

# Summary and Lessons for the United States | 1

The largest item of expenditure in the health care budgets of most industrialized countries—including the United States—is the acute care hospital sector. As a consequence, hospitals have attracted the attention of policymakers attempting to curb growth in health care costs by changing the financial landscape for hospitals. Hospital use has declined, particularly dramatically since the early 1980s, in response to economic signals and the development of new medical technologies. The rate of growth in hospital costs also has slowed, but at least some costs have been diverted to other health care sectors, particularly outpatient care and long-term care. What happens in one part of the health care system often reverberates in other sectors, so no component can be studied in complete isolation. Nonetheless, payment for hospital care in the United States and other countries is governed by distinct policies that bear examination.

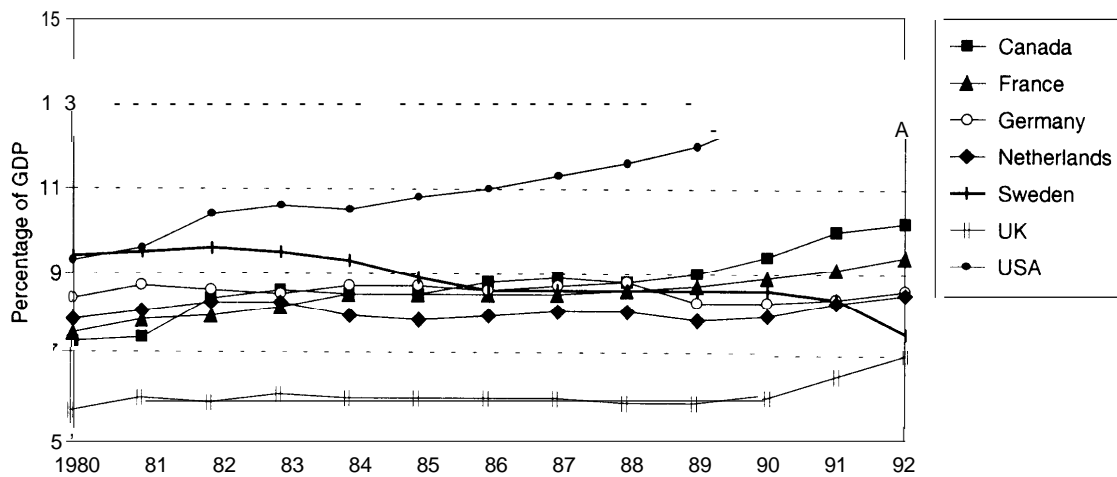
Looking around the world, it appears that health care expenditures in other industrialized countries have remained lower than in the United States, while at the same time, everyone in those countries has financial access to care. Increasingly, U.S. policymakers and researchers have looked to other countries to find new ways of organizing and paying for health care, which might be transferable. This seven-country study of spending for hospital services and the policies that affect spending is an attempt to find lessons for the United States.

The individual experiences of the United States and six of its international peers—Canada, England, France, Germany, the Netherlands, and Sweden—in hospital financing and payment systems over the past decade are reviewed in the chapters that fol-



## 2 Hospital Financing in Seven Countries

FIGURE 1-1: Total Health Expenditures as a Percentage of GDP  
Selected Countries, 1980-92



SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995).

low.<sup>1</sup>This summary focuses on general trends in the United States and the other countries and on recent reforms directed at hospitals.

### THE CHANGING PROFILE OF HOSPITAL USE

The acute care hospital continues to be home to the most advanced medical technologies, but much about hospitals has changed, and the change has been especially rapid since 1980. Trends in key indicators in different countries give an idea of just what has occurred.<sup>2</sup>Overall, health care spending has taken up an increasing percentage of the gross domestic product (GDP), most significantly in the United States, Canada, France, and the United Kingdom, and to a lesser extent in Germany and the Netherlands, declining only in Sweden (figure 1-1). In 1980, the percentage of GDP

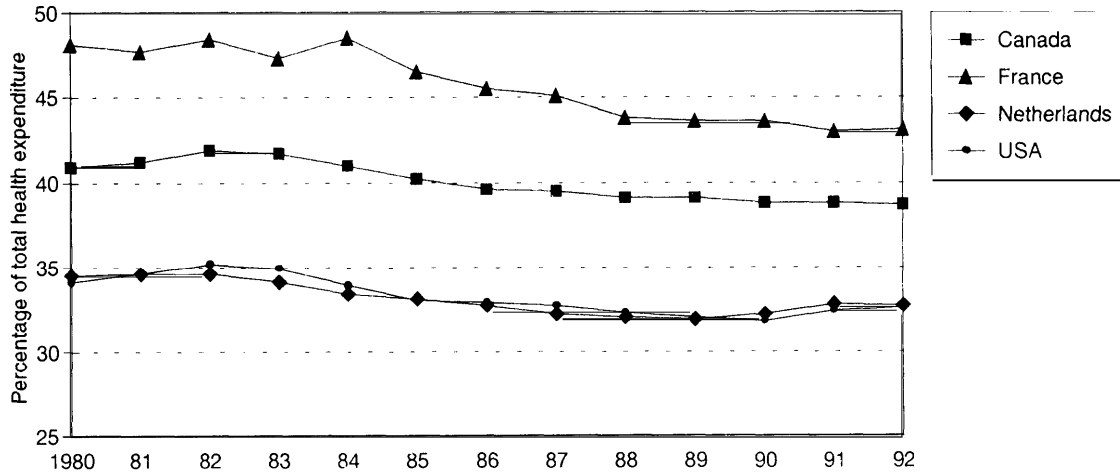
devoted to health care was between 7 and 10 percent in all the countries except the United Kingdom (which was below the rest). The United States was second to Sweden by this measure. By 1992, the United States stood well above the other six countries, having experienced a steeper rise than the rest, particularly during the late 1980s and early 1990s.

As a percentage of total health care spending, the amount devoted to acute hospital care has actually decreased since 1980 in the United States, Canada, France, and the Netherlands (the only other countries for which this figure is available) (figure 1-2), because utilization in other sectors has risen faster than hospital utilization (due in part to the shift of services out of hospitals and into other sites of care). Among these four countries, France allots the highest percentage to hospitals,

<sup>1</sup> The country chapters were first drafted in 1993. They have been updated to different degrees, and are current, on average, to early 1994.

<sup>2</sup> The data referred to in this section are from the Organisation for Cooperation and Development (OECD). The relative standings of countries are probably very reliable, but because data from different countries are not necessarily entirely comparable, the actual numbers should be interpreted with some caution.

**FIGURE 1-2: Acute Hospital Expenditures as a Percentage of Total Health Expenditures  
Selected Countries, 1980-92**

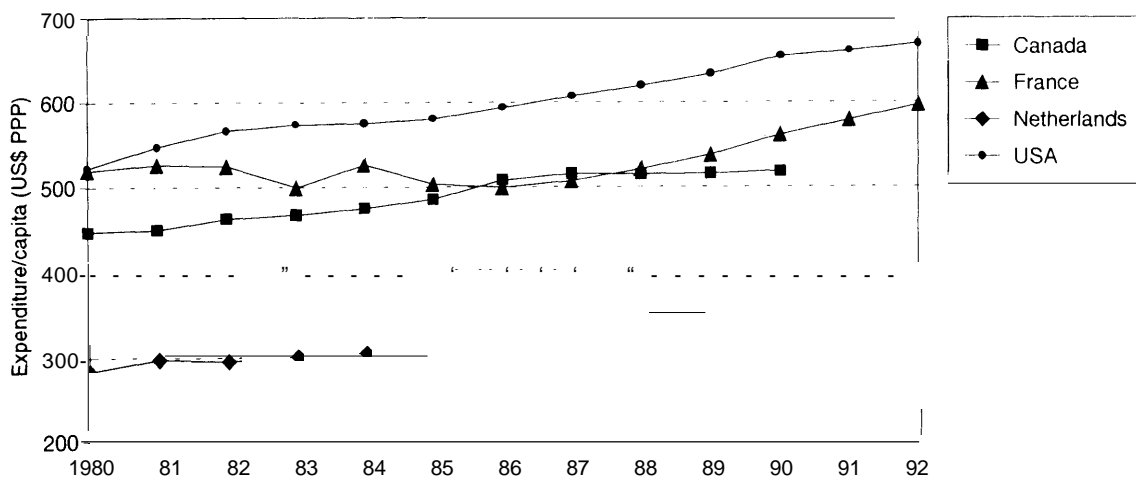


SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995)

and the United States the least (even though the United States has spent more per capita than these four countries in every year since 1980 (figure 1-3)).

Some of the reasons for changes in hospital spending can be gleaned from a few other statistics. The United States and the other six countries all have somewhat fewer hospital beds in the

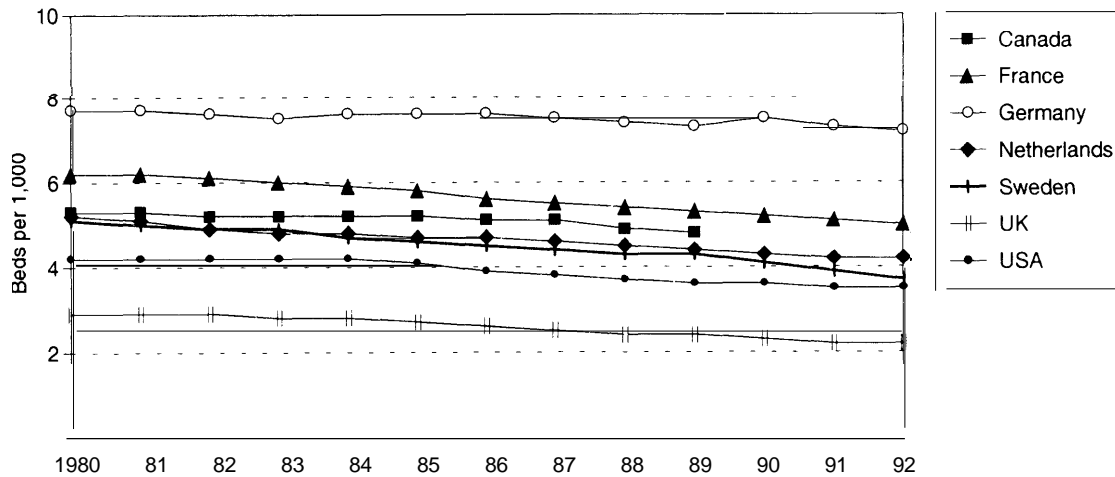
**FIGURE 1-3: Acute Hospital Expenditure Per Capita (inflation-adjusted U.S.\$ Purchasing Power Parity)  
Selected Countries, 1980-92**



SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995), Organisation for Economic Cooperation and Development, *OECD Health Systems, The Socio-Economic Environment. Statistical References, Volume II* (Paris: OECD, 1993).

#### 4 Hospital Financing in Seven Countries

FIGURE 1-4: Acute Hospital Beds/1,000 Population  
Selected Countries, 1980-91

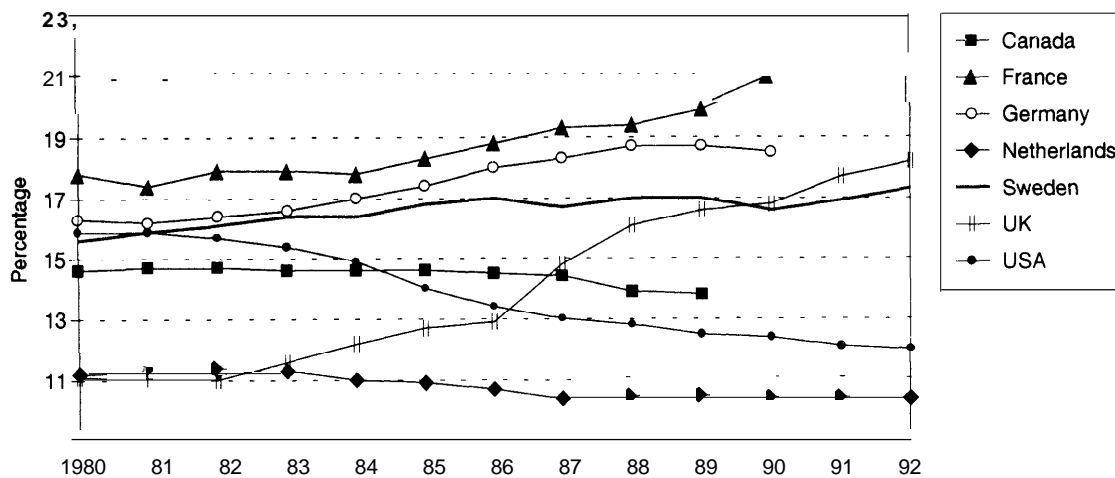


SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995).

1990s compared with 1980, in proportion to population size (i.e., fewer hospital beds/1,000 population), and the United States has the lowest ratio of any country except the United Kingdom (figure 1-4). The decline is a result of reduced demand. The percentage of the population admitted to a

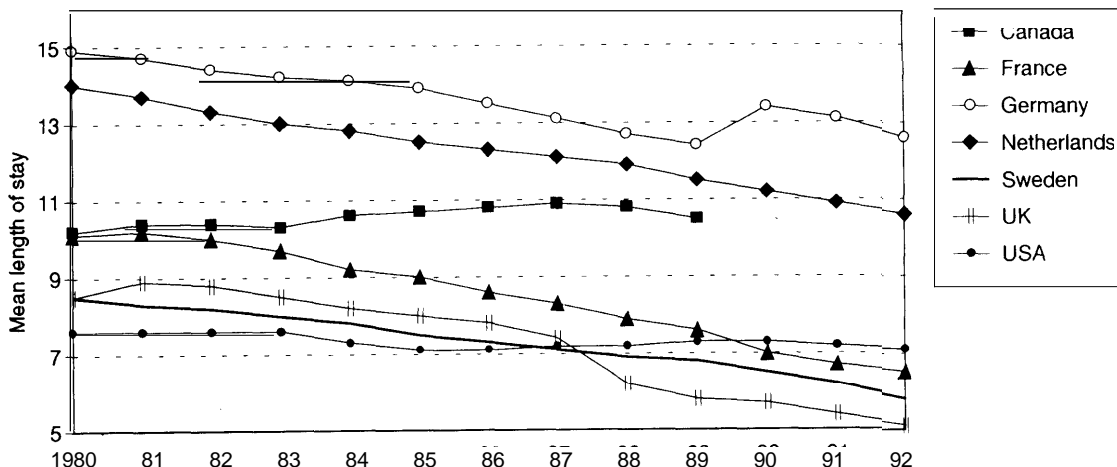
hospital has fallen steadily in the United States (this is not the case in all countries, with some trending upward and others downward) (figure 1-5). By 1992, the United States had a lower admission rate than any country except the Netherlands. And once in the hospital, people in all coun-

FIGURE 1-5: Acute Hospital Admissions as a Percentage of Population  
Selected Countries, 1980-92



SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995).

FIGURE 1-6: Mean Length of Stay in Acute Hospitals  
Selected Countries, 1980-92



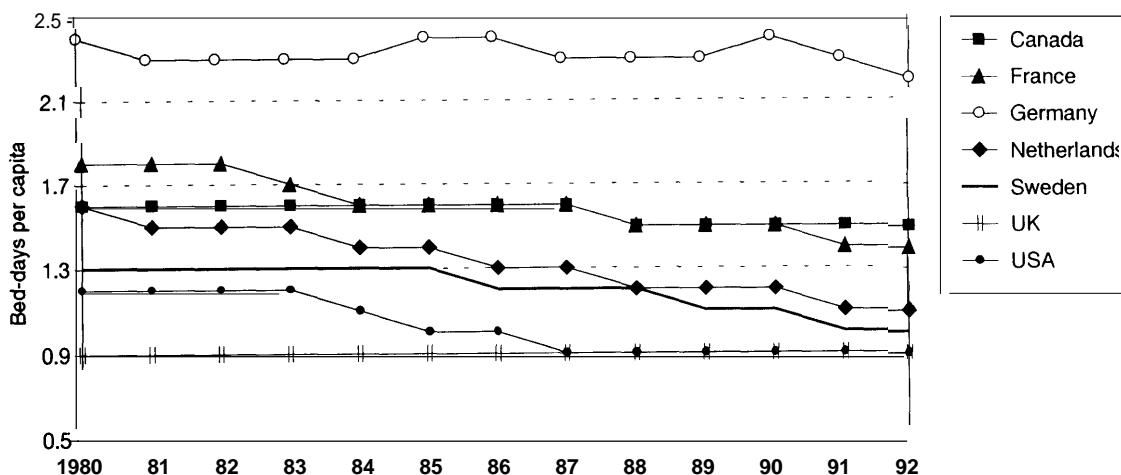
SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995)

tries stay, on average, for a shorter period than they did in 1980 (figure 1-6).

Overall, the number of days spent in the hospital each year per capita has declined in all seven countries (figure 1-7). In 1992, the United States and the United Kingdom had the lowest rates of

hospital days per person of the seven countries, and Germany has consistently had the highest rate. Hospital occupancy rates (the percentage of beds occupied as a proportion of the number available) are determined by the numbers of beds, the numbers of admissions, and how long people stay.

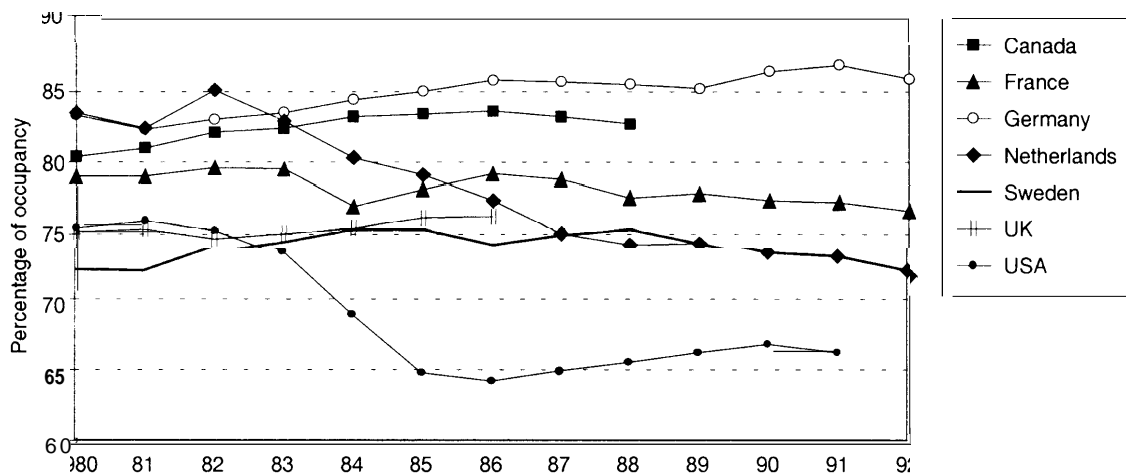
FIGURE 1-7: Acute Hospital Bed-Days per Capita  
Selected Countries, 1980-92



SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995)

## 6 Hospital Financing in Seven Countries

FIGURE 1-8: Occupancy Rates for Acute Hospitals  
Selected Countries, 1980-92



SOURCE: Organisation for Economic Cooperation and Development, *OECD Health Data* (Paris: OECD, 1995)

Since the mid-1980s, the hospital bed occupancy rate in the United States has dropped steeply, from about 75 to about 65 percent, and is lower than in the other six countries (figure 1-8). The low occupancy rates have already caused many U.S. acute care hospitals to close, downsize, or shift into other areas (e.g., long-term care) and many more will probably do so in the next few years.

### ■ Forces of Change

Two forces have been most influential in reducing the demand for acute hospital services: financial incentives and advances in medical technology. Prospectively fixed hospital payments and pricing strategies have encouraged hospitals to find ways to reduce the cost of caring for patients, which includes shifting inpatient care to outpatient settings where possible. In the United States, the rate of growth of inpatient hospital spending slowed during the mid-1980s, but outpatient expenditures rose steeply. This coincided with:

1. Medicare's adoption of a prospective payment system (discussed below), which sets per-case payment limits only for hospital inpatients,
2. the beginnings of privately insured managed care efforts to reduce inpatient expenditures, and
3. Medicare's and Medicaid's liberalized coverage rules for nursing home and home health services.

In the other six countries, most hospitals have been operating under fixed annual budgets that provide clear expenditure constraints, at least for inpatient services. Recent and ongoing reforms include pricing strategies designed to encourage greater use of outpatient sites. For an example, the Canadian province of Ontario has made outpatient care more attractive by adjusting the relative rates for the same services provided in and out of the hospital. While still lowering costs overall, providers do better financially by using outpatient sites. Several counties in Sweden also have used price differentials to influence patient flows to inpatient and outpatient sites, in some cases including differences in patient cost-sharing amounts rather than hospital reimbursement, giving the consumer an incentive to choose the less expensive setting. In the Netherlands, as part of major

health care reforms in 1992, payment rates for hospital care not requiring an overnight stay were increased to stimulate substitution of daycare for inpatient care. One of the farthest reaching reforms in this area is currently being implemented in Germany. Germany's 1993 Health Sector Act for the first time allows general hospitals to establish outpatient departments.

Existing medical technology has been exploited and the development of new technology pushed in the quest to lower hospital costs. Some of the improved efficiency in hospitals comes from such advances as laparoscopic surgery (also called "keyhole" surgery), which allows many complex procedures to be carried out through extremely small incisions, reducing hospital stays and the need for post-surgical care to a fraction of what they are for "open" surgeries. Getting people out of the hospital sooner after all kinds of procedures is also the rule now, since it is generally accepted (whether or not it is always true) that outcomes are no worse with shorter hospital stays.

## HOSPITAL FINANCING IN THE UNITED STATES AND ABROAD

Health care systems and their financing may be categorized many ways. Looking at where most of the money comes from is an obvious first cut (table 1-1). Broadly speaking, health care systems are financed either by tax revenues or by some type of insurance premiums. Of the countries covered in this report, Canada, Sweden, and England fall into the former category and the United States, France, Germany, and the Netherlands into the latter. Among the insurance-based systems, participation is mandatory in all except the United States. The source of revenue does not predict how hospitals get their money, however, and in fact there is considerable overlap between the two groups, particularly since the recent series of reforms of the late 1980s and 1990s (tables 1-1 and 1-2).

In all the countries, operating expenses—the costs of keeping the hospital running day-to-day to treat patients—account for the lion's share of hospital spending. Capital spending—the money

to buy new equipment, build new hospital wings, replace old ones, etc.—though small relative to operating expenditures, can drive up operating expenses because it creates an atmosphere where new technologies come into frequent use. In the real world, the split between operating and capital expenses is an artificial one, but in fact, policies in most countries do treat them separately to some extent, and they are discussed separately below.

Cost containment, increased efficiency, and a more equitable allocation of hospital funds are the objectives driving nearly all hospital financing reforms in the comparison countries, but other factors also are important. Enhancing patient choice in the health care system, including greater choice of hospitals, is another recurring theme. The organizational and social concerns that affect and are affected by health care and hospital reforms are discussed briefly in this chapter.

### ■ The United States

There is no single "U.S. hospital system." The U.S. health care system may be described as insurance-based with patient-based payment as the predominant approach to reimbursing hospitals for services, but really it is a combination of systems, some overlapping and others existing independently. Money flows to hospitals in the United States in much more varied ways than it does in other countries. It comes from a multitude of private insurers, the joint federal-state Medicaid program, the federal government's Medicare program, and out-of-pocket costs from both insured and uninsured people (table 1-3). (The separate hospital systems for veterans, military personnel, and for Native Americans are paid for entirely by the federal government.) Third-party payers use a vast array of methods for reimbursing U.S. community hospitals (defined as nonfederal short-term facilities), of which 59 percent are privately owned nonprofit institutions, 14 percent are privately owned for-profit institutions, and the rest are operated by state and local governments.

The Medicare program is federally funded primarily through payroll taxes on employers and

**TABLE 1-1: Approaches to Financing Hospital Operating Expenses in Seven Countries**

	<b>Canada</b>	<b>England</b>	<b>France</b>	<b>Germany</b>	<b>The Netherlands</b>	<b>Sweden</b>	<b>United States</b>
<b>Predominant financing source for inpatient hospital services</b>	General tax-based  (provincial general tax revenues and federal transfers)	General tax-based  (central government general tax revenues)	Social insurance  (payroll taxes paid to social security sickness funds)	Social insurance  (payroll taxes paid to statutory sickness funds and private insurers)	Social insurance  (payroll taxes paid to statutory sickness funds, premiums paid to private insurers)	General tax-based  (County Council income taxes)	Private insurance/ social insurance  (premiums paid to private insurers, payroll taxes and general tax revenues for social insurers)
<b>Predominant payment method for inpatient hospital services</b>	Prospective "global" budgets  (controlled by provincial governments)	Activity-based financing  (funds follow the patient; total funds cash-limited at district level)	Prospective budgets ("global allocation" plus daily charges)  (controlled by the government)	Prospective "flexible" budgets <sup>b</sup>  (negotiated between hospitals and insurance funds, with central government controls)	Prospective "functional" budgets (partially activity-based),  (negotiated between hospitals and sickness funds, with central government controls)	Prospective hospital department budgets; some activity-based financing (funds follow services or patients)  (county council controlled)	Activity-based (funds follow patients)  (some central or state government controls for social insurance programs)
<b>Ownership of hospitals (percent of total hospital beds)</b>	Public (100%)	Public (NHS) (91.3%), private (8.7%)	Public and public affiliated (75%); private nonprofit (5%); private for-profit (19%)	Public (62.3%); <sup>c</sup> private nonprofit (33.9%); private for-profit (3.8%)	Public (15%), private nonprofit (85%)	Public (nearly 100%)	Public (18.2%), private nonprofit (71%), private for-profit (1.08%)
<b>Predominant payment method for inpatient hospital services provided by physicians</b>	Fee-for-service	Salary	Salary	Salary	Fee-for-service	Salary	Fee-for-service

<sup>a</sup>The information presented in this table relates primarily to the dominant acute hospital sector at the beginning of 1994

<sup>b</sup>Beginning January 1993, effective until 1995, Germany has adopted prospective "fixed" budgets (See definitions in text).

<sup>c</sup>The figures refer to general hospitals and include both acute and nonacute services; they refer to all 16 states of unified Germany, The former East German states had a much higher proportion of public hospitals and beds than the former West German states

SOURCE: OTA, 1995.



**TABLE 1-2: Approaches to Financing Hospital Capital Expenses in Seven Countries**

	<b>Level of Responsibility</b>	<b>Source of funding</b>	<b>Basis of reimbursement for capital costs</b>	<b>Role of health sector planning</b>	<b>Relation of capital and operating costs</b>
<b>Canada</b>	Provinces	Provincial funds, often combined with <b>local</b> community or hospital funds.	Separate capital funds are granted after provincial government approval of proposed investments.	The hospital sector is subject to planning by the provincial government, which mostly determines the capacity of the system.	Depreciation for major medical equipment may be reimbursed through operating expenses.
<b>England</b>	Regional health authorities	National Health Service's capital budget is allocated to Regional and District Health Authorities (under reforms, hospitals will be able to generate their own capital funds).	Separate capital projects are funded if approved by Regional Health Authorities.	The central government, working through regional and district health authorities, fully determines the capacity of the public hospital sector.	Capital charges, including depreciation and interest charges, now included in service contracts.
<b>France</b>	Ministry of Health, in consultation with regional authorities	Public and PSPH hospitals obtain most funds from their own resources, with some funding from state or local subsidies.	Upon approval by the appropriate level of government authority, hospitals finance the investment from own sources and receive state subsidies if eligible.	The entire health care system (both public and private health institutions) are subject to formal health sector planning through the Health Map. The central government fully determines the capacity of the hospital sector.	Depreciation and interest costs are included in operating charges.
<b>Germany</b>	State authorities	State capital budgets (trend toward combined state and hospital funds).	State funding for approved projects only for hospitals included in the state hospital plan (almost all hospitals); trend toward combined state and hospital funding of capital after consensus among hospital, state, and sickness funds.	Capital investments are approved and financed by state governments on the basis of state hospital plans. State governments fully determine the capacity of the hospital sector.	Depreciation for fully state-financed capital not included in operating charges; depreciation and interest costs Included in operating charges for capital financed from combined state and hospital funds.
<b>The Netherlands</b>	Central and regional governments	Hospitals' own financial resources.	Internal sources and loans from private banks upon regional or central governmental approval of capital investment.	Construction of facilities and purchases of major medical equipment require a government-issued license, issued on the basis of regional and national health-sector planning.	Depreciation and interest costs fully recoverable through patient charges.

(continued)

TABLE 1-2 (Cont'd.): Approaches to Financing Hospital Capital Expenses in Seven Countries

	<b>Level of Responsibility</b>	<b>Source of funding</b>	<b>Basis of reimbursement for capital costs</b>	<b>Role of health sector planning</b>	<b>Relation of capital and operating costs</b>
<b>Sweden</b>	County Councils	Separate county council capital budgets, but trend toward including building and equipment costs in hospitals' operating budgets.	Buildings are rented and equipment leased upon approval from the county council.	The capacity of the hospital sector is planned and controlled at the county council level, with input from regional organizations.	Trend towards allocating building rents and capital-related costs to hospital departments.
<b>United States</b>	Hospital management	Hospitals' own financial resources.	Internal sources and private loans.	Almost none. Some states require a certificate-of-need process for reviewing and approving capital projects.	Depreciation and interest costs mostly recoverable through patient charges, although not all.

employees. In 1993 Medicare covered about 13 percent of the population and paid 28 percent of all hospital operating revenues. Until 1983, Medicare generally paid hospitals retrospectively based on the costs of care for each patient hospitalized. Explosive cost increases throughout the 1970s and early 1980s led to introduction of a “prospective payment system” (PPS) that uses nationally standardized payment rates by “diagnosis related group” (DRG). DRG-based payments were intended to provide incentives for hospitals to improve efficiency by offering a standard payment for all similar patients receiving similar services. PPS was important in decreasing the length of hospital stays. After PPS was instituted, the rate of increase in hospital costs did decline, but only temporarily. Within a couple of years, the rate of growth was back up to pre-PPS levels. PPS was also associated with a substantial shift to outpatient treatment for certain types of services, including outpatient surgery.

DRG payments have not kept pace with increases in hospital costs, but hospitals have, by and large, maintained their previous rates of growth by charging private insurers more, a practice known as “cost shifting.” Because insurers traditionally have passed along these higher charges in the form of higher premiums or copayments, the level and quality of care for Medicare patients probably has not been affected greatly. But with greater market pressure brought by private insurers on hospitals to lower their charges (discussed below), hospitals will find it more and more difficult to shift costs.

Medicare pays for most outpatient services on a cost basis. In 1986, Congress first directed the Health Care Financing Administration (HCFA, the agency that administers Medicare) to propose a PPS for outpatient services and provided a list of requirements for the system to meet. Developing a viable method turned out to be much more difficult than designing the DRG system for inpatient care, and only now, in 1995, have options for establishing an outpatient PPS been submitted to Congress. But the options developed so far would apply to only about one-third of outpatient spending. Implementation may be years off.

**TABLE 1-3: Hospital Expenditures by Source of Funds  
1993 (in billions of dollars)**

Program area	Hospital expenditures	All health expenditures
Private spending	1437	445.5
Public spending	182.9	337.0
Medicare	92.7	151.1
Medicaid	42.4	172.8
State & local public assistance programs	3.1	5.0
Dept. of Veterans Affairs	118	14.2
Dept. of Defense	104	133
Workers Compensation	10.0	20.6
State & local Hospitals	10.3	10.3
Other public programs	21	9.7

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, *Health Care Financing Review* 16(1), fall 1994

Medicaid is a tax-financed state-federal health care program for low income and disabled people, which covered 8 percent of the population in 1993 and accounted for 13 percent of hospital payments. Eligibility for Medicaid is determined by each state within federally determined guidelines and varies considerably across the country. Virtually all hospitals participate in Medicaid, although the extent of participation varies widely. Medicaid beneficiaries are more likely to get inpatient care in public nonfederal hospitals and teaching hospitals, and less likely in private hospitals, which may be reluctant to admit Medicaid patients because of low reimbursement rates and restrictions on coverage.

Before 1980, Medicaid programs were required to use the same methods as Medicare to pay for hospital services. Legislative changes in 1980 and 1981 allowed states to develop their own payment arrangements with hospitals. The substantial state autonomy and the imperative to constrain costs in Medicaid programs has led to heterogeneous approaches to reimbursing hospitals. Prospectively determined payment rates are common, but are packaged differently in different states. In addition, more and more states are introducing managed care initiatives as a way to either hold down costs, increase coverage to a broader population, or to achieve both goals.

More than half the states have applied for waivers that excuse them from certain Medicaid specifications so they can institute changes that move even farther from a “standard” Medicaid program. States are being seen as laboratories for experimentation.

Government influence on the hospital sector has been very strong, but most people—about two-thirds of the population—still are covered by private insurance, most sponsored by employers. About 35 percent of hospital expenditures are paid for by the hundreds of U.S. private insurers, under a multitude of plans. The very essence of the private insurance sector is variability in its range of plans, benefits covered, reimbursement systems, payment rates, etc. These attributes are combined with a range of payment mechanisms for beneficiary contributions, including coinsurance, co-payments, deductibles, and other out-of-pocket expenses.

The fact that health insurance benefits have been consuming an increasing share of employee compensation relative to wages has contributed to the pressure to hold down costs. The constant pressure of rising costs and expanding demands means that insurers continually seek ways to cap both expenditures and benefits. One important response to this pressure has been the extraordinary growth in managed care organizations and the increasing tendency of purchasers to form large buying groups. Managed care organizations vary in structure, scope, and size, but all constitute integrated service networks that often combine insurance functions with health care delivery. Purchasing groups (including large employer and government purchasers) tend to contract selectively with managed care organizations or to contract directly with networks of providers to supply health care services to the group’s members. The growth of managed care organizations has also been accompanied by greater financial risk-sharing by providers, which might include sharing profits or surplus funds in risk pools with providers or paying providers on a per person (capitation) basis.

In response to greater purchaser collaboration, providers are increasingly cooperating to form integrated networks or systems of care that can bargain with purchasing groups directly. During the 1980s and early 1990s, many hospitals have merged with, acquired, or affiliated with other institutions to create larger systems to compete effectively for patients under managed care contracts. This trend is, if anything, growing stronger, and is a major force putting downward pressure on hospital costs.

The effects of these changes are seen in a slowing of hospital cost growth in the 1990s, particularly dramatic since about 1993. Adjusting for the effects of inflation, the real growth in costs per case fell from 5 percent in 1992 to less than 2 percent in 1993 and the beginning of 1994. In addition to the declines in lengths of stay and per-capita admissions, discussed earlier, growth in hospital salaries also has slowed.

This is not the first time that the rate of growth in hospital costs has slowed down. Hospitals have responded before, with a decline in growth rates after introduction of the prospective payment system; earlier, in the 1970s, to the Nixon Administration’s economic stabilization program; and at other times. These earlier slowdowns did not hold, however, with rates of increase picking up within a few years.

Whether the current slowdown will continue is debatable. Part of the impetus for hospitals to improve efficiency and cut costs was undoubtedly the prospect of comprehensive health care reform at the national level. That pressure appears to be off for the foreseeable future. But today’s pressures also come from the private sector, and changes in the private insurance market are accelerating. Many people believe that these market forces holding down health care costs will be sustained and will continue to keep growth in check by wringing still more inefficiency out of the system, by promoting cost-saving new technology, and by abandoning services with only marginal health benefits.

### ***Hospital Capital Expenditures***

U.S. hospitals have great freedom to decide how much capital they need, with relatively few regulatory constraints. Public hospitals may be required to follow government guidelines for competitive bidding arrangements, but few states exert direct control over the decisionmaking or acquisition process for capital. About 30 states operate some kind of certificate-of-need program requiring prior approval of large capital expenditures, and other states limit the amount of capital available by other means, but these programs do not appear to have had much impact overall.

Capital expenditures are financed through fundraising (i.e., gifts), loans, and routine payments for services by insurers (including the federal government). About half of all capital expenditures are financed by loans and the rest by other sources. Under “traditional” cost-based reimbursement systems, capital expenditures for buildings and equipment (represented by depreciation and interest payments on debts) are passed through to payers by adding on an appropriate amount to all charges for services. But as cost-based reimbursement is being replaced more and more with prospective payment systems that pay a predetermined charge for each service, payers can exercise more control over how much allowance they make for capital costs. Medicare’s PPS system originally allowed capital costs to be paid directly as required, independent of DRG payments, but as of the 1992 fiscal year, capital costs are gradually being incorporated into DRG payments, giving the government greater control over the level of capital it provides to hospitals.

Through the 1980s, hospitals competed by continually upgrading their facilities and providing the most sophisticated medical technology. These capital expenditures were a major contributor to the rise in hospital and health care costs. Today, with price competition a much greater factor in the survival of hospitals, investments in the latest technology are no longer a given. In this case, limits on new technology may be imposed by market forces. At the moment, however, capital spending

is still growing as a percentage of total hospital spending.

### **■ International Trends**

The upward pressures of medical costs, especially in hospitals, are felt in all countries and the responses are a continual series of reforms that attempt to maintain control over costs and improve the quality of services. The six countries included in this study, though crossing the spectrum of organization and financing, all maintain near-universal coverage of their populations, and no reforms have sought to exclude segments of the population from coverage (though in some countries the amount people must pay out-of-pocket has risen, which may effectively reduce access for some people, and the range of benefits to be covered by public or sickness fund insurance is alive in policy discussions). Changes to improve the countries’ health systems have focused more on the supply side of the system through provider incentives and on the demand side through the creation of purchasing organizations.

Canada, England, France, Germany, the Netherlands, and Sweden all currently have or have recently had some form of prospective budgeting system for most hospitals, i.e., they determine ahead of time how much money a hospital will get for operations in the next year. One of the most pervasive factors underlying reform in these countries is the belief that, while prospectively fixed hospital budgets help promote overall expenditure constraint, at least for inpatient services, explicit incentives and controls are needed to encourage the efficient and equitable allocation of funds within individual hospitals or across hospitals. In simpler terms, where no appeal for more money is possible, a fixed budget can hold costs down to an absolute level, but not necessarily improve the return on the money spent in terms of the quality or quantity of hospital services.

Traditionally, annual hospital budgets have been based largely on historical costs, adjusted for such factors as general inflation, service growth, new technologies, and wage and salary increases.

A hospital budgeting system based on historical costs, however, may not encourage hospitals to try to find cheaper ways to produce hospital services or to improve the quality of services to attract patients. Hospitals only have to ensure that their expenditures stay within the amount provided from the government or insurance funds. Of course, if annual budget determinations do not keep pace with the demands placed on a hospital's services, the overall budget restraint may require hospitals to cut their costs. Historical cost budgeting may also lock in inequitable funding arrangements. Hospitals that have been historically underfunded or become underfunded because of changes in local population needs often remain underfunded while other hospitals may be inefficiently overfunded.

For these reasons, countries with prospectively fixed budgets have chosen to redesign hospital financing or payment mechanisms to better account for patient flows and patient needs, and to promote more efficient use of resources. Cost containment has not been abandoned as a primary goal in hospital financing reforms, but this goal is increasingly accompanied by attempts to encourage more efficient production of hospital services. Reallocation of funds among hospitals is not always designed to decrease aggregate hospital spending, but may be used to provide more money to hospitals where health care needs are greatest and less where needs are lower in order to obtain better "value" for the same amount of resources spent. Different ways of paying individual hospitals (e.g., a fixed payment per hospital episode) have also been adopted to a limited extent in some countries to motivate hospitals to lower their production costs by reducing lengths of stay, using less expensive labor, or using cheaper medical technologies or settings where appropriate.

Financing reforms adopted by the six studied countries follow one or both of the following broad strategies:

1. strategies that depend on greater internal or external market competition to reallocate funds among hospitals and within hospital departments, and
2. strategies that depend on activity- or case-mix based budget determinations.

The first strategy has recently been adopted by the Netherlands, England, and some Swedish county councils. In these places, reforms have focused on separating the purchasers of hospital services from service providers. Money is directed to individual hospitals either through patient decisions to choose a specific hospital (i.e., "money follows the patient"), through a purchasing organization's decision to contract with a hospital to provide services to the organization's members, or, as in some Swedish hospitals, hospital departments "purchase" services from other departments.

In Sweden, several county councils have established internal hospital markets under which some hospital departments (usually clinical departments) are given budgets out of which they purchase services (e.g., diagnostic tests, food, and housekeeping services) from other departments, encouraging scrutiny of the costs and benefits of services that patients get. Other Swedish county councils have established external markets by allocating budgets to authorized purchasing organizations that are responsible for buying all health care for a defined population through contracts with health care providers.

England and the Netherlands have adopted more decentralized, market-oriented mechanisms to pay for hospital (and other) services. Following reforms in these two countries, a large part or all of a hospital's operating revenues are determined largely by the contracts it negotiates with purchasers for specific services. In England, purchasing organizations (District Health Authorities or general practitioners who have become "fundholders") receive a budget from the government, which is proportional to the size of the population for whom they provide health services. The purchasing organizations are responsible for contracting with hospitals to provide inpatient services to their enrolled populations (a very small number of British hospitals still operate on prospectively determined budgets).

In the Netherlands, about half of a hospital's revenue comes from a prospective budget based on the size of the population it serves and on the number of authorized beds and medical specialist units that it has. The other half is determined by "production contracts," the result of annual negotiations between hospitals and health insurers (both sickness funds and private insurers) over the projected volume of hospital use by each insurer's beneficiaries. Health insurers agree to pay hospitals for a predetermined number of hospital admissions, inpatient days, outpatient visits, and daycare visits, and for some specific high-cost treatments. Payment rates for hospital services are determined by a quasi-governmental agency. Production contracting acts as an instrument for adapting hospital budgets to changes in demand for a hospital's services, making the budgeting scheme more flexible. Production contracts have also increased the role of health insurers in the budgeting process and have tended to decentralize the process.

The second broad strategy for financing reforms moves from budgets based on historical costs to allocating money in ways that more accurately reflect each hospital's patient load and activity. These methods use measures of the hospital's case mix or severity mix, often derived from the diagnosis-related groups (DRGs) used in U.S. Medicare's prospective payment system, to determine at least a portion of the budget. The Canadian provinces of British Columbia, Alberta, and Manitoba have begun using various forms of population- or case-mix based measures to set a percentage of hospitals' budgets to encourage hospitals to produce services more efficiently or to align hospital funding more closely with population needs. France is also conducting limited experiments in a number of hospitals to test a case-mix based approach to financing, with hospital charges based on homogeneous patient groups that are similar to DRGs. Germany has recently expanded the use of special fees and case-based payments that are conceptually similar to U.S. Medicare's DRGs with the goal of bringing most hospital inpatient care under a more performance-related system.

### *Hospital Capital Expenditures*

Trends toward greater hospital efficiency are echoed, but to a much lesser extent, in the six countries' reforms of capital financing. Some reforms have been aimed at requiring explicit consideration of the "opportunity costs" of making specific capital expenditures—i.e., what other opportunities there are for investing the money that will be lost by spending it a certain way. Others have changed the threshold for approving capital expenditures in countries where approval is required and changing the way in which hospitals are paid for capital expenditures.

In England, before recent National Health Service (NHS) reforms, depreciation and the opportunity costs of using capital assets were not explicitly separated out in NHS accounts because all hospitals were owned, operated, and funded by the NHS. But since 1991 and the reforms that have separated purchasers and providers, charges for capital have begun to be incorporated into contracted rates for hospital services. The reforms also for the first time allow NHS Trusts to finance their capital requirements from within their own budgets and by borrowing.

Until recently, private loans to hospitals in the Netherlands were guaranteed by the national government, which is estimated to have decreased interest payments by about 1 percent. This arrangement was recently ended to encourage hospitals to behave like private companies in obtaining loans for capital investments. A general trend in Sweden's county councils is to allocate rents for hospital buildings and investment costs directly to hospital departments to motivate them to more efficiently use different kinds of hospital inputs (e.g., labor versus high-technology equipment) to provide services. Although France has not changed its policy of providing free state and local government subsidies and interest-free loans from sickness funds for public hospital investment, public hospitals are obtaining an increasing share of their capital funds from internal sources and interest-bearing loans.

Because of the split between capital planning and budgeting and operating cost budgeting, the impact that capital investments will have on future

hospital operating costs often is not considered when decisions about capital investments are made, but this, too, is being addressed in some countries. The Canadian provinces are increasingly requiring that requests for approval of hospital capital expenditures include an “economic case” that the capital purchase will either reduce operating costs by improving technical efficiency or that it will lead to improvements in patient outcomes sufficient to justify the expenditures. In the province of Manitoba, getting approval for new equipment requires that the implications for future hospital operating costs be predicted before a decision is made. If it is likely to significantly increase operating costs, e.g., require additional staff or maintenance, it may be treated as a new program proposal, which is evaluated more rigorously. In Germany, with only some recent exceptions, the law has allowed the cost of capital investment to be added directly to hospital charges only for projects designed to reduce operating costs.

U.S. hospitals must raise their own funds, usually through equity or borrowing, and therefore already include the opportunity costs of capital investment funds and possible impacts on future operating costs in their decisionmaking process. Individually, U.S. hospitals have incentives to purchase capital when the expected benefits of an investment project outweigh its cost, but the lack of overall planning and allocation of capital among regions and hospitals does not promote maximization of the net benefits of capital investments in the hospital industry or country as a whole.

### ***Overall Hospital Spending***

Recent and ongoing reforms are expected to increase hospital efficiency and patient satisfaction. However, unlike the United States, in all six comparison countries there are still explicit limits on the total amount of money available to pay for hospital services.

In Sweden, hospital funds are limited by the county councils, which determine hospital department budgets or the budgets of purchasing organizations; beginning in 1991, the central govern-

ment restricted county councils’ ability to further increase tax revenues. In England, the amount of money flowing to District Health Authorities or to general practitioner fundholders to purchase hospital services is still cash-limited by their respective Regional Health Authority, and, ultimately, by aggregate limits on National Health Service funding from general tax revenues.

French public (and affiliated private) hospital budgets are still largely constrained by prospective budgets (called global allocations) that must be approved by government authorities. Negotiations between German sickness funds and German hospitals over a hospital’s prospective budget are more constrained since that country’s most recent health reforms were adopted. The German Health Sector Act of 1993 requires fixed prospective hospital budgets from 1993 to 1995 that can no longer be adjusted for the difference between the actual number of inpatient days delivered and the predicted number. The Health Sector Act also strictly constrained growth in hospital budgets during that period, tying growth to increases in sickness fund income.

The Canadian provinces have also become more forceful in the 1990s in developing institutional expectations that hospital budgets are binding. The Netherlands’ hospital reforms provide a partial exception to this rule of aggregate limits on hospital spending. The new budgeting scheme with production contracts leaves one avenue for hospital spending open-ended, and the Health Ministry may now only issue expenditure *targets* for any given year. However, the Ministry may make up a cost overrun by reducing the next year’s budget.

### **■ Other Areas of Health Care and Hospital Reform**

A trend in the six countries, though not as pervasive as strategies to improve efficiency, is the movement toward allowing greater patient choice of insurance organization, health care providers, or both. Strategies to achieve this goal often overlap with schemes to promote greater efficiency. Greater choice may not only make consumers



more satisfied with their health care system, but it also may encourage providers and insurers to try to improve quality and lower costs to attract customers.

In 1997, blue-collar workers in Germany will for the first time have the right to choose among sickness funds.<sup>3</sup> In Sweden's traditional health care system, patients were assigned to a primary health center and a hospital. However, the established, well-defined catchment areas of health centers and hospitals have been increasingly questioned by the general public. In response, the Swedish Federation of County Councils adopted a statement in 1991 that calls for all Swedes to be allowed to choose their physician and hospital.

Under the Netherlands' reformed system, patients may choose their health insurer—either a sickness fund or a private insurer—and insurers compete to attract subscribers. A major element of the United Kingdom's reforms was increased consumer choice of providers and services. General practitioner fundholders will compete for patient enrollment, and public and private hospitals in turn are expected to compete for their patients. Canadian citizens have always had free choice of physicians and hospitals under Canada's Medicare system. France's 1991 health reform act reiterated patients' freedom to choose a physician or hospital.

Decentralization of decisionmaking is another trend in these countries. England's purchaser-provider split shifts hospital decisionmaking from local government entities to individual hospital managers. Canada has always been decentralized to the provincial level, which allows for experimentation and for funds to be more closely aligned with local population needs. British Columbia's new restructuring initiatives attempt to create a more efficient and patient-friendly match of needs and levels of care by downsizing large urban hospitals, expanding community-based pro-

grams, and generally moving patients "closer to home." The Netherlands' production contracts have decentralized the hospital budgeting process. Some Swedish county councils' and England's purchaser-provider splits have put more power into the hands of health care purchasers. In Sweden, the tax and planning powers of county councils allows different councils to experiment with financing and payment arrangements.

## CONCLUSIONS

The period since 1980 has seen constant change in the role of hospitals all over the world, reflecting both the dynamism of medicine and the tightening financial climate. The countries studied by OTA all started from different places, but all have shared the reform goals of greater cost containment, efficiency, and health service coverage. The prevailing approaches to hospital financing and the recent reforms emerge from specific historical, cultural, political, and societal contexts that do not lend themselves to unidimensional categorization. Broadly, financing models are tax-based (Canada, Sweden, England) or insurance-based (France, Germany, the Netherlands, and the United States), but the mode of financing appears to be neither a constraint against nor a requirement for any particular type of hospital financing reform.

The United States stands out among its international peers as having the highest level of hospital costs since 1980, but also for pioneering financing mechanisms—especially prospective payment systems—that have led hospitals to reduce the hospital resources used to care for individual patients, including shifting the site of care away from the inpatient setting for many patients. These mechanisms, especially the DRG system introduced in the mid-1980s in the United States, are now, in the 1990s being adopted by other countries as ways to allocate funds among hospi-

<sup>3</sup>White-collar workers already have this right, and they can also choose to leave the statutory insurance system and go to a private insurer. German consumers have always been able to choose their physicians, but sickness fund patients usually have to go the nearest hospital with suitable facilities.

tals, most often within the constraints of prospective budgets.

Other countries have had greater control over total hospital spending at a central level. To a large degree, these countries' reforms seek to integrate the advantages of spending controls that they have already with more efficient and equitable production of hospital services. Decentralizing hospital financing, creating incentives for competition within the hospital system, and basing a greater amount of a hospital's revenues on the needs of the population it serves are the goals of reform, while also giving consumers more choice in where and from whom they get their health care. Basically, they are attempting to introduce selected market-type forces into their systems, choosing largely from mechanisms deemed successful in the U.S. system.

The United States is moving to a more forcefully market-driven health care system in which price competition has become more important than it has ever been. In the early 1980s, the Medicare program's prospective payment system led to a slowdown in cost increases to the federal government, though not in national health care spending. In the 1990s, the private sector is applying the greatest pressure to slow cost growth. Ratcheting down by private insurers will also affect publicly funded health care by making it more difficult for hospitals to recoup their deficits from Medicare and Medicaid patients by shifting costs to the privately insured. Ultimately, this will mean constraining the growth of services, finding ways of providing the same services at lower cost, or both. Advances in medical technology already have contributed to this effort and will probably continue to do so. Continuing to wring inefficiency out of the system—by eliminating unnecessary care and by further streamlining the functions that remain—also will contribute.

The Medicare program's move to eliminate the historical separation of operating costs and capital expenditures is also a step toward increasing the rationality of the system. Some other countries also are moving in this direction, a move that should place their health care systems—regardless of how they are financed—in a more market-drive mode.

What can the United States learn from its international peers about the costs of hospital care? The way that other countries have kept spending at a lower level than the United States is no mystery: fixed (or relatively fixed) budgets have been set in virtually all these countries by some central authority. The U.S. system as it is today and is likely to be in the foreseeable future does not allow for this type of centralized decisionmaking. Fixed, prospective budgets have apparently not made the other countries' systems more efficient, either; in fact, they may have had the opposite effect.

There is intrinsic value in understanding more about how other countries function, and their similarities and differences with the United States. There may well be some important lessons to be learned at the operational level of hospitals from international comparisons, but at a national policy level, the great efforts that have gone into international comparative studies over the past decade or so have produced relatively little practical return for the United States. They may be of greater value among countries with systems that are more similar in their health care systems. The United States should continue to be aware of and examine other countries' successes and failures in managing health care, but with limited expectations. The U.S. health care system is peculiarly our own. In the 1990s, progress is more likely to come from within than from imported solutions.

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