Policies

Health Care Systems in...

By Derrick A. Max

United States

Health care in the United States, unlike most other countries, is predominantly financed and delivered by the private sector. Individuals receive health coverage in one of three ways: through private insurance (group or individual), through direct purchase (including self-insurance), or through government programs such as Medicare and Medicaid. Private insurance is typically provided by employers because it is exempt from taxable income and is a deductible expense for the employer. Individuals and the self-employed can also purchase private insurance, but are not afforded the same tax benefits as employer-based plans. Approximately 86% of the population is covered by some form of insurance. Seventy-four percent of the insured are covered by private insurance, while 26% are covered under public programs. Fourteen percent of the US population is estimated to be uninsured, though by law, if they show up in an emergency room, they must receive screening and, if necessary, treatment.

Employer-based insurance typically requires minimal deductibles and co-payments, while offering fairly comprehensive benefits. Average plans cover inpatient and outpatient care, limited dental and vision coverage, and mental health benefits. However, the deductibles and co-payments can be quite high, especially for out-of-network services.

Canada

Until recently, the Canadian health care system was very similar to the system in the US. Then, in 1972, Canada finalized the transition to a universal health insurance program financed jointly by the federal and provincial and territorial governments and administered by the provinces and the territories through not-for-profit public authorities. Every Canadian citizen receives a health insurance card which guarantees access to medically necessary treatments. All billing and reimbursement is administered centrally by provincial authorities.

While provinces have some leeway in the services they can provide, they must cover all medically necessary hospital and physician services (inpatient and outpatient), certain surgical and dental procedures, laboratory, radiological and diagnostic tests, necessary drugs, and nursing services. Provinces are not required to cover outpatient prescription drugs, general dental care or eye wear. Most provinces do include outpatient prescription drugs for the needy and for the elderly. One province, Ontario, even offers mental health and chiropractic care. While long-term care is not mandated, the federal government subsidizes nursing home services within the provinces.

Canada cont. p. 18/column 2

France

The French health insurance model is a combination of the German sickness funds and the British system of central planning and organization. The French system is broadly viewed as the most complicated of all European models. The compulsory French National Health Insurance (NHI) system is composed of local sickness funds that cover nearly 100% of the population. More than 80% of the population is covered by the "general fund" which is a congregation of over 100 local sickness funds.

NHI offers a comprehensive set of benefits that include inpatient and outpatient care, laboratory testing, prescription drugs, dental care and maternity services.

NHI is financed through a payroll tax. Employers pay a tax of approximately 12.5% of payroll, while employees pay approximately 3.5%. Co-insurance is assessed for nearly all medical services at a rate averaging nearly 10%. Unlike most other systems discussed here, French physicians (non-hospital based) can charge fees above the scheduled amount for the procedure they perform. Nearly 25% of such physicians charge patients separately for amounts above the fee schedule.

France cont. p. 18/column 3

This account of international health care systems is not intended to give detailed analysis of the nuances and particulars of each. Instead, it gives the reader basic background knowledge. It provides, I believe, a decent picture of how health care is organized and financed, what benefits are typically offered, and how health professionals are paid for the services they provide in Canada, the UK, Germany, France, Japan, as well as the US. Because of its limited scope, this article makes no attempt to compare the successes or failures of any particular system, or to highlight the lessons that can be learned from the experiences. —D.A.M.
...Six Industrial Democracies

The United Kingdom

The British system was originally established after the Bismarck model and was similar in organization to the German and Japanese systems. However, in the late 1940s, the postwar Labour party altered the entire British economy, nationalizing major industries, including the health care sector. The National Health Service (NHS) was formed with the nationalization of some 2,000 private hospitals in 1948.

The NHS falls under the auspices of the Department of Health and Social Security (DHSS) and is directed in conjunction with 14 Regional Health Authorities (RHAs). The RHAs coordinate the health plans and report to the Secretary, and supervise the efforts of 190 smaller District Health Authorities (DHAs). DHAs are responsible for administering the health system within their localities, reporting their budgets to the RHAs and assessing the quality of services they provide. Each British citizen enrols with a General Practitioner (GP) who is a member of a Family Practitioner Committee (FPC). The FPCs cover several DHA areas and receive funding from the DHSS. GPs are a patient’s primary contact with the health system and act as gatekeepers to the rest of the system.

The NHS is in the process of significantly altering its system to allow greater budget and managerial authority to the DHAs in an attempt to decentralize the entire system. The NHS is also allowing many hospitals to opt out of the system and operate on a free market basis with minimal NHS funding. Another reform that is just being tried is the move to allow large GP groups to utilize their NHS-budgeted amounts to contract out services for their patients with private physician practices.

The NHS provides a very comprehensive set of medical benefits that include unlimited inpatient and outpatient services, dental care, prescription drugs, maternity services, limited long-term care and much more. Sickness funds even provide income replacement in cases of long term illness.

Sickness funds set and collect payroll taxes from their members. Payroll tax rates, which vary between funds (averaging 12.9% in 1990), are split evenly between employers and employees. Rates do not differ by age, health status or even number of dependents. The federal government pays the premiums for the unemployed and the disabled. Retirees stay in the same sickness fund as when they were employed and pay premiums through a flat social security tax and a tax on their private pensions. Because this tax is too low to cover costs, sickness funds with a disproportionate number of elderly can apply for federal assistance. Modest co-payments have recently been instituted for nearly all medical services in an attempt to limit the growth in expenditures.

UK cont. p. 34/column 1

Germany

The German health care system dates back to 1883 and is based on the Bismarck model of social insurance. Most of the system is administered through highly regulated, government chartered, not-for-profit organizations known as sickness funds. These funds are organized around geographic areas, companies, guilds, or other segmented areas of the economy (seamen, miners, agriculture, etc.). Workers earning under $36,580 (1990) are required to join a sickness fund, while workers earning above that level can either join a sickness fund or purchase private insurance. Approximately 90% of the population is covered by one of the 1,145 sickness funds.

The sickness funds provide a very comprehensive set of medical benefits that include unlimited inpatient and outpatient services, dental care, prescription drugs, maternity services, limited long-term care and much more. Sickness funds even provide income replacement in cases of long term illness.

Japan

Also based on the German (Bismarck) model, the Japanese health care system covers the entire population in one of three ways: by Health Insurance for Employees (HIE), run privately through health insurance "societies" or by local governments, by National Health Insurance (NHI) or by a pooled fund for the elderly. Coverage is mandatory for all Japanese citizens. Under HIE, companies with more than 700 employees can set up societies to administer their health plan, while medium and small businesses can join a government administered plan run by the Social Insurance Agency (not to be confused with NHI). Almost 60% of the population is covered by some 1,800 employer-sponsored plans.

Insurance companies must provide a very comprehensive set of benefits which include inpatient and outpatient care, transportation, physician visits, prescription drugs and dental services. Preventive treatments and normal childbirth costs are not included in the minimum benefits package. Some plans offer these services as supplemental benefits while public programs provide these services for those in financial need. Income replacement for long-term illness are also provided in the minimum package.

Under HIEs managed by the societies, premiums are assessed based on an employee's pay grade. Societies are authorized to assess premiums within a mandatory range. Premiums are split (not necessarily evenly) between employers and employees, and average around 8% of monthly wages. Under government managed HIE plans, the premium is set at 8.3% of pay (1986) and is split evenly between employers and employees. NHI is financed through taxes on NHI-insured households. Taxes are based on income, property, number of dependents and the actuarial value of the

Germany cont. p. 34/column 2

Japan cont. p. 34/column 3

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US continued

sion care, inpatient prescription drugs, mar-
ternity and well-baby care, as well as a host
of preventive services. Employer contribu-
tions to such plans average around 80% of
premium costs.

Traditional indemnity or fee-for-ser-
vice plans (which allow one to choose any
doctor with some limit on coverage) are no longer the dominant form of
private insurance. Managed care arrange-
ments (HMOs, PPOs, etc.) have been increas-
ingly utilized by employers hoping to
reduce their medical costs. Managed-care
facilities charge a flat up-front premium
with small co-payments, and restrict cover-
age to a predetermined set of contracted
physicians. Managed-care facilities focus
on preventive care and try to limit utiliza-
tion through gatekeepers who act as inter-
mediaries between patients and specialists.
Benefits offered by managed-care facilities
tend to be somewhat more generous than
traditional fee-for-service plans.

Public insurance in the US dates back
to the mid-1960s, with the passage of Medi-
care and Medicaid. Medicare is a manda-
tory entitlement program offering a base
level of benefits for the elderly and the
long-term disabled. These services are
financed through a payroll tax of 2.9%,
split evenly between employers and em-
ployees. Significant co-payments and lim-
its do apply to most Medicare services. The
other predominant public program, Medici-
ad, is a joint federal/state program de-
signated to cover the poor and the medically indigent. Benefits vary by state but are very
comprehensive in scope. Medicaid ser-
vice are financed out of general tax revenue
with the cost split evenly between the
states and the federal government.

Medical care in the US is provided
almost entirely by the private sector. Hos-
pitals and physicians negotiate their rates
with private insurance companies and pa-
patients. In the case of both Medicare and
Medicaid, physicians and hospitals must
accept the government-determined reim-
bursement rates if they opt to serve patients
insured by these programs.

Canada continued

Private insurance is allowed to cover
services not guaranteed in the provincial
plans. Supplemental insurance typically
covers payment for private and semi-prive-
tive rooms, dental services, outpatient pre-
scription drugs, and some long-term care.
Nearly 90% of Canadians purchase supple-
mental private insurance directly from pri-
ivate insurance companies.

The Canadian health care system is
financed jointly by the federal and provin-
cial and territorial governments. The fed-
eral share is paid by block grants based on
a per capita share, adjusted annually to
account for increases in gross domestic
product. Provinces can finance their por-
tion through insurance premiums, sales
taxes, general revenues, or a combination
thereof. They are not allowed to impose
user fees or co-payments. Three provinces
use payroll tax premiums; access to mand-
dated services, however, cannot be denied
to those who fail to pay their premiums.

Physicians are reimbursed from a ne-
gotiated fee schedule on a fee-for-service
basis. Negotiations are between the prov-
vincial governments and physician organi-
zations. Physicians must accept the nego-
tiated fee as payment in full. To dissuade
physicians from increasing their volume
(to increase their pay) several provinces
have instituted expenditure caps, whereby—
if utilization increases beyond negotiated
budget levels—reimbursement levels are
lowered retroactively for the year or pro-
spectively for the upcoming year; or physi-
cians are required to work at reduced pay
for specified periods of time. Hospital
operating expenses are limited by global
budgets determined prospectively by the
provincial governments. Capital costs for
new facilities and medical equipment are
controlled separately and must be approved
by the federal government.

France continued

Because of the large mandatory co-
insurance rates, and the prevalence of extra
billing by physicians, private insurance is
rapidly growing in France and is estimated
to cover almost 8% of total health expendi-
tures. French companies consider volun-
tary supplemental insurance an important
part of their compensation packages for
their employees, their spouses and their
dependents.

Reimbursement arrangements differ
for hospital and non-hospital based physi-
cians. As noted above, non-hospital physi-
cians can receive extra reimbursements
above and in addition to the negotiated fee
schedule determined by the federal govern-
ment. Hospital-based physicians are salar-
ied. Public and private hospitals are also
reimbursed differently. Public hospitals
are owned and operated by the State, must
operate within a strict budget and are not
allowed to receive payment from pa-
tients who have supplemental private in-
surance. Private hospitals and clinics are
reimbursed on a negotiated per diem basis
for services provided to NHI insured pa-
tients.

Recommended reading and source material:

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Health care systems (continued from p.18)

The UK

vise set of benefits including all inpatient and outpatient care, dental and paramedic services, and prescription drugs (with minimal co-payments). Recent efforts have been made to increase the availability of preventive services.

The system is financed out of general revenues (85%) and through a payroll tax of the NHS. A very minimal amount (3-4%) of financing comes from non-nationals—patients who wish to upgrade their services—and other direct-fee services (certain vaccines, tests, etc.).

Because almost all spending is by the government, budget amounts are set, prospectively based on projected utilization rates. There is virtually no adjustment to these budgeted amounts. Physicians are reimbursed in one of two ways. A GP, who is not a government employee, must contract with the NHS as a consultant, and will receive a base amount to cover the cost of his practice. GPs also receive an additional payment based on the number of patients that choose them as gatekeepers. They also receive a minimal amount from direct fee services. Specialists can either take a full-time position with the NHS and receive a salary, in which case they must limit their private earnings to 10% of their base salary, or they can remain private and perform as many private services as they wish.

Private insurance in the UK is rapidly increasing, currently covering almost 15% of the population. Private insurance acts as a complement to NHS services allowing patients to thwart some of the waiting lists and provide access to private physicians operating outside the NHS. However, because one cannot opt out of NHS taxes, patients move frequently between the two systems.

Germany

Private insurance (covering the other 10% of the population) is highly regulated and must offer benefits similar to sickness funds. Employers are required to contribute equally on behalf of employees who choose private insurance. However, premiums for private insurance are actually determined by risk, with costs spread evenly over one’s life. Privately insured individuals must pay the entire cost of coverage for their dependents. For this reason, most families opt for the sickness funds. Private insurance also offers supplemental insurance for those in sickness funds, providing coverage for such items as private hospital rooms, televisions, and phones. Currently, 16% of persons in sickness funds purchase supplemental private insurance.

In general, health care is provided by the private sector. However, because Federal law limits increases in health expenditures to the increase in employee earnings, all spending for physicians and hospitals and more recently all dentists and pharmaceuticals must fall under a negotiated "global budget." Under this constraint, reimbursements for services are negotiated annually in a "Concerted Action" between sickness funds, private insurers, hospitals, and provider organizations. These negotiations provide the groundwork for the government set fee schedules and the per diem reimbursement rates.

Ambulatory care physicians are paid on a negotiated "relative value scale," meaning that payments are adjusted for the value of the procedure. Hospital physicians are paid a salary based on their experience and years of service. Hospital capital costs (including medical technology) are paid by the federal government, with all proposed expenditures needing approval by a central planning board. If utilization increases, and expenditures exceed the negotiated global budget, reimbursement rates can be reduced retroactively.

Japan

insurance package to the NHI-insured individual. Under both HIE and NHI, there is a limit to the amount that can be charged. In addition, all administrative insurance charges are paid for by the federal government. Insurance for the aged is financed by national and local governments as well as through a supplemental charge on HIE and NHI plans. The elderly finance approximately 1% of cost through charges at the point of service. All insurance plans require copayments ranging from 10 to 30% of the cost of services, but monthly out-of-pocket costs are limited by law to protect those with catastrophic illnesses.

Nearly all hospitals and clinics in Japan are privately owned. In fact, by law, all hospitals must be physician-owned. Fee schedules are established by the federal government and the Social Insurance Council, which, like the Concerted Action in Germany, comprises representatives of the insurance companies, providers and consumers. Hospital and physician reimbursement rates are based on a negotiated fee schedule for each service, prescription or device administered. Hospital physicians are salaried employees of the hospital and receive fixed wages regardless of the number of patients they serve. Clinical physicians are paid on a fee-for-service basis according to the negotiated fee schedule.

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