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Testimony of
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Chairman Sanders, Senator Burr, and distinguished members of the Committee, thank you for the invitation to testify on what the United States can learn from France's health care system.

My name is Victor Rodwin. I am a professor at New York University's Wagner School of Public Service. I have worked my whole career on studying health care systems abroad, and have a special interest in France given my family background and bilingualism. I was honored to hold the Fulbright-Tocqueville Distinguished Chair at the University of Paris-Orsay during the spring semester of 2010, and was on sabbatical leave, in Paris, studying French health policy just two years ago.

The French health care system is a model of national health insurance (NHI) that provides health care coverage to all legal residents.[1] It is not an example of socialized medicine, e.g. Cuba. It is not an example of a national health service, as in the United Kingdom; nor is it an instance of a government-run health care system like our Veterans

Health Administration. French NHI, in contrast, is an example of public, social security and private health care financing, combined with a public-private mix in the provision of health care services.

The French health care system reflects three political values embraced by Americans:
1) liberalism, in the sense of giving patients free choice of doctors and hospitals;
2) pluralism, in offering diverse health care delivery options ranging from private fee-for-service practice, health centers and outpatient hospital consultations for ambulatory care; and a range of public, non-profit and for-profit hospitals; and
3) solidarity, in the sense of having those with greater wealth and better health finance services for those who are less well-off and in poorer health.

There are, of course, important differences in the degree to which these values have influenced the financing and organization of our respective health systems. Also, France has a unitary, more centralized parliamentary democracy than our federal system known for its strong separation of powers and fragmentation of decision-making.

Despite these differences, the French health care system is worthy of attention by health policymakers, worldwide, for three reasons. First, France is among those countries that enjoy the highest levels of population health among wealthy nations. Second, France ranks #1 among OECD nations on an important indicator of health system performance – avoidable mortality. Third, the French have easy access to primary health care, as well as specialty services, at half the per capita cost (Table 1) of what we spend in the U.S.

Population health status

Health systems are often compared and ranked, based on their population's health status. Insofar as access to public health services and medical care can significantly improve a population's health, this is a good starting point in evaluating a health system.

Whether one compares life expectancy at birth, life expectancy at 65 years, infant mortality rates, or disability-adjusted life expectancy at birth, France performs better than the U.S. (Table 1). France is also noted for having the highest longevity for women, after Japan. These indicators, however, are not sufficient to assess the system's performance because they reflect many other important determinants of health, e.g. poverty rates (Figs. 1-3); other socio-economic disparities; maternal and child health programs; work and family policies; and nutrition. Although the U.S. spends more on

health care, as a share of GDP, than any other nation, France spends a significantly higher share of its GDP on social service programs, particularly family support and employment training programs (Fig. 4). There is good evidence to suggest that France's government spending on these programs contributes to its impressive population health status.

Health system performance

France's claim to fame with respect to health system performance is its top ranking among wealthy OECD nations, based on its success in averting deaths from a range of curable cancers, pneumonia, ischemic heart disease, maternal deaths in childbirth, and a host of other causes of mortality considered to be "amenable to health care interventions." Avoidable mortality (AM) attempts to capture the extent to which deaths under the age of 75 years would *not* have occurred had the population benefitted from access to effective disease prevention programs, primary care, as well as specialty services.

Based on a comparison of avoidable mortality among 19 OECD nations, France has the lowest rate (ranks #1) and the U.S. has the highest rate (ranks #19).[2] Moreover, between 1999-2007, the percentage decline in AM in France (27.7%) was higher than in the U.S. (18.5%).[3] Based on these findings, Nolte and McKee estimate that if the U.S. were to achieve levels of AM of the three top-performing countries (France, Japan and Australia), about 101,000 deaths could be avoided.

An exclusive focus on AM does not allow one to disentangle the consequences of poor access to disease prevention versus primary or specialty health care services. Thus, it is useful to consider other indicators that capture the consequences of barriers in access to primary and specialty care.[4] Together with my colleagues, Michael Gusmano (Hastings Center) and Daniel Weisz (International Longevity Center-USA), we have compared France and the United States along two other dimensions of health care access. The first is well-established – hospital discharges for ambulatory care sensitive conditions (ACSC). It measures hospitalizations for exacerbations of conditions (e.g. asthma, diabetes, and hypertension) that are less costly and less painful to treat in community-based medical settings.[5] The second indicator is less well known. It concerns access to specialized cardiac care for those patients who require revascularization – coronary artery bypass surgery or angioplasty.

We have found that the rate of ACSC in the U.S. is almost twice that of France, whether one examines national-level data or compares New York City and Paris. This demonstrates that access to primary care is significantly worse in the U.S. than in France, leading to many more hospitalizations that could be avoided if we improve our health care system.[6] With respect to cardiac services, contrary to conventional views that the U.S. makes available greater access to life-saving medical technologies than other nations, we found that after adjusting for the fact that the French have less heart disease than Americans, our use of revascularization is not as high – neither for adults (35-64 years) nor for older persons (65+).[7] This supports the claim that the French health care system provides relatively easy access to specialized health care services.

Along with access to primary and specialty care, there is another important dimension of health system performance that merits attention – satisfaction with the health care system as reported in comparative surveys not only of the adult population, but also by chronically ill patients and physicians. Comparisons across Europe place France among those nations with the highest rates of consumer satisfaction.[8] In June of 2008, Harris Interactive, France 24 and the International Tribune collaborated on a survey that placed France at the top with 55 percent of respondents "satisfied" in contrast to the 28 % in the U.S.[9]

Results of the 2008 Commonwealth Fund International Survey of Sicker Adults are consistent with these positive views of the French health system.[10] For example, with regard to "overall health system" assessments, sicker French patients (41%), along with their Dutch counterparts (42%), had among the highest rates of those who felt that "only minor changes (were) needed." Comparable rates for the U.S. were considerably lower – 20%).

Beyond measuring satisfaction, a number of other questions in the Commonwealth Fund Survey provide further evidence that the French have far easier access to health care than their American counterparts. For example, on the question of medical homes – "do you have a doctor you usually see" – 99% of sicker adults, in France, answered "yes" in contrast to 82% in the U.S. Finally, the percent of sicker adults with out-of-pocket expenses over $1000, in the past year, was among the lowest in France (5%), compared to 41% in the U.S.

One can safely conclude that the French are generally more satisfied with the overall structure of their health care system than Americans. Indeed, health care reform

campaigns, in France, typically assume that the main goal is to preserve the existing system and avert any changes that would make it resemble that in the U.S. or the U.K.[11] French policymakers assume that their NHI system is a realistic compromise between Britain's national health service, which they believe requires too much rationing and offers insufficient choice, and the mosaic of subsystems in the U.S., which they consider socially irresponsible because of the large share of the population that remains uninsured, under-insured or even forced to declare bankruptcy after a serious episode of illness.

Lessons from the French health system

Health systems cannot be transplanted from one country to another; nor should they be. Looking abroad, at best, can inform policy debates at home. Beyond France's impressive population health status and health care system performance, there are some distinctive features of the system that raise important questions for health policy, in general. Assuming we really want to provide all of our population with access to quality health services, while also keeping expenditures under better control, I propose to highlight six of these features because they will likely contribute to our discussion about what the U.S. health care system can learn from other countries.

1. **There is no choice of insurance plan for the standardized benefits:** The French health system differs from most other European health systems in its strong resistance to the most recent wave of reform efforts that have sought to introduce a dose of competition and market forces within a social context that maintains its commitment to national solidarity.[12] In France, American nostrums of unleashing market forces under the banner of "consumer-directed health care," and selective contracting by private health insurers, have gained little traction.[13] French NHI does not allow a choice among health-insurance plans for the essential benefits covered under the program. Nor does it allow local health-insurance funds to engage in selective contracts with "preferred providers." As under our Medicare Program, all French residents covered under NHI are entitled to seek care from the 99% of French physicians and hospitals that accept NHI. The competition occurs among health care providers, not among the small number of insurers to which beneficiaries are assigned based on their occupation.
2. **All insurers reimburse providers according to nationally set rates:** Much like Maryland's all-payer system, in France, all insurers pay the same price for hospital services. Likewise, all physicians receive the same reimbursement under

a national fee schedule that is negotiated every year. Approximately one-quarter of all physicians (12% of general practitioners) have opted for what is called "sector 2" and are entitled balance bill their patients, i.e. to set fees above the national fee schedule. In these cases, physicians lose their own health insurance benefits and must pay for their own insurance like all others who are self-employed. Health centers and public hospital outpatient departments (where the most prestigious specialists work) may only charge patients the national rates.

3. **There are no physician gate-keepers:** Like our Medicare Program, French NHI allows patients the freedom to consult general practitioners, specialists and hospitals of their own choosing. There are no restricted networks, no concept of out-of-network surcharges. Beginning in 2005, policymakers have imposed a soft gate-keeping system by requiring French residents to sign up with a primary care doctor (*médecin traita*nt). It is still easy, however, conditional on a slightly higher co-insurance payment, to have direct access to a specialist without a referral.[14]
4. **There is extensive co-insurance and voluntary health insurance coverage:** As in the United States, in France, co-insurance (the so-called *ticket modérateur)* remains a component of the reimbursement system. Almost 90% of the population have the equivalent of Medigap insurance in the U.S., which offers a wide range of insurance products covering portions of co-insurance, extra-billing and supplementary benefits beyond the basic plan (mainly dental and optometry services). Most of the remaining population has free voluntary health insurance provided by the NHI fund or the government.
5. **Sicker patients have better insurance coverage:** In contrast to Medicare and private insurance in the U.S., where severe illness usually results in increasing out-of-pocket costs, in France, when patients become severely ill, their health insurance coverage improves. Although co-insurance and direct payment is symbolically an important part of French NHI, patients are exempted from both when: 1) expenditures exceed approximately $100 per month; 2) hospital stays exceed 30 days; 3) patients suffer from serious, debilitating or chronic illness (e.g. cancer, heart disease, diabetes..); or 4) patient income is below a minimum ceiling thereby qualifying them for exemption from co-insurance payments.
6. **Parliament sets annual health care expenditure targets:** All of the features noted above operate within a system in which Parliament approves an annual health care expenditure target for the coming year. This includes spending targets for specific components of health care (hospitals, community-based

physician services and other sub-sectors). If hospitals and physicians exceed their targets by billing for higher than the projected volume of services, prices are negotiated downward the following year.

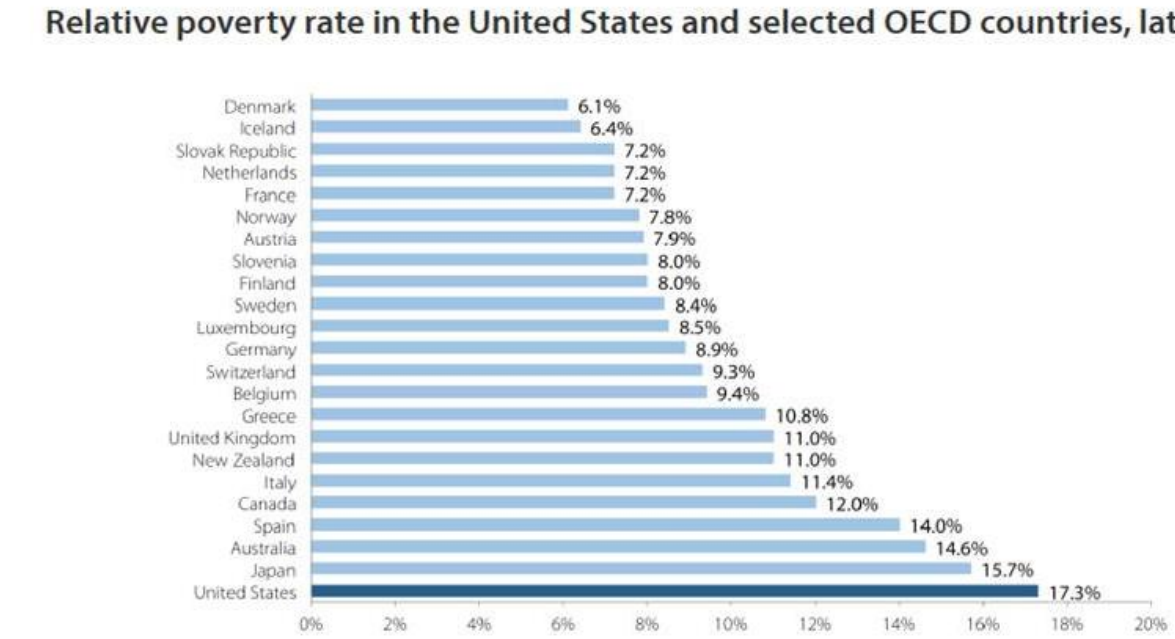
Table 1. Basic Indicators: France and the United States (2011-2012)

	France	United States
Demographic and economic characteristics		
Total population	65,327,700	313,914,000
Percent of population >65 yr of age (2011)	17.1	13.2
Gross domestic product (GDP) per capita ($)	39,901.4	49,685.6
Health care system		
Heath care expenditures as percent of GDP	11.2	17.0
Per capita health expenditures in $PPPs	8,175	4,028.7
Public expenditures on health as% of GDP	8.7	8.3
Practicing physicians per 10,000 population	33.2	26
Physician consultations per capita	6.8	4.1[1]
Acute care bed-days per 1,000 population	900[1]	700[4]
Acute care beds per 1,000 population	3.43	2.56[2]
Health status		
Infant deaths per 1,000 live births	3.9[1]	6.2[2]
Maternal deaths per 100,000 live births	8.9[2]	12.7[5]
Life expectancy at birth	82.2	78.7[2]
Female Life expectancy at 65 yrs	23.8[3]	20.3 [2]
Male Life expectancy at 65yrs	19.3[3]	17.7[2]
Female Life expectancy at 80 yrs of age	11.8	9.7[2]
Male Life expectancy at 80 yrs of age	9.2	8.2[2]
Disability-adjusted life expectancy at birth	73.1[3]	70.0[3]
Years of life lost per 100,000 population due to death before 70 yrs of age	3,500[1]	4,629[2]

[1] data are for 2009;[2] data are for 2010;[3]data are for 1999;[4] data are for 2001; [5]data are for 2007
Table assembled by Christine Lai based on data from the Organization for Economic Cooperation and Development (OECD).

Fig. 1 **U.S. Poverty Rates Higher, Safety Net Weaker than in Peer Countries**

Economic Policy Institute, Issue Brief, 7/24/2012

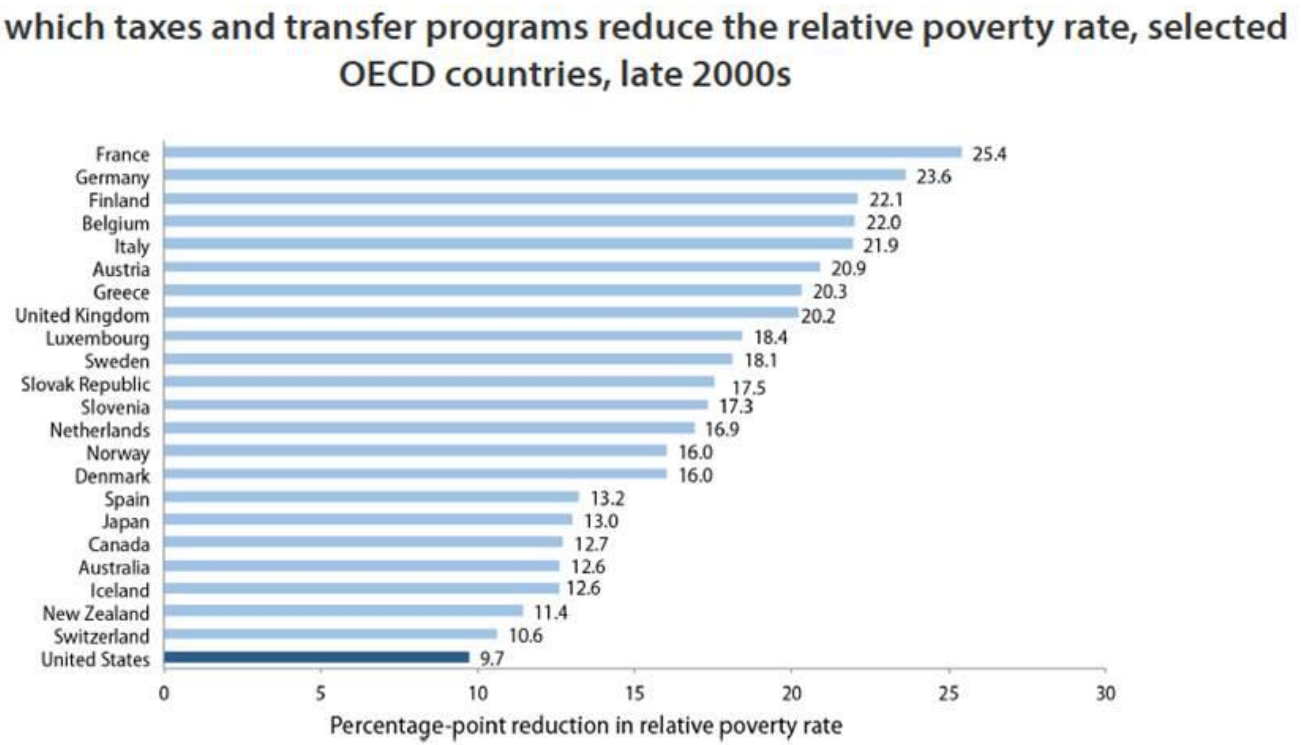


Note: The relative poverty rate is defined here as the share of individuals living in households with income below half of household-size-adjusted median income. Poverty rates are based on income after taxes and transfers.

Source: Authors' analysis of Organisation for Economic Co-operation and Development *Stat Extracts* (data group labelled "late 2000s")

Fig. 2 **U.S. Poverty Rates Higher, Safety Net Weaker than in Peer Countries**

Economic Policy Institute, Issue Brief, 7/24/2012



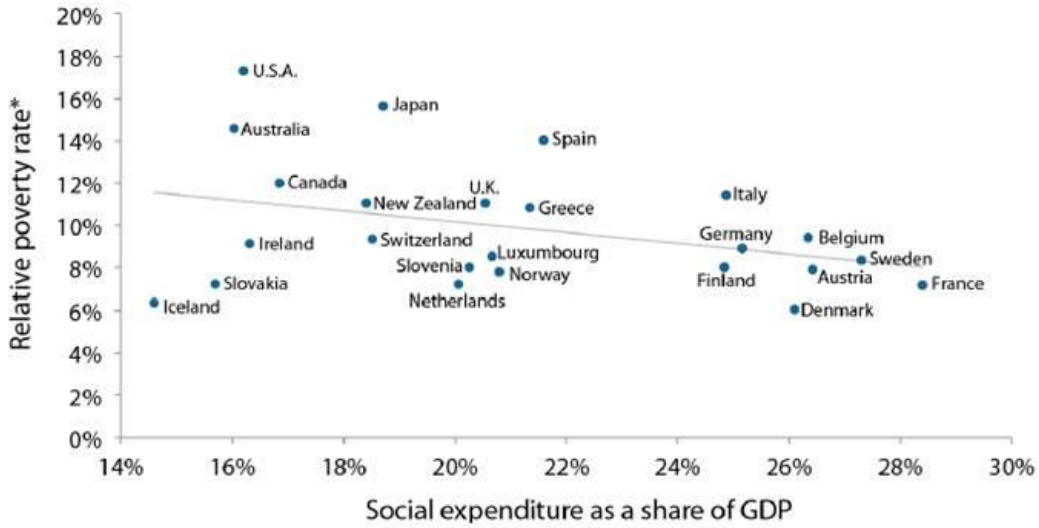
Note: This figure plots the differences between each country's pre- and post-tax and transfer relative poverty rate, where relative poverty is the share of individuals with income below half of household-size-adjusted median income.

Source: Authors' analysis of Organisation for Economic Co-operation and Development Stat Extracts (data group labelled "late 2000s")

Fig. 3 **U.S. Poverty Rates Higher, Safety Net Weaker than in Peer Countries**

Economic Policy Institute, Issue Brief, 7/24/2012

Social expenditure and relative poverty rates in selected OECD countries, late 2000s



* The relative poverty rate is the share of individuals with income below half of household-size-adjusted median income. Poverty rates are based on income after taxes and transfers.

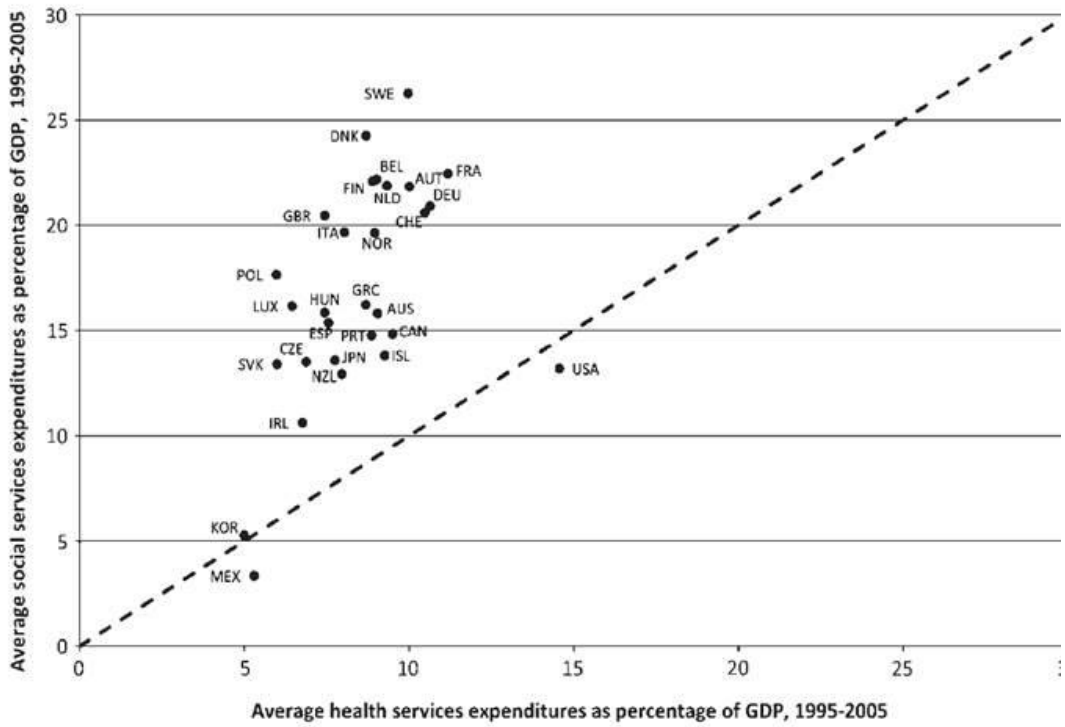
Note: Social expenditure is government expenditure on social programs, such as Social Security and Medicare in the United States. The equation for the trend line is $y = -0.2559x + 0.1528$ and the $R^2 = 0.1266$.

Source: Authors' analysis of Organisation for Economic Co-operation and Development *Stat Extracts* (data group labelled "late 2000s")

Fig. 4

Health and social services expenditures: associations with health outcomes

Figure 2 Average social-services expenditures versus average health-services expenditures as percentages of gross domestic product (GDP) from 1995 to 2005, by country. *Social services expenditures Hungary are missing for 1995–1998, and for Portugal for 2005; health-services expenditure data are missing for the Slovak Republic for 1995–1996. Source: *OECD Health Data 2009* (accessed June 2009); *OECD Social Expenditure Dataset* (accessed December 2009); authors' calculations.



Bradley EH, Elkins BR, Herrin J, *et al. BMJ Qual Saf* (2011). doi:10.1136/bmjqs.2010.048363

Fig. 5 **In Amenable Mortality – Deaths Avoidable through Health Care – Progress in U.S. Lags that of 3 European Countries**

Nolte, E. and M. McKee. *Health Affairs.* 2012; 31(9):2114-2122.

Age-Standardized Mortality Rates From Selected Causes In Four Countries, 1999 And 2006/2007

	Mortality rates per 100,000 people ages 0–74, 2006/2007				Percent change from 1999 to 2006/2007			
Country	Amenable causes	Heart disease (50%)	Other causes	All causes	Amenable causes	Heart disease (50%)	Other causes	All causes
MEN								
France	60.97	13.67	326.96	401.60	27.7	30.7	16.9	19.2
Germany	90.29	30.45	286.32	407.05	24.3	33.2	15.3	19.0
UK	91.27	34.47	253.76	379.51	36.9	41.7	8.4	21.1
US	106.90	37.18	328.20	472.26	18.5	32.6	8.8	13.6
WOMEN								
France	49.39	2.84	126.88	179.10	23.4	37.9	11.2	15.5
Germany	65.87	9.23	133.06	208.15	22.7	37.9	11.3	16.8
UK	74.14	10.82	153.81	238.76	31.9	47.8	6.0	18.6
US	84.50	14.52	191.47	290.49	17.5	35.8	6.1	11.7

SOURCE Authors' calculations based on data from the World Health Organization mortality database (Note 15 in text) and Centers for Disease Control and Prevention vital statistics data (Note 16 in text). **NOTES** Data for Germany for 2007 were not available; we used data for 2006 instead. As explained in the text, we assumed that 50 percent of deaths from heart disease were amenable deaths. Numbers may not sum to the total because of rounding.

REFERENCES

[1] Rodwin, V. and contributors, *Universal Health Insurance in France: How Sustainable? Essays on the French Health Care System*. Washington D.C.: Embassy of France, 2006; Chevreul K, et. al. France: Health System Review. *Health Systems in Transition,* 2010; 12(6): 1-291; Tabuteau, D. and Rodwin, V. *A la santé de l'Oncle Sam.* Paris: Jacob-Duvernet, *2010.*

[2] Nolte, E. and M. McKee. Measuring the Health of Nations: Updating an Earlier Analysis. *Health Affairs.* 2008; 27(1):58-70.

[3] Nolte, E. and M. McKee. In Amenable Mortality – Deaths Avoidable through Health Care – Progress in U.S. Lags that of 3 European Countries. *Health Affairs.* 2012; 31(9):2114-2122.

[4] Gusmano, M., Rodwin, V. and Weisz, D. *Health Care in World Cities.* Baltimore. Johns Hopkins U. Press, 2010.

[5] Millman, M. (ed.). *Access to Health Care in America*. Committee on Monitoring Access to Personal Health Care Services, Institute of Medicine. Washington D.C.: National Academy Press; 1993; The Agency for Healthcare Research and Quality (AHRQ) currently devotes part of its efforts to tracking access to primary care by examining rates of ACSC. Likewise, the Commonwealth Fund monitors ACSC as a measure of access across states.

[6] Gusmano, M. Rodwin, VG and Weisz. "Beyond 'US' and 'Them' ": Access Dimensions of Health System Performance in the U.S., France, Germany and England." *International Journal of Health Services (44)3, 2014;* Gusmano, M. Rodwin, V. and Weisz, D. Hospitalization for Ambulatory-Care Sensitive Conditions (ACSC) in Ile de France: A view from across the Atlantic. *Revue Francaise des Affaires Sociales* (3), 2013.

[7] Gusmano, MK, Das, D., Rodwin, VG and Weisz, D. A New Approach to the Comparative Analysis of Health Systems: Invasive Treatment for Heart Disease in the U.S. France and their two World Cities. *Health Economics, Policy and Law.*(2): 73-92. 2007.

[8] Countries Which Europeans Admire for Their Systems of Government, Quality of Life, Environment, Economies and Health Care Systems, 2007, HI Europe, (Available at: http://www.prnewswire.com/cgi-bin/stories.pl?ACCT=104&STORY=/www/story/06-29-2004/0002202084&EDATE=#)

[9] Harris Interactive /France 24/International Herald Tribune survey, June 2, 2008. See Harris Interactive News Room - Western European and U.S. Adults Tear Down this Health Care System!

[10] Schoen, C. et. al. In Chronic Condition: Experiences of Patients with Complex Needs in Eight Countries. *Health Affairs.* Doi.10.1377, 2008.

[11] Rodwin, V. The Health Care System Under French National Health Insurance: Lessons for Health Reform in the United States. *American Journal of Public Health*, January (93)1; 2003.

[12] Oliver A. Mossialos, E. Maynard, A. eds. *Analysing the Impact of Health System Changes in the EU Member States.* Special Issue of *Health Economics (14) 51, September 2005.*

[13] Le Pen, C. and Rodwin, VG. Health Care Reform in France: The Birth of State-Led Managed Care. *New England J. of Medicine.*351(2):2259-2262.

[14] Dourgnon, P. Naiditch M. The preferred doctor scheme: A political reading of a French experiment of gate-keeping. *Health Policy* 94. 2010: 129-134.