

LESSONS FROM ABROAD ON HEALTHCARE REFORM

Universal Access and Cost Constraint Work In Canada and in Germany

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By carefully studying the Canadian and German healthcare systems, we may learn how to design a delivery system within our current gross domestic product expenditures for health that offers universal access, consumer choice, cost constraint, and high-quality patient care.

The United States urgently needs comprehensive healthcare reform to provide universal access and to constrain costs. Neither the single-payer Canadian system nor the multipayer German system is a totally appropriate model for the United States, but we can learn what might be appropriate if we study how those nations deliver hospital and other healthcare services.

In such a pursuit, it is critical to remember that any healthcare system involves compromises. The ways in which various nations organize and finance their hospital, physician, and other healthcare services are often driven by many factors: precedent, consumer pressures, the nation's economic outlook, payer receptivity, providers' attitude, and a host of other variables.

Consumers, providers, third-party payers, and elected officials agree that our current healthcare system requires modifications along the following lines:

- Providing every American with at least basic comprehensive benefits
- Controlling rising healthcare costs
- Maintaining a pluralistic approach that allows consumer choice in coverage and in care
- Reforming delivery and controlling the current inflationary trend in healthcare costs—a prerequisite to successful economic recovery

Within the context of these tenets, I will discuss some lessons Americans could learn from the Canadian and German healthcare systems.

COST CONSTRAINTS

The national health insurance plans in Canada and the former West Germany provide universal, comprehensive national health insurance benefits at a fourth and a third less respectively, of their gross domestic product (GDP) for health, compared with the United States (see Table, p. 76). Whereas the average 1990 hospital expenditure per capita in the United States was \$998, it was \$745 in Canada and \$729 in West Germany. (All German statistics are from the former West Germany.)

The Canadians and Germans set national health policies and maximum healthcare expenditures in a way similar to that proposed in the

Summary Neither the single-payer Canadian healthcare system nor the multipayer German healthcare system is a totally appropriate model for the United States. But we can learn something by studying both.

Nations such as Canada and Germany use global budgetary target approaches, which have been shown to be more effective in controlling healthcare costs than the United States' micromanagement methodology of allocating resources.

As Congress decides on a basic comprehensive

benefit package, it must keep in mind that a universal, comprehensive plan results in a significant additional demand for healthcare services, as seen in Canada and in Germany.

The Canadian and German healthcare systems encourage consumers to select their physicians and hospitals. Germany has a distinct separation of community-based, fee-for-service physicians and hospital-based salaried doctors. This arrangement causes difficulty in providing continuity of patient care.

Catholic Health Association (CHA) reform plan, which recommends a national health board. This board would be similar in independence to the U.S. Federal Reserve Bank system and would recommend national health-care expenditures and allocate monies to state health organizations (SHOs). Considerable empirical evidence

shows that those nations using global budgetary target approaches are more effective in controlling healthcare costs than those relying more on decentralized mechanisms of allocating resources.

The success of this global budgetary target model can be illustrated by the 1990 average hospital discharge costs of \$4,130 and \$2,972 in Canada and West Germany, respectively, in comparison to \$6,535 in the United States (see Table, p. 77). Cost comparisons of Canadian and U.S. medium-size and teaching hospitals (1989-90) suggest that Canadian acute care facilities, with an almost 11-day length of stay, manage with significantly fewer nursing, emergency department, pharmacy and drugs, administrative and fiscal, and interest and depreciation expenses per discharge.

The direct nursing expense per discharge in Canada is slightly less than here because less paperwork is required at the nursing stations, and nurses are responsible for coordinating fewer nonnursing functions. Yet Canadian patients receive more registered nurses' (RNs') hours per discharge, which could be influenced in part by the fact that the supply of RNs per 1,000 persons in Canada is twice that in the United States.

Although Canada has four times as many primary care physicians as the United States, Canadians annually make almost twice as many emergency department visits per 1,000 persons. Canada's emergency departments provide significantly more primary care services at almost half the cost per visit in comparison with the United States. Canadian hospitals also have lower phar-



macy and drug expenses per discharge than here. This finding is consistent with a General Accounting Office study reporting that manufacturers' prices to wholesalers for frequently prescribed items were on average one-third less in Canada than in the United States.

Because their facilities obtain grants from the provinces for their capital ex-

penditures or secure funding for expansion and renovation from local fund-raising efforts, Canada's cost per discharge for interest and depreciation expenses is significantly lower than in the United States. Most U.S. facilities use long-term debt to fund major capital projects.

Canadian and German hospitals are able to manage on significantly lower average administrative and fiscal costs per discharge because they do not have to screen patients for benefit eligibility; prepare detailed bills for third-party payers; or respond to utilization, quality assurance, and other similar statutory requirements. Finding innovative ways to cost shift more expense to a decreasing percentage of private-pay patients or using resources to market their services to generate a larger regional market share (as U.S. hospitals do) are alien to Canadian and German hospitals.

Although Canadian hospitals annually deliver more ambulatory and inpatient care per person than do U.S. hospitals, these cost comparisons suggest that if Congress mandates global budgetary targets and simplifies reimbursement, the U.S. might be able to replicate Canada's staffing patterns. As a result, there could be layoffs of 15 percent of our current full-time equivalent (FTE) hospital employees (roughly 480,000 positions). A similar percentage decrease for the total healthcare field would result in a loss of 1.2 million FTEs.

Although such potential retrenchment has serious political and economic consequences, the nation's reduction in healthcare expenditures has to be at least partially tied to payroll savings. Under severe cost constraints, the U.S. health-

Mark Fisher

care system could require downsizing similar to that experienced by heavy manufacturing, banking, retailing, defense, automobile, computer hardware, and other industries during the past seven years.

BASIC COMPREHENSIVE BENEFITS

A congressional mandate for universal access in the United States would be extremely complicated. Historically, the amount and the content of healthcare services an individual has received have been related to whether he or she has health insurance coverage. National surveys report that on average uninsured persons receive 20 percent to 24 percent less healthcare than those eligible for third-party payer benefits.

Most of the basic comprehensive benefit packages now being discussed include ambulatory care, inpatient hospital care, prescription drugs, ambulatory mental health services, and preventive services known to have positive cost-benefit relationships. The CHA healthcare reform plan adds long-term coverage to this list.

To avoid competition with existing health insurance contracts and to contain taxes or the cost of premiums, Congress may initially curtail the scope of these basic comprehensive benefits. Apparently, tertiary services will be excluded from these initial benefits, which hints that Congress at the outset might be mandating a two-tier healthcare system.

A major lesson from the Canadian and the West German healthcare systems is that a universal, comprehensive plan results in a significant increase in the demand for healthcare services. If we were to replicate the 1990 inpatient day-use rates in Canada or West Germany (after the passage of a healthcare reform plan), our staffed acute care beds would be 128.1 percent or 212.6 percent occupied, respectively. There would be significant pressures to add beds.

Physicians could likewise be affected by a mandate for universal access. Doctors may find themselves following the West German use pattern, where a third more physicians than in the United States provide virtually double (117.0 percent) the number of visits per person annually. The Canadian experience (with roughly the same number of doctors per 1,000 persons as in the United States) would come to 24.5 percent more physician contacts per person annually.

Canadian and West German hospitals are able to provide universal, comprehensive benefits at a significantly lower percentage of their GDP than U.S. hospitals. They accomplish this by providing far greater volumes of care at a significantly lower cost per unit of service.

CONSUMER CHOICE IN COVERAGE AND IN CARE

The Canadian and German healthcare systems encourage consumers to select their physicians and hospitals. Germany has a distinct separation of community-based, fee-for-service physicians and hospital-based, salaried doctors. This arrangement causes difficulty in providing continuity of patient care. It should not be replicated in the United States.

Canada has a single-payer system. Although the various provinces have some differences in coverage, flexibility in choice of coverage is limited. In contrast, Germany has a multipayer system that allows consumers a choice of third-party payer and benefits. This is a model that could be easily followed in the United States. What is particularly attractive about the German system is that its sickness funds (acting as third-party payers) can negotiate reimbursement rates within global budgetary targets, without direct governmental intervention.

Canadians and Germans ration healthcare by limiting their GDP expenditure for health on the

BACKGROUND DATA ON HEALTHCARE (1990)*

Variable	Canada	West Germany	United States
Population (millions)	26.6	63.3	248.7
Healthcare expenditures divided by GDP	9.2%	8.1%	12.1%
Hospital expenditures per capita	\$745	\$729	\$998
Private expenditures for healthcare	27.5%	25.6%	58.0%
Acute care beds per 1,000 persons	5.1	7.1	3.8
Physicians per 1,000 persons	2.23	3.06	2.30
Acute care admissions per 1,000 persons	136.3	173.6	125.0
Acute care patient days per 1,000 persons	1,468	2,237	910
Average length of hospital stay (days)	10.8	12.9	7.3
Physician visits per 1,000 persons	6.6	11.5	5.3

* Values are in 1990 U.S. dollars. Canadian figures are adjusted according to the purchasing-power-parity rate of exchange. U.S. \$1.00 equals Canadian \$1.315; U.S. \$1.00 equals 1.598 DM.

SELECTED HOSPITAL OPERATING DATA (1989-90)*

Variable	Canada	West Germany	United States
Operating expense per discharge	\$4,130	\$2,972	\$6,535
Operating expense per day	\$382	\$215	\$901
Full-time equivalent personnel per occupied bed	3.3	1.4	5.5
Surgical visits per 1,000 persons	109.6	102.7	88.1
Emergency department visits per 1,000 persons	640.3	†	348.9
Outpatient visits per 1,000 persons	927.6	†	868.1
Average percentage of occupancy	78.9%	86.2%	66.8%
Paid hours per discharge			
All hospitals	285.1	144.5	321.2
Medium-size hospitals	228.0	†	276.3
Teaching hospitals	348.5	†	424.7
Direct nursing expense per discharge			
Medium-size hospitals	\$744.56	†	\$ 926.09
Teaching hospitals	\$947.14	†	\$1,123.20
Number of paid RN hours per discharge			
Medium-size hospitals	35.1	†	34.8
Teaching hospitals	48.1	†	39.9
Emergency department direct expenses per visit			
Medium-size hospitals	\$19.04	†	\$38.90
Teaching hospitals	\$28.54	†	\$42.94
Pharmacy and drugs			
Medium-size hospitals	\$141.74	†	\$258.70
Teaching hospitals	\$286.92	†	\$361.79
Total administrative and fiscal direct expense per discharge			
Medium-size hospitals	\$260.02	†	\$546.70
Teaching hospitals	\$382.20	†	\$838.95
Interest and depreciation per discharge			
Medium-size hospitals	\$ 99.00	†	\$460.00
Teaching hospitals	\$168.00	†	\$617.00
Current ratio, all hospitals	1.36	†	2.01
Days in net patient accounts receivable, all hospitals	26.7	†	77.0
Long-term debt-to-equity ratio, all hospitals	0.263	†	0.525
Inventory turnover, all hospitals	55.01	†	59.34
Average age of plant (years), all hospitals	8.18	†	7.76

* Values are in 1990 U.S. dollars. Canadian figures are adjusted according to the purchasing-power-parity rate of exchange. U.S. \$1.00 equals Canadian \$1.315; U.S. \$1.00 equals 1.598 DM.

† Similar departmentally oriented information is unavailable for German hospitals.

NOTE: Canadian and U.S. medium-size and teaching hospitals in 1988-89 had an average daily census of 200 and 500 patients, respectively.

basis of setting global budgetary targets nationally. The United States rations healthcare on the basis of an individual's health insurance coverage and other available resources. As our healthcare reform debate unfolds, we may come to the conclusion that the United States can no longer afford all the healthcare that a market-driven system is capable of offering and that tighter macro-managed constraints are needed.

The implementation of a global budgetary target (as CHA recommends) would make SHOs responsible for allocating total dollars to regions within the borders of their states. Even though we now spend at least 25 percent more per person for healthcare than Canada or Germany, communities, trustees, hospitals, physicians, and other interested parties may feel compelled to undertake some implicit rationing of resources. This is particularly relevant if we are faced with the higher utilization rates of hospital days and physician visits experienced in Canada and Germany.

Collaborative efforts would be required at the regional and local levels to shape the delivery of healthcare services to the available dollars provided by a SHO. This could be a trying process for many providers, since they would need to redefine their mission and goals in an environment that focuses on universal access and cost constraint.

ECONOMIC IMPACT OF HEALTHCARE REFORM

U.S. healthcare expenditures are projected to increase by the year 2000 to 16 percent or more of our nation's GDP. Hospitals could consume on average \$1 out of \$15 of each person's disposable income. What is currently driving the United States to healthcare reform is simply that too many persons are without health insurance and the cost of American healthcare is considered excessive. There is also recognition that we may have the world's finest medical care, but that the highest-quality care is only available to those with adequate insurance coverage.

After reviewing Canada's average hospital discharge cost (\$4,130), one might wonder whether their national health insurance plan wrecked the fiscal viability and bankrupted their acute care facilities. Possibly the most effective and efficient way to determine this is to compare the financial ratios of all Canadian and U.S. hospitals in 1988-89 (the latest data available in Canada). These 673 Canadian hospitals had a 9.0 percent operating loss that was offset by an 11.9 percent nonoperating gain, so they ended that year with a 2.9 percent surplus of revenues over expenses.

Some revealing Canadian-U.S. financial data

(see Table, p. 77) suggest Canada has a weaker current ratio, but far fewer days in net patient accounts receivable. The average Canadian acute care facility has half the debt-to-equity ratio of a U.S. hospital and an average plant that is only six months older than U.S. facilities. These fiscal data convey that Canadian hospitals (with a universal, comprehensive health insurance plan) have been able to maintain their fiscal viability.

HAVING IT ALL

The outcome of our nation's healthcare reform initiatives will be unique. But we should emulate the Canadians' and Germans' ability to have lower healthcare expenditures with no adverse effect on patient outcomes, as shown by their lower infant mortality rates and longer life expectancies.

The major lesson that we can learn by studying the Canadian and German healthcare systems is that we should be able to design a delivery system within our current GDP expenditures for health that offers universal access, consumer choice, cost constraint, and high-quality patient care. □

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