UpDate

I. CONFERENCE SUMMARY

American Business Looks Abroad

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Learning from Other Health Care Systems
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In every Western industrialized nation, health needs and demands continue to outstrip the resources available to meet them. Needs rise inexorably along with the average age of populations; demands increase as a consequence of real and perceived needs, medical advances, and growing public expectations. In most major Western nations (Canada, France, the Federal Republic of Germany, Italy, Japan, and the United Kingdom), the resources that are consumed every year by personal health services have essentially stabilized; that is, health spending growth is no more rapid than that of other goods and services.

The American health care system, however, continues to outspend other sectors of the U.S. economy. Thus, health expenditures, which totaled 10.5 percent of the gross national product (GNP) in 1984, increased to 11.1 percent of GNP in 1987 and are projected to exceed 12.0 percent by the end of this decade. U.S. medical care not only is the most expensive in the world and consumes a larger percentage of its country's national income, but it also is growing faster than in other countries.

This growth rate, which exceeds that of virtually all other goods and services in the American economy—as has been the case almost without exception since World War II—is a source of mounting concern among America's business community, which pays a substantial part of the bill. Major corporations share a particular concern because they compete in international markets, where the differential in health care spending becomes an additional expense in the cost of the goods and services they produce. Also, American business is being called upon not only to pay for the care used by employees and their families but to underwrite the large and growing expenses of the services used by the uninsured and those protected by government programs.

As a reflection of these concerns, several large, major corporations, all among the Fortune 500 and including Chrysler Corporation, Ford Motor Company, General Electric Company, Hewlett-Packard Company, and Xerox Corporation, sponsored a symposium in March 1989 at Brandeis University to examine policies employed by other Western nations in stabilizing their spending for health care and to explore whether these policies are a detrimental influence on access to and quality of care.

The meeting brought together corporate representatives and academicians recognized for their knowledge of foreign health systems and health economics, including Stuart H. Altman, dean of the Graduate School of Social Welfare, Brandeis University, who chaired the meeting; Robert J. Blendon, chairman, Department of Health Policy and Management, Harvard School of Public Health; Robert G. Evans, professor of economics, University of British Columbia; William A. Glaser, professor of health services management, New School for So-

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cial Research; Sidney Lee, Harvard Medical School; Joseph P. Newhouse, professor of economics, Harvard University; Uwe E. Reinhardt, professor of economics, Princeton University; Victor G. Rodwin, director, Advanced Management Program for Clinicians, New York University; and George J. Schieber, an economist at the Health Care Financing Administration (HCFA).

Overriding Themes

Centralization. Several overriding messages dominated the meeting. One was that the health care systems of most Western countries—all of them democracies—depend far more heavily on centralized mechanisms to constrain spending than does the United States, which features a high degree of pluralism among payers and providers of care.[1] In most instances, when analysts discussed the importance of such controls, they referred to centralized or regionalized payment mechanisms, although also mentioned in this regard were governmental policies that affected capital investment in plant and equipment, extent of specialization by physicians and others, and other factors that influence spending.

Within this context, the analysts emphasized that: (1) these centralized control mechanisms influence both public and private health insurance payment flows and out-of-pocket spending by patients; (2) they were fashioned by Western governments with substantial participation by the medical profession and other interested parties; (3) they are structured in ways that create a framework or an organized system through which government, the medical profession, and other parties pursue ongoing interaction; (4) they were deemed as necessary policies to balance the ever-increasing demands for care with the limited resources available; and (5) they were generally accepted by the citizens of the respective countries without provoking unmanageable controversy.

Without more central or regional controls, the assembled analysts cited a remote likelihood that the United States will find a formula for moderating the rapid growth of health care spending. Payers and physicians in the United States wage constant guerrilla warfare because the U.S. system lacks any form of organized relationship. The warfare, waged on legal, political, and social fronts and without the overarching policy framework that exists in other major Western countries, involves continuing efforts by the embattled participants over physician income levels, shifting costs between payers, and other issues that reflect the economic rift between payers and physicians.

An important corollary to this first message was that those Western countries that have opted for central or regional spending controls neglected to build into their systems incentives that encourage experimentation with alternative delivery modes. The rigidity of centralized policy mechanisms often can make constructive change more difficult. Also, such policies tend to favor general access to adequate care over specialized responses to individual need. The analysts characterized the most important strength of the pluralistic U.S. system of health care delivery and finance as its capacity to innovate in response to new health care problems. Few Western systems have demonstrated a similar degree of interest or capacity to test such delivery and finance approaches as prepaid group practice and other variations of the health maintenance organization (HMO) model, the multispecialty medical group, and the preferred provider organization (PPO).[2] However, the importance of these models to promoting cost-constraining physician behavior in the United States remains a question in the minds of more than a few corporate employee benefits managers.

Spreading risk among sectors. The second overriding theme dealt with the preference of other Western countries to embrace policies that spread the financial risk of illness across substantial segments of the population, rather than simply on each employer's work force, as is increasingly the case in the United States. By spreading the insurance risk in this fashion, industries whose employees are greater medical risks or older, on average, are not saddled with the higher premiums to finance these extra expenses. Rather, the cost of care is distrib-

uted across the population in a way that no one employer or industry is faced with differentially higher health costs.

Such a broad-based approach reflects a belief that illness is a social phenomenon and that its financial consequences should be shared equitably by society. It further reflects the view that the higher expenses of protecting an older and/or sicker work force cannot be influenced or controlled by that work force or its employer. A counterargument is that, without such a focused responsibility, U.S. industry will lose its few incentives at the individual employer level to control unnecessary or marginal health care use.

Nevertheless, most participants believed that the individual employer alone, no matter how large, lacked the ability to affect seriously its health care spending. One company representative said, "We must certainly explore more seriously state and regional systems of care where risks could be spread on a more equitable basis." But, reflecting the division of opinion in the corporate community on this issue, another company representative asserted that there is "a cultural shift against [continued] cross-subsidization" of the cost of care, and, as a consequence, many companies no longer are willing to share the health cost burdens of other, usually older, industrial firms.

The prevalence of "experience rating" of employer-based health insurance was apparent in a recent survey of small, medium, and large employers (private and public), all of which offered group health insurance to their employees in 1987. The survey found that 52 percent of the employers surveyed assumed the financial risk (self-insurance) for protecting their workers against the economic consequences of illness. The survey estimated that of 117 million Americans with conventional, employer-provided health insurance coverage, an estimated 60 percent are enrolled in some type of self-insurance—up from 5 percent in 1975.[3]

In opening presentations, Schieber discussed health spending trends in the Western world, and Blendon presented results from a survey that compared public attitudes about health care in Canada, the United Kingdom, and the United States.[4] Schieber noted that centralized or regionalized controls allow other countries to manage their systems under one set of operational controls. Many other countries, he said, also impose tighter restrictions on hospital-based physicians, use less inflationary ways of paying all physicians, and control hospital capital investments more tightly by requiring prior governmental approval before allowing further development.

Health System Models

Most Western societies view *basic* health care services as necessities to which every member of society should, by virtue of citizenship, be guaranteed access regardless of ability to pay. Whatever the cultural and political complexion of most Western countries, this general proposition is universally shared, except in the United States. Thus, in this country, those without adequate coverage find it much more difficult to locate and pay for care and thus rely disproportionately on public hospitals.

While universal access to health care is the norm in the Western world, the approaches to such care vary among nations along cultural and political lines. Glaser outlined three distinct models. Government plays the most formidable role in the first model: a centralized health service (the United Kingdom, Sweden, and Finland), which nationalizes hospitals and assures access to ambulatory services. Under this approach, central governments set policy and usually administer the scheme, although in Sweden and the United Kingdom, subnational governments also play a management and financial role.

The second model is a national health insurance approach, in which governments assure comprehensive coverage for health care services and establish policies for all payers. The provision of hospital services may be in both the public and private sectors. Ambulatory care is predominantly in the private, fee-for-service sector. A remarkable variety of mechanisms exist under this model. For example, in Canada, govern-

ments (national and provincial) finance health services, but physicians are private, fee-for-service practitioners; plan administration is performed by provincial governments or quasi-public authorities. Canadian hospitals themselves are quasi-public institutions; that is, they remain private, nonprofit organizations but operate with negotiated annual budgets derived from governmental sources. They have little flexibility to move in directions that are not agreed to by government authorities.

In France, 99 percent of the population are covered under national health insurance. Health services are financed through the social security system on the basis of employer and employee contributions. Health insurance funds within this system operate under close supervision of the central government. In Germany, virtually the entire population is covered by comprehensive, mostly private insurance plans—"sickness funds." As in France, the German government provides a statutory framework that affects private and public payers. The German government also finances hospital capital expenditures and thus is an active participant in planning inpatient capacity. However, the independent sickness funds are the major negotiator with physicians and hospitals.

The third model reflects the U.S. approach: strong reliance on the private (nonprofit as well as for-profit sectors) with multiple government roles. At the federal level, there is a strong government role in the *regulation* of health care providers and payers. Government also figures strongly in the *provision* of care for certain categorical groups (for example, veterans and Native Americans) and the *financing* of care for the disabled and elderly populations and categorically defined individuals of all ages who lack the resources to pay for their own care. Increasingly, though, federal and state government roles are growing more intrusive as frustrations mount over the largely uncontrolled cost of care.

Altman concluded from the discussion of the different models that (1) Americans may learn more from the non-English-speaking systems of Germany, France, and Japan, where systems reflect a partnership between government and private employers, than from Canada and Great Britain, where health care is financed by government and private employers play a relatively inactive role in health policy making; and (2) the administrative entities of many foreign health care systems are not simply management arms of the central government but have a degree of independence, thus placing a buffer between the profession and strict government control.

The discussion then turned to the consequences of different methods of financing medical care. One analyst noted that, increasingly, Americans pay different premiums based on their experiences with the health care system (that is, use of services, health status, and age). One company representative noted that some 30 percent of health care payments ($150–$175 billion) are made by users at the point of service. He asked: "How do you shift those payments to some other funding source? Should we remove it from a direct patient obligation and pay for it another way?"

Another analyst responded that these payments represent a wide variety of services—long-term care, dental services, prescription drugs, and others. He noted three sources of financing: tax revenues, health insurance premiums, and patient cost sharing. "All of these payment mechanisms involve distortions" in the manner in which the services are used; "some mix of the three is not such a bad approach," he said.

Organized Decision-Making Policies

Time and again, analysts returned to the importance of central management in gaining tighter control over medical spending, physicians and their specialty distribution, the geographic availability of hospital beds, and the degree of specialization of individual hospitals. Reinhardt asserted that "the multiplicity of flows of dollars, totally uncontrolled, is designed to maximize the resources consumed by the health care delivery system. Even the largest funding spigots are small. That is to say, no one funder, with the exception of Medicare, has enough le-

verage to exercise it in a fashion that moderates medical spending growth in the United States." Rodwin reminded the group that national health insurance "may be necessary but certainly not sufficient to solve either the access or cost problems in a system. In health systems that rely on large components of private provision, however, it is a useful mechanism for combining global budgeting and physician fee schedules with financial security."

In response to Reinhardt, one company representative asked whether "the United States should reconfigure its health care financing scheme along more centralized lines." If so, what should the system look like? Altman suggested a specific model: a state-based, all-payer system. Such a model would blend decentralized private insurance administration with regionally determined health care reimbursement. The regional or state authority, which would have governmental authority, would operate independently of government and would set physician fees and hospital rates for all payers, public and private. Individual employers would still be responsible to determine their level of health care benefits above a government-mandated minimum and their control over employees' use of services.

The Canadian Example

One system that features combined national and provincial public financing with administration of the payment system at the provincial government level is Canada. Evans, a Canadian economist and a strong advocate of Canada's provincial health insurance plans, outlined reasons for Canada's success at constraining health spending. Virtually the entire difference between U.S./Canadian share of GNP devoted to medical care stems, he believes, from three factors: (1) the higher U.S. costs of administering a plethora of health insurance plans; (2) higher U.S. payments to hospitals; and (3) the higher fees and incomes of U.S. physicians. Evans estimated that, relative to the expenditures that might have been generated by a system comparable to Canada's, in 1985 Americans spent about $20 billion more for insurance and just under $30 billion more each for physician services and hospital costs.

Evans estimated that in 1985 the overhead component of health insurance—the share of premiums that pays for the handling of the flow of paper and dollars—cost Americans each $95 of their overall $1,710 per capita expenditure. Canadians spent $21 per capita in Canadian dollars, which are worth about 20–25 percent less than American dollars. He further pointed out that Canada spent less per capita to administer its universal, provincial health insurance plans than did Americans to administer Medicare and Medicaid alone, which finances the care of only one-fourth of the U.S. population.

Evans emphasized that Canada's provincial health insurance plans control expenditures through the allocation of global budgets to hospitals and ongoing negotiations with physicians over price and, in some provinces, volume of service. Hospitals' operating budgets are approved and funded almost entirely by the ministry of health in each province, but they include no allowance for capital expenditures. New facilities, equipment, and major renovations are funded from a variety of sources, but they require the approval of the same provincial agency, which generally also contributes the major share of financing. This process of centralized approval bars hospitals from private capital markets.

Spending on physician services in Canada has been restrained by fee schedules that are negotiated by the provincial ministries of health and provincial medical associations. These processes provoke considerable conflict, but they are accepted by physicians as an integral part of their ongoing relationship with government. Evans concluded that "the crisis rhetoric utilized by physicians is a necessary part of negotiations, so Canada will never get away from the crisis atmosphere." But he asserted that "the stylized political combat in Canada" has done little to intrude on the professional autonomy enjoyed by physicians there. Indeed, he declared, while the economic freedom of physicians in Canada is constrained, they

enjoy considerably more clinical autonomy than do physicians in the United States. He concluded his remarks by saying that Canada has done "incredibly little to evaluate the appropriateness of health care provided to that country's twenty-five million consumers, but that the provincial plans are now moving to examine the efficacy of care they finance."

Newhouse discussed the findings of his recent study comparing inpatient hospital volume in two Canadian provinces (Ontario and Manitoba) with both the United States as a whole and selected states.[5] His analysis was limited to the care provided to individuals age sixty-five and over because they receive universal public insurance in both countries. The study found that, in the early 1980s, the United States spent nearly 50 percent more per person on hospital services than did Canada. Newhouse indicated that he was not certain what accounted for the differences in spending; hospital admission rates were quite comparable between the two countries, and patient lengths-of-stay were markedly longer in Canada.

The study did not address the question, What, if anything, of value are Canadians giving up as a consequence of their lower hospital expenditures and surgical rates? Later in the conference, Thomas Moloney, senior vice-president of The Commonwealth Fund, noted that Commonwealth is considering (and has since approved) a major new initiative to fund a series of studies to examine the Canadian health care system in more depth.[6]

Physician Payment

How a society pays physicians, Reinhardt said, is a measure of how it chooses to protect the public trust. He suggested that the United States may be the only industrialized country that has not yet subjected the level of physician compensation to social arbitration, depending largely instead on market forces. "Most countries have recognized that they must create a quasi-market," he said, to allocate health care resources in a way that broadly reflects the interests of society. The Physician Payment Review Commission (PPRC), of which Reinhardt is a member, has embraced the creation of a Medicare fee schedule as one element of such a regulated market.

Western countries compensate physicians using three methods: by salary, by capitation, and by fee for service. A salaried physician works for a larger institution, interacting freely with colleagues. This payment approach is most frequently found among hospital-based physicians, particularly in Germany, Italy, England, and the publicly owned hospitals of France—two-thirds of all French hospitals.

There are two approaches to payment by capitation: (1) indirect capitation, which is prepaid capitation for comprehensive care, paid to an organization, which in turn procures services either from an employed, salaried physician or from self-employed physicians on some form of fee basis; and (2) direct capitation, which is prepaid capitation, paid directly to a physician for services rendered. Indirect capitation is essentially an American phenomenon, typical of the payment method used by HMOs. Great Britain's National Health Service relies on direct capitation to pay primary care physicians, but such payments represent no more than 60 percent of their incomes.

Where physicians are compensated on a fee-for-service basis (Canada, France, the Netherlands, and Germany), fee schedules are negotiated between insurance funds or governments and associations of physicians. By embracing the development of a Medicare physician fee schedule, Reinhardt said, PPRC is moving the United States in the direction of negotiated payment arrangements between payers and physicians.

One major distinction that exists between the United States and most other Western health care systems is that, for the most part in the foreign systems, patients have considerably less financial dealings with their physicians. In most foreign systems, physicians accept as payment in full fees that are established by a negotiated schedule. In Great Britain and Italy, physicians in the public sector do not have the discretion to bill patients directly for amounts above set fees. In Germany and in Canada's provinces,

physicians accept the insurance carrier's fees as payment in full. By 1986, direct charges to patients had virtually disappeared. Reinhardt said PPRC has "tiptoed around" the issue of whether to recommend that Congress apply a mandatory assignment policy to physicians who treat Medicare patients, thus requiring them to accept Medicare's allowable reimbursement as payment in full for their services. Another analyst who is knowledgeable about congressional thinking said that Congress has demonstrated a preference for encouraging physicians to accept assignment voluntarily rather than dictating such a policy.

Reinhardt took particular note of the absence of private business attention to PPRC's activities: "No business representative has asked to testify, although physician payment reform certainly must include cohesion among {public and private} payers." He predicted that the business community might "savage" the commission's recommendations because the creation of a Medicare fee schedule would affect only about one-quarter of physician billings, thus increasing the likelihood that doctors may increase their fees to private-pay patients in an effort to maintain their incomes. The prospect of such a possibility is less if the business community becomes involved in PPRC's activities, Reinhardt suggested.

Following this discussion, the participants returned to a recurring theme: until the United States fashions a health policy that incorporates all payers, medical expenditures will continue upward at rates deemed unacceptable over the long run. One analyst suggested "global budgeting" for all health care expenditures. A company representative said, "We tried in Michigan to control physician spending by constraining prices, but the effort failed because controls must apply to the whole picture through total budget planning and expenditure caps." The collective response of the analysts suggested that they were not sanguine about the prospect that any instrument other than political judgment could determine the proper size of a global budget. Once the size of the budget was set, technical criteria such as population, age distribution, and morbidity could determine its allocation.

Urgency Of Reform: Corporate View

The pluralism that dominates American medicine also reflects the culture of the corporate community. As a consequence, American corporations hold a range of views on what steps should be taken to make health care universally available but affordable in the future. This diversity was demonstrated at the meeting; however, the corporate representatives shared two important opinions: (1) the status quo of health policy is unacceptable to a large number of firms, and (2) in the future, greater attention must be paid to educating America's corporate chieftains about health care issues and, most importantly, determining how they will be involved in key national legislation.

A company representative who spoke to these points said, "The level of interest and understanding of the importance of this problem is higher than it has ever been before, but the executives who must make the decisions are not fully up to speed on the issues. The interest has been fueled by the forthcoming FASB (Financial Accounting Standards Board) standards." The standards are expected to require employers to phase in recognition of their unfunded liabilities for retiree health benefits promises as an offset to corporate income in 1992. Employers may be required to recognize fully the present value of their unfunded liabilities by 1997 for both current retirees and workers eligible for retirement.

At the same time, another corporate representative conceded that "most CEOs are looking for the magic bullet, the painless solution. They must be educated that these are complex problems that will require corporations to take risks and at times introduce policies which will not be liked by their employees." One of the necessary but currently missing ingredients for the pursuit of reform, he emphasized, was the development of a more ambitious research effort through which alternative health system models could be fashioned.

Another company representative re-

sponded, "The CEOs must be the target of any effort, and the effort must go beyond a definition of the problem. CEOs must also understand that mandated benefits have some positive features" that may balance the corporate community's opposition to government mandates of almost any sort.

To balance out these views, one representative said his corporation has not lost faith in the pluralistic system of American medical care. He said his company was, however, seeking to assure itself that it was getting "the best bang for its health care buck." The company was pursuing this goal in part by striving to establish defined high levels of quality and then locating cost-effective providers meeting that standard. For example, in adding a heart transplantation benefit, the company has pursued this agenda aggressively, with encouraging results.

Conclusions

After a day of discussion, no effort was made to achieve consensus, given the vexing nature of the issues involved and the divergent interests of the parties who participated in the discussion. Nevertheless, several items garnered considerable support, particularly among the analysts present: (1) the importance of a degree of centralized or coordinated control mechanisms for moderating the growth of health care spending; (2) the value of a community-rated health insurance system that spreads the financial risk across society rather than basing it on a fragmented experience-rating system; (3) the likelihood that health spending growth would remain uncontrolled absent a national health insurance system, the fashioning of which simply would not take place without stronger government leadership; (4) the necessity for private corporate chieftains to become involved and more informed about the critical stake they have in health care reform; and (5) a more substantial research investment in examining medical care for its appropriateness and efficacy.

Perhaps most important was the level of interest by the corporate sponsors to work closely with the research community in fashioning a solution to the twin problems of increased access to care for the uninsured and the excessive costs of the American health care system.

Along with decent compensation, working Americans have generally come to expect that their jobs will provide adequate health insurance coverage. Unfortunately, the increasing cost of care at rates that outstrip spending growth of virtually any other commodity is causing some companies, both large and small, to pull back from the comprehensive coverage they previously made available to their employees. Other companies are questioning whether to consider alternatives to the financing system the United States has developed to pay for health care.

While government must be an instrumental force in the pursuit of any broad-scale reform, little progress will occur without serious expressions on the part of American business that it will not continue to underwrite the uncontrolled growth in health spending and that it is willing to consider significant changes in the structural characteristics of the U.S. health care financing system.

NOTES

1. In several nations studied, the "centralized" authority of the national government has been delegated to either regional governmental bodies, such as provinces (Canada), or semi-independent authorities.
2. V.G. Rodwin, "New Ideas for Health Policy in France, Canada, and Britain," in *Success and Crisis in National Health Systems: A Comparative Approach*, ed. M.G. Field (New York and London: Routledge, 1989), 265–284.
3. J. Gabel et al., "The Changing World of Group Health Insurance," *Health Affairs* (Summer 1988): 48–65.
4. G.J. Schieber and J.P. Poullier, "International Health Care Expenditure Trends: 1987," *Health Affairs* (Fall 1989): 169–177; and R.J. Blendon and H. Taylor, "Views on Health Care: Public Opinion in Three Nations," *Health Affairs* (Spring 1989): 149–157.
5. J.P. Newhouse, G. Anderson, and L.L. Roos, "Hospital Spending in the United States and Canada: A Comparison," *Health Affairs* (Winter 1988): 6–16.
6. T.W. Moloney and B. Paul, "A New Financial Framework: Lessons from Canada," *Health Affairs* (Summer 1989): 148–159.