TRENDS & Ideas

HEALTHCARE POLICY

French Lessons

Although U.S. policymakers have often looked to Germany, Canada, and England as models for healthcare reform, they might also consider the French healthcare system, which provides nearly universal coverage with per capita costs 42 percent lower than those in the United States.

Several explicit principles guide the French system, Jonathan E. Fielding and Pierre-Jean Lancry report in *JAMA*: (1) Government has the basic responsibility for ensuring that people do not incur large out-of-pocket expenses for healthcare, (2) younger workers will subsidize the older generation, (3) various groups of workers subsidize other groups whose members are less able pay into obligatory insurance funds, and (4) consumers have free choice of physicians, and physicians are free to choose treatment methods.

French workers and employers pay a specified percentage of workers' salaries into various Sickness Insurance Funds (SIFs). For example, employers in industry, commerce, and government pay 12.8 percent of workers' gross pay into a "general fund" that covers 81 percent of the population. Employees in this group pay 6.8 percent of their salaries to the general SIF. Self-employed individuals contribute at the same rate (12.8 percent) as employers.

In 1991 payments through SIFs covered 75.5 percent of total healthcare costs in France. Copayments from individuals account for nearly one-fifth of expenditures. A system of supplemental insurance covers most charges not paid for by the SIF. More than 80 percent of the population obtain such coverage, indicating "that a strong market for supplementary insurance can exist even in the presence of a national health care system."

French physicians, who are paid at the time of service, receive the same rate regardless of what a patient's SIF covers. Their average annual income is significantly lower than that of their U.S. counterparts. Public hospitals and some not-for-profit facilities receive annual global budgets. Facilities not subject to global budgets—private hospitals, for the most part—are paid per diem rates for inpatient services.

The SIFs reimburse at higher rates for 30 "long, costly or otherwise defined sicknesses," including cancer and AIDS. Medical care for persons in long-term care beds is paid for in full. But lodging, which accounts for about two-thirds of total costs, is paid for by the individual or the local government.

Demographic trends, most notably an aging population and high unemployment, have increased healthcare expenditures in France while reducing the amount of money the population contributes to the system. Healthcare spending as a percentage of gross domestic product grew from 8.5 percent in 1985 to 9.1 percent in 1991—a lower rate of increase than in the United States but higher than that of most European nations. To control costs, public officials have set or negotiated fees for ambulatory services. Together with the institution of global budgets for hospitals, the practice has effected about a 1 percent decrease per year in prices from 1980 to 1991.

The government has also taken steps to limit demand for medical services. A 1971 regulation reduced the total number of students eligible to complete medical education from 8,600 in that year to 3,500 in 1993. In addition, a law requiring regional planning for public and private hospitals is currently being implemented.

Lower physician incomes and better control of service utilization have enabled France to hold down healthcare costs more effectively than has the United States, the authors point out. But they add that French healthcare is far from perfect and many barriers exist to the importation of some of its stronger features.

COMMUNITY BENEFIT

Mobile Homes

Five houses took to the roads of Zanesville, OH, on June 15, 1993. Rather than tear the homes down to make room for expansion, Good Samaritan Medical Center donated them to Zanesville Habitat for Humanity. "This was a perfect opportunity for the medical center to assist in a community project as we began expansion of our campus," says Tom Barone, Good Samaritan's president.

Good Samaritan Medical Center and Zanesville Habitat for Humanity celebrated their transaction by presenting "Homes on Parade." A local high school marching band led the procession in which the five houses were moved to new foundations nearly two miles away.

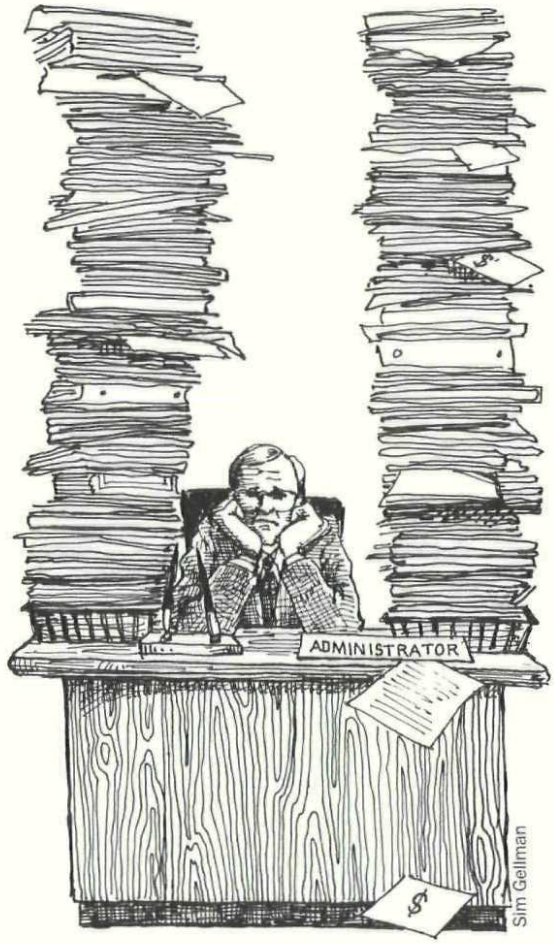
Good Samaritan's donation has more than doubled Zanesville Habitat's available housing. The agency will provide the homes to persons ineligible for conventional financing.

In addition to donating the homes, Good Samaritan committed the money saved from demolition costs to kick off the campaign. Zanesville Habitat and volunteers from states as far away as Minnesota spent eight weeks this past summer readying the homes for their new residents. Local churches are also donating funds and volunteers for the project. Zanesville Habitat hopes all homes will be completed by December 1994.

"We are responsible for the careful stewardship of our material assets," explains Barone. "Moving these homes, instead of destroying them, is an example of how Good Samaritan Medical Center cooperates with local agencies and organizations to help those in need".

ACUTE CARE

Despite Reforms, Administrative Costs Still High



Hospitals working in a managed care environment, an environment the U.S. healthcare system seems destined for, have higher administrative costs than hospitals in the Canadian healthcare system, report Steffie Woolhandler, David U. Himmelstein, and James P. Lewontin in the *New England Journal of Medicine*. "Trimming the hospital bureaucracy to the Canadian level would save about $50 billion annually," they write, adding that "a similar amount could be saved on insurance overhead and physicians' paperwork."

Using data from Medicare reports submitted by 6,400 U.S. hospitals for fiscal year 1990, Woolhandler and colleagues calculated each hospital's administrative costs by summing expenses in pertinent Medicare cost-accounting categories.

In fiscal year 1990 administrative costs accounted for an average of 24.8 percent of U.S. hospitals' spending—"more than the highest previous estimates," note the authors. They point out that hospitals have not only had to compete with one another to attract a declining number of patients, they have been forced to hire more bureaucrats "to battle with competing hospitals over market share and with insurers over payment."

Average hospital administrative costs ranged from 20.5 percent in Minnesota to 30.6 percent in Hawaii, a state that has claimed "strikingly low administrative costs." But, note Woolhandler et al., "no state had administrative costs nearly as low as those at most Canadian hospitals—on average between 9 and 11 percent of total hospital expenditures."

The percentage of a state's health maintenance organization (HMO) enrollment seems to have little effect on hospital administrative costs. In states where more than 25 percent of the population was enrolled in HMOs, administrative costs accounted for 25.6 percent of the average hospital's total costs and 22.6 percent of salary costs. Hospitals in states with a lower percentage HMO enrollment reported similar administrative costs—24.6 percent of total costs and 22.3 percent of salary costs.

Hospitals in states with the most competitive bidding for hospital services have lower administrative costs than do hospitals in states where HMO enrollment is high. But this difference seems to be of no consequence in areas using both approaches. Woolhandler and colleagues point out that in the Boston area, where there is high HMO enrollment and competition for managed-care contracts, hospital administrative costs "are comparable to those in other U.S. hospitals."

THE ELDERLY

Easy Targets

Many states are cracking down on scam artists who each year bilk the elderly out of large sums of money by leading them to believe they have won a prize or need a service like a home improvement. Jack A. Norris reports in *State Government News* that the elderly may account for as much as one-third ($5 billion) of the total amount of money lost by all Americans in telemarketing scams each year. But he cautions that this figure is difficult to verify because "the elderly are less likely to report telemarketing crimes." Many feel embarrassed. "Others fear that friends or relatives will think they are unable to handle their personal affairs," notes Norris.

Swindling the elderly can be a lucrative business. A list of persons older than 60 years of age who have already been defrauded can sell for "10 to 15 times the price of a regular mailing list," writes Norris. And the elderly can be easy marks because "they tend to be more trusting than younger persons," points out the American Association of Retired Persons' Lee Norrgard. He adds that the elderly are more accessible than younger persons because they are at home during the day.

To protect the elderly from scams, the Elder Affairs and Consumer Law Subcommittee of the National Association of Attorneys General has collaborated with about 20 states in an information exchange network.

Individual states are also fighting back, reports Norris. For example, through a state-filed action in New York, the Health Care financing Administration has been compelled to provide information on physicians who may be overcharging on Medicare benefits. And the West Virginia attorney general's office is trying to stop consumer fraud in the hearing-aid industry by taking a hearing-aid company to court for advertising free hearing examinations and then charging $125 to persons who refused to purchase a hearing aid.