LESSONS US TAKES FROM A SINGLE PAYER SYSTEM IN MANAGING HEALTCARE COST: FRENCH HEALTHCARE SYSTEM

AMERİKA'NIN SAĞLIK HARCAMALARINI KONTROL ALTINA ALMAK İÇİN TEK GERİ ÖDEYİCİLİ SİSTEMLERDEN ÇIKARACAĞI DERSLER: FRANSIZ SAĞLIK SİSTEMİ

Özlem GÖÇMEZ* Kadir GÜRSOY**

ABSTRACT

Healthcare spending in the US is characterized as being the most costly per person while health system is not delivering superior results on health outcomes. There have been many explanations that the US having the highest healthcare spending, such as prices, high prevalence of new-technology, chronic diseases and administrative cost.

This study focuses on the structure of the US healthcare system and discusses the results for replacing the present public-private system with a single payer public system to restrain or reduce healthcare spending. In this context, the paper analyzes the US and France healthcare systems and then compares both systems in terms of costs. Finally the paper concludes the US payer system has not been exercising the same monopsony power that has enabled the French healthcare system keeping costs considerably lower, while proving equal, if not better care.

Keywords: US healthcare system, French healthcare system, single payer, health spending

* Sosyal Güvenlik Uzmanı, Genel Sağlık Sigortası Genel Müdürlüğü İzleme ve Sağlık Teknolojileri Değerlendirme Daire Başkanlığı, Ziyabey Cad. No: 6 Ankara, eposta:ooktem@sgk.gov.tr Tel: 0 312 207 81 60

** Sosyal Güvenlik Uzmanı, Genel Sağlık Sigortası Genel Müdürlüğü İlaç ve Eczacılık Daire Başkanlığı, Ziyabey Cad. No: 6 Ankara, eposta:kgursoy@sgk.gov.tr Tel: 0 312 207 8730

ÖZET

Amerikan sağlık sistemi, sağlık çıktılarında iyi sonuçlar alamamakla birlikte, ülkedeki kişi başına düşen sağlık harcamaları çok yüksektir. Amerika'nın en yüksek sağlık harcamalarına sahip olmasının en önemli nedenleri sırasıyla, yüksek fiyatlar, ileri teknolojinin sık kullanımı, kronik hastalıklar ve yönetim giderleridir.

Bu çalışmada, Amerikan sağlık sisteminin yapısına odaklanılıp, sağlık harcamalarının azaltılması ya da kısıtlanması için mevcut kamu-özel çok yapılı karmaşık sistemin tek ödeyicili (monopson) kamu sistemi ile değiştirilmesi durumu tartışılmıştır. Bu çerçevede her iki ülkenin de sağlık sistemlerini incelenmiş, sonrasında sağlık harcamaları ve maliyetler açısından karşılaştırılmıştır. Amerikan ve Fransız sağlık sistemleri birbirine yakın sağlık çıktıları üretirken, Amerikan'ın sağlık harcamalarını önemli ölçüde düşük tutmaya katkı sağlayan monopson güce sahip olmadığı sonucuna ulaşılmıştır.

Anahtar Kelimeler: ABD sağlık sistemi, Fransa sağlık sistemi, tek ödeyici, sağlık harcamaları

INTRODUCTION

United States (US) is famous for its complicated healthcare system with many distinct organizations taking part. The U.S. does not have a uniform health system, has no universal healthcare coverage, and recent legislation (Affordable Care Act) mandating coverage is not yet fully put into practice. Instead of operating as a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, the U.S. health care system can best be described as a hybrid system. Healthcare spending in the US is characterized as being the most costly per person as compared to all other countries, nearly 50% higher than the second highest cost country, US $8,508 per capita in 2011 (OECD, 2013) while U.S. health system is not delivering superior results on health outcomes and from patients' perspective and based on outcome indicators US lags behind many developed nations (Davis et al., 2014). There have been many

explanations that US having the highest healthcare spending. Many claim that prices are the key reason for the highest spending. Some state that high prevalence of new-technology tests drive spending, others point out chronic diseases skyrocket the spending, and some argue that administrative cost is the one to blame. Our approach here is that since there are many purchasers of healthcare (reimburser) such as insurance companies, government, and citizens; they do not have the power to negotiate for the price. Therefore replacing the present public−private system with a single−payer public system will contribute to restrain or reduce healthcare spending. In this context, this paper will focus on the fundamentals of US healthcare system then will dig into French healthcare system as a country example showing how single payer works on the basis of mitigating costs. Then it compares France and US in terms of costs and lists main findings. Finally it draws a conclusion how the US can achieve bending the cost curve.

1. US Healthcare System

a. Fundamentals of Health Care System in US

As mentioned before, healthcare system in US is designed as a combination of public and private funding and provision (Irvine, 2002). Medicare and Medicaid are the two main public programs covering 27 percent of residents (Commonwealth Fund, 2013). Medicare dates back to 1966, administered and funded by federal government that guarantees access to health insurance for elderly and younger people with disabilities. On the other hand, Medicaid, managed by both federal and state level, protects and guarantees the health insurance of mainly 'the poor citizens'.

Looking at the private insurance and its coverage, approximately 55 percent of residents receive primary care coverage from voluntary health insurance (OECD, 2011). The rest of the population, 16 percent of the residents, is uninsured. In the US many young and healthy population prefers to stay out of private health insurance and pays health spending out-of-pocket.

To discuss the point that makes the US health system complex and "multiple payer", we need to look at the funding of the health system. Medicare and Medicaid are mainly financed through taxes, premiums and federal revenues and comprise 49 percent of total healthcare spending in 2010. On the other hand, approximately 500 health insurance companies provide residents with health insurance, resulting with 35 percent of total health care spending (Commonwealth Fund, 2013). The rest of the healthcare spending is the individual payments, both out-of-pocket and cost- sharing.

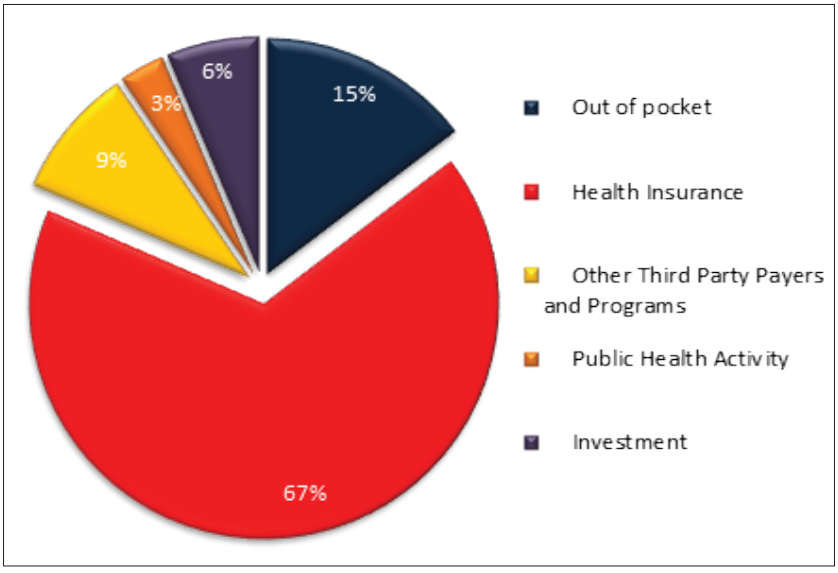
US healthcare system mainly relies on private health insurance however the system is much more complicated than the traditional private insurance schemes with government ceding primary responsibility to the states. Looking at the sponsors, most of the private insurance plans are employer-sponsored (only 9% is self-insured) mainly covering the employees' healthcare spending but the employees have the chance to add their dependents to the insurance plan by paying their premiums. Based on the insurance plan employees have to contribute to the system through deductibles, co-payment and co-insurance. For example, under an insurance plan an employee can cover its healthcare spending up to a certain level and then the exceeding amount is shared between the insurance company and the employee through coinsurance. There are copayments when an employee receives ambulatory and impatient care or purchase drugs from the pharmacies. The premium for an employee does not depend on the person's income and differs according to age, health status and to the benefit package itself. According to Kaiser Family Foundation study, in 2013 average cost of private health insurance in the US for a single person reached to US$5,615 and family coverage of US$15,745. Those figures are quite high compared to other developed countries and this mainly stems from not having a universal health insurance.

Before Affordable Care Act, employers were not obliged to offer insurance plans to their employees but after the act employers hiring employees more than a predetermined number in the act should provide those employers with private healthcare insurance plans. Furthermore, while in the past private insurance companies had the

right to opt out individuals for health insurance regarding their health status; with the transition in the act they cannot reject individuals for health insurance. As shown in Figure 1, health insurance gets the largest share in total health expenditure. Approximately 50% of this total belongs to private health insurance, Medicare follows it with 30% and the third largest share belongs to Medicare with 20%. Second biggest share in total health expenditure is the out-of-pocket payments (OOP) and public health payments, federal and state payments constitute the lowest share with 3%.

Comparing with OECD countries, public expenditure on health is the second lowest in US with approximately 50%, combined with 12% of OOP expenditure. US is top on the ranking of healthcare expenditure per capita based on purchasing power parity, with US $8.508 meaning more than twice as high as the OECD average of US $3.322. Health spending accounted for approximately 13.7% of GDP in 2000, reached approximately 18% of GDP in 2011 (OECD (2), 2013).

Figure 1: Total health expenditures in the US, 2012



Source:NHE 2012

b. Why US spends too much on health

Even though US ranked the highest in OECD figures regarding total health expenditure both per capita and as a percentage of GDP, health outcomes figures such as the physicians per capita, number of hospital beds are among the lowest (Squires, 2011). This shows us that not only access to healthcare is a problem in the US (Irvine, 2002) but also costs are high. In 2011, practicing doctors per 1000 population reached to 2.5 from 2,1 in 2000, which in both years below the OECD average of 3,2 and 2,8 respectively (OECD (2), 2013). Besides regarding the waiting times US is the third lowest out of eleven countries (Irvine, 2002). Seeming contradictory, there are mainly three reasons stated to explain this situation, the high costs. First one is new technologies and prescription drugs. The debate on new technologies is interesting as it focuses on the increase in demand even though it's not proven to be cost effective. As for the prescription drugs, studies showed that this may not be the case as the annual growth in real prescription drug spending has slowed since 2003, as a result of more patent expirations of blockbusters (NHE, 2012), increased generic penetration and reduced new product innovation (Aitken et al, 2009).

Secondly it is the chronic diseases; these costs are increasing especially during end of life care as the cost of hospitalization increases. As supported with studies, two out of every three elderly have multiple chronic conditions and costing 66% of total health budget (Centers for Disease Control and Prevention, 2013).

Finally it is the administrative cost, which we argue that the main initiative to blame for the high costs, as US spends the highest proportion to the insurance administration.(Department for Professional Employees, 2013).There are two aspects to analyze the costs, to specify, insurance companies' costs. First one is more obvious in terms of high costs combining with the financial incentives of doctors under fee-for-service arrangements, the fear of malpractice leading to over testing and overtreatment and fixed percentage payment of insurers of the claims they administer (Pfeffer, 2013). Second one is the hidden cost and mainly depending on the negotiating leverage between insurers

and hospitals. Whereas primary care and specialty physicians are price takers in the negotiations with insurance companies, hospitals have stronger negotiation power resulted in higher prices. As a result in different parts of the US, hospital prices vary widely across and within markets for privately insured patients and surprisingly but as expected much higher than Medicare payment rates (White et al, 2013).

2. French Healthcare System

2.1. Background

As opposed to fragmented hybrid US healthcare system, healthcare system in France is characterized by a national program of social health insurance, managed almost entirely by the state, publicly financed through employee and employer payroll contributions, and earmarked taxes reflected in a single public payer system. Although public health insurance covers a reasonable proportion of a patient's health care costs, the compulsory government scheme is accompanied by a prominent voluntary private health insurance.

The healthcare system in France dates back to 1945 and has experienced many alterations since then (Glaser, 1991). It is a universal health insurance scheme on a citizenship basis with a mixture of public and private healthcare providers and purchasers including Bismarkian principles of social insurance. Public health insurance, financed through both employees and employer contributions and collected taxes, is mandatory and covers practically the whole population (roughly 99.9%), while private insurance is of a complementary type and is based on voluntary contributions (Chevreul et al, 2010). The French health system relies on solidarity and provides a relatively high level of freedom of choice for patients to healthcare providers and freedom of practice for professionals. However, the government determines the benefits package, to what degree the benefits are reimbursed, and the responsibilities of the participating authorities.

Funds of the insurance scheme are independent of the state, financed by payroll taxes (60%) and, since 1990, by a proportional income tax (40%), called the CSG ("Contribution sociale généralisée"). The funds are ruled by boards with representatives of the government, the main workers unions, and the association of French manufacturers. There are several funds but people do not have the choice of their affiliation, which depends on their professional status. The recent employer and employee contribution rates were 13.1% and 0.85% of gross earnings respectively (Cases, 2006). Another source of funding for public health insurance is a general social contribution equal to 5.1% of earned income, 4.2% of benefits, and 3.8% of other sources of revenue (Chevreul et al, 2010). Practically nearly all the population holds a complementary private health insurance contract on top of the public insurance coverage. Premiums paid to private insurance companies have dramatically increased in the last 10 years. While the average annual premium of an individual contract was €340 (US $397) in 1998, it was €530 (US $706) in 2006, and rising (Allonier et al, 2008).

2.2. Delivery and Benefit Package

The delivery of care is shared among private fee-for service physicians, private profit-making and non-profit-making hospitals, and public hospitals. Primary care is delivered by self-employed professionals. Since late 1990s, general practitioners (GPs) have been playing a major role in the semi-gatekeeping system that provides incentives to people who visit their GP before consulting a specialist (Naiditch and Dourgnon, 2009). Moreover, drugs are dispensed by self-employed pharmacists, while the price of drugs is set administratively for all drugs covered by the public health insurance.

Public health insurance covers a broad range of services and goods that are provided in hospital or defined in positive lists for outpatient care except for cosmetic surgery or most types of thermal spa treatment, as well as some services of uncertain effectiveness (Chevreul et al, 2010). The rate of coverage varies across goods and services. However, there are several conditions for which patients are exempted from co-insurance, such as certain chronic conditions

pregnancy after the fifth month. The public health insurance (known as L'Assurance Maladie, or Statutory Health Insurance) generally refunds patients 70% of most health care costs, and 100% in case of the specified costly or chronic ailments (*Table 1*) (Chevreul et al, 2010).

Table 1: Examples of reimbursement rates

Categories of goods and services	Reimbursement rate (%)
Inpatient Care	80
Visitor to a doctor	70
Dental Care	70
Medical auxiliary	60
Laboratories	60
Pharmaceuticals[a]	15, 35, 65 or 100

a: Can vary by level of medical benefit and severity of illness

Source: Chevreul et al, 2010

On the other hand, complementary private insurance provides reimbursement for co-insurance and better coverage for medical goods and services that are poorly covered, most notably dental and optical care (Thomson and Mossialos, 2009).

2.3. Healthcare Spending

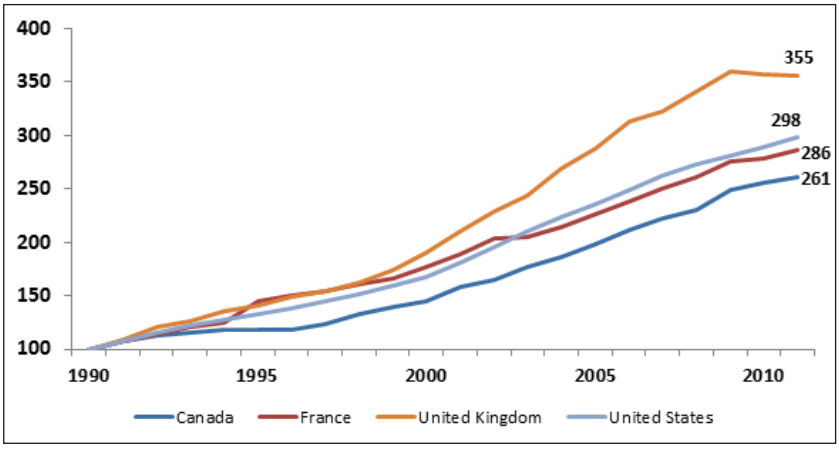
In the context of its national economy, France spends about 11.6 % of its GDP on health care (OECD, 2013). Spending on personal health care makes up the majority of this total expenditure (about 88%), while the remaining expenditure is made up of health administration and insurance costs (6.9%), research (3.4%), public health and prevention (1.9%), and teaching (0.6%) (Chevreul et al, 2010). The payment of these costs comes from various sources: the publicly funded Statutory Health Insurance (SHI), the mostly privately funded Voluntary Health

Insurance (VHI), and out-of-pocket payments. In 2011, approximately 76.8% of health expenditures were covered by government funded agencies and 15.5% by private health insurance providers; while roughly 7.5% was paid by consumers themselves (OECD, 2013).

As is the case in many nations, spending on health care in France has been rising, making up an ever-growing proportion of the GDP (growing from 8.4% in 1990 to 11.6% in 2011). In fact, France's increase in health care spending ranks only third, behind the United States and the United Kingdom (Figure 2).

About 85% of SHI spending goes towards health care costs, while the other 15% goes towards benefits like maternity leave, sick leave, and disability pension. Of the spending that goes toward health care costs, the majority can be attributed to hospital inpatient care (42.5%), followed by outpatient care (29.7%—this can be further broken into 17.5% for physician services, 4.5% for dental care, 5% for ancillary laboratory testing and imaging, and 2.7% long term nursing care), drugs (16.3%), medical devices (4.2%), and domiciliary services (2.7%) (Chevreul et al, 2010).

Figure 2: Total expenditure on health per capita, US$ purchasing power parity, 1990-2011 (1990=100)



Source: OECD Health Data

Concerning trends, both personal and public spending on *hospital care* decreased until 2000, and then has remained stable. This has been attributed to France's control over hospital budgets and efforts to emphasize outpatient care, although this second point is subject to debate. While the proportion of personal spending on ambulatory services has slightly increased, the proportion of public spending on ambulatory care has actually decreased. This has resulted in a mixed picture of whether or not the emphasis on outpatient care has been effective. Noticeable trends within ambulatory care include a decreasing proportion of spending on physician services contrasted with increasing spending on ancillary services (testing and medical devices) and home care.

2.4. The Structure of Reimbursement in France

The bedrock of France's health care system is the Statutory Health Insurance plan, which offers near-universal coverage and accounts for 75% of the nation's health care costs, effectively making the country a single payer system (Figure 3).

The SHI is essentially a monopsony, in which there are many sellers but only one buyer. This ability to set prices and negotiate powerfully with private physicians, pharmaceutical companies and hospitals is one of the most effective cost control components in France's health care system.

The central government oversees the process of these price negotiations with providers and assures that all providers are paid uniform reimbursement in the national schemes. Outpatient providers are mostly private clinicians who are paid through the SHI.

France has a robust pharmaceutical market, being the third largest market for drugs in the world, but is also able to keep drug costs down due to the negotiating ability inherent to the single payer monopsony (Chevreul et al, 2010). The majority of prescription drugs are filled through SHI and so prices for allowable prescription drugs are largely set by a national commission that includes representatives from the Ministries of Health, Finance and Industry. The commission

is responsible for establishing prices based on current analogous drugs on the market. It also sets the prices for new innovative drugs based on estimates of cost of production, including costs of research and therapeutic trials. Patients are then protected with a "value-based" tiered system for prescription drugs that lowers the cost sharing for highly effective medications, regardless of their price (Rodwin and Sandier, 1993). Health care technology prices are also set in the same manner through negotiations with the government over prices of medical devices and which ones should utilized.

For establishing set hospital prices, the SHI now pays based on disease-related group (DRG) tariffs that are determined by the MoH. Although, DRG tariffs are not currently unified among public vs. private non-profit making and profit-making hospitals, they are moving toward a unified direction (Chevreul et al, 2010). The public hospitals also receive an annual operating budget that is negotiated within this framework set by the national agreements.

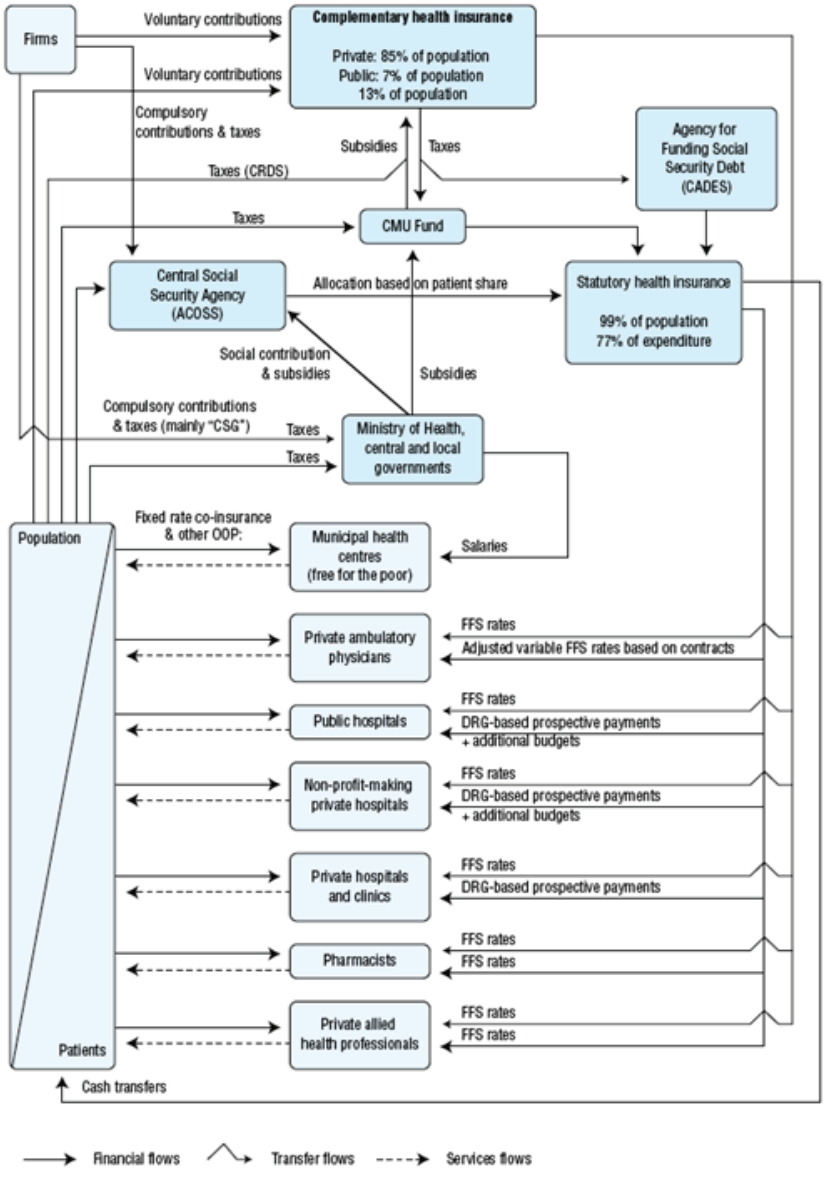
These price regulations are managed by the central government with input from the regional sectors. The French parliament passes an annual Act on Social Security Finance. This Act is based on reports from several commissions including the Accounts commission, the High Council of Public Health and the High Council for the Future of Health Insurance. The government uses these reports to set an annual soft ceiling (ONDAM) for SHI spending (amount and distribution) for the coming year. Of note, this ceiling has been regularly exceeded in recent years. Part of the reason for this is that the providers are paid on a fee-for-service basis. So even though the unit prices are set, the volume is not controlled. Notably, the set targets have never been met.

MoH is ultimately responsible for a large part of the regulation of health care costs in France. For example, the MoH directly approves the agreements signed between SHI and the unions that represent the private health care professionals. They also set the prices of specific medical procedures and drugs based on recommendations from the National Authority for Health.

The reimbursement rates are negotiated between the providers and SHI and then approved by the Ministry of Health (MoH). The National Union for Health Professions (UNPS) is an umbrella organization that represents health professionals and negotiates with SHI at the national level (they must also negotiate VHI prices with the National Union of Complementary Health Insurance Organizations, made up of 1500 private insurance companies). These unions of healthcare professionals sign multi-year national contracts on the behalf of healthcare providers, creating agreements about rates, types of services provided and quality measures. Physicians and other health care professionals are then paid on a fee-for-service basis based on the negotiated statutory tariffs.

Figure 3: Financial flows in French healthcare system, 2008

Financial flows in the health care system, 2008 (excluding long-term care and prevention)



Source: OECD 2002 (data updated by IRDES in 2006 (Allonier et al. 2006) DREE in 2007 (Fenina et al. 2007) and URC Eco in 2008).
Notes: FFS: Fee-for-service.

2.5. Cost Containment Policies & Success

Despite rising overall healthcare costs, France has been praised for keeping the health care costs that are actually paid by patients lower than many other similar countries. This has been done through significant cost controls as well as increasing taxes to support increased public spending.[1] Yet, as many policies have been instituted to curb public health spending, a greater percentage of the population has purchased VHI—from 30% in the 1960s to around 92% today. In fact, because VHI is commonly used to pay rising co-insurance costs, many would argue that the rise of VHI coverage has negated the consumer effect of cost sharing and further driven consumption.

Cost control is a key issue in France, as the health insurance scheme has faced large deficits over the past 20 years. The economic downturn constitutes a further threat to the state budget in general (the public deficit for 2011 is 5.2% of GDP)[2] and to the health insurance scheme in particular as the revenue base shrinks. More recently, however, the health insurance scheme's deficit has fallen, from an annual €10 to €12 billion (US$13.5 to 16.2 billion) in 2003 to €7.7 billion (US$10 billion) in 2013. This drop may be partly due to the following changes that have taken place in the past three years (The Commonwealth Fund, 2013).

- a reduction in the number of acute-care hospital beds,
- restrictions on the number of drugs reimbursed,
- the removal of 600 drugs from public reimbursement in the past few years,
- an increase in generic prescribing and use of over-the-counter drugs; a requirement to deliver a generic drug unless specified otherwise on the prescription,
- the introduction of a voluntary gatekeeping system in primary care; and a basic benefit package for the management of chronic conditions.

1 The French Lesson In Health Care. (2007, July 9). *Bloomberg Businessweek*. New York. Retrieved from http://www.businessweek.com/magazine/content/07_28/b4042070.htm

2 INSEE (2012). "General Government National Accounts – First Results – Year 2011" http://www.insee.fr/fr/themes/info-rapide.asp?id=37

Since 2008, reimbursement by private health insurance of some copayments has been discontinued for prescription drugs, doctor visits, and ambulance transport. As of 2011, the drug reimbursement rate has been curtailed, newly diagnosed hypertension has been excluded from the list of fully covered chronic diseases, and reimbursement of transportation for chronically ill patients has been made contingent on whether it is medically justified.

The most effective cost control for drugs was the implementation in September 2012 of the 'generic versus third party' scheme. According to this scheme, patients who agree to generic substitution do not have to pay anything in exchange for their drugs. According to SHI figures, the rate of substitution jumped from 71% to 84% in one year, resulting in cost savings over €200 million (US$270 million).

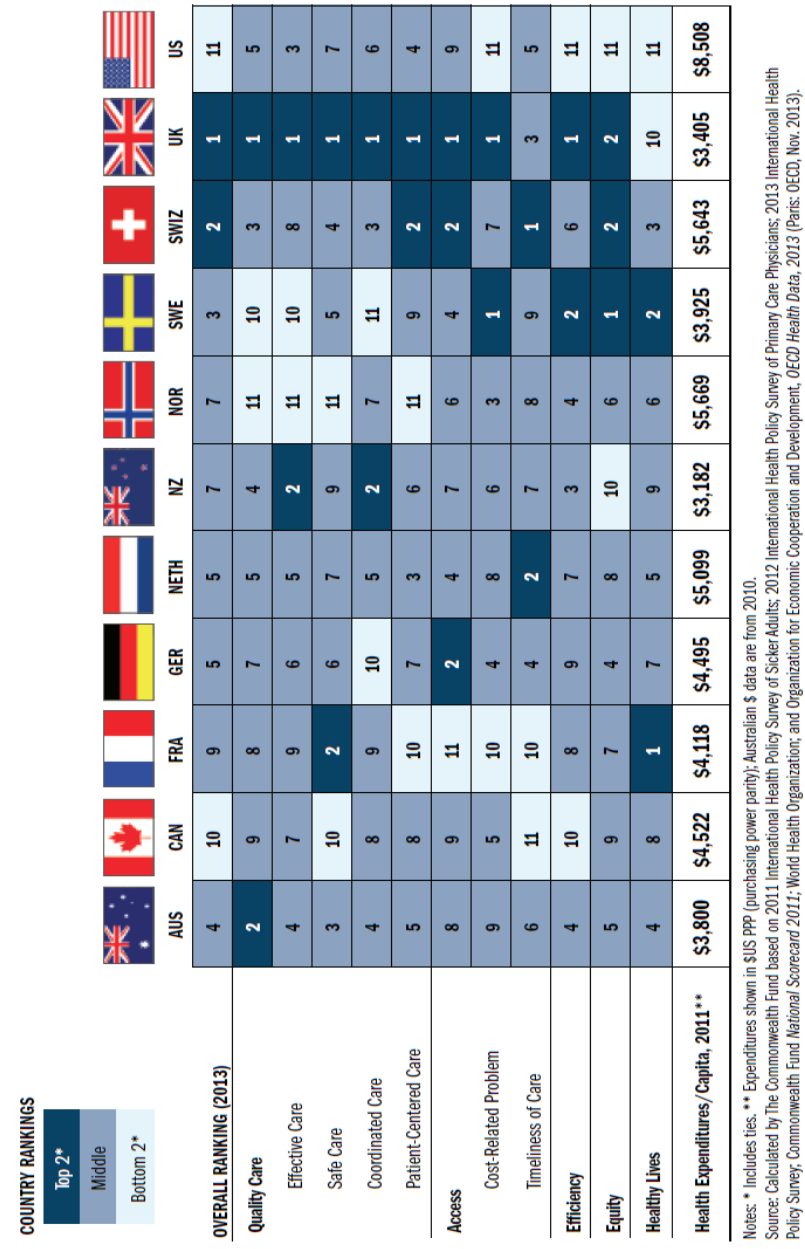
All in all, France as a single payer is quite successful in curbing healthcare costs by using its monopsony power.

3. US versus France: Cost Comparison

Centralized price setting through a single payer modality is a critically important cost containment strategy in France and has not resulted in much worse access for patients or excessive cost shifting to patients. For example, in 2012 Commonwealth Fund international survey France only had 6% of respondents with more than $1000 OOP expenses compared to the US which had 36% with greater than $1000 expenditures. Additionally, in France only 19% of those surveyed reported cost-related access problems, while in the US this percentage was 42% (Squires, 2011). Based on a Commonwealth Fund report in 2014, France ranks first among 11 developed nations (US, UK, Australia, Canada, Switzerland, Germany, Netherlands, New Zealand, Sweden, Norway, and France) in terms of well-functioning healthcare system providing their citizens long, healthy, and productive lives (Davis et al., 2014). It is evident that this cost control has been achieved with high patient satisfaction and high scores on key clinical indicators (Rodwin, 2003).

Although France spends considerably less than the U.S. on healthcare (US$4,118 per capita of GDP vs. the US US$8,508 per capita GDP in 2011), both countries have experienced comparable cost growth in the last decade that continues to outpace rises in their respective GDPs (Squires, 2011). This means that while costs are considerably lower in France than in the US, both countries should be actively engaged in new creative approaches at controlling costs (Chevreul et al., 2010). The fact that US costs are double those of France and most other OECD countries, means the US is not performing near the economic efficiency of its European friends. This is particularly significant in light of the consistently poor U.S. rankings relative to France and others with regard to quality, effectiveness, patient-centeredness, safety, and coordination (Squires, 2011; Davis et al, 2010; Davis et al, 2014).

Figure 4: Overall ranking of 11 health systems



COUNTRY RANKINGS
Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Source: Davis et al, 2014

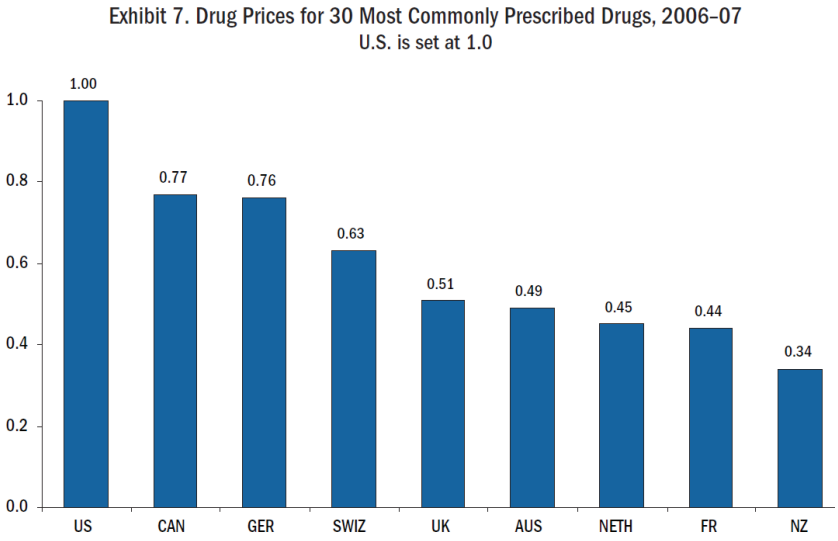
As one would imagine, great research emphasis has been placed on how and why the US costs are so high. Many thought to be largely due to increasing prices, which might have been controlled easier by non-US systems, as seen in France's single-payer system (Ginsburg, 2008). Many also have argued that higher costs in the U.S. are due to a variety of reasons such as high utilization, an aging population, and a large chronic disease burden. Research has shown, however, that the US, compared with other OECD countries like France, has a relatively young population, average or below-average rates of chronic disease, and relatively low volume of doctor visits and hospitalizations (Anderson et al, 2003; Squires, 2011).

The fact that the U.S. then has lower amounts of per capita services clearly implies that higher prices are to blame (prices x services = spending) (Anderson et al, 2003). These high prices in the U.S. are seen primarily across the three fronts that the France single-payer system regulates and price controls (Laugesen and Glied, 2011; Ginsburg, 2008; Kanavos and Vandaros, 2011; Koechlin et al, 2010):

- physician compensation -France 0.51 the U.S. primary care salary,
- hospital payments -France 0.285 the U.S. adjusted spending per discharge,
- drug prices and medical device usage -France 0.41 the U.S. price for the most commonly prescribed drugs and U.S. 54% higher usage than OECD countries of the top five in-patient devices.

Moreover, 2010 OECD study found that the price of a normal delivery in the US was estimated to be more than 50% higher than in France, while the price of a caesarean section was 30% higher than in France. The price of a knee replacement was about 20% higher in the US than in France whereas a hip replacement cost 45% more in the US. (Koechlin et al, 2010).

Figure 5: Drug Prices for 30 most commonly Prescribed Drugs, 2006-7



Source: IMS Health

Table 2: Average unit quasi-prices of certain hospital procedures, in US dollars, 2007

Procedures	AUS	CAN	DEU	FIN	FRA	SWE	USA
Appendectomy	5 044	5 004	2 943	3 739	4 558	4 961	7 962
Normal delivery	2 984	2 800	1 789	1 521	2 894	2 591	4 451
Caesarean section	7 092	4 820	3 732	4 808	5 820	6 375	7 449
Percutaneaous transluminal coronary angioplasty (PTCA)	7 131	9 277	3 347	5 574	7 027	9 296	14 378
Coronary artery bypass graft	21 698	22 694	14 067	23 468	23 126	21 218	34 358
Hip replacement	15 918	11 983	8 899	10 834	11 162	11 568	17 406
Knee replacement	14 608	9 910	10 011	9 931	12 424	10 348	14 946

Source: Koechlin et al. (2010).

Table 3: Physician Capacity, Earnings, and Spending in Six Countries, 2008

Exhibit 4

Physician Capacity, Earnings, And Spending In Six Countries, 2008

Country	Density per 10,000	Density relative to US	Pretax earnings net of expenses (US$ 2008)	Earnings relative to US	Payments to MDs per 1,000 ($)	Payments to MDs relative to US	Primary care MD earnings relative to orthopedic surgeons (%)
Primary care physicians							
Australia	14	1.4	92,844	0.50	129,982	0.70	49
Canada	10	1.0	125,104	0.67	125,104	0.67	60
France	17	1.7	95,585	0.51	162,494	0.87	62
Germany	10	1.0	131,809	0.71	131,809	0.71	65
United Kingdom	7	0.7	159,532	0.86	111,672	0.60	49
United States	10	1.0	186,582	1.00	186,582	1.00	42
Orthopedic surgeons							
Australia	0.45	0.68	187,609	0.42	8,442	0.29	—[a]
Canada	0.32	0.48	208,634	0.47	6,676	0.23	—[a]
France	0.34	0.52	154,380	0.35	5,249	0.18	—[a]
Germany	0.44	0.67	202,771	0.46	8,922	0.31	—[a]
United Kingdom	0.28	0.42	324,138	0.73	9,076	0.31	—[a]
United States	0.66	1.00	442,450	1.00	29,202	1.00	—[a]

Source: Squiles, 2011

Conclusion

It is clear that the fragmented U.S. payer system has not been able to exercise the same monopsony power that has enabled the France healthcare system to keep costs considerably lower, while providing equal, if not, better care. According to the Commonwealth Fund report, among 11 developed nations France ranks 9th whereas US comes the last in terms of quality, access, efficiency, equity and health outcomes (Davis et al, 2014). The U.S. would do well to consider how it could creatively implement greater negotiating power over providers through a more integrated insurance program that would fit within American ideals. It was proved that the US has the highest prices regarding drug prices, hospital procedures, and physician compensations due to lack of negotiation power. Unfortunately, the

idea of giving more negotiating power to the government or insurance companies smacks of cartelism and goes against the grain of American political thought, free market. Furthermore, it has been suggested that high physician compensation persists in the US as a result of the need to attract talent in a more right-skewed income structure than other countries, where skilled candidates can more easily be swayed to other more lucrative fields (Laugesan and Glied, 2011).Lastly, with a majority of pharmaceutical breakthroughs coming through the U.S., debates continue regarding the necessary costs and benefits of innovation.

REFERENCES

Aitken M, Ernst R. Berndt and David M. Cutler, Prescription Drug Spending Trends In The United States: Looking Beyond The Turning Point, Health Affairs, 28, no.1 (2009):w151-w160

Allonier C et al (2008). Enquête santé protection sociale 2006, un panel pour l'analyse des politiques de santé, la santé publique et la recherche en économie de la santé. Paris, Institut de recherche et documentation en économie de la santé (IRDES rapport 1701) http://www.irdes.fr/EspaceRecherche/BiblioResumeEtSommaire/2008/rap1701.htm.

Anderson, G. F., Reinhardt, U. E., Hussey, P. S., & Petrosyan, V. (2003). It's The Prices, Stupid: Why The United States Is So Different From Other Countries. Health Affairs, 22(3), 89-105.

Cases C (2006). French health system reform: recent implementation and future challenges. Eurohealth, 12:10–11.

Centers for Disease Control and Prevention. The State of Aging and Health in America 2013. Atlanta

Chevreul K., Durand-zaleski, I. Bahrami, S. Hernández-quevedo, C., & Mladovsky, P. (2010). France: Health system review. Health Systems in Transition (European Observatory on Health Systems and Policies), 12(6), 1-291.

Davis K., Schoen C., Stremikis K. (2010). Mirror, mirror on the wall: How the performe of US healthcare system compares internationally, 2010 update. Commonwealth Fund. June 2010.

Davis K., Schoen C., Stremikis K. and Squires D. (2014). Mirror, mirror on the wall: How the performance of US healthcare system compares internationally, 2014 update. Commonwealth Fund. June 2014.

Ginsburg, P. B. (2008). High and rising health care costs: Demystifying U.S. health care spending. Robert Wood Johnson Foundation, 1-32. Retrieved from http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf

Glaser W. A. (1991). Health Insurance in Practice: international variations in financing, benefits, and problems. Jossey-Bass Publishers: Oxford, UK.

http://dx.doi.org/10.1787/health_glance-2011-53-en

http://dx.doi.org/10.1787/health_glance-2013-en

http://www.businessweek.com/articles/2013-04-10/the-reason-health-care-is-so-expensive-insurance-companies

http://www.irdes.fr/EspaceAnglais/Publications/WorkingPapers/DT22PrefDocSchemePolitFrenchExpGatekeeping.pdf

Irvine, B (2002), updated by Clarke, E (2011) and Bidgood, E (January 2013) Healthcare Systems:The USA, Civitas Publishing

Kanavos P. and S. Vandoros (2011), Drugs US: are prices too high?. Significance, The Royal Statistical Society, March 2011, pp.15-18.

Koechlin F., L. Lorenzoni and P. Schreyer (2010), Comparing Price Levels of Hospital Services across Countries: Results of a Pilot Study, OECD Health Working Paper, No. 53, OECD Publishing, Paris.

Laugesen M. J., Glied S.A. (2011). Higher Fees Paid To US Physicians Drive Higher Spending For Physician Services Compared To Other Countries. Health Affairs 2011;30:1647-1656.

Naiditch M, Dourgnon P (2009). The preferred doctor scheme: a political reading of a French experiment of gate-keeping. Paris, Institut de recherché et documentation en économie de la santé(IRDES document du travail 22)

National Health Expenditures, 2012 Highlights

OECD (2011), "Coverage for health care", in Health at a Glance 2011: OECD Indicators, OECD Publishing.

OECD (2013). OECD Health Data, 2013.

OECD(2) (2013), Health at a Glance 2013: OECD Indicators, OECD Publishing.

Pfeffer, J. (2013), The Reason Health Care Is So Expensive: Insurance Companies

Squires, D. A. (2011). The U.S. Health System in Perspective: A Comparison of Twelve Industrialized Nations. The Commonwealth Fund, 16, 1-14.

The Commonwealth Fund (2013). International Profiles of Healthcare Systems, 2013. Commonwealth Fund pub. no. 1717.

The U.S Health Care System: An International Perspective, Fact Sheet 2013, Department for Professional Employees

Thomson, S., & Mossialos, E. (2009). Private health insurance in the European Union: Final report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities. Political Science (pp. 1-9).

Victor G. Rodwin and Simone Sandier (1993). Health Care Under French National Health Insurance. Health Affairs. 1993:12(3);111.

White C, M. Bond A, D. Reschovsky J, (2013) High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power, Center for Studying Health System Change, HSC Research Brief No. 27, September 2013