

Global Budgets: A Key To Clinton's Reform Strategy?

BY JANE H. WHITE

Bringing health costs in line with inflation would do more for the private sector in this country than any tax cut we could give, than any spending program we could promote," urged President Bill Clinton in his February 17 address to Congress and the nation. At several points in the speech, he returned to healthcare and the need to get a handle on out-of-control costs—even throwing out healthcare spending statistics with off-the-cuff ease. Yet curbing these costs will be anything but easy.

Next month, Clinton plans to unveil his proposal to reform healthcare, with the twin goals of providing universal coverage and cutting costs. It is the spending goal, however, that has become a linchpin in his overall strategy to reduce the deficit, thus raising the political stakes of success.

A COMBINED STRATEGY

Early indications show that President Clinton favors managed competition with the added regulatory mechanism of a global budget to hold healthcare costs in check. Indeed, two key White House staff members working on Clinton's healthcare reform plan are pushing this strategy of managed competition constrained from above. As these analysts—sociologist Paul Starr (on leave from Princeton University) and Walter A. Zelman (from California's Department of Insurance)—explain, "A combined strategy of managed competition and global cost controls is the best way . . . to achieve what other Western countries have long had—an economically sustainable system of universal health insurance."¹

Managed competition is a strategy for restructuring the healthcare marketplace for more efficient competition among health plans, coupled with regulatory safeguards for consumer protection, equity, and universal coverage, as well as incentives to control costs with managed care and changes in the insurance market (see last month's column, "Cutting through the Confusion of Managed Competition," pp. 10-12). New insti-



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tutions called health insurance purchasing cooperatives (HIPCs) would hold the key to marketplace reform by monitoring and managing approved healthcare plans, from which consumers could choose their healthcare coverage.

Global budgets—the "regulatory" half of Starr and Zelman's plan—serve as an overall cap or limit on healthcare services. "In some contexts, global budgeting has come to mean setting a limit on spending by sector—that is, specific allocations for doctors, hospitals, and so on," explain Starr and Zelman.² Yet they fear this definition will lead to freezing in place the current system's inappropriate cost biases. Their goal instead is to "use the capitated health plans at the local level to carry out nationally set targets for health care spending"—a sort of "market-determined" global budget. Indeed, managed competition guru Alain Enthoven, who heretofore has eschewed global budgets as incompatible with his definition of "managed competition," has endorsed what he called "a Paul Starr global budget," in comments this past January at a meeting held by the Alpha Center in Washington, DC.

HOW OTHER NATIONS CONTROL COSTS

Canada and most European countries have demonstrated that budget limits can control rising healthcare costs. These countries have kept costs 30 percent to 50 percent lower than U.S. healthcare spending rates. Indeed, "even the conservative, market-prone Kohl government of Germany introduced a new health reform law that provides for strict, global, top-down budgeting of all sectors of the health system, effective January 1, 1993," noted Princeton economist Uwe Reinhardt at a January meeting of the Institute of Medicine (IOM).³

Two widely respected scholars and collaborators—economist Henry J. Aaron of the Brookings Institution and William B. Schwartz, professor of medicine at the University of Southern California, Los Angeles—reinforce the view that the United States could learn from other coun-

tries' experience with global budgeting. They wrote last month:

Neither a global budget nor managed competition alone is capable of stemming the meteoric rise in national health expenditures. In fact, it may be argued that the two strategies require one another in complementary, mutually reinforcing fashion. Global budgets differ from managed competition, however, in that [they] actually exist in various forms in several other countries where they actually have worked to suppress growth of health care spending. Managed competition exists nowhere.⁴

So how do other countries do it? Canada and European countries have managed their healthcare costs without the day-by-day oversight and micromanagement practices that U.S. insurance companies and public-sector payers have adopted to determine when they will pay for care. The Canadian-European strategy to control overall healthcare spending, according to Reinhardt, is to "(a) constrain the *physical* capacity of the system, (b) control prices, and, for good measure, (c) impose something as close as possible to global monetary budgets on the entire system. Within these constraints, however, they allow doctors and their patients considerable clinical freedom."⁵

Past U.S. efforts at budgeting have had somewhat checkered histories. They have tended to focus only on parts of the system—a single payer such as Medicare or one segment of the healthcare market such as hospitals or physicians. This piecemeal approach may show some healthcare savings for one portion of the market because costs have been shifted to another part.

Indeed, when one sees that overall U.S. healthcare spending topped 13 percent of the gross national product (GNP) in 1991 (\$751 billion) and at current rates will reach 20 percent of GNP by the end of the decade, cost shifting clearly is not the answer.⁶ For budgeting to work here as it has abroad, a more comprehensive approach is needed, requiring new roles for public and private sectors.

DEFINING GLOBAL BUDGETS

If we transplant global budgeting to the U.S. healthcare system, some key questions emerge. Stuart H. Altman of Brandeis University, who served on Clinton's healthcare policy transition team, and his colleague Alan B. Cohen, a research professor at Brandeis, recently set out their vision of a global budget, American style.⁷

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Services What services are included under a global budget? Altman and Cohen would include traditionally insured core healthcare benefits and related supplemental benefits. Less clear-cut is coverage for areas not widely covered under current plans: long-term care, mental healthcare, and substance abuse services. Altman and Cohen suggest that nonpersonal healthcare spending areas such as medical education and capital expenditures be given budget limits separate from those for the services provided under a core benefit package. Public health spending would most likely be excluded from the budget limit.

Spending Limit Definition How is the spending limit defined? To track healthcare spending and set budget limits, Altman and Cohen note, most analysts prefer using income-output measures such as gross domestic product (GDP), "since it reflects national income and is relatively easy to estimate." They go on to define a national limit in terms of "adjusted annual per capita growth in GDP."

Spending Limit Allocation What is the best method for allocating the spending limit across areas, populations, and providers? Altman and Cohen believe a "top-down" approach to capping insurance premiums (for fee-for-service providers) and capitated rates (for managed care plans) is necessary for effective cost control. They question, however, whether government programs for special populations such as Medicare and Medicaid should be included in the spending limit.

Management Who would govern the spending limit? Most analysts suggest a federal board, perhaps similar to the Federal Reserve Board, or a commission should monitor spending and enforce the global budget. Altman and Cohen also push for flexibility at the state level for budget implementation.

Monitoring How is spending monitored? Current data systems in the United States are inadequate for effectively monitoring a global spending limit. Although federal spending data are good, state- and regional-level estimates are of inconsistent quality, depth, and comparability. Good private-sector healthcare spending data are also needed. Developing adequate information for consumers on outcomes, quality, and practice patterns also requires much work.

Enforcement How is the spending limit enforced? Given the major data problems, effective enforcement of a global budget will be limited in the short run, predict Altman and Cohen. They suggest that, during a phase-in period, global budgets be treated as "targets" rather than "fixed limits." "Ultimately, once reform structures are

in place and data systems fully implemented, enforcement mechanisms may be employed that target the state, individual HIPCs, or both." Such mechanisms could include liability for excess spending, federally imposed penalties and incentives, price controls, and suspension and revocation of HIPC licensure.

BUILDING ON A MANAGED COMPETITION FRAMEWORK

As Clinton offers the country his prescription for healthcare reform this spring, he must be assured it will indeed save money. Parts of managed competition have been tested in state programs in California and Minnesota, at Stanford University, and to some extent in the Federal Employees Health Benefit Program. Yet the concept has not been tried in its entirety. Its effect on healthcare spending thus remains somewhat theoretical. Global budgets offer a proven track record of cost control in other countries, albeit a regulatory one. Thus, as Reinhardt presents the conundrum, "Should [Clinton] set aside global budgeting for now, gambling his first-term health policy on the *faith* that managed competition will perform as advertised, or should he be cautious and couple a move toward managed competition with a global budget?"⁸

Reinhardt argues that managed competition actually provides the president "the perfect platform" on which to build top-down budgeting. He can thus move ahead with managed competition now, get the restructured incentives and HIPCs in place, build the necessary data systems and infrastructure, and then impose spending limits to ensure healthcare cost savings. Other analysts, including White House insiders such as Starr, agree with Reinhardt that grafting global budgets onto a managed competition system that emphasizes managed care should be much easier and more effective than simply employing such spending limits within the current fee-for-service system.

At the IOM meeting, however, Reinhardt urged the health policy community to take reform in stages. "It would be unwise to go to global budgets right away; we should wait until the HIPCs are there and then you can budget to your heart's content," he said. He also noted that it is "unfair to this president to hold him to victories in cost containment in health care in the next two to three years" given the size of the system and the time it will take to see real change. Nevertheless, curbing healthcare costs is a critical part of Clinton's political strategy.

Assuming Clinton can get his plan enacted this year—a big assumption—implementation will take

at least two years. In addition, many parts of the United States do not have the managed care entities or infrastructure to rapidly adopt the major tenets of managed competition. In several years' time, healthcare costs will have pushed up to roughly 16 percent of GNP, and the 1996 election will be around the corner with little visible success on the healthcare spending front.

As one way out of this political dilemma, Aaron and Schwartz suggest Clinton can show some quick savings by putting an early global budget on one sector of the healthcare system—hospitals, "the largest single component of total acute care spending." They explain their strategy this way:

While the administrative obstacles to such controls are formidable, the necessary framework for achieving significant reductions in costs is in place in a few states and could be extended nationally in less than one year. . . . It would be essential to prohibit hospitals from sloughing off various services in order to comply with spending limits or to penalize these providers if they do so.

Aaron and Schwartz see this proposal as a short-term stopgap: Full-scale reform would supersede such a hospital-only global budget. "Short-term" in Washington policy terms, however, takes on new meaning when one considers that Medicare and Medicaid were enacted in 1965 as a short-term, first step on the way to national healthcare reform.

HOSPITALS' CONCERNS

Meanwhile, some hospital representatives remain skeptical about global budgeting. The American Hospital Association's (AHA's) James Bentley, senior vice president for policy, set out his concerns at the IOM meeting. He spoke of the need for a more open discussion of spending limits as viewed by the Clinton administration and argued that "the nation currently lacks the integration of providers, data systems, and infrastructure of delivery organizations to implement global budgets." He cautioned that "there is no shared financial interest across providers," which he said was necessary if global budgets are to work. In addition, Bentley argued that the imposition of spending caps could "undermine the community interest" and mission of many hospitals.

The AHA (as well as the Catholic Health Association) plan puts reform of the delivery sys-

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tem at the core of healthcare reform. Bentley argued that "the current emphasis on global budgeting and cost control will undermine the possibility of delivery reform. If the debate disintegrates into a political debate about cost control, it will divide groups against each other."

At the same IOM meeting, however, Reinhardt argued that healthcare providers should seek to "exploit the inevitable." He urged providers to "prepare themselves to demonstrate convincingly the benefit-cost ratios implied by their various offerings, . . . to anticipate the errors that naturally occur in any budget-driven system, and to cooperate with the private- and public-sector budgeteers in attempts to avoid such errors."

Whether hospitals will spend their time and effort fighting global budgets and pointing to its flaws or preparing to cooperate with budgeteers and helping to structure spending limits to their advantage, it is essential that the provider community learn all it can about such budgeting. Political necessity demands it. □

NOTES

1. Paul Starr and Walter A. Zelman, "A Bridge to Compromise: Competition under a Budget," *Health Affairs*, Suppl., March 1993, pp. 7-23.
2. Starr and Zelman.
3. Uwe Reinhardt, "Health Care in an Age of Constrained (Though Not Shrinking) Budgets," paper presented at Institute of Medicine, Washington, DC, January 11, 1993.
4. Henry J. Aaron and William B. Schwartz, "Managed Competition: Little Cost Containment without Budget Limits," *Health Affairs*, Suppl., March 1993, pp. 204-215.
5. Reinhardt.
6. Suzanne W. Letsch, "National Health Spending Trends, 1991," *Health Affairs*, Spring 1993.
7. Stuart H. Altman and Alan B. Cohen, "The Need for a National Global Budget," *Health Affairs*, Suppl., March 1993, pp. 194-203.
8. Reinhardt.
9. Aaron and Schwartz.

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Related Issues" (1992), clarifies issues in light of the new audit guide. These documents are helpful in establishing procedures within an institution to define and measure the charity care rendered.

The measurement of charity care and community services is facilitated by use of the Social Accountability Budget (*Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint*, CHA, St. Louis, 1989). This tool helps managers and others within the institution determine which services it renders for the good of the community and the fulfillment of the facility's mission in contrast to those rendered for marketing or other reasons.

Once a facility knows what to classify as charity care or community service, it must measure these services. A health-care organization must follow predetermined procedures and maintain good records. Financial statement information must be reported to all members of the community, all who interact with the institution, lenders and other providers of financial services, and governing boards. The information quantifying the costs of these social goods should be prominent in financial statements. Even though disclosure of the costs of providing community services is not required, reporting this information will greatly expand readers' knowledge of the facility and its mission.

Presentation in Financial Statements Disclosure in financial statements is critical to the institution's explanation of how it fulfilled the charity care and community service portion of its mission. After reviewing the alternative methods of providing the disclosure, healthcare managers might find it prudent to disclose as much information as possible on the face of the income statement.

Rather than merely writing, "See footnotes for information," managers could draw attention to the disclosure by writing, "See footnote number X, which details the patient charity care service provided in the amount of \$X and community service in the amount of \$X." This disclosure can be placed near the total revenue line on the face of the income statement.

A table might present footnote information more clearly than a narrative. Tables are easier to read and will catch the reader's eye. The disclosures can be expanded in the footnote to describe the charity care and community services as a percentage of patient revenue or net income.

A final place for managers to emphasize the organization's contribution to the good of the community is in a discussion and analysis. This may be incorporated into the audit report and included in part in the facility's annual report.

Such a discussion is a common feature of the financial reporting of corporations to stockholders and should be used more often by not-for-profit organizations. By explaining in a clear, narrative fashion the significant events that occurred during the year and their impact on the institution's performance, managers can answer all questions that may arise. Surely the facility's contribution to the community through its provision of charity care can be well explained in this manner.

ACT NOW

Now is a good time for managers to review the new financial reporting formats. They have an opportunity to make the institution's mission, its contributions to the community, and the true financial implications of these contributions clearer and more easily understood by all users of financial statements. □