# Paying the Hospital: Foreign Lessons For the United States

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*This special report synthesizes the findings of a Health Care Financing Administration grant which allowed the author to analyze hospital finance in six foreign countries and in the United States. The author identified the principal problems facing hospital owners, carriers, and governments in the United States, and he conducted lengthy field work abroad to learn how each country dealt with the same problems.*

*One set of the author's conclusions makes more clear issues that are debated in the United States, such as the meaning of "cost-based reimbursement" and "prospective reimbursement". Some of the author's findings show the difficulty of implementing policies often proposed in the United States, such as incentive reimbursement schemes. Other findings of the author show the conditions necessary for cost containment, such as strong representation of consumers and firm political will by government.*

## Introduction

Nonprofit and public hospitals originated in Europe as custodial and treatment establishments for the poor. For centuries, patients were not expected to pay cash, although many contributed their modest property and labor. Hospitals were not part of the cash economy: most owned rather than rented land and buildings; most produced their own fuel and food on their lands; labor was donated by religious as callings or by indigents in return for room and board. The owners of hospitals—religious orders, lay associations, local governments—had the task of finding needed resources in kind and in money. The middle classes usually did not go to hospitals, since they had homes and families; they were treated by doctors and midwives for fees at home.

During the nineteenth century, hospitals were transformed clinically and organizationally. New techniques in surgery and medicine reduced infectious diseases among patients and made cures possible. More persons were willing to enter nonprofit and public hospitals, including the middle classes. Hospitals entered the cash economy, since they had to modernize their buildings, buy equipment, hire employees, and buy supplies.

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Physicians had been patronized long before the turning point for hospitals, and patients customarily paid cash. Throughout Europe and (later) in North America, groups of self-employed craftsmen and employed workers formed mutual aid societies for several purposes, including the hire of doctors on retainers to treat members. During the nineteenth century, the sick funds for employees were expanded and stabilized, by means of financial and administrative help from many employers. When hospitalization became safer and more successful than home care, many sick funds agreed to pay their members' hospital bills.

As nonprofit and public hospitals became more complex and in need of cash, they raised funds from many sources. Patients in private rooms were charged by the day, and some ward patients were also charged. Sick funds agreed to indemnify their members. In some countries, the welfare offices of local governments and of private associations paid daily charges for their clients. In the absence of modern cost accounting, the charges were set to cover costs by intelligent guesswork, and they were collected unsystematically. Endowments yielded some income. Owners and managers constantly searched for money to pay remaining annual operating costs, to buy new equipment, and to modernize the buildings.

For the last century in all countries, the costs of hospitals have steadily risen, usually faster than the consumer price index, absorbing a larger proportion of the Gross National Product (GNP). The trend has

many causes. Once personnel were few, they worked long hours, and they received little pay. The wage bill steadily rose as hospital workers obtained normal pay and shorter hours, as the higher quality care required larger and more credentialled staffs. Technology was introduced at an accelerating rate, and each new item was more expensive to purchase and operate. The new buildings to accommodate the complex care and middle class patients were more expensive to build and operate.

In all countries, steadily higher proportions of the hospitals' total costs were met by charges to patients. To cover the charges, sick funds acquired more members and collected higher premiums. Laws mandated membership and benefits. When the unemployed and aged were added to membership by law, governments began to subsidize the sick funds from general revenue. When hospital costs outran the resources of the sick funds, several countries gave up trying to finance them through the channel of payroll taxes, and they switched to general revenue coverage of hospital operations and investment.

Proprietary hospitals evolved differently. When surgical and obstetrical innovations made institutional care superior to home care, middle class patients needed an alternative to the public and charitable hospitals. Their attending physicians set up small "private clinics" as extensions to their offices, where private patients could recuperate for several days. In all countries during the nineteenth century, the private clinics outnumbered the public and nonprofit hospitals and contained a large proportion of all beds. Patients personally paid their doctors in full for treatment and housing. During the twentieth century, the private clinics gradually diminished in number. The nonprofit hospitals installed private rooms for the medical staff's private patients; as medical care became more complex in technology and in staffing, the nonprofit and public hospitals received all the difficult cases and the private clinics could take profitably only the simple cases. Parallel to National Health Insurance (NHI), private health insurance spread to enable a few private hospitals to work on a larger scale, and proprietaries in some countries were admitted to national health insurance practice.

## Standardization

At one time hospital economics everywhere was primitive. Each organization kept financial records in its own way. The hospitals' owners and managers raised money to pay their bills by whatever methods they could. Each organization charged and collected from some patients, experienced defaults from others, and decided not to bill others. Since managers did not use cost accounting, they fixed charges for procedures and individual patients by guesswork, merely to reduce the deficits that had to be covered by the normal fund-raising in the community. Hospitals differed in outside income, in reliance on all patient charges, and in the height of charges. Hospitals' reliance on charges steadily increased; the sick funds to cover bills spread in membership and grew in revenue.

### Method and Unit of Payment

The rise of organized third parties to cover the hospitals' operating costs has brought about uniformity within countries. Nations differ in their methods—there are no standard international practices—but all third parties and hospitals within a country converge on the same procedure, either by law or by custom. The United States is the last internally heterogeneous country, but the trend toward standardization is visible there.

Countries with national health insurance and personal payments usually pay their nonprofit and public hospitals by all-inclusive daily rates. These became common during the nineteenth century in billing of private patients and in the billing of welfare offices for poor patients. Hospitals lacked the cost accounting to itemize services—like the billing by doctors for their office care—and gradually the sick funds and hospitals throughout each country became accustomed to the daily charge. If a government created a regulatory agency to arbitrate between hospitals and payers and to protect the interests of both, the regulators usually fixed rates on the daily charge because it was customary and easy to calculate. Some itemized billing of private patients still persisted within nonprofit hospitals in a few countries, but it is unusual now. In contrast, the same American hospital bills payers by different principles, namely, comprehensive daily charges for some and itemized billing for others; posted charges for some and strictly cost-based figures for others.

An important reason for standardization of payment methods in Europe is recognition of common interests among the sick funds. They unite when negotiating with the hospitals, as in Germany. Or, they take for granted that all pay the identical rate set by regulators, as in France and Holland. In contrast, American third parties are rivals; each tries to minimize its costs and premiums by limiting the payment to the hospital, each tacitly invites the hospital to find its extra money from the other third parties, each hopes that the rival third parties will suffer high costs and competitively disadvantageous high premiums. If American payers united in negotiations, the hospitals would charge them with violating the antitrust laws, since hospitals think the present disunity works to their advantage.

In the long run, if they cannot have a completely free hand to charge everyone high rates, European and probably American hospital managers prefer to collect the same rates from everyone, at a level high enough to cover their costs. Low rates for some payers cause uncertainty, and the managers must struggle to make up the money from other payers or from donors. A sliding scale harms public relations: the hospital managers must conceal it, lest the overcharged patients and carriers complain.

Americans will be disappointed if they think that lower hospital charges for some patients lead to price-cutting competition among carriers, leading in turn to lower offers to the hospitals. In practice, the carriers that save money on the basic benefits use it to offer additional benefits. Competition in health insurance lies in efficient servicing of claims and in the extent of benefits, not in lower prices.

## Definition of Allowable Costs

The unit of payment is tied to the hospital's costs in some way. Because all payers within a country unite in paying the same charge to each hospital, they also unite in defining the costs that they will and will not cover. A regulatory agency performs the important function of expert analysis of the prospective budgets and end-of-the-year expenditure reports to make sure that all hospitals include the same types of costs when billing all payers.

In contrast, each American organized payer tries to minimize its liability by restricting the costs it will cover and by tacitly inviting the hospital to transfer the extra costs surreptitiously to the other payers. At times state regulatory agencies seem to move payers toward a consensus on the principles of reimbursement. But when government finances become tight, the National Government's Medicare and the State Governments' Medicaid revert back to much narrower definitions of what they will cover.

The attempts by each American carrier to attribute hospital costs to patients other than its own results from the unusual categorical evolution of American third party payment. Each carrier has a different type of patient, with different patterns of utilization and cost. European carriers were created by principles other than clinical need, they have always been partial cross-sections of the community, and they have become more inclusive and representative as they expanded.

## Uniform Reporting

Regardless of the method of payment, every developed country—except the United States—has uniform reporting of every nonprofit and public hospital's prospective budget and retrospective expenditures. Just before the start of the fiscal year, every hospital fills out the same budget form according to the same principles, when it is seeking approval of a daily rate from regulators or negotiators, or when it is seeking installments on a global institutional sum from a government. At the end of the year, to account for its use of the money to the regulator or to the payers, all the country's hospitals fill out the same expenditure report. The report covers the entire finances of the hospital, not merely the subscribers of one third party.

Uniform reporting is expected by regulators (in countries with rate-setting, like France or Holland), by negotiating committees of third parties (in countries with negotiated rates), and in countries with full public financing. Only by uniform reporting can the regulators and payers understand the hospitals' submissions. Computerization of the reports is becoming common, and the regulators and payers detect the more wasteful hospitals by statistical comparison of peer groups.

Uniform reporting usually leads to uniform accounting. Since the regulators and payers expect all hospitals to fill out the budget and expenditure reports according to certain rules, hospitals tend to adopt the chart of accounts and costing practices that fit the reports. Uniform accounting may be mandated by the regulatory laws, so that if investigators or arbitrators are called in they can understand the original records. A system can require uniform reporting without requiring that all nonprofit and public hospitals keep their original books in identical ways, as done in Holland.

Hospital managers at first resist uniform reporting and uniform accounting, since their administrative work increases and the regulators and payers gain valuable information. The hospital association soon makes a virtue of necessity, using the reporting/accounting requirements to teach modern financial management to all the country's hospitals. Without legal or financial obligations, hospital managers drift along with simpler and diverse methods. Several hospital associations (such as Holland and Switzerland) call meetings of the managers in the same peer group to compare notes about methods.

In contrast, American hospitals resist nationwide uniform reporting and accounting. Only Medicare can require a common methodology. The American tradition of organizational autonomy and trade secrets, practiced by hospitals as well as by business firms, leads to resistance of the System of Hospital Uniform Reporting (SHUR) and of other proposals for uniform reporting of hospitals' entire finances, even from the nonprofit and public establishments. State regulatory agencies can compel or persuade some limited standardized reporting for their particular purposes, but only Medicare transcends State boundaries. Some regulatory agencies have limited jurisdiction (perhaps only over the hospitals' Medicaid business), and most States have no regulatory requirements at all. Even when uniform reports are required by Medicare or by a State rate regulator, the hospital can keep its books by any conventional accounting methods, and an outside investigator cannot easily pry.

## Proprietary Hospitals

Hospital managers everywhere prefer a free hand, without giving away the information that strengthens the hands of regulators and payers. But nonprofit and public hospitals eventually concede, since the reporting obligation is a condition for the payment-in-full that relieves them of the constant struggle to balance their budgets.

The for-profit hospitals owned by doctors (and sometimes by others) share with private business in all countries the antipathy toward revealing too much to government and to sick funds. The doctors conceal their office accounts from sick funds under national health insurance and merely negotiate fee schedules that list estimated average charges for everyone. But since hospital charges are related to costs under all national health insurance programs, the sick funds insist that the private clinics submit the standard reports about prospective budgets and retrospective expenditures if they want payment in full. Some proprietaries refuse the reporting requirements and try to survive with limited charges to patients and without investment grants from public funds. The larger proprietaries, however, cannot survive unless they become assimilated into the general hospital payment system, and most accept the reporting obligations along with the money.

## Units of Payment

### Daily Rates

Most countries use *per diems* because of custom and administrative ease. The goal is to guarantee full coverage of a hospital's operating expenses without waste and without stinting. The daily charge is a simple way of delivering the money, and it is the result of elementary arithmetic rather than precise calculations about the components of care each day. The regulators or negotiators—depending on the decision-making system in the country—examine the totals and lines in the hospital's prospective budget, reduce some amounts that might be excessive, judge the reasonableness of the expected total patient-days, and calculate the average.

The daily charge has the advantage of administrative economy: a hospital can bill a sick fund for all its patients for a period by merely listing the number of patient-days for each patient, and multiplying the total by the hospital's particular daily charge. The many items appearing in bills in the United States are included in the European *per diem*. The simplicity is one reason why European hospitals have smaller administrative staffs than the American hospitals.

Usually the only separate billing is for the doctors. In countries where hospital doctors are paid by fee-for-service directly by the sick funds (Holland), the daily charge includes all other hospital costs. In countries where many senior doctors are full-time salaried, the daily charge includes their pay.

### Global Budgets

The intent of hospital reimbursement in other developed countries is to cover the hospital's operating costs. If the exactly predicted numbers of patient-days occur and if prices fulfill expectations, the budget is delivered. However, the total of *per diems* is rarely on precise target. Higher morbidity, a growing catchment area, or deliberate length of stay manipulation by the hospital staff might increase the hospital's work load and income. Patient-days might be fewer if the population is declining, if the hospital works more efficiently, or if unemployment causes a drop in the membership of sick funds.

Some critics of hospital finance have recommended paying the hospital their budgets directly, without the outcome depending on the fluctuating and perhaps manipulated number of patient-days. Usually global budgeting of a hospital is associated with a single payer, and usually with government. But several third parties can pool their funds and share in the hospital's budgets according to their percentage shares of the total work load, as in several Swiss cantons.

Usually global budgeting is adopted because of a breakdown in the capacity of private or national health insurance to deliver full reimbursement to hospitals. Hospitals may have too many patients who are covered by no insurance or by impecunious sick funds, they go bankrupt, and government rescues them with full Treasury payment of their annual budgets. Examples are Great Britain and Italy. Or, insurance may reach a ceiling in its voluntary membership, and the hospitals press for the full guarantee of costs that only complete Treasury financing can realize. An example is Canada. Under global budgeting, usually the prospective budget is examined and approved by a government agency, which then pays installments throughout the year. No item-of-service or *per diems* are used.

Global budgeting of hospitals always becomes involved in the total budgetary planning of the government. At first, as the hospital managers hoped, it is bottoms-up: the managers state what they need, argue with the government, and get most or all of it. But, particularly during periods of financial stringency, the system changes to top-down: the Treasury gives the spending Ministries their shares, the Ministry of Health allocates a total amount, and each hospital's share fits within the available total. The hospital must limit its services to the budget it is given by the government; it can no longer press government to supply the money it thinks it "needs." Global budgeting is ideal for the control of costs, but that was not what the hospital managers originally intended.

## Methods of Deciding Pay

### Unilateral Decisions

In a free market, each firm sets its own strategy and fixes its own prices. A hospital might charge what it can for basic care and specialized services, perhaps losing on some and profiting on others. It might develop a tacit sliding scale, diligently collecting from the rich and accepting bad debts from the poor. Certain comforts used by the rich, such as pri-

vate rooms, may be overpriced and profitable.

During the nineteenth and early twentieth centuries, all hospitals and private clinics in Europe and North America used such free and discretionary pricing. But unlike a business firm, no nonprofit or public hospital has ever met its entire budget by collecting such unilaterally set charges, much less earning a profit for reinvestment. The charges were designed to raise as much money as possible from patients and their sick funds, deficits remained, and the managers and governing boards devoted much effort to finding the rest of the money.

The sick funds had arisen before the nineteenth century to pay doctors in full for their members' office and home care. The sick funds fixed fee schedules according to what they could afford, and the doctors went along. During the nineteenth century, as hospital inpatient care became more tolerable to the workers and middle class, the sick funds offered to pay hospital charges in whole (by direct third-party payment to the hospital) or in part (by indemnifying the patient). The sick funds covered the new expenses by increasing their premiums and memberships. Statutory national health insurance greatly increased the coverage and extended the payroll tax collections to the employers, thereby raising much more money for the hospitals. By the late 1940's, European hospitals could cover their full budgets from third party payments.

## Negotiations

Facing large third parties whose revenue was determined by laws, the hospitals could not behave like business firms, setting their own prices and maximizing their own revenue. The money was "public". The sick funds were nonprofit associations for social protection, their premiums were really taxes set by Parliaments and Ministries of Finance. The large majority of hospitals were nonprofit private and publicly owned establishments, and all bore a social responsibility to use public money efficiently and without waste. Laws about hospitals and about national health insurance guaranteed the hospitals full payment to perform their work efficiently.

Faced with large third parties administering public money and obligated to perform a public trust, hospital managers could no longer fix prices unilaterally and secretly. They had to discuss them with the sick funds, at first individually and soon in some collective form. Each hospital's budget and costs were and still are unique, and each hospital negotiates individually. In countries relying primarily on negotiated rates, such as Germany, the hospital managers face a committee of all sick funds, to agree on a daily charge binding all. The sick funds demand justification of the hospital's claims, and the hospital is expected to reveal its prospective budget. As in all collective bargaining, the hospital managers reveal as little as possible, overstating their costs and understating their outside revenue; and the sick funds try to pay as little as possible, on the grounds that the hospital's pleas of poverty are overwrought. In order to make the negotiation more factual, the national government of Germany has mandated full, uniform, and open reporting by the hospitals, backed up by uniform accounting.

Every payment system has an appeals process. Its form is particularly influential on the outcome of payment negotiations. If the method of deciding deadlocks were weak, the sick funds could dictate the rates. Often government arbitrates deadlocks, and it is more generous to the hospitals, since government passed the laws guaranteeing full payment of the hospitals' legitimate operating costs.

Hospitals abroad are compelled to negotiate contracts with the sick funds. Without them, hospitals would collect nothing directly from the third parties, and the insured patients would be reimbursed little or nothing. American hospitals enjoy a much stronger bargaining position with Blue Cross Plans, since patients are reimbursed at very high rates if the hospital and Blue Cross cannot agree.

Hospitals can be paid generously or stingily, depending on the stance of the sick funds and the laxity of the appeals process. If the sick funds are independent of the hospital and must operate within a tight revenue ceiling from premiums, they are tough bargainers. American hospital costs rose rapidly in the past in large part because Blue Cross was allied with the hospitals as a collection agency from the public, because State insurance commissioners freely granted premium increases, and because hospitals and doctors could charge patients extra. But Blue Cross has become more independent, many State insurance commissioners require it to bargain more strictly, and more of its policies provide payment in full. The American commercial insurers still have less leverage, because usually they only indemnify the patient. But the United States obviously is evolving toward the European pattern.

## Rate Regulation

The European regulator is not a representative of the public interest in restraining a venal private interest—a common model for regulation in the United States. The European regulator is really a referee. He picks a rate that is fair to both the hospital and the sick fund. A reason for regulation rather than letting the two sides bargain is the complexity of hospital accounts. European sick funds do not employ large accounting staffs, and the hospitals are not completely candid. But a regulator has official power and the hospitals report more accurately to regulators than to sick funds; a regulatory agency that fixes the rates in health hires enough technical experts.

The regulators in France are the field staffs of the national Ministry of Health. They have the right to monitor all transactions of the hospitals owned by lo-

cal governments, including price regulation, to protect both the hospitals and their payers. The setting of the daily rate began when the officials needed to set reasonable transfers from one public account to another, namely, from the local social welfare office to the public hospital. But such rate setting has since been applied to all payments.

Holland's regulatory body is a joint committee representing both the hospitals and the sick funds, and receiving official status in law. Rather than leave the rate determination to power bargaining, the two sides hire expert investigators to analyze hospitals' budgets and recommend daily charges. The two sides on the committee could then bargain on the basis of the report, but in practice they accept the staff's recommendations.

Hospital rate regulation abroad bears many lessons for Americans. It cannot be effective if—as often happens in the United States—it lacks political support, and if it is based on a statute with unclear goals and with ambiguous grants of power. Rate regulation is not captured by providers if consumer interests (that is, the sick funds) are vigilant and the civil servants' careers are secure. Constant alteration of the rules produces confusion; regulation becomes effective and generally accepted if everyone knows the rules. A regulatory agency that learns about hospital management can be a creative force in advising the directors and fostering a more efficient division of labor among organizations. If regulators can easily be overruled in the courts, they buy peace by generosity. Complicated rules, procedures, and payment units foster confusion and conflict.

Americans hope to find automatic regulation by formulae, lest a regulatory agency be captured by the providers or by corrupt politicians. But this is a mirage. The struggle among competing interests produces very complicated formulae, hard to understand and yielding unexpected results. Since no regulatory staff exists to defuse complaint and make exceptions, the system is clogged by lawsuits. Other countries have regulatory agencies that use judgment to apply the formulae.

American regulatory efforts, in hospitals as in other fields, are performed in policy vacuums. The statutory mandate is vague; often the regulators are independent both of line departments and of advisory commissions. But European experience shows how rate regulation and all other payment methods can be led by guidelines from national economic policymakers. America's Voluntary Effort is a hesitant beginning.

## Grants

Several countries scrapped hospital insurance because of its financial limits in economies with great inequalities or other barriers. The governments of Great Britain, Italy, and Canada grant the hospitals their budgets in full. All countries with national health services (NHS)—Eastern Europe, most developing countries, and Britain—employ this method. Sweden opted to pay all its hospitals in this way, since they were publicly owned, but government ownership can be reconciled with daily charges and rate regulation, as in France. Because of the limited resources of its sick funds, Switzerland has a mixture of *per diem* payments by the sick funds and cantonal grants for the rest of each hospital's budget.

If the hospitals are owned and managed by private persons or by levels of government other than the payer, several of the steps in negotiation and regulation are followed. The hospital submits a detailed prospective budget to the payer, and the latter's analysts examine and often cut it. If the payer is given less money from its public Treasury than the total of all hospital budgets, it asks all or most of the hospitals to revise their submissions. Because of the fiscal restraints since the late 1970's, the trend is to reduce the haggling between hospital managers and the payer's financial analysts by simply telling each hospital the amount it will get. Deficiency appropriations have become rare: the hospital is warned that it must look elsewhere to cover any deficits.

Global budgeting and public grants can be administered strictly, so that hospital spending rises only slightly faster than the general inflation rate and occasionally even lower. Most countries with national health services, such as Britain and the Soviet Union, devote a lower proportion of GNP to health and hospitals than countries with national health insurance do, but this depends on conscious public priorities. It is possible to spend a great deal on health and hospitals under public budgeting, as in Sweden. NHI spending and utilization is determined more by patients' demand and the judgments of doctors. An NHS can limit spending and facilities, forcing patients to queue for the limited services. Policy-makers under NHS as well as in all other countries are thereby presented with a central problem that they invariably evade, namely, the criteria for prioritizing patients and limiting care.

Some American reformers think global budgeting and grants generate incentives to efficiency: the hospital is given a lump sum, the managers have full discretion, and the hospital keeps its savings. However, all incentive reimbursement schemes—like this one—fail to work out, either abroad or in the United States. Third parties want a full accounting of how their money is used for their members, and they never give the hospital managers complete discretion. All insurance money and public grants are considered "public" rather than "private" in all countries, hospital managers are not supposed to use them at their discretion, and the third parties always expect that savings will go back to their true owners. Third parties are suspicious that savings are due to underservicing. If the savings are due to declining utilization or greater efficiency, the payers try to give less money next year, and hospital managers fight budget reductions more than anything else. Cutting spending pits the hospital manager against the doctors, and his life is happier if he leaves them alone.

## Covering the Hospital's Costs

### Reimbursing Costs versus Paying Charges

Much American rhetoric assumes that cost reimbursement of hospitals invites inflation and sloppy management, while charge-based payment instils discipline and efficiency. The dichotomy is false. No organized payment system automatically gives hospitals whatever the managers claim as their costs. No hospital system on a large scale can survive simply on arbitrary charges, since usually they cannot cover all actual or intended costs. Third parties never accept the hospitals' posted charges and hospitals never accept the carriers' own schedule of indemnities. Every cost reimbursement system begins the year with interim rates and in practice, therefore, is no different from a system of negotiated charges.

Nonprofit and public hospitals everywhere are supposed to break even and use public money prudently; sick funds and government payers are supposed to use public money efficiently. The regulators and payers do not agree to pay whatever hospitals want but insist that the hospital document its needs, in prospective budgets and in end-of-the-year expenditure reports. The only basis on which payers and hospitals can agree is reimbursement of the costs of efficient operations. Therefore, the regulation and bargaining is devoted not to fixing a "fair price" but to the necessity of certain claims by the hospital for specific items of cost.

At one time American hospitals—like foreign ones in the past—fixed charges, bringing in a substantial part of the budget, while the rest was covered by donors. Cross-subsidization has been common in the United States, with the labs, x-ray, pharmacy, and the out-patient department (OPD) bringing in extra money. Cross-subsidization has been less common in European nonprofit and public hospitals, because of the all-inclusive rate. The calculating conventions resulting from Medicare have brought charges in the United States close to costs in all departments, making itemized charges somewhat obsolete. Where Blue Cross Plans pay charges rather than costs, the limited negotiations result in bringing them close to costs, although the absence of detailed reporting and scrutiny makes it an approximation.

Cost-based reimbursement is a common method of health care financing. In theory medical associations and sick funds abroad negotiate a charge schedule for doctors' pay, and the outcome could result entirely from power bargaining. In practice, they converge on the practice costs for each act plus an honorarium. In the absence of the detailed cost reports in hospital finance, the medical associations and sick funds guess at the profession's average costs.

### Prospective versus Retrospective Reimbursement

The political power of the medical profession in the United States has blocked the method of determining pay that is normal in every other country, namely, annual negotiation of a fee schedule or salary scale between the medical association and sick funds or between the medical association and doctors' employers. However, something as complicated and expensive as hospital payment cannot avoid advance agreement. All cost-based payers agree on interim rates with hospitals, in the United States as well as abroad.

The true distinction is not prospective versus retrospective reimbursement, but whether the hospital can run a deficit with confidence of getting a supplement, either extra money this year or an addition to the cost-based rate in next year's negotiations. Some American State regulatory programs and some State Blue Cross Plans have been strict, particularly as payers are constrained in their own revenue. One reason why several European countries have had surprisingly great increases in hospital costs—in particular, France and Holland—has been the generosity of their end-of-the-year settlements. Hospitals could overspend with impunity. German costs rose more slowly in large part because the sick funds would add nothing to the initial rate.

### Charity and Bad Debts

At one time all public and nonprofit hospitals everywhere were charities for the unfortunate. Managers once tried to overcharge their private patients to defray the costs of the many who paid little or nothing. Prepayment has spread in every country, to relieve the financial problems of the hospitals, enable them to give the more expensive modern forms of care, and enable the managers to concentrate on internal management rather than constant public fund-raising.

National health insurance has been based on employment, leaving the poor and the retired uncovered. Social welfare offices of local governments and of private organizations paid for the unemployed and the retired persons without pensions. Recently they have been folded into the sick funds, thereby giving them full benefits and giving the hospitals normal paid-in-full rates. Since the unemployed and retired pay no premiums, the government subsidizes the sick funds. In countries where too many persons were not covered by NHI and the hospitals were going bankrupt from their non-paying load, such as Britain and Italy, the system was changed to a national health service. This service provided full coverage of the population, and full Treasury financing. A country with a hospital system and private insurance much like the United States—namely, Canada—switched to full government financing and universal coverage, because of the many non-payers.

The United States is the last developed country with a large number of health care bad debts and charity cases. The Hill-Burton Act even requires the hospital managers to find non-payers, an inconceivable idea elsewhere. As a result, American hospital managers juggle their accounts and shift costs among payers in ways that all other developed countries have eliminated. America's urban public hospitals experience a financial crisis reminiscent of the nineteenth century.

## Payments by Patients

### Cost-sharing

For basic benefits cost sharing varies by purpose. Nearly every country's NHI or NHS requires copayments for drugs to deter waste. A few countries require small coinsurance in fees under NHI for physicians' services, to deter unnecessary visits or relieve financial pressure on the sick funds.

The least cost-sharing occurs for the most expensive care, namely, hospitalization. If the purpose of NHI and NHS is to make services available to those who need them at difficult times, policy-makers think that the patient's finances should not be a barrier, that provision should be decided on clinical grounds. In the few countries where cost-sharing is required for inpatient hospitalization, the patients who are most likely to be deterred are exempt, that is, the poor, the elderly, the severely ill, and those with catastrophic bills.

Cost-sharing rules in every other country are simple and known to the patient in advance. Except in the United States, patients do not discover long afterward that they must pay substantial parts of their bills. Unlike American Medicare, where the cost-sharing amounts change every year, the foreign rates remain the same. Few countries rely on copayments as much as the United States, few have deductibles; copayments require frequent changes, and deductibles in health insurance are difficult to understand.

### Insurance

The populations of all countries—including the United States—prefer more complete coverage, even if premiums and taxes are higher. Health insurance premiums are lower in the United States than in any other developed country because its insurance coverage is less complete: inpatient stays are limited, indemnities for physicians' fees are low.

Besides the basic NHI coverage, many citizens abroad buy private insurance for any cost-sharing or for benefits omitted from the basic package.

The share in the payroll taxes by employers and employees is part of the full package of social security programs and payroll taxes. The shares abroad are decided by law, not by labor-management bargaining and no longer by the employer unilaterally. If anyone wanted the worker to pay more of this basic health insurance premium, the entire package of social security taxes would have to be redesigned, and the total shares would remain the same. All premiums are counted by employers as tax-exempt business expenses, like the wages.

The American system of leaving the employers' share of health insurance premiums to labor-management negotiation gives the employer an incentive to spend as little as possible. Compared to the higher payroll taxes and generous benefits abroad, the result in the United States is really "underinsurance" rather than "overinsurance."

### Private Practice

Once every country had a double system: charitable hospitals with few or no point-of-service charges for the poor and workers, private clinics for those with cash; third party payment for the workers, personal payments (perhaps with insurance reimbursement) for the middle and upper classes; general practice for the poor, and specialty practice for the rich.

Official NHI and NHS practice has steadily grown within each country and private practice has diminished. Third party coverage has become universal for a basic package of benefits; the middle and upper classes are members either compulsorily or (because it is a good buy) voluntarily. Hospitals and doctors' offices have become more attractive in all developed countries. Therefore the middle and upper classes usually rely on the benefits under NHI and NHS, because they have already paid for them. If the richer person wants a special extra benefit, such as a private room in the hospital, he pays out-of-pocket or with the help of a supplementary insurance policy sold by the official sick funds or sold by private companies. The senior physicians in nonprofit and public hospitals now spend all their time on the premises, instead of going off to private clinics for most of the day. They earn high salaries or fees for treating NHI and NHS patients and they have fewer private patients.

Some private hospital care remains. By paying the senior hospital doctor a private fee, the patient gets more personal attention. If the local hospital is crowded, the patient may be admitted to a private clinic for simple elective care. The patient may not personally pay the physician or private insurance company, but the private care is a fringe benefit of his job in business management (in Britain and Germany) or in the civil service (in Germany).

Because any citizen can join NHI or use the service of an NHS, private practice keeps its fees low. Private for-profit hospitals are very cautious, lest they quickly price themselves out of the market. They take the less expensive short stays rather than provide a complete alternative to the nonprofit and public hospitals. They usually charge lower rates than the non-

profit and public hospitals, since they must leave the patient enough cash to pay the doctors. The for-profit hospitals rarely earn net profits, because their rates are low and because the sick funds (if they have agreements) do not recognize profits as allowable costs. The for-profit hospitals survive by sharing in their doctors' private fees.

## Investment

At one time in every country, buildings and heavy equipment were donated by owners, benefactors, and governments. That remains the pattern in most countries. Public investment funds are common. Plans can be drawn and implemented ensuring that expensive installations and expensive programs do not proliferate excessively.

American construction and equipment were constrained by reliance on donations and public grants until a sudden and unexpected change during the 1960's. Medicare, Medicaid, Blue Cross, and private reimbursement recognized the repayment of debt as an allowable cost in calculating rates. Because rates were generous, lenders considered hospitals a good risk. Managers were confident they could bring in the revenue to amortize large debts through the case-finding and energetic treatments by their doctors. New buildings and new equipment spread with little restraint. Borrowing and repaying in this fashion gave hospital managers and medical staffs great independence, an incentive to compete with other "nonprofit" hospitals for market share, and an incentive to increase work and costs.

Only one other country—the Netherlands—has relied so extensively on borrowing in the private capital market. Its hospitals too have undergone spectacular increases in modernization and in costs. Its hospitals too have evaded strict planning controls.

Mere Certificates of Need (CON's) are no substitute for public grants as a force to restrain the proliferation of underutilized services and to induce a cooperative division of labor among hospitals. Disallowing the costs of disapproved services from the rates can discourage their installation only if the disallowance is complete—that is, capital costs and all operating costs are excluded from the charges for all patients. Like so many constraints, the American limitations are weak (for example, excluding only capital costs and only from Medicare reimbursement), they are not enforced in actual practice, and they invite contempt.

It is very difficult to use planning agencies and rate regulation to force the closing of privately owned hospital beds. Even publicly owned beds can be closed only with difficulty, because of community protest. Usually a deal converts the acute beds to something else, such as chronic care.

## Workers

Once hospital workers in all countries were paid little, worked long hours, and received much of their income in room and board. The situation changed rapidly in Europe after World War II, thereby causing great increases in hospital operating costs. Nearly all countries now recognize the hospital workers' unions and grant hospital workers the same wages as comparable occupations. Often the wages are indexed to inflation or linked to the rest of the society's wages. Labor relations therefore are taken out of contention over wages.

The Anglo-Saxon countries still rely on plant-level bargaining; American hospitals try to avoid all bargaining by fighting the mere recognition of unions. Britain and the United States pay lower wages than Europe but pay a heavy price in conflict. America's low wages enable it to staff its hospitals more lavishly than do other countries.

The United States has achieved the world's highest levels of hospital spending without the single largest force for high costs, namely, high wages. America's biggest cost explosion is yet to come.

## Doctors

The training, clinical habits, and financial incentives of hospital doctors conduce to more work and higher costs, not to fiscal restraint. Appealing to managers alone to make hospitals more efficient and more economical is futile, since a key to hospital finance is the organization and motives of the doctors.

Europe's hospitals have structures that make feasible the participation of the doctors in the financial management of the organization. The smaller and more select number of doctors in a closed European staff is easier to lead—in both quality and cost—than the large number of detached members of an open American staff. If the hospital must submit applications for limited investment money by priority, the medical staff becomes very active discussing the merits of all schemes, framing the serious proposals, and ranking them. After these experiences, the doctors become more conscious of needs and costs than they do from exhortations.

## Management

A hospital cannot be run like a commercial and industrial firm manufacturing "capital goods" or "consumer goods." It is one of society's institutions to handle misfortune. It has a different mission from maximizing its cash return: it is supposed to make health and give comfort, not make money. If someone cannot pay, the nonprofit and public hospital admits him anyway and finds the money elsewhere, as it always has done.

European hospital managers are often aware of larger obligations. Many hospitals are part of religious groupings. French public hospital managers belong to an elite national corps; their careers depend on fulfilling national policies (such as restraining costs) as well as pleasing their employers in the commune. The hospital associations in many countries bring man-

agers together regularly to share experiences. In contrast, the orientation of the American hospital manager is toward his own organization, and he is motivated to grow at the expense of others.

As in many other economic sectors, competition among hospitals increases costs of the system rather than reduces them. (Cutting prices to gain sales is not the same thing as cutting costs.) Competition among hospitals leads to adding new equipment and new services, in order to attract new patients. Rather than struggling over a finite market, doctors are encouraged to expand it. Competition leads to bankruptcies in areas with few payers, but government and charitable organizations would not tolerate this sort of "rationalization of production." They would have to step in to preserve hospital services.

## Determinants of Costs

The motive for most American research about hospital finance during the last decade has been restraint on rising costs. Experiences abroad show certain administrative arrangements that restrain costs, others that allow spending to increase. In the real world, of course, each administrative device is combined with many others in a system; some other characteristics have the same effect, others work in opposite directions. The following are principal influences on levels of costs, as they usually operate in practice abroad. These are organizational influences, which could be emulated in the United States—if reduction of spending is a policy goal.

| Determinant | Higher Costs | Lower Costs |
|---|---|---|
| Method of Payment | Rates related to services rendered | Global budget |
| Pricing and billing | Itemized | Bundled |
| If global budgeting and public grants | Bottoms-up | Top-down |
| Source of money | Insurance, especially private | Government Treasury |
| Characteristics of payers: | | |
| (a) Number | Many | One or few |
| (b) Relations among payers | Rivals | United |
| If rate regulation, nature of the agency | Commission dominated by interest groups | Line agency of government, staffed by civil servants |
| Procedure of the regulator or grantor: | | |
| (a) Parent bodies issue guidelines about allowable increases | None. Or, few and vague | Yes |
| (b) Can prescribe allowable increases in utilization, not merely rates | No | Yes |
| (c) Can authorize any new jobs in hospital | No | Yes |
| (d) Have voice in planning of building and programs | No | Yes |
| Uniform reporting by hospitals to regulators and payers | No | Yes |
| Interim monitoring during the year by the regulator or grantor | No | Yes |
| (a) Expenditure reports | No | Yes |
| (b) Liaison officers | No | Yes |
| Possible increases in budget or rates during year | Yes | No |
| Carryover of deficit into next year | Yes | No |
| Relations between reviews of last year's expenditure report and next year's prospective budget | Combined | Separate |

| Determinant | Higher Costs | Lower Costs |
|---|---|---|
| Regulator or payer can examine the hospital's books | No | Yes |
| Scope of hospital budget review by regulator or grantor | Inpatient only | Inpatient and outpatient |
| Subsidies by government, if any | To sick funds | To hospitals directly |
| Planning of hospital services: | | |
| (a) Does it exist | No. Or, indicative planning with voluntary compliance | Yes, with sanctions for noncompliance |
| (b) Coordination between planning and reimbursement. If hospital refuses to cooperate: | Payer reimburses patient at high rate | Payer reimburses patient little or nothing |
| (c) Source of money for new building and major equipment | Borrowed, with amortization in rates | Granted, with no amortization |
| Organization of hospital: | | |
| (a) Position of individual establishment | Autonomous | Part of regional or larger system |
| (b) Orientation of the manager | His single unit | Larger collectivity |
| (c) Function | Teaching | Non-teaching |
| Physicians: | | |
| (a) Medical staff structure | Open | Closed |
| (b) Relations to hospital | Hospitals compete for doctors | Doctors com pete for hospital posts |
| (c) Authority of regulators or grantors over pay of senior hospital doctors | No | Yes |
| (d) Payment of senior doctors | Fees | Salaries |
| Wage determination: | | |
| (a) Scope of decisions | National or regional | Each unit |
| (b) Number covered by agreement | Entire hospital work force together | Separate contracts, each for different period |
| (c) Connection with rest of labor force | Linked | Not linked |
| Standards by law: | | |
| (a) Quality of personnel | Strong | Weak |
| (b) Safety | Strong | Weak |

A system can be expensive not only in money but in contention. Americans are concerned about cutting health care costs but take for granted a level of bickering that is inconceivable in nearly every other developed country. Weary officials in American governments are belatedly realizing this is a problem, at least as important as the loss of money. The following are some system attributes that result in high and low conflict in hospital regulation.

| Determinant | Higher Conflict | Lower Conflict |
|---|---|---|
| Life of the statute | (a) Must be renewed frequently | (a) Permanent |
| | (b) Amended often | (b) Amended rarely |
| Power of legislature | High | Low |
| Role of courts | Active, overrules regulators and legislators | Passive, accepts executive discretion |
| Security of the civil service | Low | High |
| Method of regulation | Automatic formulae | Personal administration |

| Determinant | Higher Conflict | Lower Conflict |
|---|---|---|
| Complexity of the system in rules and in administration | High | Low |
| Stability in the rules | Changes are frequent and numerous | Changes are rare and few |
| Coverage of litigation costs | Included in budget for care of patients | Cannot be passed on to third parties |

Whether a system is "generous" or "stingy" has no effect on contention. The biggest spenders include a country that placidly accepts government decisions (Sweden) and one that constantly fights and evades them (the United States).