Third Party Payment System in the United States

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Concerns over the effectiveness of the third party payment system which was initiated in the United States, largely following the implementation of the Patient Protection and Affordable Care Act has resulted in debate within the policy scholarly field as well as among the healthcare professionals. Over the recent years, studies over effective implantation of the system increased the level of knowledge of the various implementation techniques and the uniqueness of these practices (Eldridge & Korda, 2011). Following on this, the discussion presents an evaluation of the evolution of the American third party payment system, while pitting it against the various other systems which have been employed in countries with similar economic capacities as the United States and other developing countries such as China. Additionally, the potential and the realized effects of the Hospital Value Based Purchasing, an element of the system shall be evaluated with regards to the resultant financial performance on account of the system. It is hoped that at the end of the discussion the salient strengths and weaknesses of the American payment system will be showed from a global perspective.

**Evaluating the Evolution of the US Third Party Payment System**

Upon inception and borrowing from the insurance practices, the Third Party Payment System was instituted in order to provide a more effective healthcare system for the population. This was based on the institution of the Affordable Care Act and served as the basis through which payment for services would be effected. At the very initial stages of its implementation, the system focused on the volumes of patient care as opposed to the value of the care (Centers for Medicare & Medicaid Services, 2009). As a result, the incentive was centered on the number of patients which a practitioner would attend to. This arose from the objective of the policy which sought to provide affordable care to most citizens of the United States. As a result of this orientation, there emerged a high number of returnees to the hospital on account of the inefficiency of the quality of care. Consequently, the reforms were suggested and implemented which sought to realign the objectives of the incentive programs to the value of the care as opposed to the volume. The result was more affordable and more quality-care for the patients (Centers for Medicare & Medicaid Services, 2009). The alignment, while effective in improving the quality of care which is accorded to the citizens of the country, has occasioned to wastages, more on account of the health-seeking behaviors of the citizens rather than the structure of the system. The development of the value based system has increased the efficacy of the incentives attributable to the quality of care offered by the practitioners.

**Assessing Different Payment Systems**

**Differences and Similarities**

The fee-for-service payment system is one of the first established payment systems. Under the system, payment for medical services was attached to the number of services which were performed on the patient (McClellan, 2011). The system required the practitioner not to all the services offered including the administration of medicine, diagnoses, and interventions. On the other hand, the cost reimbursement system was particularly different and involved the reinstatement of the costs which were incurred by the practitioner to offer the medical service (McClellan, 2011). The problem of this system was the lack of homogeneity of the quantification of the doctors’ experiences and skills in monetary terms in order to calculate the costs. The last system is the value-based system. This system requires payment for the quality of service which is offered. In other words, the practitioner is not paid until the patient is back to better health.

The similarity which can be noted in all the systems above is that the focus of the systems is on the determination of the services offered to the patient. An individual is supposed to determine the various methods of quantifying the services of the practitioner. Another similarity is the determination of the costs of the practitioner. The medical services field has associated costs which make it difficult to determine the costs of some of the services offered. Some items necessary for the recuperation of a patient cannot be quantified, and therefore there arises a problem in the establishment of homogenous costs. It makes the identification of the actual price of healthcare to be undeterminable.

**Examining Realized and Potential Effects of Value Based Purchasing on US Hospitals**

**Realized Effects of Value Based Purchasing on US Hospitals**

The first realized effects of the value based purchasing is the improvement of reporting on medical practices. The reporting of medical practices and the quality of service helps in determining improvement models which would contribute to evidence-based practices (Centers for Medicare & Medicaid Services, 2013). The second realized benefit is the improvement of quality of healthcare. As opposed to the fee-for-service system which concentrated on the volumes, the value based system provides a means though which the quality of healthcare can be improved by the effective changes in the incentive structure, and by extension offering a means through which the quality of the services which are provided by the sector can be changed.

**Potential Effects of Value Based Purchasing on US Hospitals**

The potential effects include: greater citizen health indices, reduction of costs of healthcare, and improvement of the methods of providing healthcare. The increased quality of healthcare would ensure that the patient is fully-healed, and when this is applied to the general population, the likelihood of repeat visits to the hospital will reduce, and the wellness of the society will be increased (Centers for Medicare & Medicaid Services, 2013). With regards to the reduction of costs, the system decreases the risk of inflated payments on account of unnecessary procedures which may be offered to the patient to increase the costs. Similarly, the increased reporting would inform the body of knowledge related to the field, and thereby increasing the efficiency of succeeding methods.

**Analyzing Key Differences between the US Payment Systems and Other Nations**

**Key Differences between the US Payment Systems and Germany**

The difference between the US payment system and that of Germany is in the centralization of the payment authority. While the United States payment is from a single party who is the government through its agency, the German system is based on the autonomous payment from the collective agency (Ridic, Gleason, & Ridic, 2012). Additionally, the autonomy requires the different agencies to collect the contributions of the employees from the various employers in Germany. This is different from the United States where the collection of the funds is through taxes which are applicable to the general population at the prevailing tax rates. The German system is applied through the limits of contributions which are determined by the level of incomes of individuals. In the United States, on the other hand, the payment is universal on account of the fact that the contribution is generated from general taxes.

The difference between the United States system and that of Canada, on the other hand, is the co-pay system. Unlike in the United States, the amount that the patient is required to pay is negligible on account of the normal treatments (Ridic, Gleason, & Ridic, 2012). However, where there extensive healthcare required, the patient is required to pay the whole amount over and above what is classified as ordinary care. In the United States, on the other hand, the system is such that the citizens are required to pay a certain percentage of the total hospital expense. Additionally, in Canada, the negotiation between the payer and the provider is on an individual basis, and thus this is determined by the negotiations between the two parties (Ridic, Gleason, & Ridic, 2012). On the contrary, the United States serves generalized negotiations for various levels of quality of service which results in an incentive based system which is more efficient than that of the Canadian.

**Key Differences between the US Payment System and the Indian One**

The main difference between the US payment system and that of India is in the structure of the payment system. The United States health insurance is mandatory, and therefore all members of the public have access to the health system. On the other hand, the Indian system is not mandatory, and as a result, there are very few individuals who can access the system. Additionally, there is the separation of the private and the public hospitals in terms of facilities and costs in India, and as a result, the paying agency in India only offers payment for treatment done in the public facilities. In the United States, on the other hand, the payment covers treatment in all the hospitals.

**Conclusion**

The payment system of the United States has come a long way in the improvement of the efficiency of the healthcare services being offered. Additionally, the payment system which is based on value has increased the quality of services which are offered by the different providers. While there is efficiency, the absence of structures which can be used to evaluate the quality of services means that the system becomes cumbersome, and in some cases it reduces the motivation of the providers. Additionally, the lack of facilities in some of the rural areas means that while the objective was to offer universal insurance to the citizens, this is yet to be fully realized.

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