. POPE: I say that almost is like the heart of the art of health policy. It is -- like, China, like, gets this ideal where private spending supplements public spending, or public spending supplements private spending, rather than supplanting it, and that's -- it's -- there is no simple recipe because all the sources of all the potential pitfalls there are pretty numerous.

There are -- everyone wants to game the system, and the more complex it gets, the more difficult that gets to prevent, but I think that that -- that really is the game, like, if done well. You are bringing more private resources into the healthcare industry to add onto the public resources that would otherwise be available. If not done well, then it's -- you can end up with a system where, like, wealthy people get all the care, and the public system gets higher costs, and then that's -- that's definitely not what you want to set up, and you can easily fall in that kind of system, just because of the way the interest group politics might push you.

MR. GINSBURG: Yeah.

MR. ELSHAUG: And I think some countries are facing that problem, where there's cherry-picking of the services that the private hospitals, for example, might offer. So, they're more profitable. Services we found, in a number of countries that have, you know, the private systems have longer or length of risk adjusted lengths of stay, and the like, so, and there is an administrative burden as well, which is a drag on efficiency. So, you're starting to add in these inefficiencies the more you go down that road, potentially, unless you can control or regulate.

MR. GINSBURG: Now I guess the analog of this in the United States, which did not come from policy, is concierge medicine, where some physicians take themselves completely out of the delivery system for the bulk of us to give a higher level of care, and, you know, my sense is that it's been

going on for quite a long time. I used to get calls from the press, 10-15 years ago, about it, and it hasn't really become that dominant.

We've just about run out of time, and I want to close by thanking a bunch of people, first, the panelists, who I thought did magnificent work for this webinar. You really made the webinar, a good thing because of your work. I'd also like to thank my Brookings colleagues, Matt Fiedler and Lauren Adler, who work with me over what seems to be a very long period of time. This meeting, initially, was supposed to be an in-person, in May, and, obviously, we didn't go forward with that. I want to thank Brianna Knicker, and many at Brookings who provide a terrific support, and, finally, I wanted to thank the Robert Wood Johnson Foundation for a financial support that made these webinars possible. Thank you very much.

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