# National Healthcare Systems: A Worldview

# 14

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**Learning Objectives**

*After completing this chapter, the reader should be able to answer the following questions*:

- What are basic tenants of other healthcare systems across the world, including the United Kingdom, France, Republic of Korea, Switzerland, and Canada?
- What similarities tie these healthcare systems together, and what sets them apart?
- What principals can one take from international systems to improve health care in the United States?
- How have other countries dealt with the rising costs of health care?

## Introduction

To gain further insight into American health care, it is important to examine healthcare systems in other countries, so that one can assess and compare various plans and paths of reform. Health systems in the United Kingdom, France, South Korea, Canada, and Switzerland provide a broad international sampling that includes another massive North American country (Canada), three European powers (France, Switzerland, and the UK), and a rising Asian superpower (South Korea). In examining these nations' healthcare structures, we must understand that their efficacy and outcomes are influenced by several modulating factors besides the system's inherent design: politics, history, and economics must all be considered when assessing a foreign system and translating successful strategies appropriately to the landscape of American health care.

For example, though the UK's National Health Service has retained its basic structure since its formation in 1948, it was not until 2001–2003—when

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political action established financial incentives for high-performing doctors and hospitals—that the British quality of care rose to what it is today. The Republic of Korea faces the logistical problem of supporting a rapidly growing and aging populace with the funds of a yet-developing economy. Switzerland's both famous and infamous healthcare system reflects its government's commitment to allowing individual choice within a mandatory coverage.

This examination explores not just what alternative healthcare systems are possible but *why* they are possible, given the different political and historical landscapes of individual countries. How might these various international systems affect our understanding of American health care?

## United Kingdom

The United Kingdom—comprised by England, Scotland, Wales, and Northern Ireland—organizes its health care through four separate national systems that arose from dividing the common UK National Health Service (NHS) in 1999. While each of the four new national systems has taken slightly divergent paths since "devolution," the British NHS can be described as a fair representative of the essential system: that is, a single-payer system with publically provided care [1]. Worldwide, the British health system is known for its economy: the UK only spent $3,503 per capita on health care in 2010 [2] (compared to $8,233 per capita in the USA) [3]. Because the NHS is directly responsible for regulating both payment, as managed through the taxpayer-funded NHS, and reimbursement, by employing the majority of physicians, and funding most hospital operations costs, the British government has tight control over how much it spends on health care and what services it will pay for [4].

The NHS was originally formed in 1948 to provide health care to citizens who could not afford to pay at the time of service. This original iteration established a universal single-payer system funded by general taxes, allowing any UK citizen to receive health care free at the point of delivery. Individuals could—and still can—purchase private insurance to receive additional perks (such as shorter waiting lists for appointments and procedures), but this did not preclude them from paying their income-dependent NHS taxes. As of 2000, only 11.5 % of UK citizens chose private insurers, with the vast majority of the country receiving health care through either the NHS or employer-based private insurance [5].

After the NHS receives taxpayer money, it channels it directly to doctors and hospitals, both of which are reimbursed depending on performance, specialty, and volume of patients. Most doctors are employed directly by the NHS and hence have their income tightly regulated in many ways by the NHS. For example, in regulating the income of general practitioners (GPs), the NHS (1) mandates that all of its subscribers have a GP, (2) controls the total number of GPs trained and employed, and (3) determines the level of capitation, along with other reimbursements, that these physicians receive. Recent developments to this model include a 2004 "pay-for-performance" scheme that incentivizes general practitioners with up to $77,000 for providing thorough preventative care; successfully managing chronic conditions; keeping thorough, easy-to-access health records; and satisfying patients [5]. Specialist physicians receive salaries for their public work—though some also receive fee-for-service from private insurance companies.

Because the NHS determines both the money received from taxpayers and money paid for services, the British government is in a uniquely strong position to choose what will or will not be standard practice, by choosing which practices it will pay for. Strict budgets can actually be adhered to, resulting in low spending. The NHS extended its "pay-for-performance" model to hospitals [4] to increase quality and timeliness of care. Healthcare recipients themselves—because they choose their own GPs—can also influence quality of care through their role in free market competition between GPs.

The process of health care follows a hierarchy that starts with a local general practitioner and

continues regionally. GPs are truly the "gatekeepers" to care, such that—excepting emergencies—one can only access specialist services through a GP referral. Patients with difficult problems must go first to their GP, get a referral (usually) to a local hospital, and if their problems warrant more treatment, progress to a regional teaching hospital. Hospitals are responsible for the entire population within their geographic vicinity. This allows cheaper care to be provided with fewer specialists.

However, a side effect of having fewer specialists is long wait lines: the 1995 UK "charter standard" for the waiting period between a referral and a specialist appointment was 6 months for an outpatient visit and 18 months for an inpatient visit [5]. Recent efforts to improve quality have lowered the 2009 target waiting period to 3–6 months for an inpatient visit. Yet, perhaps the most notable benefit of private insurance in the UK remains the ability to jump in queue or bypass long waiting lines.

2003 studies showed that the British are generally satisfied with the cost of their health care, with only 6 % of Brits (compared to 48 % of Americans) citing cost as a major problem with health care. However, 39 % of British patients (and 3 % of Americans) cited long waiting times as one of the most important problems of their national health system [4].

The British NHS's current success can be understood as the result of two major, targeted political pushes in 2001 and 2002 to incentivize quality improvement. As recently as the 1990s, the UK had "the highest mortality from major diseases" compared to other European countries in addition to its then-infamous waiting times.[1] In an attempt to move past a phase where "hospitals with long waiting lists and times [were] rewarded with extra money to bail them out," Prime Minister Tony Blair introduced a "target-driven culture" in which receiving NHS funding for hospitals became contingent on meeting Treasury targets for basic measures of healthcare success such as "reducing mortality rates from major killers, narrowing health inequalities, treating patients at a time that suits their medical need, reducing waiting times, and increasing patient satisfaction" [6].

This culture shift was enacted in order to reduce the gap in quality between private and public health care, because this gap necessarily reflects the income-based inequity of health care. Specifically, the NHS hoped to move past the dichotomy of "a privately financed high-quality service for those who can afford to pay for it and a publicly funded service of low quality for the rest." Part of this era of accountability included publishing the names of all NHS organizations along with "star ratings" of their performances to encourage good practices while simultaneously "naming and shaming" subpar hospitals.

Yet, the target-driven system, though effective, also allowed people to attempt to "game" the system. As noted by Bevan, narrow targets can successfully be used to achieve wide health goals, but often not without some idiosyncrasies:

> It is often said, and it is true, that government targets can lead to perverse consequences. Ambulances wait outside hospitals because there is a target that no patient should wait more than four hours in A & E[2]… Ninety-eight per cent of patients do, indeed, now get seen in A & E in less than four hours. [7]

In 2002 and 2003, the flavor of British healthcare reform began emphasizing provider competition over "targets." By allowing patients to attend whichever hospital they chose, and reimbursing hospitals and physicians with a blend of capitation[3] and salary, the British government ensured that "money follow[ed] the patient." As a cumulative result of these reforms, British health care is now a success story in terms of manufacturing its own competition to increase the quality

[1] Despite these criticisms, the UK gained a 1997 "Overall health system attainment" score of 91.6/100 and a 9th best ranking out of all WHO Member States. That year Switzerland placed 2nd, France placed 6th, Canada 7th, the USA 15th, and the Republic of Korea 35th.

[2] Accident and Emergency.

[3] Pay determined by the number of patients seen rather than quality of care.

of state-provided health care [8]. The percentage of the population reporting being "quite satisfied" or "very satisfied" with the general running of the English NHS increased from 35 % in 1996 to over 50 % in 2006 [5].

## France

In 2000, the French healthcare system was ranked No. 1 by the World Health Organization. Although some have criticized the methods of assessment used in this report, overall satisfaction ratings and health status indicate that the French system is worthy of attention. The French healthcare system combines universal health insurance coverage with a mixed public-private system of hospital and ambulatory care. In addition, it provides higher levels of resources and greater volumes of care than the American system while maintaining significantly lower costs [9].

It is important to note that the French healthcare system, the National Health Insurance (NHI) system, was implemented in stages in response to a national call for greater coverage. The original program, passed in 1928, covered low-income, salaried industry, and commerce workers. It was not until 2000—following several expansions of program coverage throughout the century—that France achieved true universal health insurance coverage [10]. Public health insurance benefits are available to all citizens, regardless of employment status.

NHI in France revolves around a system of reimbursement for medical care; patients pay their physicians directly and are reimbursed[4] by specific health insurance funds [9]. All workers in France are required to pay a portion of their income into a specific health insurance fund,[5] the sum of which is then used to reimburse medical expenses at predetermined rates. This process helps to mutualize health risks between individuals. Although workers are grouped into different health insurance funds based on their employment, the funds all share a common legal framework, and competition between funds is prohibited.[6] Retirees and the unemployed receive automatic coverage by the fund that corresponds to their previous occupational category [11].

The government shapes this process by determining which health services are considered reimbursable[7] and the rate at which those services will be reimbursed.[8] Physicians are permitted to set and collect their own fees, but services will only be reimbursed at the predetermined government rate [10]. In this way, fees remain fairly competitive, as patients are likely to choose the service with the smallest difference between the physician and reimbursement rates.

The French NHI is relatively generous in terms of benefits, covering a broad range of services such as hospital care, outpatient services, prescription drugs, and nursing home care; dental and vision care are covered to a lesser extent, and small differences in coverage exist between different NHI funds. Competitive private insurance is available to cover gaps in NHI and expand benefits. Private insurance is often employer subsidized or is government provided for low-income citizens [12].

The French NHI was founded on the principle of solidarity: the notion that "health insurance is a right for all—sick and well, high and low income, active and inactive—and that premiums ought therefore to be calculated on the basis of ability to pay, not anticipated risk" [13]. Essentially, the sicker a person becomes, the less they are expected to pay. For example, patients are exempted from co-pay requirements and receive complete reimbursement of healthcare costs if they are diagnosed with one of thirty

[4] Presentation of Sécurité Sociale card, enhanced with a microchip, at a physician's office allows for an electronic transfer of funds to the patient's bank account. This transaction takes place almost immediately.

[5] Workers are automatically enrolled in a group based on employment. Three major health insurance funds exist: [1] commerce and industry workers, [2] agriculture workers, [3] nonagriculture workers and the self-employed.

[6] Examples of competition would include the lowering of health premiums and the micromanagement of health care.

[7] Most medical services are considered reimbursable.

[8] Reimbursement typically ranges from 70 % for procedures such as x-rays to 95 % for minor surgeries or childbirth.

specified chronic conditions or if their hospital stay exceeds 30 days. This is in direct contrast to the American healthcare system, where chronic illness and long-term recovery are associated with increased costs for the afflicted individual.

## South Korea

Over the past 50 years, South Korea's economy has grown rapidly, earning it a place among the G-20 major economies. As the nation's economy developed, so did its standard of living expectations and thus its need for a quality, affordable healthcare system. In an attempt to maintain continued economic growth and political stability, the South Korean government developed a health insurance program intended to improve the social welfare of its citizens [14]. In just 12 years, South Korea was able to implement a system of universal health insurance, bringing coverage to over 96 % of its population.

South Korea's first compulsory health insurance act was signed into law in 1977.[9] In addition to establishing several health insurance societies, this act required all companies with more than 500 employees to provide health insurance to their workers. By 1989, through a series of government-directed program expansions, South Korea had achieved universal health insurance coverage, requiring health insurance of both public and private sector employees, as well as the self-employed.

Eleven years later, in 2000, the nation's multiple health insurance societies were merged into a solitary government-run, single-payer system, the National Health Insurance (NHI) program. Until this point, health insurance had been provided primarily by private insurance societies, with the government offering direct coverage to those who were unable to obtain private insurance[10] [15]. All people are eligible for coverage under the NHI program, and, as of 2006, 96.3 % of South Koreans were insured under its umbrella.[11] The remaining 3.7 % were covered by the nation's Medical Aid Program (MAP), which is similar to the American Medicaid program [16].

The National Health Insurance program uses a combination of public and private financing derived from government subsidies, tobacco surcharges, and individual contributions (premiums). While a uniform contribution amount[12] is set for those who are employer-insured, expected contributions for the self-employed are determined based on income.[13] Co-payments for medical services are also collected, with costs being dependent upon the services provided [14].

The South Korean healthcare plan, while providing comprehensive care, does little to address the root of the nation's health issues, choosing to focus on the treatment of disease rather than its prevention. In addition, an increase in expenditures for chronic degenerative diseases has followed an increase in South Korean life expectancy, placing a financial and social burden on younger populations [16]. As the American healthcare system continues to progress and develop, it should take into account the need for both an emphasis on preventative services and a strategy for the management of age-related costs.

## Canada

The Canadian province of Saskatchewan founded the first publicly-financed universal hospital insurance program in North America in 1947, and the other provinces soon followed suit. In 1957, the Canadian government passed the Hospital Insurance Act, creating a national universal hospital insurance program to replace the

[9] Prior to this time, health insurance enrollment was voluntary.

[10] According to the Center for Health Market Innovations, 90 % of South Koreans were covered through private insurers prior to 1997; direct coverage through the government was provided to the remaining 10 %.

[11] 57.7 % were employer insured and 38.6 % were self-employed.

[12] Employer-insured premium rates are levied as a percentage of the employee's gross income; the employer and employee each pay 50 % of the premium amount. The premium rate was 5.08 % in 2008.

[13] Income calculations include factors such as property value, age, and gender.

**Table 14.1** Healthcare expenditures: USA versus Canada

| | | Total current expenditure (individual and collective health care) | | | | |
|---|---|---|---|---|---|---|
| | Total healthcare expenditure | Services of curative and rehabilitative care | Services of long-term nursing care | Medical goods | Prevention and public health services | Health administration and health insurance |
| United States | $8,232.9 | $5,486.0 | $463.0 | $1,105.2 | $286.1 | $569.8 |
| Canada | $4,444.9 | $1,990.4 | $624.7 | $853.5 | $291.7 | $143.9 |

Note: Values expressed are per capita costs, in US$ purchasing power parity

fragmented provincial one. Although the creation of this program was a large step toward universal health insurance coverage, the program covered only hospital services, not physician services. A true universal health insurance plan was passed in 1966, and the program was fully implemented in 1971 [4].

The Canadian universal health insurance program, named Medicare, is a public, single-payer[14] system that is financed through taxation. As of 2010, the federal government financed 33 % of the cost of provincial health services[15] [4]. The provinces themselves use a variety of taxes to finance their health budgets, including compulsory premiums,[16] and payroll, income, and sales taxes [17].

In contrast to many other systems, the Canadian Medicare system has completely separated health insurance from employment; every Canadian receives the same benefits, regardless of occupation or employment status. Benefits under the program are broad, covering physician, hospital, and ancillary services[17] [4]. Canadian patients are free to choose their own primary care physicians (PCP) and are able to see specialists without referrals from their PCP.[18] Physicians are typically prohibited from billing above the provincially-mandated service fees [18].

The Canadian system is also unique in that it prohibits citizens from purchasing private health insurance that duplicates the basic benefits covered under the national plan. This policy is designed to prevent physicians from offering preferential treatment to patients with private insurance. Private insurance may be purchased, but only to cover gaps in coverage[19] or for special amenities such as private hospital rooms [18].

Compared to costs for care in the United States, Canadian healthcare expenditures are relatively low [19]. Several key differences between the USA and Canadian systems account for the variance in cost of health services between the two nations. In the USA, administrative costs are more than 300 % greater than in Canada. American physicians also utilize expensive, high-tech services (such as MRI scans) at a much higher rate than their Canadian counterparts. Finally, hospital stays in general are more expensive in the USA, as are physician fees and pharmaceutical prices (Table 14.1) [20].

Although the cost for care is significantly lower in Canada than in the United States, health-related expenditures in Canada have risen in recent years, and, in 2010, Canada was reported as having the fifth highest per capita healthcare costs among developed nations.[20] Since that time, Canada has taken steps to curb health costs and increase federal funding to provinces. Tax expansions have increased the federal payout to provinces, while a planned reorganization of the

[14] Within each Canadian province, the provincial government is the single payer.

[15] The Canadian federal government originally financed 50 % of health services costs in the 1970s.

[16] British Columbia and Alberta provinces.

[17] Ancillary services include diagnostic, therapeutic, and custodial services.

[18] Specialists receive a specialist fee, but only if the patient is referred by a PCP. For this reason, many specialists refuse to see patients without a referral.

[19] Dental care, physical therapy, prescription drug coverage, etc.

[20] According to a report published by the Organisation for Economic Co-operation and Development (OECD).

Medicare system aims to simultaneously decrease administrative costs and improve efficiency [4].

Overall, the Canadian universal insurance program has been successful in providing a means for the fair distribution of healthcare services. Critics of the system target long wait times for elective procedures and decreased access to primary care physicians compared to insured Americans [12]. In addition, payments to Canadian physicians on a fee-for-service basis have been said to emphasize volume of patient visits over quality of patient care [18].

## Switzerland

Switzerland provides the classic model of universal coverage achieved through highly regulated private insurance companies. An individual mandate requires all Swiss to purchase at minimum a "basic plan," with a minimum, predetermined amount of coverage. These basic plans are heavily regulated by the government to ensure quality and affordability, though private plans are available to those who can afford them. As a whole, Switzerland's health system is known for retaining a great plurality of consumer options and promoting consumer autonomy around the standard for minimum individual coverage—though critics often dispute its cost-effectiveness [21].

Swiss health care, though possibly successful through its own design, must nevertheless be considered in the context of the Swiss history of government, with its limited federalism and emphasis on individual autonomy. For the latter half of the twentieth century, Switzerland had already established for itself "universal social insurances" in case of widowhood, orphanage, unemployment, or disability [22]. From this history of social support came the federal 1996 Law on Health Insurance, which set forth an individual mandate for health insurance, along with measures to maintain the individual's options for coverage and providers.

These protective measures allow the Swiss complete freedom to define their own health coverage, as long as they meet the individual mandate.[21] In fact, insurance companies are prohibited by federal law from penalizing citizens who switch healthcare plans. Individuals are thus encouraged to take an active role in choosing from the 90 or so private insurers in Switzerland, thus shaping the free market and perhaps leading to better coverage and service [23]. To increase transparency in selecting from the multitude of insurance choices, the Swiss government publishes an annual list of insurance companies along with their rates for "basic" plans, which are identical in form and provide essential coverage as defined by federal law. Besides monthly premiums, healthcare recipients must also pay for their own co-pays; this is to encourage patients to participate in the process of keeping healthcare costs low—for example, by declining unnecessary lab tests their doctor might otherwise have ordered.

"Basic insurance," by Swiss law, provides the same services and benefits (including sick treatment, preventative care, and approved prescriptions) to all insured under it, for premiums legally determinable only by age and geographic location. While the Swiss government does not fix specific prices for these basic plans, it directly prohibits insurance companies from profiting from them. Theoretically, since the numerous basic plans are identical in content, insurers will compete for customers via secondary services, such as customer service and administrative support.

Insurance companies may also offer "private plans" that offer greater amenities (such as private hospital rooms) or more advanced treatments (such as those that are infeasible to provide to the entire population) [18], and it is legally permissible to profit from these private plans. While companies are prohibited from using most personalized information to determine basic premiums, they may—in determining private premiums—consider gender, risk factors,

[21] Swiss government revolves around the individual; as a direct democracy, *any* of its laws or decisions can be delayed, or decided by public referendum, if enough signatures are obtained. This is in contrast to indirect democracy, which is used in the USA.

and preexisting conditions. Insurers may even reject applicants for private insurance, while they are required to insure anyone who seeks a basic plan from them.

A Swiss citizen has increased freedom in choosing not only insurance plans but providers as well. Furthermore, there is no requirement that a general practitioner "keep the gates" and make referrals in Switzerland, so an individual may choose and seek specialist treatment directly. The only limitation, outside times of emergency, is that one must seek treatment within the confines of one's geographic subdivision or "canton."

Cantons are responsible for running local hospitals, determining insurance subsidies for low-income families, and determining reimbursement amounts for services. Though hospitals are primarily funded by insurance companies based on diagnoses and/or lengths of hospital stays, cantons provide additional funds to cover any deficits [18]. However, because cantons operate independently from each other, the health care experience of a Swiss resident can depend greatly on where they live within Switzerland. As an extreme example, a Swiss family of four living on $42,000 PPP[22] in 2007 might have spent anywhere between 4.4 % and 16.4 % of their income on health care depending on their local canton's health premium subsidies for low-income families [22].

Theoretically, segmentation might allow competition between cantons, that is, if people were to relocate according to their preferences for canton-provided health care.[23] However, due to the actual reality of relocation, as well as differences in language and culture between the cantons, this seems unlikely to be a great determinant of Swiss health care. Further criticisms of the canton system include that it "encourages the creation of regional monopolies and segmentation of hospital supply" and lacks the benefits of a centralized federal system, such as economies of scale and coordination of effort.

[22] PPP = product purchasing power, a quantified representation of the buying power of a currency in its home nation, translated roughly into USD.

[23] As Crivelli and Bolgiani put it, "voting with their feet."

In summary, health care provided by cantons must still conform to federal standards that require that: (1) all individuals purchase insurance; (2) identical, "basic insurance" plans covering the minimum amount of health coverage for an individual are available from each of the 90 or so private insurance companies; (3) private insurance companies offer these basic plans not for profit (companies may profit off supplementary plans that provide increased comfort and/or service); and (4) individuals have great freedom in choosing providers and hospitals.

## Conclusion

The United Kingdom, France, Switzerland, Republic of Korea, and Canada have evolved different healthcare solutions to differing sets of circumstances; yet, each system aims to save money and maximize human potential by redistributing the flow of time, money, and attention through different venues under differing sets of restriction.

In this international analysis, all of the examined countries achieved universal health care, and the majority of the healthcare models (UK, France, Republic of Korea, and Canada) offered public insurance. Switzerland alone differs in this respect, as it lacks government-provided coverage, relying instead on a great multiplicity of private insurers. Yet, Swiss insurers are so heavily regulated that their basic coverage plans may be considered as essentially similar to public plans, but without direct government administration.

The USA, in contrast, is far from universal coverage and does not yet have universally available public insurance. Health costs per capita are greatest in the USA and Switzerland ($8,233 and $7,812, respectively) and least in the UK and the yet-developing Republic of Korea ($3,503 and $1,439). France is in between with $4,691 per capita spending. When these costs are viewed relative to their country's economic strength, however, we see that each of the international systems spent approximately 10–12 % of the GDP on health care, while the USA spent closer to 18 %. See Table 14.2 for a comparison of healthcare systems between the United Kingdom,

**Table 14.2** Comparison of healthcare systems between the United Kingdom, France, Republic of Korea, Switzerland, Canada, and the United States

| | Insurance type | Single payer? | Payment singularities | Amount of GDP spent on health care (%) | Gross national income per capita (US dollars) | $ USD spent on health care per capita |
|---|---|---|---|---|---|---|
| United Kingdom (*National Health Services*) | Public, universal | Yes | Free at the point of delivery; state money follows the patient | 9.6 | $30,600 | $3,503 |
| France (*National Health Insurance*) | Public, universal | No | Patients pay physicians and are reimbursed by the state | 11.9 | $29,700 | $4,691 |
| Republic of Korea (*National Health Insurance*) | Public, universal | Yes | Institutions provide care to patients and are later reimbursed by the state | 12.4 | $24,900 | $1,439 |
| Switzerland | Private (heavily regulated), universal | No | | 11.5 | $42,700 | $7,812 |
| Canada (*Medicare*) | Public, universal | Yes | | 11.3 | $32,800 | $5,222 |
| United States | Mixed public + private, not universal | No | | 17.6 | $38,900 | $8,233 |

France, Republic of Korea, Switzerland, Canada, and the United States.

It is clear that there are multiple functional models for funding and delivering health care, and, within those models, there are many modes of variation. Even grossly similar systems, such as those in Canada and the UK, may achieve different results depending on the timing, implementation, and politics involved. It is important to keep in mind both the strengths and weaknesses of each of the systems described as our American healthcare system continues to progress.

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