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 vi-

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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.

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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 conglomeration 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 enrolls 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 comprehen-

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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.

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.

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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

Japan cont. p. 34/column 3

US continued

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

Traditional indemnity or fee-for-service plans (which allow one to choose any doctor with some limit on types of coverage) are no longer the dominant form of private insurance. Managed care arrangements (HMOs, PPOs, etc.) have been increasingly utilized by employers hoping to reduce their medical costs. Managed -care facilities charge a flat up-front premium with small co-payments, and restrict coverage to a predetermined set of contracted physicians. Managed-care facilities focus on preventive care and try to limit utilization through gatekeepers who act as intermediaries 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 Medicare and Medicaid. Medicare is a mandatory 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 employees. Significant co-payments and limits do apply to most Medicare services. The other predominant public program, Medicaid, is a joint federal/state program designed to cover the poor and the medically indigent. Benefits vary by state but are very comprehensive in scope. Medicaid services 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. Hospitals and physicians negotiate their rates with private insurance companies and patients. In the case of both Medicare and Medicaid, physicians and hospitals must accept the government-determined reimbursement 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-private rooms, dental services, outpatient prescription drugs, and some long-term care. Nearly 90% of Canadians purchase supplemental private insurance directly from private insurance companies.

The Canadian health care system is financed jointly by the federal and provincial and territorial governments. The federal 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 portion 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 mandated services, however, cannot be denied to those who fail to pay their premiums.

Physicians are reimbursed from a negotiated fee schedule on a fee-for-service basis. Negotiations are between the provincial governments and physician organizations. Physicians must accept the negotiated 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 prospectively for the upcoming year; or physicians 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.

The Public Opinion Report, which follows, contains 7 pages of public opinion data on health care for the US and other principal industrial democracies.

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 expenditures. French companies consider voluntary 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 physicians. As noted above, non-hospital physicians can receive extra reimbursements above and in addition to the negotiated fee schedule determined by the federal government. Hospital-based physicians are salaried. Public and private hospitals are also reimbursed differently. Public hospitals are owned and operated by the State, must operate within a strict global budget and are not allowed to receive payment from patients who have supplemental private insurance. Private hospitals and clinics are reimbursed on a negotiated per diem basis for services provided to NHI insured patients.

Recommended reading and source material:

Robert B. Helms, editor, *Health Care Policy and Politics: Lessons from Four Countries.* AEI Press, Washington DC, 1993.

The Wyatt Co., *Health of Nations: An International Perspective on US Health Care Reform,* Washington DC, 1991.

1991 Advisory Council on Social Security, *Critical Issues in American Health Care Delivery and Financing Policy,* Washington DC, 1991, pp. 433-66.

Jeremy W. Hurst, *Reforming Health Care in Seven European Nations,* Health Affairs, Fall 1991, pp. 7-12.

General Accounting Office, *Health Care Spending Controls: The Experience of France, Germany and Japan,* Washington DC, November 1991.

Employee Benefits Research Institute, *International Benefits: Part One-Health Care,* Washington DC, September 1990.

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Health care systems (continued from p.18)

The UK

sive 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 telephones. 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 co-payments 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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