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GLOBAL BUDGETS:
An Effective Approach To Control U.S. Health Expenditures?

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ABSTRACT

Global budgets, as utilized in Canada, Germany, and in most other European countries, could be a possible approach to control increasing U.S. health care expenditures. This paper starts with a discussion of why making modifications of how hospitals and physicians are reimbursed, but still maintaining fee-for-service incentives, is not the long-term solution to the U.S. healthcare cost dilemma. After in the most general terms outlining the key elements of a possible U.S. global budgetary reimbursement methodology, some potential targets for organizational and management-type cost reductions are outlined. Billions of dollars could be saved in the U.S. by implementing a smart card for processing health insurance claims; by shuttering underutilized hospitals and other health facilities; by eliminating almost half of the available high tech equipment; and, other proposed approaches. This paper concludes with a discussion of how global budgets might impact the delivery of health services as it relates to consumers, the providers, the insurers, and to the potential formation of a Federal Health Commission and of state health commissions organized as public utilities.

It is widely agreed upon that a continuing growth of U.S. healthcare expenditures is unsustainable and without significant changes will eventually bankrupt our economy. For most of the past four decades, health spending has grown by three percentage points above gross domestic product (GDP)/per person every year. The Congressional Budget Office projections suggest that by 2037 federal health expenditures will consume at least 40% of our total federal spending.(1) Meanwhile, most of the currently proposed solutions, such as accountable care organizations (ACOs) and medical homes, focus on modifying our-time honored, fee-for-service reimbursement methodology, an approach that encourages providers to increase their volume of services rendered in order to enhance their bottom line.

Further complicating any workable resolution to our cost quandary is that consumers, because of their insurance coverage, are largely insulated from healthcare expenditures and rarely can be engaged in competitive price shopping for services. Yet, a global budgetary reimbursement approach, such as utilized in Canada, Germany, and among almost all European nations, could save 30% of our current health expenditures. (2-3)

There are also currently some "halfway approaches" being considered, such as a global payment system (4) or the use of global budgets. (5) When these reimbursement methodologies are outlined in operational terms, they are virtually synonymous with a bundled payment: a total fixed reimbursement amount to health providers as the basis of expected costs for a package of clinically-delineated episodes of care. In fact, a bundled payment might be considered by some providers as representing a middle ground between fee-for-service and capitated reimbursement so it sounds something like a broader version of managed care (e.g., HMOs) of the 1980s and early 1990s that most often was loathed by both patients and physicians. (6)

A far more radical form of a global budgetary reimbursement methodology is the focus of this paper. It is defined herein as being consistent with how health systems in many countries provide national health or social insurance: to constrain total healthcare expenditures within a fixed maximum expenditure that is typically set by a governmental mandate for a delineated set of health services.

With such an approach, hospitals and other facilities are entrusted with a total annual expenditure budget and are required to deliver their care within those dollar limits. Physicians are reimbursed on a fee-for-service or on a capitated basis, but in either case within a targeted dollar maximum. If doctors this year exceed that fixed dollar ceiling, fees or capitation would be decreased proportionately in the next fiscal cycle. This should all sound similar to some of the key principles utilized by Canada, France, Germany, and many other European countries to control their total healthcare costs. Often overlooked in these discussions is that a somewhat analogous "model" does exist in the U.S.: the Veterans Administration network, where the quality of care was until recently generally considered to be adequate, the expenditures for its 1,700 facilities are limited by global budgets, and its physicians most often are salaried.

To further explore how the U.S. in the long-haul might significantly reduce its healthcare expenditures, this paper has three purposes: (a) to suggest that the demonstration projects now underway have inadequate cost reduction incentives that are necessary to significantly decrease the costs of delivering healthcare, so that in the long-term the U.S. would eventually avoid bankruptcy due to its health expenditures; (b) to outline in the most general terms how a global budgetary reimbursement approach might be effectively implemented in the U.S.; and, finally, (c) to discuss the impact that might be expected in the U.S. by implementing a global budgetary reimbursement methodology. Interestingly, the projected cost reductions discussed herein are primarily the result of making modifications in how U.S. healthcare services are organized and managed rather than directing efforts toward reducing utilization or adversely effecting quality of care.

Key Words: global budgets. health policy, healthcare reimbursement, federal health commission.

Demonstration Projects Now Underway

The numerous demonstration projects that are now underway, generally funded by the Center of Medicare and Medical Services (CMS) or by traditional third-party payers, are to experiment with different approaches to organize, manage, and finance hospital and physician services with the specific purposes of reducing cost and improving quality of care.

a. ACOs

In brief, the 500 or more ACOs in the U.S. comprise of groups of physicians, hospitals, and other providers that have agreed to work together to provide high-quality, coordinated care to their patients and to achieve significant levels of fiscal savings. ACOs share with the government those cost reductions that can result from a better coordination of care as long as the ACO generates a minimum savings of two percent and meets 33 quality metrics specified in the initial CMS regulations.

The early results of these ACOs indicated an uneven performance in cost savings in spite of the fact that many of the sponsoring organizations have had long histories in providing coordinated care. (7) Most ACOs meet the quality metrics with reasonable ease, but were unable to provide cost savings large enough to share them with CMS. These outcomes could have been expected, since most physicians and hospitals in the ACOs are reimbursed on a fee-for-service basis; their patients can seek care outside the network without financial penalty; and, more integrated physicians and hospitals often tend to increase costs.

b. Medical homes

Patient-centered medical home projects focus on providing comprehensive primary care that is patient centric and can better coordinate the care patients receive from all of their various providers. Under this model, a monthly fee is generally paid to a physician or to a nurse manager to monitor various coordinating activities. Reimbursement for the delivery of specific services remains on a fee-for-service basis thus encouraging providers to increase their volume of services.

Most of the medical home pilot studies to date have experienced modest savings at best and insignificant improvement in quality of care.(8) It could be anticipated that not more than modest savings are forthcoming given that the basic structure and financial incentives of the practice of medicine and of providing hospital care with medical homes is fee-for-service and with an added expense for coordinating and integrating care.

c. Bundled payment

Probably the most noteworthy bundled payment projects that are now underway are sponsored by the CMS Innovation Center's Bundled Payment for Care Improvement Initiatives. Provider organizations can indicate what

services they want to bundle and then propose a price that offers a discount from what CMS historically would have paid for such a similar set of services.

Perhaps the major reason for so limited experimentation to develop such episode-based payments is that general surgeons, and the surgical and medical sub-specialists are relatively content with their current fee-for-service level of reimbursement and are not anxious to bundle services where there is every likelihood of earning less for providing the same care. The primary care physicians, in contrast, are usually interested in ACOs, medical homes, and bundled payment experiments, since they can envision enhanced income by participating in these pilot endeavors. It is hard to imagine that our nation's teaching hospitals, and their secondary- and tertiary-physicians on their medical staffs responding very favorably to giving up a sufficient amount of income to make a bundled payment reimbursement methodology such an attractive option, so it is possible to substantially reduce the nation's healthcare expenditures.

Although these current pilot experiments are attracting significant interest from public officials, experts in health policy and finance, hospital and physician groups of various types, and the public, there is currently no empirical evidence supported by solid peer review research that suggests that the outcome of any one of these three pilot experiments offers the fiscal incentives to significantly reduce U.S. healthcare expenditures. The major reasons being that they are too closely tied to fee-for-service reimbursement; and, that a projected two or three percent reduction in total health expenditures is insufficient to tackle our nation's long-term inflationary health cost trends. Therefore, it might be appropriate to review the efficacy of a global budgetary reimbursement methodology that has been used by many western industrialized countries as a key element to set a specific limit on the percentage of their nation's GDP (roughly 13% compared to 18% in the U.S.) to pay for their healthcare services.

Framework for a Proposed Global Budget Reimbursement

For purposes of discussion here, a possible global budgetary reimbursement approach for the U.S., modeling most closely after the German social (sickness) insurance plan, is broadly summarized along these lines: universal access; multi-payer (unlike Canada); relatively comprehensive statutory benefits with an emphasis on preventive services, but offering those with significant incomes the option to purchase additional coverage at an added expense from a private insurer; health insurance benefits for the vast majority of employees and his/her family to be financed by a payroll tax that could be paid in full by the employer or the expense shared with the employee; the cost of providing coverage for the poor and the uninsured to be paid by state-federal funding with federally mandated minimum provisions as a Medicaid-type program; and, Medicare to be continued without significant change. For those unable to obtain coverage in the competitive (e.g., with insurers such as a Blue Cross-Blue Shield, Aetna, United Healthcare) or from the government-sponsored marketplace, a state agency would need to offer health insurance benefits possibly to be administered in a similar manner to our current state workers' compensation plans.

State medical societies would negotiate their fee schedules on a state by state basis with the representatives of the sickness funds and would be paid on a fee-for-service or capitated basis within a specific budgetary maximum amount approved by the state health commission functioning as a public utility. Hospitals, and other facilities and services would negotiate in a similar manner with the sickness funds and would receive annually a maximum budgetary amount to be approved by the state health commission acting as a public utility. Reviewing accessibility to care, utilization of services, quality of care provided, payments to various providers, and other similar benchmarks to be documented and be published annually by a proposed new Federal Health Commission or an independent federal governmental agency possibly tied to the National Institutes of Health so as to be reasonably objective and to provide needed independence. The initial global budgetary amounts paid to hospitals, physicians, and other providers to be tied to historical costs adjusted by the severity of illness (DRG) of the patients served.

How to Potentially Derive Savings

Having described in the broadest terms a proposed global budgetary reimbursement methodology, some areas of potential fiscal savings for the U.S. health care system more readily implemented under such an approach are outlined as follows:

a. Smart card

Critical to this proposal is that every American would be issued with a smart (e.g., credit) card that contains an individual's pertinent identification and third-party payment information, summary of critical medical information, and brief notes concerning the last provider visits. Major savings could be achieved by eliminating almost all of the paper work experienced in the offices of various providers and of the insurers, thereby potentially eliminating up to 2.5 million white-collar jobs and causing significant additional unemployment.

This personnel reduction estimate is based on two Canadian-U.S. comparative reports: A study (9) analyzing administrative healthcare costs in Canada and in the U.S., that not only included the insurers' costs, but also the expenses incurred by employers, providers, and government agencies when arranging third-party coverage, concluded that the Americans spent $1,059 per capita on health insurance compared to $307 in Canada. In another study (10) in the Canadian province of Ontario, physician practices spent $22,205 per physician/annum for third party transactional costs compared to $82,975 per physician/annum in the U.S., a potential saving here of approximately $276 billion per year.

b. Shuttering underutilized facilities

Since healthcare services have high-fixed and low-variable costs, significant fiscal savings could be potentially achieved by shuttering most of the nation's underutilized hospitals, ambulatory care facilities, outpatient surgery centers,

and offices where a low volume of specialized procedures such as MRIs and CT scans are provided. An example is where a small not-for-profit or public hospital experiencing fiscal distress, most often because of low inpatient census, is now often being privatized rather than being shuttered; thereby, perpetuating the existing accessibility for care to its local residents, preserving current jobs, and not having to be concerned with an acute care facility standing empty downtown. This is inconsistent with the significant savings that could be generated by phasing out these underutilized facilities and services that obviously would cause the community and some local practicing physicians considerable distress.

c. Reducing the availability of some high tech services

A far greater supply and utilization of expensive medical technology is one of several explanations given why the U.S. spends a greater percentage of its GDP for health compared to other industrialized countries. Per million persons, the U.S. has available twice the number of MRI machines, CT scanners, PET scanners, and mammograms than Canada and most European countries; and, as predictable, therefore, the Americans use MRIs and CT scanners twice as often per million persons. (11) This high tech equipment, when experiencing reasonable volumes, is most often highly profitable to hospitals, the radiologists, and the investor groups, who are often dominated by physicians.

To reduce the risk of misdiagnosis or improper therapy, physicians order MRI and CT procedures to protect themselves and hospitals from possible malpractice claims. Some believe that significant savings could be forthcoming by modifying our current tort law. More likely, cost savings could be achieved by simply reducing the availability of this technology and requiring more patients in non-emergency situations to queue up for these procedures, causing some patient inconvenience.

Based on our previous experiences, every state enforcing certificate of need legislation for high tech equipment regulated by regional, state and federal authorities is not recommended.(12) Setting lower reimbursement rates for these high tech procedures would be far more advantageous in order to achieve savings in total healthcare expenditures, since it would almost immediately result in the shuttering of the low utilization, marginally profitable providers of this expensive medical technology.

d. More critically scrutinizing mergers and acquisitions

Studies of the overall efficacy of hospital mergers and acquisitions in Canada, the United Kingdom, and the U.S. concluded that these consolidations usually culminate in the formation of large systems – monopolists that result in decreasing accessibility of health care services, increasing medical costs, and the lowering of the quality of care. (13) Another concern is when U.S. hospitals acquire physician practices, a claim's filing to Medicare and, therefore, to most other insurers, is 30% higher than as a stand-alone

doctor's office. This price shift is simply because the services are now being provided under the aegis of an acute care facility.

In the U.S. for several decades, federal and state anti-trust regulatory agencies have been relatively unsuccessful in the courts to prevent hospital mergers even when they are clearly not in the public interest. The providers in these proceedings often propose that economies of scale, greater accessibility of services, and higher quality of care will be forthcoming, but the outcome of most of these consolidations in terms of meeting the public's interest, unfortunately, has been disappointing. Shuttering of excess facilities and services, although politically stormy, might be the objective of what the general public should be pursuing with some of these anti-trust proceedings.

e. Prescribed drug cost containment

For the thirty most commonly prescribed drugs, prices are one-third higher in the U.S. than in Canada and Germany, and more than double the prices in Australia, France, the Netherlands, New Zealand, and the United Kingdom. Conversely, prices for generic drugs are lower in the U.S. than in other countries. (14) These findings have led some consumer groups to complain that the U.S. is subsidizing European health expenditures.

One proposed solution for our nation's prescription drug cost dilemma is to impose drug cost regulations (a statutory cost commission) as enforced elsewhere. The pricing in the U.S. would need to reflect research, development, and production costs; and, a reasonable profit margin to encourage further research endeavors. Proponents of such legislation would contend that consumers would benefit from lower prices, while critics would raise concerns that additional regulations will cut pharmaceutical company revenues that, in turn, will slow down the pace of innovation.

Globally, in recent years, the regulation of prescription drug prices has intensified and, thereby, these federal commissions have reduced pharmaceutical manufacturers' revenues. In fact, there is probably not a more potentially contentious issue in U.S. health care than attempting to pass legislation regulating pharmaceutical prices. Lobbyists for the drug companies would harass any member of the House and Senate who would support any form of this legislation. There would be so much money on the sidelines to defeat any drug pricing regulations as evidenced by the health industry being among the five most generous sources of campaign contributions.

Others designing a global budgeting reimbursement methodology might target different areas for cost savings, but the proposals outlined above should provide a starting point to embark on further discussions. Interestingly, the difficulties when implementing global budgets might not necessarily be in formulating the overall principles of such a new reimbursement methodology, but instead at arriving at some concurrence on

the details that generally have a cost or an income impact on the consuming public, the providers, the insurers, and the federal/state governmental agencies when trying to fulfill their complicated healthcare delivery-social-fiscal responsibilities.

The Impact of Global Budgets

A commonly held adage is that "the U.S. has the world's best healthcare delivery system." yet it ranks eighth lowest in life expectancy among the 34 developed countries that participate in the Organization of Economic Cooperation and Development (OECD) studies. (15) Data going back 15 years or longer, show that the Americans pay more for healthcare than anyone else and in return are sicker, die younger, and are most unhappy with the health services they receive, compared to those living, for example, in Australia, Canada, New Zealand, and the United Kingdom. (16) An international Commonwealth Foundation survey of primary care physicians in ten countries reveals the U.S. lagging in access, quality, and use of medical information technology, and this study underscores the need for major health reform. (17)

Any potential change in our reimbursement methodology is complicated by the fact that the U.S. political right opposes the use of global budgeting since it considers the concept synonymous with rationing. And, to bolster their position, some conservatives have proposed that death panels will be formed and be utilized to judge whether or not individuals with serious sicknesses and disabilities should receive additional medical services or be just left to die. But the reality is that for centuries the Americans have rationed healthcare by virtue of the individual's ability to pay. The U.S. has an environment where the bottom one-third generally require more health services, but are consistently faced with the problem of finding some way to pay for the frequently inadequate care they receive.

Assuming that the U.S. would eventually implement a global budgetary reimbursement methodology, it is of some importance to speculate what might be the impact of this "form of rationing" on patients, providers, insurers, and governmental regulatory agencies. Overall, there is reasonable likelihood that by enacting universal access and offering a broader range of insured benefits that there would be a significant increase in the demand for healthcare services; and, that providers would need to deliver additional care dependent on the fiscal incentives inherent in the new reimbursement methodology, both being among the various factors that now need more analysis.

a. Impact on patients

No one could be completely sure what specific impact the global budgetary reimbursement approach might have on U.S. healthcare utilization, spending, and quality of care, although comparative data suggests it is unlikely that the U.S. will be able to reduce the number of its physicians and hospital beds, or its physician visits and hospital days or its expenditures by decreasing the volume of its patient care services.

Based on 2013 OECD data (18), the number of physician visits per annum in the U.S. with a new global budgetary reimbursement could eventually increase from currently 4.1 physician visits per 1,000 persons to possibly approaching 7.4 and 9.7 physician visits/1,000 as in Canada and Germany, respectively. In 2011, the Germans utilized 2,197 acute patient days per l,000 persons (8.2 day average length of stay) compared to 615 days/1,000 and 707 days/1,000 in Canada and the U.S., respectively. These data suggest that the Canadians, Germans, and others with national health insurance may too frequently consider health care compared to U.S. norms, as a free public service.

With a greater volume of physician visits and hospital patient days in Canada, Germany, and elsewhere under a fixed budgetary reimbursement methodology, approaches often used by providers to accommodate that "excess" demand for tertiary-type elective procedures are: to "cherry pick" patients with easy diagnoses; and, to increase the waiting times for tertiary-type elective procedures. Those Canadians unwilling to wait, travel across the border, and are admitted to teaching hospitals in Buffalo, Detroit, Seattle, or elsewhere to receive almost immediate care and most often pay out-of-pocket for otherwise free services at home. In the United Kingdom, an option used to avoid long waits for admission to National Health Service hospitals is to subscribe to a private insurance plan (16% of the population are so insured) and are admitted within days to a private facility. The French and the Germans have relatively similar alternatives and this "private option" would need to be available in the U.S. in order to make global budgets politically acceptable.

Unfortunately, being able to deliver appropriate services to those with low-income and less education is where both the fee-for-service and the global budgetary reimbursement approaches continue to demonstrate shortcomings. A study (19) that tracked 14,800 patients for over 10 years with access to Canada's universal health insurance reported the following findings: socially disadvantaged patients used healthcare services more frequently that those with higher incomes and education, but by their simply receiving more care this had little impact on improving their poorer health outcomes (e.g., mortality rates). Just offering "free" health services does not necessarily result in "enhanced results" suggesting that putting into effect a comprehensive health education plan for low-income families must play a critical role in implementing a universal health insurance plan here.

b. Impact on physicians and hospitals

A commonly assumed explanation for higher U.S. healthcare spending compared with other countries is our greater available supply of physicians and hospitals. But surprisingly in 2013, there were only 2.4 physicians per l,000 persons in the U.S., fewer than any other industrialized nation except for Japan. (20) So, not only do the Americans now experience fewer physician visits per year, but they pay a higher fee (price) per visit allowing

doctors here to earn significantly more than elsewhere. What is predictable with universal access and global budgets is that physicians will be pressured to consult with more patients at lower fees per visit. A major question is whether with the use of smart cards and with hopefully a less regulatory environment, American physicians might no longer incur more than 50% of their gross revenues for overhead expenses and, thereby, be able to reduce their fees without a significant loss of personal income?

The U.S. compared to other nations not only has fewer physicians and physician visits per 1,000 persons, but also has fewer hospital beds, admissions, and patient days per 1,000 persons and shorter average lengths of stay. But hospital stays in the U.S. are far more expensive per discharge than other countries, since our acute care facilities are more resource intensive (due to DRGs) and the Americans tend to pay their employees significantly higher salaries. (21) These patterns would need to be modified as the U.S. cost dilemma is not one of higher utilization, but one of significantly higher cost or prices. The U.S. healthcare system is simply too expensive – it is price stupid!

Providing Americans with universal access will undoubtedly result in an increased demand for healthcare services. As a result, patients would need to wait longer for an appointment to see a physician or be admitted to a hospital for an elective procedure. Physicians will be pressured to consult with more patients at lower fees for each visit or procedure. The change from DRGs and fee-for-service to a global budget reimbursement methodology will produce among hospitals a far higher percentage of occupancy, longer average lengths of stay, and potentially, a shift back with more procedures performed on an inpatient rather than an outpatient basis. The most major change will be among the lower-income, previously uninsured populace, who traditionally received minimal care often via the emergency department, now will have the opportunity to seek a far more comprehensive range of services.

Since it is doubtful that it is possible to reduce health expenditures in the U.S. by decreasing physician visits and hospital days, some other alternatives, in addition to those outlined earlier, need to be considered. One potential saving possible, as used in other industrialized nations, is to offer a smaller percentage of residency positions among the specialties (since they tend to be major users of expensive ancillary services) and to concurrently increase the number of primary care physician training slots. (22) Another potential saving possible, that also encourages a more evenly geographic distribution of physicians, is to replicate the German approach that can limit the opening of new offices in the more attractive locations. (23) This is accomplished by restricting the number of doctors by specialty in each geographic market by only allowing a specific number of physicians there to be eligible to bill patients for statutory and private health insurance benefits.

This global budgetary proposal has some significant economic implications. The most noteworthy is the eventual reduction of possibly up to 25% of those currently employed in the health field – 4.0 to 4.5 million jobs. Most decidedly impacted would be white-collar type positions, while nurses and other allied health personal providing hands on patient care would experience a far fewer number of layoffs. Some cities like Louisville would be more seriously affected as healthcare now accounts for 12 of its 25 largest employers. Boston, Houston, Minneapolis, and Nashville are other health meccas that would also experience a significant number of unemployed with global budgets.

Finally and worrisome, is that global budgetary reimbursement has the tendency to stifle the innovation of new clinical programs, since competition for additional admissions between healthcare systems under global budgets is significantly lessened. Facilities operating near capacity and experiencing long waiting lists for elective procedures perceive no need to make major capital investments to increase market share.

c. Insurers

With a new global budgetary reimbursement methodology in the U.S., the existing and maybe even some new, not-for-profit and investor-owned health insurance plans would process simpler claims filed with smart cards. Most large corporations here offer a "cafeteria plan" that allows their employees considerable latitude in selecting the range or level of their health and life insurance coverage, retirement contributions to their 401k, and other benefits. As is the pattern in Germany, American employees would become far more sensitive to their health insurance coverage and to their premium costs, if they paid out-of-pocket for say half the expense and bargained directly with the sickness funds as an equal partner with their employers. Another potential change from current approaches in the U.S. is rather than insurers denying physician benefits, all disputed claims would be resolved by the state medical society by specialty and their decisions would be final (i.e., physicians controlling physician practices/ billing).

d. Governmental oversight

Highly controversial issues under a global budgetary reimbursement methodology would be establishing the scope of minimum statutory benefits, specifying the health professionals/facilities eligible for benefits (e.g., dentists, chiropractors, podiatrists, psychologists), and allocating the total dollars to be received by the authorized providers for their services. Moreover, in an attempt to reduce health expenditures from 18% to 13% of the GDP, whatever approaches a governmental oversight agency uses "to divide the available healthcare dollars," significant political pressures will be experienced from the competing providers for available dollars.

One possible alternative is to establish a Federal Health Commission, similar in policy formation and operations to the Federal Communications Commission, that functions as a quasi-competitive and quasi-regulatory

authority that is inherent in the provisions of the Telecommunication Act of 1996. (24) The new federal commission could have oversight over the entire U.S. health care system including all the nation's health programs, services, and facilities; could enforce the legislative acts passed by the U.S. Congress and then signed by the President; and, could follow up on the directives of the Department of Health and Human Services and other related governmental agencies.

The appointed commissioners of the Federal Health Commission could include representatives of the public, physicians, hospitals, long-term care facilities, pharmaceutical companies, educational institutions seriously committed to the training of the health professions, and others. The Commission would be responsible to develop and implement overall health policy and to obtain from Congress some general guidance on the allocation of available funds. Useful in this process would be for the Federal Health Commission to forward to Congress its independent recommendations in a similar manner as the Department of Defense used in the Defense Base Closure and Realignment process. These recommendations to include such provisions as to who is eligible for coverage, the scope of the statutory benefits, how the benefits are to be financed, and the overall administrative guidelines that could be used by the state health (utility) commissions that could be responsible for actually allocating to various providers the limited available resources.

Among some of the more onerous responsibilities of such a federal health commission, with the assistance of the state health commissions, might include assuring that: (a) the then current level of global budgetary funding was providing reasonable access to care and a sufficient range of needed health care services; (b) an appropriate quality of care and that safety standards were being judiciously implemented; and, (c) waste, fraud, and abuse were being carefully monitored, and for all practical purposes were virtually eliminated. These are major assignments that can possibly be somewhat more effectively implemented with a global budget rather than a fee for service approach, simply because the sources and the amount of provider revenues and expenditures will be more transparent.

Independent regulatory commissions are a unique American institution as in most other countries public utilities (e.g., energy) are owned and operated by government. As more of these independent federal and state regulatory commissions have evolved here in the last century, they have become our major organizational approach to regulate services that serve as a natural monopoly and thereby, are responsible to allocate sizeable shares of our nation's GDP. A fundamental issue surrounding the possible use of the public utility concept for the health or any field is to find the appropriate balance among the rights of consumers, providers, and insurers, and the extent of appropriate governmental control when regulating health services.

The ability of a global budgetary reimbursement methodology to reduce health expenditures, improve access to care, and to enhance quality of care

will be heavily dependent on the performance of these proposed state health commissions. They will be responsible to set reimbursement rates for all providers; and, to monitor all the negotiations with employers-employees, all the insurers (sickness funds), and the providers. Since the enactment of global budget reimbursement methodology focuses on a significantly lowering of the GDP expenditure for health, most providers could expect up to a 25% reduction in revenues so that the GDP for health could be reduced from 18% to 13% – a most contentious undertaking.

The state's hospital and physicians' associations could well make recommendations to the commission on how the available healthcare dollars might be spent. In addition, if either a hospital or a physician was thought to be involved in fraud or similar act, it could be the responsibility of these hospital or physician associations to hold hearings possibly disciplining their own members. To obtain significant fiscal savings without seriously impinging on quality patient care, the commission, after carefully reviewing the evidence, should be able to shutter a facility or service, or request a physician to possibly relocate or give up practicing medicine. Establishing a Federal Health Commission and state health commissions as public utilities is not a perfect solution to manage healthcare resources, but it may be difficult to find a better one to implement a global budgetary reimbursement methodology.

Concluding Comments

When defined in economic terms, healthcare services should be evaluated as a scarce resource. Given that the U.S. spends considerably more of its GDP for health than other western industrialized nations and obtains poorer outcomes by almost any measure of morbidity or mortality, it is hard to assume that we are currently rationing very rationally.

Health care expenditures in the U.S. have been soaring for over four decades for several reasons: improved technology; enhanced clinical services and improved patient care; consumers are largely insulated from costs and therefore, can be rarely engaged in competitive price shopping for services; and, with a fee-for-service reimbursement methodology, providers can most readily improve their bottom lines by rendering more and more services. Further complicating our current cost concerns is that most of the reimbursement pilot projects now underway are encouraging providers to offer less costly and more targeted services, and with higher quality of care, but to date they have demonstrated only a marginal impact on reducing expenditures because they are so closely tied to fee-for-service arrangements. And in such discussions, what is sometimes forgotten is that there is no perfect healthcare reimbursement methodology – all of them have significant downfalls. Global budgets are certainly no exception.

By using global budgets, Canada and many European counties have been successful in constraining healthcare expenditures by one-fourth less of their GDP than the

U.S. Admittedly, these nations are starting to experience an increasing trend toward the privatization of hospitals and third-party coverage conflicting with their early egalitarian ideals. This is obviously a concern to those leaning toward the political left.

It is somewhat noteworthy that implementing the global budgetary approach here has some significant drawbacks: (a) could eventually result in 4.0 to 4.5 million Americans in the health field losing their jobs causing serious increases in the number unemployed (in comparison to 10.5 million Americans being unemployed at the end of April 2014); (b) would tend to stifle innovation such as when thinking of developing new clinical programs; (c) could easily complicate the providers' ability to effectively organize and manage their resources when many Americans will experience long waiting lines for elective care; and, (d) financing healthcare will become far more bureaucratic as decisions relating to allocating resources will be primarily tied to approval from a federal and state health commissions. In support of the global budgetary approach, however, it does provide an opportunity to save significant dollars by simply placing a ceiling on a nation's healthcare expenditures forcing providers to make difficult choices of how to expend available dollars; and thereby, offers the opportunity to reduce prices and costs in the delivery of healthcare services.

Maybe the dilemma is that our current approach to organize and to finance the U.S. healthcare system is economically unsustainable, but the global budgetary proposal outlined in this paper for political reasons has so little chance of being enacted. It is simply unacceptable to too many Americans, because it will be viewed as being inconsistent with our nation's traditional values. The questions now, therefore, might be: Is there some compromise between our current competitive and this suggested new regulatory approach or stated somewhat differently: is there a workable option between fee-for-service and global budgets?

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REFERENCES

1. Congressional Budget Office. The 2012 long- term budget outlook. (CBO Publication No. 450). 2012. Washington, DC: U.S. Government Printing Office. Retrieved from http//www.cbo.gov/sites/default/files/cbolfiles/attachments/06-05.

2. Robinson A. The potential of global payment: Insights from the field. New York: Commonwealth Fund; 2010.

3. Himmelstein DU, Woolhander S. Socialized medicine: a solution to the cost crisis in health care in the United States. Int J Health Serv. 1986;16(3):339-54.

4. Landon BE. Keeping score under a global payment system. N Eng J Med. 2012;366(5):393-95.

5. Fickenscher files. The move toward global budgets in health care. 2012; 2:4. Http/www.theflickenscherfiles.com/2012/02/08/the-move-toward-global budget.

6. Robinson JC, Ginsburg PB. Consumer-driven health care: promise and performance. Health Aff (Millwood). 2009;28(2):w272-81.

7. Toussaint J, Milstein A, Shortell S. How the Pioneer ACO model needs to change: lessons from its best-performing ACO. JAMA. 2013;310(13):1341-42.

8. Reid RJ, Larson EB. Financial implications of the patient-centered medical home. JAMA. 2012;308(1):83-84.

9. Woolhandler S, Campbell T, Himmelstein DU. Costs of healthcare administration in the U.S. and Canada. N Eng J Med. 2003;349(8):768-75.

10. Morra D, Nicholson S, Levinson W, Gans DM, Hammonds T, Casalino LP. U.S. physician practices versus Canadians. Spending nearly four times as much money interacting with payers. Health Aff(Millwood). 2011;30(8):1443-50.

11. Squires, DA. Explaining high health care spending in the United States: An international comparison of supply, utilization, prices, and quality. New York: Commonwealth Fund; 2012.

12. Salkever DS, Rice TW. The hospital certificate of need controls: Impact on investment, costs, and use. Washington, DC: American Enterprise Institute; 1978.

13. Weil TP. Hospital mergers: A panacea? J. Health Serv Res Policy. 2010;15(4):251-53.

14 Holt MA. International prescription drug cost containment strategies and suggestions for reform in the United States. 26 BC Int'l & Comp. L. Rev 325; 2003.

15 Organization for Economic Cooperation and Development (OECD). OECD health data 2013. Paris: OECD; March 2014.

16. Donelan K, Blendon RJ, Schoen C, Davis K, Binns K. The cost of health system change: public discontent in five countries. Health Aff (Millwood). 1999;18(13):206-16.

17. Schoen C, Osborn R, Squire D, Doty M, Rasmussen P, Pierson R, Applebaum S. A survey of primary care in ten countries shows progress in use of medical information technology, less in other areas. Health Aff (Millwood). 2012;31(12):2805-16.

18. OECD, ibid.

19. Alter DA, Stukel T, Chong A. Henry D. Lessons from Canada's universal care. Socially disadvantaged patients use more health services, Still have poorer health. Health Aff. (Millwood). 2011:30(2):274-83.

20. The World Bank. Physicians per 1,000 persons. Washington, DC: The World Bank; 2013.

21. Reinhardt UE. The pricing on U.S. health services: Chaos behind a veil of secrecy. Health Aff (Millwood) 2006;25(1):57-69.

22. Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. Health Aff (Millwood) 2005;w5-97-W5-107.

23. Blumel M, The German health care system, 2012. New York: Commonwealth Fund; 2012.

24. Jorgensen NE, Weil TP. Regulating managed care plans: Is the telecommunications industry a possible model? Managed Care Q. 1998;6(3):7-16.