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An Examination of Three Model Healthcare Delivery Systems

Gavin Stern

The United States is just now beginning its journey into a universal healthcare delivery system. On March 30, 2010, President Obama signed into law the “Health Care and Education Reconciliation Act of 2010” (H.R. 4872), which completed the work of the “Patient Protection and Affordable Care Act” (H.R. 3590) signed on March 23, 2010. The effects of this legislation are phased in over the course of this new decade, but the final product is far from certain. Implementation could be legislated away with one election cycle. This article examines three model healthcare delivery systems that the United States could look towards on its march to universal coverage: those of France, Germany, and the Netherlands.

France: Government-run Universal Insurance

In 2000, France had the best healthcare system in the world, according to the World Health Organization.¹ The basic French system - *Sécurité Sociale* - covers “Hospital care, ambulatory care and prescription drugs” along with “minimal coverage of outpatient eye and dental care”² and “nursing home benefits.”¹ This is a mandatory system.

“Complementary insurance” covers individual cost sharing, and is usually provided by the employer. More recently, the *Couverture Maladie Universelle* (CMU) is provided to individuals who cannot afford the public system due to unemployment², estimated at 0.4% of the population. Another system *L’Aide Médicale d’Etat* (AME) covers “Illegal residents.” In general, “poorer patients are exempt from cost-sharing.”² Therefore, one could infer that that none go without basic health insurance in France – even noncitizens.¹

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The French medical system is not nearly as government-centralized as, for instance, the United Kingdom, which has a socialized system. Rather, the government of France finances basic healthcare via legislation “that creates the annual prospective global budget for the public health expenditures,” which “funds the *Sécurité Sociale* and CMU and is financed through national income taxes and the General Social Tax – a supplementary income tax (7.5%) introduced in 1991 to help offset health care costs; 5.25% of which helps pay for the health care system.” Further, “Complementary insurance” reduces financial burden on individual cost sharing. Ninety-two percent of the population carries the complementary insurance, “roughly half of which is funded by employers.”¹

France controls healthcare costs with financial leverage. For instance, individual co-payment for a drug is linked to effectiveness. Drugs with proven therapeutic effects are basically free, while those of dubious or limited use are cost-shared to a greater extent. While individuals may visit any physician, reimbursements are better when one starts with a gatekeeper general practitioner: “Visits to the gatekeeping general practitioner are subject to a 30% co-insurance rate, while visits to other GPs are subject to a 50% co-insurance rate.”² This is a new

concept, introduced via the Douste-Blazy law in order to reduce large budget deficits. Overall, the practice of medicine in France is a “self-regulating market.” A “reference price” determines what the public system will reimburse. Technology reduces paperwork and increases efficiency: “patients carry Sécurité Sociale cards containing microchips storing their comprehensive medical information, allowing physicians immediate access to a patient’s record.” Physicians are private employees, “mostly self-employed and paid on a fee-for-service basis.”¹

Out of pocket spending for healthcare is still an issue in France, as “patients visiting physicians and dentists pay full price and are later reimbursed for costs by the public health insurance and complementary insurance.” Out of pocket expenses were 6.9% of total health expenditures in 2005.¹ However, some conditions are completely reimbursed, “including cancer, diabetes and other chronic conditions... includ[ing] all pharmaceuticals [and] experimental drugs.” Pricing and reimbursements are “negotiated between the health insurance funds and unions representing providers.” The supplemental insurance plans “are not allowed to compete by lowering health insurance premiums”,¹ which may have the effect of reducing competition but is done for the purposes of solidarity. To reduce the effects of moral hazard, there are additional co-payments per office visit, with an annual ceiling of 50 Euros. The French system in totality does not provide the same level of expertise to all income levels, as “doctors and dentists may charge above this reference price based on their level of professional experience.”² The wealthy, then, can afford more skilled practitioners despite the French principle of solidarity. However, the ability for skilled physicians to set a higher price also provides an incentive to achieve that higher level of skill – a capitalist tenet.

Is the French healthcare system a good deal? Healthcare spending in France was 11.1% of GDP in 2005, much lower than 15.3% in the United States.³ Per capita spending in 2003 was \$2903 in France compared to \$5635 in the United States. There are proportionally more physicians in France: 3.4 to 2.3 per 1000.⁴ French infant mortality was 4.3 deaths per 1000 births compared to 7.2 per 1000, and life expectancy at birth was 82.2/74.6 (female/male) compared to 79.4/73.9 in the United States.⁵ Clearly, the French system performs better. However, US implementation of the French system would be difficult because it requires a strong central government (France is arguably a single-payer system). A system of government-regulated insurance coverage (more like that of Germany or the Netherlands) might be a more reasonable long-term goal for the United States.

Germany: Social Insurance and Sickness Funds

The healthcare system of Germany consists of governmentally independent sickness funds, along with a separate private insurance system. Sickness funds are “autonomous, not for profit, nongovernmental bodies regulated by law,” which act as “the collectors, purchasers, and payers in both health and long-term care insurance” in Germany.⁶ This system of more than 200 sickness funds is “the oldest system of social insurance in the world.”⁷ The notion is that these funds will compete against one another, encouraging greater efficiency and reduced cost.

In 2006, 88% of Germans were covered by the sickness fund system. Only 0.22% of Germans were uninsured. A “special state program” covered 9.7% as government employees, and 2% purchased private health insurance.⁷ Individuals with income levels of less than €48,000 annually (75% of the German population) are required to enter into the public program. 75% of

people with income above this level remain in the public system by choice. This helps to demonstrate that the public healthcare system of Germany is considered to be satisfactory even for those with greater income levels, as private insurance enrollment is very low. After 2009, “health insurance will be mandatory” in “either the social or private health insurance scheme.”⁶ Before that, insurance was optional for individuals with yearly income over € 48,000.

The sickness funds are financed by employee and employer contributions of (on average) 8% and 7% of income, respectively. The unemployed are still expected to make a contribution. Patients may incur cost sharing or copayments of up to “2% of household income.” This figure is cut in half for those declared “chronically ill.” This system of contribution also changes in 2009, in that “all contributions will be centrally pooled by a new national health fund, which will allocate resources to each [sickness fund] based on an improved risk-adjusted capitation formula.”⁶ This should help to evenly spread the risk of more ill, more needy, more expensive patients on particular sickness funds. However, this does show a trend towards more centralized control via the government.

The sickness fund program is more comprehensive than other social health programs discussed in this analysis – including, “dental, inpatient, and preventive care” along with “prescription drugs and rehabilitative treatments” and disability payments to those who cannot work.”⁷ Patients receive incentives to utilize general practitioners in a “family physician care model.” The German system encourages cost effectiveness as sickness funds and physicians collaborate on price control. Physicians maintain their autonomy to practice and are generally “paid by a mixture of fees per time period and per medical procedure.”⁶ Physicians are compensated “by sickness funds via their regional physician associations.”⁸ It should be noted that, unlike the United States system, physicians are encouraged to collaborate and lobby, similar to the French system.

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Healthcare spending in Germany was 10.7% of GDP in 2005, lower than 15.3% in the United

States and 11.1% for France.³ Per capita spending in 2003 was \$2996 in Germany, much lower than \$5635 in the United States. Germany and France had the same per capita number of physicians at 3.4 per 1000, higher than 2.3 per 1000 in the United States.⁴ German infant mortality was 4.6 deaths per 1000 births in 1999 (7.2 per 1000 in the US) while life expectancy at birth in 1998 was 80.5/74.5 (female/male) compared to 79.4/73.9 in the United States.⁵ The German healthcare model receives generally good reviews, with 66% of Germans approving of the system in 1996,⁵ and 11% disapproving.⁸ The German system would be difficult to implement in the United States because it involves a large degree of government control. The sickness funds do not operate capitalistically (as in the Netherlands) but rather as a nonprofit, indirect extension of government.

The German healthcare system significantly outperforms that of the United States, with results comparable to France but with less expenditure as a percentage of GDP. American imple-

mentation of the German system is feasible because the sickness funds are analogous to private insurance companies. However, the German system requires these funds to be not-for-profit, and they now pay into a single national fund. Employers would have to contribute to the system, a policy that United States has been trending away from. While a system similar to that of Germany could practically evolve in the United States by capping insurance company profits, the political reality is that it would be attacked as anti-capitalist. The healthcare system of the Netherlands might be more palatable.

The Netherlands: Multi-Payer Private Competition With Government Regulation

The Dutch healthcare system has been referenced as a possible route to universal healthcare coverage in the United States.⁹ The Health Insurance Act (2006) established a system of government-regulated private insurance companies. As in the United States, insurers retain their for-profit status. However, in the Netherlands the Supervisory Board For Health regulates these companies. The emerging American model may benefit from the Dutch example of increased regulation.

The Dutch government does not exert direct control over healthcare treatments (no rationing). Rather, insurance companies are obligated to accept anyone who applies for the government-mandated standard insurance package. Each policy must include basic services: “medical care... hospitals and midwives, hospitalization... medical aids, medicines, maternity care, ambulance and patient transport services” as well as limited remedial, speech, and occupational therapy. Nursing care, home care, chronic and mental illnesses are covered under the separate Exceptional Medical Expenses Act. All working adult citizens of the Netherlands are obligated to purchase a standard insurance policy. The government pays for

the health policies of children (under 18 years of age). The government also subsidizes individuals who cannot afford such a policy, defined as greater than 5% of income, by providing an allowance proportionate to income. Nevertheless, an estimated 1.5% of Dutch citizens remained uninsured as of 2007.¹⁰ The lack of 100% coverage remains a consequence of blunted government intervention, an issue that the United States will also be left with.

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Individuals, employers, and the government finance the Dutch system. Individuals pay “6.5% of the first €30,000 of annual taxable income.” The rate is reduced to 4.4% for the unemployed. Purchasers of these policies retain free choice, in that they may change policies once per year. Citizens also benefit from lowered prices as insurers compete for business. This competition-based model also forces increased efficiency and cost reduction. Physicians operate on a fee for service basis. General practitioners “receive a capitation payment for each patient on

their practice list and a fee per consultation,” a vast improvement over American reimbursement for primary care services. Physicians maintain their autonomy, in that they are not employees of the government. The billing process is simplified via Diagnosis Treatment Combinations (DTCs). DTCs incorporate all the costs of treatment and diagnosis, so that individuals do not receive billings for every minute detail in a single office visit.¹⁰

Insurance companies charge a “flat rate premium,” which is based on the policy itself – not the risk of the insured as in the American system. The cost of these annual premiums was €1,050 on average in 2006. Government-mandated deductibles have been in effect since 2007, and the insured pay “the first €150 of any health care costs in a given year.” However, costs to the individual remain low, as “out of pocket payments as a proportion of total health expenditure are around 8%.” Payments “are collected centrally and distributed among insurers based on a risk-adjusted capitation formula” in order to equilibrate risk.¹⁰

Healthcare spending in the Netherlands was 9.2% of GDP in 2004, lower than the United States, France, and Germany.³ Per capita spending in 2003 was \$2,976. The Netherlands employed slightly fewer physicians per capita (3.1 per 1000) than Germany and France, but still outperformed the United States.⁴ Dutch infant mortality was 4.3 deaths per 1000 births, and life expectancy at birth was 82.1 for females and 76.8 for males – rates almost unanimously equal or better than all countries compared in this analysis.¹¹

This system is far from perfect. Although the Dutch system encourages competition and free choice, “four insurers control 90% of the market.” Additionally, the basic healthcare package does not cover what Americans might consider to be essential services, such as dental care, eyeglasses, alternative therapies, and cosmetic surgery (in some cases of disfigurement). Citizens still have to pay extra for these services. Indeed, “90% [of citizens] buy supplemental packages.”

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The Future of The United States:

Of the healthcare systems examined in this analysis – France, Germany, and the Netherlands – the Dutch model is most compatible with the emerging healthcare system adopted by the United States in 2010. The Dutch model produces the best results at the lowest price, with a high degree of freedom and coverage while retaining capitalistic principles. The United States would do well to follow the path of mandated coverage and strong government regulation of insurance companies. There is some optimism that the United States may be moving in this direction. Those who support such a system and the benefits outlined herein will need to be vigilant of insurance companies that defend profit, of misplaced political accusations, and a political movement to repeal this reform or declare it unconstitutional.

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