Moving Beyond the Drug Budget Silo Mentality in Europe

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Introduction

The funding and organization of health-care systems are designed to meet multiple goals. A major goal is cost containment, particularly in the case of public health-care expenditure, since this is a major component of the government’s budget, and all countries have a problem in balancing public expenditures and revenue. However, in most European countries, public financing has been introduced to meet the goal of equality of access to health care or some related notion of equity. A third important goal is economic efficiency, namely to maximize the output, in terms of improved health, from the resources available.

It is not surprising to find that the various goals sometimes conflict with one another, in so far as a policy designed to pursue one goal infringes on the achievement of another. Economists have pointed out numerous situations where equality of access may be in conflict with efficiency, as in cases where attempts are made to offer the same level of access to health-care facilities to individuals whether they live in cities or in remote rural areas. There is an obvious conflict between cost containment and equity goals, because public financing has been introduced to improve access in the first place. There is also a conflict between third-party payment (public or private) and economic efficiency, because this creates moral hazard—that is, insurance coverage affects the probability and amount of medical care used. However, during the past decade the focus has been on how the pursuit of cost containment may conflict with efficiency and the measures that can be taken to deal with this problem. There are many reasons for this. One is the slow economic growth in Europe in combination with increasing public expenditures for an aging population. A second is the continuous introduction of new medical technologies, pharmaceuticals in particular. These give new opportunities for prevention, treatment, and rehabilitation, but also put a strain on public finances when health-care systems want to make these technologies generally available to the population. Tensions develop, despite the fact that the funds have been provided to allow health-care expenditure to increase faster than the gross domestic product, and pharmaceutical expenditure to increase faster than health-care expenditure as a whole, in most European countries.

The articles in this supplement to *Value in Health* examine how six European countries have sought to control expenditure on pharmaceuticals, within the framework of the overall funding and organization of health care, and the consequences of these policies for economic efficiency. In the main, the focus is on public health expenditure, although in all countries there is some amount of private drug expenditure, financed through supplementary health insurance, copayments, or out-of-pocket expenditures. To some extent public policies also affect this spending, but cost containment measures have focused on public financing of prescription drugs in ambulatory care. This is also the largest and fastest growing part of pharmaceutical expenditure.

The supplement contains articles relating to each of the six countries (France, Germany, Italy, Netherlands, Spain, and the United Kingdom) and an introduction and overview by Garrison and Towse [1]. Various measures to influence pharmaceutical expenditure have been applied in the various countries. It can also be seen that the predominant goal has been cost containment and that, in applying the various measures, there is a tendency to adopt a “silo mentality,” that is, to consider separately the expenditure on particular health-care resources, in this case pharmaceuticals, rather than resource use overall. Adopting such a drug budget mentality is often likely to lead to inefficiency, since restricting expenditure on one budget might lead to even greater costs elsewhere in the health-care system. For example, pressures to reduce consumption of pharmaceuticals, or to use less expensive but less efficacious products, may lead to increased consumption of other health-care resources.

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This is not to deny the importance of cost containment as a goal for health-care systems or the need to place a specific emphasis on pharmaceuticals. Indeed, a number of the country contributors point out that pharmaceutical expenditure has risen more quickly than other health-care expenditure in recent years and that this has attracted particular attention. Some of the authors cite this as one reason why pharmaceuticals may have been “singled out” for additional cost containment. Another reason cited in the articles is that pharmaceutical expenditure is relatively easy to identify and is therefore an easy target for cost containment measures.

An additional possible reason is that other items of health-care resources are constrained in other ways and the government may feel more comfortable about keeping these under control. For example, in many countries there are controls on the number of health-care personnel, and their wages are subject to national pay bargaining. There are also often controls on investment in hospital capacity, which may help contain hospital expenditure. There are few such constraints on pharmaceutical prices or utilization. The moral hazard problem is also greater for pharmaceuticals than for services where patients’ time is an essential input to the production, such as visits and hospitalizations. The potential economic inefficiencies from policies aimed at controlling this are also greater, particularly when these policies affect not only static economic efficiency, but also dynamic efficiency through their effect on innovation and introduction of new technologies.

Rather than denying the need for cost containment and the conflicting goals, our aim here is to explore which policies to influence pharmaceutical expenditure have the potential to take us beyond the drug budget mentality and thus reduce the adverse effects, on efficiency, of cost containment measures. The discussion below distinguishes between policies at the macro level (normally central government) and the micro level (i.e., policies to influence the behavior of individual actors in the health-care system). Some of the country contributors also distinguish a meso level, focused on regional government. At this level there is often a mixture of macro and micro policies to influence pharmaceutical expenditure.

**Policies at the Macro Level**

The various articles outline a range of policies at this level, including mechanisms to allocate expenditure to the health-care system, pharmaceutical price regulation, and pharmaceutical reimbursement. To move beyond a drug budget mentality, expenditure targets or goals should relate to total health-care expenditure rather than individual components, such as pharmaceuticals, dentistry, and so on. For example, there is no reason to suppose that a given fixed percentage of health-care expenditure on pharmaceuticals, such as the mandated 13% in Italy, is the efficient level of allocation [2]. Nor is there any reason to suppose that the same percentage would be the efficient allocation over time, since this would depend on the level of innovation in the different sectors of health care.

Specific expenditure targets at the macro level for different types of health-care resources and services, be they private and public hospitals, ambulatory care, pharmaceuticals, etc., create the risk for inefficient resource allocation, at the same time as making cost-containment ineffective. In addition, expenditure targets should relate to public expenditures and not total expenditures, since there is no reason why the government should restrict private spending on health care.

It would be much better to make allocations of total public expenditure to lower tiers in the system (e.g., regions or local health authorities) and to let the decision makers at each level decide on the best allocation of funds among different types of services. In many of the countries studied, this approach is already followed, with allocations to the regional level made according to an agreed formula. However, countries differ in the respect to which these allocations represent firm budgets. Comparing the developments in France, Italy, and Spain, there is a trend toward regionalizing decisions about health-care spending, which gives the central government an opportunity to restrict cost-containment policies at the central level to a target for total public expenditures, distributed to the regions as a block grant.

A typical separation is between the budgets for primary and secondary care. However, some countries have even tried to break down this barrier, such as the United Kingdom, where the majority of the budget is allocated to primary care trusts (PCTs) that can then provide services themselves or contract with hospitals [3]. In principle this should encourage the efficient use of pharmaceuticals, since the PCTs need to consider costs both in primary and in secondary care when making their prescribing decisions.

Policies at the macro level for pricing and reimbursement of drugs vary greatly, often for historical reasons [1]. Those that focus on international price comparisons (e.g., Italy and Spain) by definition
only focus on drug acquisition costs. In contrast, policies that determine the price and reimbursement status of innovative drugs based on cost-effectiveness evidence in principle allow a wide range of costs and benefits to be considered. Some health economists have criticized these approaches as being inflationary, in that the true opportunity cost of adopting the new drug is not explicitly considered [4]. However, the decision to adopt a new technology (i.e., a new drug) should be based, at least in part, on the added value it provides in relation to the price.

Policies are also required to determine the adequate level of reimbursement for the wider range of drugs already on the market. Two policies predominate here, the promotion of generic drugs and reference pricing (i.e., reference-based reimbursement). These policies have similar aims, that is, to promote the use of a lower cost drug where one or more similar drugs exist. These two policies are also sometimes used in parallel. Probably the main difference is that reference pricing potentially infringes the goal of equality of access if patients face high levels of patient copay.

In many cases the potential equity problem created by the increased out-of-pocket payment for some prescribed drugs has not arisen since, on the introduction of reference pricing, manufacturers have reduced the prices of their products to the reimbursement level to avoid losing market share. Nevertheless, problems could occur in situations where reference pricing is extended beyond products with similar chemical composition to products with similar therapeutic effects. Here the potential exists for different levels of copayment if a given manufacturer believes its product is superior and consequently does not reduce the price.

The general conclusion must be that policies aimed at setting prices for drugs administratively are inefficient as cost-containment measures. Price controls of different types control prices, at best, not expenditures. Expenditures on pharmaceuticals are mainly determined by quantities or indications and the introduction of new drugs. Since price controls are inefficient as cost-containment measures, but have well-documented negative consequences for efficiency, it may make sense to abandon these policies. However, as mentioned above, it would be reasonable to have a mechanism at the central level to decide which drugs and other medical technologies should qualify for public financing. Clear criteria for reimbursement and a transparent decision process are lacking in all the reviewed countries, with the possible exception of the National Institute for Clinical Excellence (NICE) in the UK. This does not mean that there needs to be a central target for pharmaceutical expenditures. The decisions about use of the reimbursed technologies could still be made at a lower level in the health-care system, with proper incentives for cost-effective use. They should also apply equally to all health technologies, not just drugs.

**Policies at the Micro Level**

One major deficiency of most of the macro policies is that they have very little influence on prescribing volume, although this may be partly influenced by the reimbursement status that is granted to a particular product. However, at the micro level there is a much greater possibility to influence not only which drugs are prescribed, but also how much is prescribed. The authors of the articles identify a wide range of policies to influence prescribing at the local level, including providing information to prescribers, offering financial and other incentives, and developing clinical practice guidelines.

Policies that focus on pharmaceutical expenditure alone run the risk of inefficiency in situations where reductions in drug costs lead to increased costs elsewhere. Therefore, it may be unwise to offer incentives for measures that go beyond generic substitution without having evidence that these measures are cost-effective. Indeed, a major impediment to developing policies at the micro level is the absence of a good evidence base on cost-effectiveness. This further emphasizes the need for national policies to promote health technology assessment and the dissemination of the findings of these studies.

The articles report an increasing, but still limited, importance for economic evaluation of drugs and other health-care technologies in the six countries. One reason for this seems to be that these studies are seen as, and used as, a cost-containment instrument. However, health technology assessment, including economic evaluation, is an instrument that aims at improving the efficiency in the use of resources. Because technology assessment and economic evaluation takes a broad societal perspective, including the health-care sector but not limited to health-care expenditures, it is an instrument that can be used to identify and counteract the silo mentality.

In principle, the development of clinical practice guidelines that usually have a broader disease focus offers the potential to take us beyond the drug budget mentality. However, the development of
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... guidelines is not itself a costless process. In addition, decisions must be taken on whether guidelines are better developed from the bottom up or promulgated from the top down [2]. However, at the micro level the development of disease-based guidelines, backed up by the appropriate incentives, offers the best chance of going beyond the drug budget mentality.

Conclusions

We have considered the various policies for influencing pharmaceutical expenditure in Europe in relation to whether they encourage or discourage the drug budget mentality. Our views are summarized in Table 1. Given the multiplicity of goals in health-care provision, we recognize that compromises are always necessary in the development of health policies. However, the main conclusion here is that economic efficiency—maximizing health outcomes for a given total budget—is too often sacrificed in the pursuit of cost containment. Therefore, the adoption of policies that take us beyond the drug budget silo mentality and reduce the conflict between cost-containment and efficiency should be encouraged.

References


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<td>• Specific funding for specific types of health-care</td>
<td>• Assessment of value based on technology assessment and cost-effectiveness analysis.</td>
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<td>• Allocation of specific budgets for individual resource items (e.g., pharmaceuticals) or types of services</td>
<td>• Overall allocations of health-care expenditure based on block grants (population-based budgeting)</td>
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<td>• Cost-containment measures aimed at specific resources or services</td>
<td>• Allocation of resources for specific disease programs rather than types of services or resources</td>
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<td>• Price controls</td>
<td>• Rewarding providers by capitation, for example, DRG payment to hospitals and payment per patient listed to GPs</td>
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<td>• National-level line-item budget allocations for drugs</td>
<td>• Development of disease-based practice guidelines and related monitoring of care provision.</td>
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<td>• National-level, across-the-board percentage price reductions or paybacks for drugs</td>
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Table 1  Policies in relation to the “drug budget silo mentality”