



## backgrounder

# International Case Studies of For-Profit Health Care Reform: Learning from others' mistakes

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## Table of Contents

Introduction .....	1
<i>Australia – Public system works longer and harder</i> .....	2
<i>New Zealand - Competition reduces cooperation between health care professionals</i> .....	4
<i>United Kingdom – Increased waiting lists</i> .....	6
<i>Sweden – For the first time ever - two-tiers of care</i> .....	8
<i>United States – Unequal access to care</i> .....	12
<i>Singapore – Inefficient duplication of services</i> .....	14
Health Care as an Example of Market Failure .....	15
References .....	19
Appendix 1: PNHP International Health Care Systems.....	21



## Introduction

As the debate about the future of health care continues we are repeatedly being presented with possible solutions and options. Many attempt to portray the private sector as a white knight that will ride in to save the day. Politicians, think tanks and mainstream outline a multitude of benefits that “market mechanisms” would supposedly introduce. For example, Canadians are promised innovation, efficiency, cost-effectiveness and improved quality of care if they accept a more market-controlled health care system.

But what are the real facts and figures? Have market-oriented health-care options been tried elsewhere and, if so, how successful have they been? It makes sense to examine experience elsewhere before accepting such measures on faith in Canada.

This document is intended to provide an overview of how effective market mechanisms have been in improving health care in other countries.

International comparisons of health care systems are often delicate exercises. Political and social factors influence the way health care systems develop, and differences can vary greatly. It therefore makes no sense to compare Canadian health care with systems that exist in many other countries around the world. For example, to extrapolate patterns from Haiti, one of the poorest countries on earth, to Canada, one of the richest, is clearly nonsensical. Instead, it makes sense to look at countries that:

- are relatively wealthy and developed;
- have now, or had, an extensive system of public health care;
- have tried some of the policy changes now being considered in Canada; and
- have developed the research needed to make such comparisons.

For these reasons we have decided to focus on the United Kingdom, New Zealand, Australia, Sweden, the United States and Singapore. Each case study will provide an overview of the historical development of health care in each country, its experience with public and private care and the resulting impact on medical services.

The overall conclusion drawn from this overview is that the introduction of market mechanisms is a recipe for health care disaster. In almost all instances the quality of services provided has suffered and costs have invariably increased with the growth of private care.

Health care is perhaps the best example available of what economists call “market failure”. Simply put, economic rules applied to most commodities and goods do not work when applied to health care. This really isn’t a surprise. Someone in need of kidney dialysis, for example, faces a far more complex situation than someone who is merely looking for a meal at a fast food outlet. Unfortunately, there are those who would argue that the market rules are basically the same.

## **Australia**

### *Public system works longer and harder*

Ironically, many Canadian legislators are examining the experience that Australia has had with market-driven health care reforms. Originally, Australia looked to Canada for guidance based on Canada's pioneering experience with a public health care system.

Australia has had a different cultural perspective on health care all along. While private hospitals have been viewed historically with suspicion in Canada – justifiably so, since as late as 1920 they provided demonstrably poorer care – Australians have always been leery of “free” care. Historically, Australians considered it a sign of superior status to use a private hospital.

However, inequities in access and treatment convinced Australia of the need for a more comprehensive health care system, and public health insurance was introduced in 1974. The original program, called Medibank, was modeled directly after the Canadian system. As a result of doctors' opposition and a wary public, the program was adjusted to allow a hybrid of public and private care. Two parallel systems of public and private hospitals were created, allowing patients to jump from one to the other.

Physicians employed in public hospitals were placed on salary to control costs. They were also permitted to work outside the public system and were free to set their own fees when they did. As a result, specialists were able to maintain high incomes. Unlike Canadian hospitals, the patient in an Australian public hospital has no choice in the physician assigned to their care. If an Australian wants treatment by a specific specialist, private payment is required.

Since the early 1990s Australian state governments, in an effort to reduce costs, have gradually allowed for-profit health care corporations to take over public hospitals. Patients in the newly-privatized hospitals receive a range of services paid for by public funds. Not surprisingly, many companies jumped at the chance to take over public hospitals.

It is easy to see why Canadian advocates of market-driven health care reform would look to Australia. Historically, the two countries are similar in that some form of universal health coverage has been implemented in the recent past. But how successful has Australia's modern two-tier system delivered promised improvements in health care?

Evidence suggests the public system has suffered. Some governments have favoured the private system more than the public, resulting in a gradual reduction in funding.

But increased private hospital services have also meant longer waiting lists and bed shortages in the public system. Also, the private system tends to not perform as many high cost procedures as public hospitals. For example, most private hospitals lack emergency wards, leaving the public system to handle almost all emergency calls. Thus, the public system is left with a disproportionate share of critical cases – while the private system handles a greater proportion of easier cases. In turn, the more acute nature of cases in the public system further decreases the number of hospital beds available.

In addition, private hospitals find it far more profitable to handle patients with private insurance or those who can afford specialized services as opposed to more common procedures. Since the same physicians work in both systems, the public system suffers when physicians switch over to the private system to perform for-profit procedures. Not surprisingly, public waiting lists for most procedures have dramatically increased.

Despite such factors, it is also true that as the Australian public system improved in care and quality, the private system suffered when average Australians began to realize that they could receive comparable, or better, care in a public institution. Considering the innate Australian suspicion of public health care, this actually amounts to quite a strong endorsement of the public system.

As confidence in the public system increased, the proportion of the Australian population with private health insurance declined. In 1974 about 70% of Australians had private health insurance – today the figure stands at about 30%. Citizens who maintain private insurance tend to be those requiring greater care than has been the norm. Thus, revenues have plummeted in the insurance industry.

By 1998, private insurance companies and hospitals were facing a funding crisis in Australia. In response, the central government introduced extensive tax breaks and incentives for Australians to take out private insurance. It also conducted an expensive ad campaign to promote the private system. All of this resulted in reduced funding for public hospitals by state governments. In spite of all these measures, the proportion of Australians taking out private insurance has increased only marginally.

Many Australians are opposed to central government measures in support of private health care. Currently, the private system can only afford to operate because of a massive \$2.2 billion subsidy from the public purse. Evidence suggests that the money from the tax break alone, if redirected into the public system, would put an end to waiting lists.

Despite the size of the subsidy, the for-profit sector continues to lose money – and is looking for yet more funding from the government. In March of 2000 one of the country's largest health care companies, Health Care of Australia, sued a state government for \$10 million, claiming that public funding was not generous enough.

Dick Scotton, an Australian health economist and an architect of Medicare, says “efficiencies are always illusory. Governments think they will save money. But the private operators always bid low – then they threaten to go into bankruptcy and the contracts have to be restructured.”

## **New Zealand**

### *Competition reduces cooperation between health care professionals*

A recent headline in the British Medical Journal (May 2001) described the current round of New Zealand health care reforms as “Back to the Future” – a reference to the current government’s efforts to undo more than a decade of market-driven health care reforms. Rather than improve the system, the reforms have generally damaged health care and been unpopular with New Zealanders.

Historically, there have always been “two tiers” of medical care in New Zealand. General Practitioners operate as private businesses and, while heavily subsidized by government, can set their own fees. In 1938, all hospital in-patient treatment became publicly financed and was provided free of charge. The adoption of universal health insurance followed in 1947, opening the way to what was to become a primarily publicly-funded health care system.

To access subsidized New Zealand health care services a patient must present either a Community Services Card, with eligibility based on income, or a High Use Health Card, issued to those with a chronic illness who visit a physician more than 12 times a year. Under both plans the patient pays a reduced fee to the GP as well as a reduced amount for prescriptions from the community pharmacist (restricted to government approved medications).

In the late 1980s and early 1990s, New Zealand went through a health care “crisis” similar to the one now occurring in Canada. Public confidence declined with growing media coverage of waiting lists, poor management, deficits, inefficiency and deteriorating conditions in hospitals. The country’s 14 regionally elected health boards were under attack for failing to implement reforms and improve efficiency.

In 1993 the government of the day attempted to make the health care system more efficient by introducing a series of market-oriented and “competitive” measures. The assumption was that the application of business practices would radically improve the system.

The initial strategy was to separate the provision and purchase of services. Hospitals were converted to publicly-owned companies known as Crown health enterprises. As such, they were expected to operate under corporate legislation and earn a profit comparable to the private sector. Four appointed health boards were then to be charged with the purchase of services. Their goal was to encourage competition between publicly-funded health plans. However, the change would have meant competition for both the provision and purchase of services and, because of public opposition, the second component of the plan, the competition between publicly funded plans, was never implemented.

A startling admission on the overall impact of the reforms was contained in a 1996 briefing document for the minister of Crown health enterprises. “The health reforms have yet to yield the original expectations,” it said. “By a range of measures ... the pace of performance seems, if anything, to have weakened since the advent of the reforms.”

This was a telling statement, coming from the government that introduced the “reforms” and was strongly committed to a market-driven model of health care. Expected savings never materialized – indeed evidence suggests that deficits and costs rose, while service declined.

Even more revealing was a report from an inquiry into seven deaths at Christchurch Hospital in the winter of 1996, where it was noted by a treasury group monitoring the situation that staff and service reductions for “efficient gains . . . were aggressive.” The group cited a lack of cooperation between health care providers, who had been thrown into competition with each other, as a factor contributing to the tragedy.

“The model emphasized the production of service outputs, with too little attention to the quality of services and their effects on health outcomes,” it concluded. “Major inquiries into quality of care and patient safety argued (whether justifiably or not) that the quasi-market model contributed directly to specific instances of poor care.” (BMJ, May 2001). Plainly put – the emphasis on the bottom line adversely affected the service provided.

New Zealand also experienced a dramatic increase in the cost of collecting user fees. Administration costs soared. In turn, user fees rose so high that some patients refused to pay them, and the government was forced to reduce the rates in an attempt to raise the level fees paid.

In 1999, a new coalition government came to power in New Zealand, elected under the country’s proportional representation electoral model. Undoing the damage done to the health system was a priority. Crown health enterprises were stripped of their “for-profit” status and given a new name – “hospital and health services”. Regional health authorities were replaced by a single purchaser – the Health Funding Authority. (The purchaser-provider split remains for primary care, but this too is being reviewed.) Finally, there policy focus has shifted noticeably from “competition” to “cooperation.”

Perhaps the most interesting aspect of New Zealand’s return to public health care is an increased commitment to democratic process. The network of 14 original district health boards has been expanded to 21, with a strong emphasis on regional representation. At the same time, the central government has put a priority on upward. An effort is being made to remove regional disparities in health care and a new willingness on the part of the minister to intervene. Questions remain about the sustainability of the large number of district health authorities, but it is acknowledged that they have greatly enhanced the level of democratic participation in the debate over health care.

## **United Kingdom**

### *Increased waiting lists*

Health care in the United Kingdom is funded primarily by general tax revenue and administered by the National Health Service (NHS). Regional health services are funded by the NHS on the basis of population and other factors (such as age distribution and cost of living). The overall health budget is controlled by Parliament, where health care competes for funds with other national programs such as education and defence.

In 1989 a form of internal market process was introduced. There two primary changes in the NHS: 1) existing hospitals and community service providers were permitted to become self-governing (Trusts); and 2) general practitioners (GPs) were allowed to become individual purchasers of health services. The newly self-governing Trusts could negotiate funding on the basis of services provided and costs incurred. Similarly, individual GPs received a funding allocation to purchase services from providers in their region, including private (non-NHS) hospitals. Thus, a GP could refer a patient to a specific clinic based on the cost of the service.

After a lengthy period of government arm-twisting, several regional health bodies converted to Trusts. Hospitals in these regions, public and private, were forced as a result of the changes to compete with each other for the funding required to offer specific services (such as cancer therapy). The result was an immediate and dramatic increase in health care costs, plus waiting lists for elective surgery.

To deal with rising costs the Conservative government of the day introduced the Private Finance Initiative (PFI) of 1993. Trusts were required to look to partnerships with the private sector as a means of offering hospital services. The private sector would build hospitals and rent them back to the Trusts, while at the same time providing all non-clinical services (such as food and housekeeping). The Labour party resolutely opposed the PFI program while in opposition, but later embraced it after coming to power.

The PFI has not worked out as promised. Health care costs continue to rise dramatically, and the obvious explanation lies in the fact that it is usually more expensive to rent than to buy directly. The NHS is bypassing the lower interest rates available to the government in favour of much higher rates negotiated by private operators. Moreover, there is the obvious cost of the mandatory profit required by private investors. And at the end of the day, the NHS does not own the hospital and may in fact lose its costly investment when contracts expire – or be held hostage to the threat of private institutions closing.

The other result of the PFI has been a decline in the size of new institutions built to replace older facilities. Regional Trusts face a situation in which the NHS will not fund renovations to existing facilities or build new hospitals with direct government funding. Thus, to meet the needs of the population, they are largely forced into PFI arrangements. But, with PFI interests that run 5-10% higher, and the demand of shareholders for profits, the inevitable result is smaller facilities with fewer services.

Because of this, regional health boards have been forced to sign lengthy (up to 30 years) and expensive contracts with private firms to acquire sorely needed facilities.

Also, there is the fact that renovation of existing hospitals produces less return on investment than the construction of new facilities. Thus, many existing hospitals are being closed in favour of new facilities. In some cases, private companies have acquired ownership of downtown public hospital properties, built new facilities elsewhere and then sold the original site for private gain. In other cases, where older facilities have been replaced with smaller ones, Trusts have allowed private companies to use the remainder of the land for private enterprises such as shopping malls.

The most dramatic impact of the PFI process has been a reduction in beds and hospital personnel. A report prepared by the British Medical Association examined the first 14 hospitals built under the PFI. It found that:

- 3,700 hospital beds were closed;
- 26% of beds were closed in English Trusts and 30% in Scottish Trusts;
- clinical staff budgets were cut 25%.

Even these figures masked the extent of the crisis for some regions. A study published in the British Medical Journal reported that available beds in privately-funded hospitals will decline by a further 31%. In South Manchester and Worcester this figure will be closer to 40% and it will rise as high as 50% in Durham's Dryburn Hospital.

Not surprisingly, public confidence in the system has declined steadily and is further exacerbated by secrecy and poor public consultation. In response to public pressure, and an eye on the next election, the Labour government has now embarked upon a costly effort to begin rebuilding the battered health care system.

The most recent U.K. budget included massive public investment in health care, accompanied by increased taxation. More than 80,000 health care practitioners are to be hired over the next six years. Yet, private health care is expected to increase further, in the guise of an improved choice. The government appears to have given up pretending that private health care will be cheaper and has simply resigned itself to paying the piper.

## Sweden

### *For the first time ever - two-tiers of care*

Sweden's first public hospital was established in 1752, an indication of how deep the commitment runs in this Scandinavian country to a public health care system. As early as 1765 the Diet of Sweden's four Estates established a means to collect resources and erect a local hospital.

Historically, public health care has been the norm in Sweden. Although it was initially heavily centralized, much of the system was transferred to county control in 1862 when county council administrative units were established to act as a secondary level of local government and were given the ability to tax residents. Subsequently, the responsibility for health care shifted gradually from the central government to these local bodies.

The *Hospital Act* of 1928 gave legal responsibility for overseeing hospitals to county councils. While a number of responsibilities were excluded, such as out-patient and psychiatric care, by 1967 counties had full responsibility for all hospital care. The system included a minimal level of private ambulatory care with some physicians working out of their own offices or in the hospital. In 1946 the *National Health Insurance Act* (providing universal coverage, prescription medication, physicians and sickness compensation) was passed by Parliament. It was implemented in 1955.

Similar to most of the developed world, the Swedish health care system underwent rapid expansion in the 1960s and 1970s. Most of the resources went into institutionally-based care. It is important to note that the Swedish health care system has historically been very much based in hospitals.

As part of the "seven crown reform" of 1970, county councils assumed control over hospital out-patient services. Patients were to pay the council "seven crowns" (at the time) for each out-patient visit and the remainder of the costs were then reimbursed by the national health insurance program. This was seen as a means to dramatically reduce the costs of ambulatory health care for low-income Swedes. It also resulted in physicians, in hospital out-patient departments, becoming paid employees of the county council and no longer being allowed to use public institutions for their private patients.

Another significant factor in the development of the Swedish system was the nationalization of the retail drug industry in 1971. The National Corporation of Pharmacies is a state-owned company that dispenses medication under the health insurance program. The majority of the cost for medication is publicly covered with a small contribution from the individual.

The Swedish health care system is quite inclusive and generous by international standards. The National Social Insurance Board is compulsory and is centralized at the national level. Insurance covers such things as primary medical services, prescribed medication, dental care, and income loss due to illness. Some of these services, for example, medication and dental care, require some co-payment by the patient.

Coverage extended to loss of income due to illness is an important component of the Swedish system – and represents a considerable proportion of health care costs. It is

legally mandated that employers pay an employee's wages from the second to 14<sup>th</sup> day of an illness. Beyond this the national health insurance program covers 75% of the individual's income during sick leave. The insurance program is funded by employers, public and private, who contribute an amount equal to 5.28% of each employee's salary.

The social insurance system funds about 72% of the total health care expenses and federal grants from a progressive national taxation system, comprise about 11.2%. Of the remainder, 3.5% is made up of out of pocket payments from consumers. The remainder of a council's budget often comes from other county councils. Those reporting surpluses reallocate funds to those experiencing shortfalls. Intended as a means to equalize treatment across the nation, this system sometimes means that one region ends up heavily subsidizing others. For example, for Stockholm, the largest and richest region in Sweden, the subsidy amounts to roughly 4 billion Swedish crowns (\$615 million Cdn) a year.

Swedish health care has gone through many of the same crises as experienced by other countries in the developed world. Costs escalated at the same time as international financial pressures were exerted on national governments to reduce debts and deficits. Budgetary restraints were placed on the health care sector and funding declined at about 1.5% per year between 1992 and 1997. Predictably, this resulted increased waiting lists and bed shortages, and a growing sense of discontent among the citizens of Sweden, Stockholm in particular.

One of the largest demands on the Swedish health care system is the cost of people off work on sick allowance. When the number of workers retiring as a consequence of disability is added to the calculation, the cost totals roughly, 120 billion Swedish crowns (\$8.5 billion Cdn) a year.

The current situation in the Stockholm area provides important insights into the status of Swedish health care reforms. Since 1998 a conservative majority among county and local authorities has pushed the country in the direction of health care privatisation and the sale of public health assets. This has been met by strong public opposition from much of the trade union movement, and most of the citizens of Stockholm.

Conservatives see the health care experiment in the region as politically advantageous to them and they have invested more in the private system than the public as a means to gain this end. Every effort to guarantee the success of privatisation and to mute opposition has been taken. For example, the monthly salary for a registered nurse has risen from 21,000 crowns per month (\$3,230 Cdn) to 24,000 crowns (\$3,700 Cdn). The result is that, almost from the start, the move toward private care has been more costly, and driven in part by political expediency.

Currently, nearly 20% of all regional health care is provided by the private sector. About 40% of open clinics are privately run, mostly by individual doctors, but there are other forms of co-operatives as well. Given the small scale of the experiment and the short time span, it is difficult to reach definitive conclusions, although some initial figures are coming in.

One of the criticisms frequently made of the Swedish health care model is that it has rigid policies regarding handling of staff and a very hierarchical structure. The privatization experiment appears to have exacerbated these factors. Local Authorities,

which purchase services from private clinics, are now involved in nearly 140 such contracts between buyers and suppliers of health care services. While local and regional governments still retain overall responsibility, they must put services up for tender every three years. This has meant both a dramatic increase in bureaucracy and has resulted in only large health care companies applying for the contracts.

A relatively new phenomenon has also developed in Sweden – the growth of private health insurance schemes. It involves mainly large companies providing insurance for their employees. Between 120,000 and 140,000 individuals are currently covered by such schemes, the majority young or middle-aged men in the mid-to-higher executive sectors of industry. This has created a “fast lane” in the Swedish health care system for those with better incomes, and the public has become increasingly uncomfortable with the introduction of such obvious inequities based on income.

The quality of care remains, for the most part, quite high. But some cracks in the provision of some services, as a consequence of the introduction of private hospitals and clinics, have started to appear. Reacting to problems with emergency room services provided by private hospitals, the national government has legislated that emergency services cannot be privatized.

Waiting lists in the Stockholm region have also increased, rather than decreased, with the introduction of private care. In the 2002 budget the national government added 3.75 billion Swedish Crowns (\$575 million Cdn) in an effort to cut waiting lists for treatment, but the regional government does not get access to the money until it has created schemes to achieve cuts in waiting times.

Furthermore, the predicted savings from privatization have not appeared. It is an election year and the Conservatives on a national level are using the Stockholm experiment as a platform in their campaign. But evidence showing how financially unsustainable market measures are is beginning to come to light. In the last year alone, the Conservative majority in Stockholm ran a deficit of almost 4.2 billion Swedish crowns (\$650 million Cdn). Deficits over the last four years have averaged about 2 billion Swedish Crowns (over \$300 million Cdn). Regional auditors are having difficulty getting accurate figures and are in the process of trying to take the Local Authority to court. Most analysts think that this growing debt is overwhelmingly caused by the introduction of market influences.

## **United States of America**

### *Unequal access to care*

In Canada people debate the merits of one-tier versus two-tier medical services. Many find the discussion and arguments a little confusing. But contrast this to the U.S. where commentators regularly refer to as many as 10 tiers of health care. A dizzying hodge-podge of services and funding schemes are available – most of which have been proven to be less efficient, more costly and of poorer quality than those in Canada.

The fundamental difference between the American and Canadian systems is that medical services are considered a commodity in the U.S. and not a social service. Individuals must arrange their own health care. The government only steps in when certain individuals – the elderly, disabled and extremely poor – are deemed unable to provide adequately for their own health care needs.

The U.S. government covers health care expenses for the elderly and people with disabilities through a program called Medicare. Citizens living in poverty are covered by another plan called Medicaid. But these programs do not cover everyone in these groups. For example, only 40% of people with incomes below the poverty line qualify for Medicaid. All other U.S. citizens must negotiate employer-sponsored health insurance, purchase it personally, or go without any coverage at all.

Essentially, there are four tiers of health care in the U.S. – Medicare, Medicaid, insured and uninsured. Beyond this, there are variations in coverage offered by for-profit insurance companies, regional and state variations and annual changes. Hospitals, and other health care institutions include voluntary non-profit (55%) facilities, public (27%), federal (5%) and for-profit (13%). Meanwhile, the cornerstone of the Canadian health care system, the general practitioner or family physician, is largely unknown to most U.S. citizens, who rely much more directly on specialists.

Among a significant proportion of the American people there has been a longstanding desire to introduce some form of compulsory insurance system that would cover the entire population. An initial proposal was debated in 1910, and over the years President Harry Truman (in the 1940s), Senator Ted Kennedy (in the 1970s) and President Bill Clinton (in the 1990s) have all attempted to introduce a universal system of coverage. Unfortunately, a wealthy and powerful counter-lobby, spearheaded largely by the insurance industry, has successfully opposed all such attempts.

Medicaid and Medicare programs were introduced in response to the civil rights movement and various consumer advocacy organizations in the 1960s. In general, the business community was strongly opposed and, as a result, the corresponding national standards are weak and open to interpretation. This has meant that coverage can vary widely between states. Conservative governments, in Texas, for example, have adopted highly restrictive programs while more liberal administrations in states such as Hawaii have taken a much more inclusive approach.

During the 1970s, as health care costs began to increase, employers and the insurance industry looked for measures to reduce costs. The most popular solution was “managed care,” a concept that relies on health maintenance organizations (HMOs). Physicians

working in an HMO are usually paid a salary or given a fixed sum per patient instead of fee-for-service remuneration. The Clinton health care reform proposals called for a system that would combine a nationwide program of managed care with compulsory health insurance, while still keeping for-profit hospitals, HMOs and so on. Despite a high degree of public support, it went down to defeat at the hands of a powerful insurance lobby.

The amount of information on the U.S. health care system is overwhelming to say the least. Interestingly, not much of it is positive. The New England Journal of Medicine has noted that the U.S. system is more costly than Canada's, provides less coverage, offers poorer services and is declining in quality. A couple of examples make the point:

- The U.S. spends far more than Canada or Europe on health care. American health care spending amounts to more than 13% of the U.S. Gross Domestic Product (GDP) compared to 9% in Canada. This works out to \$3,701US per person versus \$2,050US per person in Canada. Worse, this discrepancy exists despite the fact that 40 million Americans have either no health insurance coverage, or inadequate coverage – fully 15% of the U.S. population.
- Studies of public perception of for-profit medicine have repeatedly found that patients are happier with non-profit health providers. A recent study in the New England Journal of Medicine found that patients of non-profit HMOs felt that they had fewer unmet needs, fewer barriers to care, more resources devoted to their care and higher satisfaction levels than those of for-profit HMOs.

There is evidence suggesting that emergency room services in the US are probably the best in the world. The U.S. also has some of the best medical specialists and best equipped hospitals in the world – for those that can pay. But the overwhelming majority of health care services provided in the U.S. are of poorer quality than those in Canada and Europe. All indicators bear this out – for example:

- life expectancy in Canada is two years longer;
- infant mortality is 25% lower in Canada;
- the death rate for patients with kidney disease is 47% higher in the U.S. (where treatment is almost entirely private) than Canada, and Canadians are twice as likely (35% to 17%) to receive a kidney transplant.
- death rates for cardiac and cancer patients are lower in Canada; and
- Seniors in Canada receive more health care than publicly-covered U.S. seniors.

## **Singapore**

### *Inefficient duplication of services*

Until 1985 the health system in Singapore was modeled after the United Kingdom. Health care was funded through taxes and provided by way of publicly administered and operated facilities. Although small, Singapore has an extremely high standard of living with a well-developed national infrastructure.

In 1985, following a period of extensive lobbying by the business community, the government decided to introduce market-driven health care changes to control costs and to make the system more “efficient”.

A system of medical savings accounts (MSAs) was implemented as an initial step. Workers put 6-8% of their wages in a medical savings account (Medisave) to cover in-patient hospital and expensive out-patient procedures. Since the Medisave account system is insufficient to cover all hospital services, the government also introduced a “catastrophic” insurance program (to protect against medical catastrophes).

To ensure universal access to basic health services the government established three classes of hospital wards – A, B and C. Ward classes B and C are heavily subsidized by the state, with patients paying modest or nominal amounts.

Soon after the introduction of the Medisave program health costs rose rapidly. In an attempt to control expenses the government introduced market competition between public and private hospitals. This experiment was largely a failure and the government turned to regulation and planning as a means to get control of the situation.

Contrary to basic economic theory, the private health care system did not attempt to compete with public institutions by lowering prices. Instead, it invested heavily in technology and expensive services, and began recruiting medical “stars” by offering high wage packages. This resulted in a migration of skilled medical personnel to the private system, and in turn forced the public system to dramatically increase compensation in an effort to retain and recruit physicians. Health costs escalated and waiting lists increased at the public institutions. In addition, the health care system became burdened with widespread duplication of high tech equipment and specialty services. For example, there are seven in-vitro fertilization clinics in Singapore for a population of 3.3 million people. The government has acknowledged recently that the health care system is an example of “market failure” because it does not respond to accepted marketplace rules.

Harvard health economist William Hsiao, in an extensive study of the Singapore experience, concluded that “Singapore’s decade-long experience shows that its MSAs neither reduced nor controlled health care cost inflation. Instead, cost inflation rates increased....”

## Health Care As An Example Of “Market Failure”

The examples cited in this analysis all indicate that the growing role of market forces in health care leads to higher costs and lower quality of care. Why is this the case? The advocates of privatization argue that the same market processes that work for fast food or computers will make health care more efficient, cost effective and innovative. But this obviously is not the case.

An overwhelming majority of health policy researchers and analysts consider health care an example of “market failure,” meaning that normal market forces do not apply. Kevin Taft and Gillian Steward of the Parkland Institute (University of Alberta) have identified six ways in which a market model fails in health care: 1) imbalance of knowledge; 2) access to health care; 3) difficulties in shopping around; 4) fundamentally, health care is built on trust; 5) overbuilt capacity and inefficiencies; and 6) increased regulation.

### 1 Imbalance of knowledge

The array of professionals operating in the health care sector is almost dizzying. There are physicians, nurses, physiotherapists, lab technicians, and cardiologists – to name just a few of the disciplines in the health care system. All of these professions require some post-secondary education. Medicine requires a level of expertise that is quite simply beyond what the majority of Canadians possess.

This means that there is a large imbalance of knowledge between most patients and physicians. Indeed, most people want their physician to be highly educated and knowledgeable about medical procedures and conditions – that’s why we go to them! But it also means that most of us are unable to adequately evaluate or choose between the alternative treatment options offered.

Unlike purchasing a consumer good, where the purchaser can choose an item on the basis of look, taste, cost or utility, a medical treatment does not easily allow such comparative shopping.

Dr. Arnold Relman, editor-in-chief of the New England Journal of Medicine, sums it up this way in Taft and Steward:

*Unlike the independent shoppers envisioned by market theory, sick and worried patients cannot adequately look after their own interests, nor do they usually want to. Personal medical services do not come in standardized packages and in different grades for the consumer’s comparison and selection. Moreover, a sick patient often does not have the option of deferring his purchase of medical care or shopping around for the best buy.*

### 2 Access to the health care system

The gatekeepers to the system are primarily doctors – occasionally nurses or other health care professionals. Patients cannot order their own lab tests, self-refer to a

specialist, admit themselves to hospital or book their own surgery. A physician acts as a personal health adviser and advocate. Physicians provide a service and they control the purchase of other services. They are on both sides of the market equation.

Most Canadians accept this as reasonable. There is some debate about expanding the role of nurse practitioners to allow them to engage in some of these tasks traditionally performed by physicians – but the gatekeeping function stands. This model is intended to protect public health by ensuring that people do not take unnecessary or potentially harmful medication. It also guarantees that resources are not diverted to costly tests and procedures that are not needed by the patient.

But it requires physicians to operate under a moral imperative and not from a profit-making motive. Medication, referrals, surgery and other treatment options should be prescribed for a patient in the best interests of their health and not as a means of increasing profitability. “Would you like fries with that?” may be an acceptable way to increase consumer demand in a fast food restaurant, but patients do not want to be prescribed medications they don’t need.

### **3 Difficulties with shopping around**

Taking a car for a test drive before purchasing it makes sense. Collecting specification charts for a number of televisions prior to making a decision is smart shopping. Usually, within a specified period of time, a consumer good can be returned if it doesn’t work or breaks. Medical treatments are obviously not amenable to these kinds of consumer checks and balances.

It makes no sense to test drive heart surgery, for example. Treatments also differ widely and are difficult to compare. There is no way to return a cancer treatment or ask for your money back?

### **4 Fundamentally, health care is built on trust**

Imagine that a loved one is in a car accident and rushed to hospital – a familiar fear for most people. The emergency room physician explains the injuries and the proposed surgery needed. There is a fundamental trust that the doctor in charge will be honest and upfront in rendering a diagnosis. No one has time to consider cheaper alternatives elsewhere, or to bargain for a reduced rate.

It is vital that the doctor-patient relationship is based on what is necessary and critical to the health of the patient, free of market motives. This is an ideal adhered to by all medical associations and schools of medicine or nursing.

But it must be remembered that because people become doctors or nurses, they do not exist apart from the rest of humanity. Placed in a for-profit system they will eventually behave in a manner dictated to them by the logic of the market. All research indicates that when the profit motive is introduced into health care, physicians will act in a manner that increases profitability – expensive treatments, unnecessary visits, giving less attention to poor or uninsured patients. This is not a question of personal motivation, but a direct result of the market pressures placed on them. Unlike selling fast food or cars it

is more efficient and cost-effective to remove these market pressures from health care practitioners.

## **5 Overbuilt capacity and inefficiencies**

All proponents of market forces in health care argue that the private sector is inherently more efficient and that competition will drive the cost of services down. In some instances this may be true, but the overwhelming evidence is that for-profit and private care actually raises costs and results in duplication of equipment, services and providers – in short, inefficiency.

This is largely a consequence of the factors previously mentioned that make health care an example of market failure. When they seek out health care, people want the most knowledgeable practitioners and up-to-date equipment, are limited in their ability to comparison shop and depend upon and trust their physician. Most importantly, ill people want to get better as soon as possible – a desire that sometimes does not lend itself to cost-cutting or half-measures. This means that the competition between health care service providers, public and private, is based more on the “star” power of their physicians and the latest equipment than lower cost. It is easy for health care providers to over-sell a service, inflate prices and hide inefficiencies in the system.

Some argue that having too many services available is a benefit to the patient. They point to waiting lists and suggest that these would decline if people were simply allowed to step outside the public system queue and enter the private sector. But, as we have seen, the public system suffers as a consequence of the competition for prominent physicians and the latest technology. The cost of keeping the public system on a par with the private system drastically increases the fiscal pressures they are already under. In addition, the private system tends to prefer the easily treatable, most profitable cases and will engage in extensive screening procedures. This results in the public system dealing with patients who need more complicated, intensive and costly care.

By all accounts this is not an efficient or cost-effective way to provide health care.

## **6 Increased Regulation**

An overlooked source of cost in the introduction of market reforms into health care is the increased need for regulation. A publicly-funded and directed system can operate with a relatively small amount of regulatory management as one set of policy directives, focused narrowly on providing care, is equally implemented across a jurisdiction. When there are a multitude of service providers operating under a variety of funding schemes, the need for regulation and administration increases. The United States, for example, has legislation against private hospitals refusing to treat emergency patients and sending them to public institutions. This sort of legislation, its enforcement and the associated legal costs are all unnecessary under a wholly public system.

This has been the experience in New Zealand, the United Kingdom and the United States. An article in the British Medical Journal on the experience in New Zealand concluded that “continual restructuring is costly and disruptive.” (May 2001). The experience with a mixed care system in the United Kingdom also result in problems. As

noted by Taft and Steward, “Unleashing the wild and power of everyone looking out for his or her own interests is so dangerous in medicine, and there are so many ways not to compete on price or efficiency, that rules upon rules have to be written and enforced.”

In the United States the growth of the bureaucracy is nothing short of astounding. There has been an increase of 149% in nurses working in the U.S. since 1970. The number of physicians and other clinical experts has increased by approximately 250% in the same period. But these increases are absolutely dwarfed by the increase in the number of hospital administrators. Between 1970 and 1998 the number of health administrators in the United States increased by 2,348%!

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*Appendix 1*

***Physicians for a National  
Health Program (United States)***

*International Health Systems*

*Last Updated Spring 2001*





*International Health Systems*

Learning about other health care systems in the world not only expands our knowledge and understanding of them; it also helps us discover new perspectives on how to improve upon our own. Health care systems in the Organization for Economic Cooperation and Development (OECD) countries primarily reflect three types of programs.

- In a **single-payer national health insurance system**, as demonstrated by Canada, Denmark, Norway, and Sweden, health insurance is publicly administered and most physicians are in private practice.
- Great Britain and Spain are among the OECD countries with **national health services**, in which salaried physicians predominate and hospitals are publicly owned and operated.
- **Highly regulated, universal, multi-payer health insurance systems** are illustrated by countries like Germany and France, which have universal health insurance via sickness funds. The sickness funds pay physicians and hospitals uniform rates that are negotiated annually (also known as an "all-payer" system).

The OECD regularly publishes a CD-ROM with 10+ years of comparative data for those interested in pursuing further research. It is available on the OECD website at [www.oecd.org](http://www.oecd.org)

The [European Observatory on Health Care Systems](#) supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

Links to [Government Departments and Ministries of Health in the European Union](#)

[Europe's Cheaper Rx for Health](#) by LA Times staff writers John-Thor Dahlburg and Richard Boudreaux



**AUSTRALIA**

Australia's population size of 19 million people is roughly the same as that of Texas. Its infant mortality rate is 5 per 1,000 live births, and life expectancy at birth is 75.9 years for men and 81.5 years for women. In 1941, the beginnings of Australia's universal health care system emerged. Australia spends 8.5% of its GDP on health care, and its 1998 per capita expense was \$2,043-US.

The government administers the compulsory national health insurance program (Medicare). National health insurance is funded by a mixture of general tax revenue, a 1.5% levy on taxable income (which accounts for 18.5% of federal outlays on health), state revenue, and fees paid by patients. The government funds 68% of health expenditures (45% federal and 23% state) and has control over hospital benefits, pharmaceuticals, and medical services. States are charged with operating public hospitals and regulating all hospitals, nursing homes, and community based general services. Additionally, the states pay for the public hospitals with federal government assistance negotiated via five yearly agreements. Mainly not-for-profit mutual insurers (private insurance) cover the gap between Medicare benefits and schedule fees for inpatient services. Private insurance covers 1/3 of the population and accounts for 11% of health expenditures.

Patients are free to choose their GP. Primary care physicians act as gatekeepers, and physicians are generally reimbursed by a fee-for-service system. The government sets the fee schedules, but physicians are free to charge above the scheduled fee or they may directly bill the government when there is no patient charge. Prescription pharmaceuticals have a patient co-payment, and out-of-pocket payments account for 19% of health expenditures. Physicians in public outpatient hospitals are either salaried or paid on a per-session basis.



## AUSTRIA

Austria is home to 7.6 million people, approximately the same number that live in North Carolina. The country has universal access to health care through a compulsory system of social insurance. A system of private insurance also exists. About 8.2% of Austria's GDP is spent on health care, and the 1998 per capita expense was \$1,968-US.

Private doctors with contracts to the social insurance funds are paid on a fee-for-service system with expenditure limits based on the case and per doctor per pay period. Hospital physicians are salaried. Approximately 50% of the health expenditures are funded by progressive payroll taxes, 25% are financed by non-specific taxes, and the rest is funded directly out-of-pocket or through private insurance companies. The contributions to the health insurance funds (payroll taxes) are split between employers and employees on a parity basis.

Patients are free to choose their physicians, as long as the physician has a contract with the insurer. Benefits and prices of services are fixed in agreements between representatives of the insured and representatives of the providers. All medical and nursing education is free. The infant mortality rate in Austria is 4.9

per 1,000 live births, and life expectancy at birth is at 74.7 years for men and 80.9 years for women.



## BELGIUM

Belgium is home to about 10.2 million people, almost the same number of people who live in the state of Ohio. Its infant mortality rate is 6 per 1,000 live births, and its life expectancy at birth is 74.8 years for men and 81.1 years for women. Today, Belgium spends 8.8% of its GDP on health care, and the 1998 per capita expense was \$2,081-US.

The health care system is funded primarily through sickness funds. Belgium's health insurance program operates at four distinct levels: the central government, national associations, federations of local societies, and local mutual aid societies. The general attitude in Belgium is that the pluralism of the health insurance system stimulates each local fund to work hard to attract and satisfy its members.

Patients have their free choice of any doctor. Primary care physicians are paid via fee-for-service, directly from the patient, or partially reimbursed, except with low-income patients who are exempt. They are reimbursed with a negotiated fee, but extra billing is allowed. Specialists are paid via fee-for-service and are not restricted to hospitals.



## CANADA

Canada's population size of 30.5 million people is roughly the same as that of California. Its infant mortality rate is 5.5 per 1,000 live births, and its life expectancy at birth is 75.8 years for men and 81.4 years for women. National health insurance had been discussed in Canada at the federal level since 1919, but no real action was taken until 1944. Today, Canada's health system is characterized by single-payer national health insurance, and the federal government requires that insurance cover "all medically necessary services." Canada spends 9.5% of GDP towards health care, and the 1998 per capita expense was \$2,312-US.

National health insurance (Medicare) is a public program administered by the provinces and overseen by the federal government. Medicare is funded by general tax revenues. Federal contributions are tied to population and provincial economic conditions, and provinces pay the remainder. Medicare accounts for 72% of health expenditures. In addition, the majority of Canadians have supplemental private insurance coverage through group plans, which extends the

range of insured services, such as dental care, rehabilitation, prescription drugs, and private care nursing. The private sector (private insurance and out-of-pocket payments) accounts for 28% of health expenditures.

Most physicians in Canada are in private practice and accept fee-for-service Medicare payment rates set by the government. Provincial medical associations negotiate insured fee-for-service schedules with provincial health ministries. Some physicians set their own rates but are not reimbursed by the public system. Hospitals are mainly non-profit and operate under global institution-specific or regional budgets with some fee-for-service payment. Less than 5% of all Canadian hospitals are privately owned.



### FINLAND

Finland has a population size of 5 million people, which is about the same number of people who live in the state of Maryland. Finland has an infant mortality rate of 4.2 per 1,000 live births and its life expectancy at birth is 73.5 years for men and 80.6 years for women. The country spends 6.9% of GDP on health care, and its 1998 per capita expense was \$1,502-US. In 1964, national health insurance was enacted in Finland.

The Finnish health system is primarily funded (80%) by general tax revenues collected by the local and national governments. The basic administrative levels in Finland are divided into communes and municipalities. The local authorities in Finland number 445, averaging about 10,000 people each.

GP's practice mostly in health centers. They are salaried, but many are paid fee-for-service for overtime. Hospital physicians, who must be specialists, are salaried.



### DENMARK

Denmark, a small country, is home to 5.3 million people - the same number as in the state of Wisconsin. Its infant mortality rate is 4.7 per 1,000 live births, and its life expectancy at birth is 73.7 years for men and 78.6 years for women.

Denmark has had a single-payer national health system since 1961.

Approximately 8.3% of GDP is spent on health care, and the 1998 per capita expense was \$2,133-US.

The Danish health care system is funded by progressive income taxes, and is publicly administered. Hospitals are run by the 14 counties and the City of Copenhagen. Physicians who work with the hospitals receive salaries, which are determined by negotiation between government and doctor's unions. GP's are

40% per capita fee, and 60% fee-for-service. Specialists are mostly fee-for-service. All medical and nursing education is free.

There is strong incentive for patients to choose a GP in their immediate area of residence. GP's will then make referrals to specialists. There are no co-pays for physician or hospital care, but patients do pay a share of drug costs - usually between 25 and 50%. Private insurance, held by approximately 27% of the population, is used mainly for medications and dental expenses.



France has a population close to that of the entire Midwest - 60.9 million people. France has an infant mortality rate of 4.7 per 1,000 live births and a life expectancy at birth of 74.6 years for men and 82.2 years for women. The country has had a national health insurance system since 1928, but universal coverage did not occur until 1978. Approximately 9.6% of France's GDP is spent on health care, and its 1998 per capita expense was \$2,077-US.

The French health care system is primarily funded by Sickness Insurance Funds (SIF's), which are autonomous, not-for-profit, government-regulated bodies with national headquarters and regional networks. They are financed by compulsory payroll contributions (13% of wage), of employers (70% of contributions) and employees (30% of contributions). SIF's cover 99% of the population and account for 75% of health expenditures. The 3 main SIF's

(CNAMTS, MSA, and CANAM) cover about 95% of the population, and the remaining 5% of the insured population are covered under 11 smaller schemes. The remainder of health expenditures is covered by the central government, by patients' out-of-pocket payments, and by Mutual Insurance Funds (MIF's), which provide supplemental and voluntary private insurance to cover cost-sharing arrangements and extra billings. MIF's cover 80% of the population and account for 6% of health expenditures. The major public authority in the French health system is the Ministry of Health. Below this are 21 regional health offices that regulate each of the 95 provinces.

Patients are free to choose their providers and have no limits on the number of services covered. GP's have no formal gatekeeper function. Private physicians are paid on a fee-for-service basis and patients subsequently receive partial or full reimbursement from their health insurance funds. The average charge for an office visit to a GP and a specialist are \$18 and \$25, respectively. Private hospitals are profit-making and non-profit making, usually with fee-for-service physicians. Public hospitals employ salaried physicians, who make up 1/3 of all GP's in France. All medical and nursing education is free.



## GERMANY

Germany is home to approximately 82 million people, nearly 1/3 of the U.S. population. Germany's infant mortality rate is 4.7 per 1,000 live births, and its life expectancy at birth is 74.5 years for men and 80.5 years for women. In 1883, Germany was the first country to establish the foundations of a national health insurance system and has since gradually expanded coverage to over 92% of the population. Today, Germany spends 10.6% of its GDP on health care, and the 1998 per capita expense was \$2,424-US.

Everyone in Germany is eligible for health insurance, and individuals above a determined income level have the right to obtain private coverage. The German health care system is predominantly characterized by Sickness Insurance Funds (SIF's), which are funded by compulsory payroll contributions (14% of wage), equally shared by employers and employees. SIF's cover 92% of the population and account for 81% of health expenditures. The rest of the population (the affluent, self-employed, and civil servants) is covered by private insurance, which is based on voluntary, individual contributions. Private insurance accounts for 8% of health expenditures.

GP's have no formal gatekeeper function. Private physicians, over half of which are specialists, are paid on a fee-for-service basis. Representatives of the sickness funds negotiate with the regional associations of physicians to determine aggregate payments. Physicians who work in hospitals are full-time salaried specialists, whose work is entirely devoted to in-patients. All medical and nursing education is free.



## JAPAN

Japan has a population of 122 million people, nearly half that of the United States. The infant mortality rate in Japan is 3.6 per 1,000 live births, and life expectancy at birth is at 77.2 years for men and 84 years for women. Approximately 7.6% of GDP is spent on health care, and the 1998 per capita expense was \$1,822-US. Japan's current system of universal health care was initiated in 1958.

The Employee's Health Insurance System is financed by compulsory payroll contributions (8% of wage), equally shared by employers and employees, and covers employees and their dependents. The National Health Insurance System covers the self-employed, pensioners, their dependents, and members of the same occupation. The local governments act as insurers, and premiums are calculated on the basis of income, the number of individuals in the insured household, and assets. Premiums account for 57% of health expenditures. The

federal government contributes 24% to medical care expenditures and local governments contribute 7%.

About 80% of hospitals and 94% of private clinics are privately owned and operated. While some public not-for-profit hospitals exist, investor-owned for-profit hospitals are prohibited in Japan. Patients are free to choose their ambulatory care physicians, who are reimbursed on the basis of a negotiated, uniform fee-for-service schedule. Physicians have no formal gatekeeper function. Due to the combination of medical and pharmaceutical practices a large part of a physician's income is derived from prescriptions. Hospital physicians have fixed salaries.



## NETHERLANDS

The Netherlands has a population of 15.8 million, which is approximately the same number of people who live in the state of Florida. In 1997, 72% of the population had government-assured health insurance coverage. The infant mortality rate is 5.2 per 1,000 live births and life expectancy is at 75.2 years for men and 80.7 years for women. The Netherlands spend 8.6% of its GDP on health care, and the 1998 per capita expense was \$2,070-US.

The health care system in the Netherlands is very similar to that in Belgium; health care is primarily financed by employer-employee social insurance. Health care is provided by private not-for-profit institutions, and the compulsory health insurance system is financed through sickness funds. 70% of the population is in the public health care system. 30% of the population (mostly civil servants and high-income groups) has private insurance, because they are not eligible for social health insurance. There are currently plans to convert the entire system to a tax-based one.

Most primary care physicians are in a solo office practice (54%) or practice in small groups. Reimbursement is by capitation for "public patients" (2/3) and via fee-for-service (1/3). Specialists are salaried and are restricted to hospitals.



## NEW ZEALAND

New Zealand has a population size close to that of Atlanta, Georgia - 3.5 million people. In 1941, it achieved universal coverage and was the first country with a free-market economy to do so. Radical health sector restructuring occurred in

1993, which introduced a set of market-oriented ideas. However, the new system performed poorly and was thus restructured 3 years later. Today, New Zealand spends 8.1% of its GDP on health care and the 1998 per capita expense was \$1,424-U.S. The infant mortality rate is 6.8 per 1,000 live births and life expectancy is at 75.2 years for men and 80.4 years for men.

The health system is funded through taxation and administered by a national purchasing agent, the Health Funding Authority (HFA). Health care is provided by 23 hospital provider organizations (Hospital and Health Services), GP's (most of whom are grouped as Independent Practitioner Associations, IPA's), and other noncrown providers of child care, disability support services, etc. These parties compete for the provision of health services. Public funding accounts for 76% of health expenditures. Complementary, non-profit, private insurance, on the other hand, covers about 1/3 of the population and accounts for 7% of health expenditures. It is most commonly used to cover cost-sharing requirements, elective surgery in private hospitals, and specialist outpatient consultations. New Zealand's government is a purchaser and provider of health care and retains the responsibility for legislation and general policy matters.

Health care is free for children, and all patients have their free choice of GP. Out-of-pocket payments account for 17% of health expenditures. GP's act as gatekeepers and are independent, self-employed providers. They are paid via fee-for-service, partial government subsidy, and negotiated contracts with HFA through IPA's. The payment system is currently moving from fee-for-service to capitation. Private insurance and out-of-pocket contributions pay the remainder. Hospitals are mostly semiautonomous, government-owned companies that contract with the HFA. Specialists are commonly salaried, but may supplement their salaries through treatment of private patients.



Norway is home to approximately 4.4 million people, about the same number that live in Washington DC. Norway has had a single-payer national health insurance system since 1966. The National Insurance Act guaranteed citizens universal access to all forms of medical care. Norway's health system is funded by progressive income tax, and from block grants from central government, with 8.9% of GDP being spent on health care, and in 1998 the per capita expense was \$2,425-US.

Patients are free to choose their own physician and hospital, however, registration with local GP's who act as gatekeeper, will begin in 2001. Patients

are responsible for co-pays for some physician visits, approximately \$15. Patients are also responsible for co-pays for prescription drugs, up to \$216 per year. Once that level of expense has been reached, prescription drugs are covered at 100%. All hospital care is covered at 100%.

Hospital physicians have fixed salaries. GP's have either fixed salaries or fee-for-service agreements. All medical and nursing education is free. The infant mortality rate in Norway is 4 per 1,000 live births, and life expectancy at birth is at 75.5 years for men and 81.3 years for women.



## SPAIN

Spain's population size is close to that of Texas and New York combined - about 39.1 million people. The country has had a comprehensive, single-payer national health service since 1978. The Constitution of 1978 explicitly affirms everyone's right to health care. Spain spends 7.1% of its GDP on health care, and its 1998 per capita expense was \$1,218-US.

The Spanish health care system is funded by payroll taxes through the National Institute of Health program (INSALUD), which in 1984 was 75% financed by employers and 25% financed by employees. Those with higher incomes have the option of obtaining private medical care. Public hospitals are run by one of the provinces or municipalities. The INSALUD program operates a large network of hospitals and ambulatory care clinics. Hospital physicians are on full-time salaries.

All medical and nursing education is free. The infant mortality rate in Spain is 5 per 1,000 live births, and its life expectancy at birth is 74.8 years for men and 82.2 years for women.



## SWEDEN

Sweden has a population close to that of New York City - 8.8 million people. The country has an infant mortality rate of 3.6 per 1,000 live births and a life expectancy at birth of 76.9 years for men and 81.9 years for women. Sweden spends 8.4% of its GDP on health care, the 1998 per capita expense was \$1,746. Sweden has had its current universal health care system since 1962. Tuition for medical and nursing education is free, and students generally take loans for living expenses of around \$9,000-US per year.

The Swedish health care system is financed by both incomes and patient fees. County councils own and operate hospitals, employ physicians and run the

majority of general practices and outpatient facilities. Other physicians work in private practice and are paid by the counties on a fee-for-service basis.

Co-pays, which were mandated in 1970, are capped, with limits on how much a person is required to contribute annually. For example, patients over age 16 pay \$9 per day for hospitalization. The maximum individual expense for hospital and physician services is approximately \$108 per year. The maximum individual expense for prescription drugs is \$156 per year. Once these sums are met, care is covered at 100%.



## UNITED KINGDOM

Britain has a population size of 57 million, nearly three times the number of people in Texas. The infant mortality rate in the United Kingdom is 5.7 per 1,000 live births, and life expectancy at birth is 74.6 years for men and 79.7 years for women. Britain has had a National Health Service (NHS) since 1948. 6.7% of GDP goes towards health expenditures, and the 1998 per capita expense was \$1,461-US.

The British government is a purchaser and provider of health care and retains responsibility for legislation and general policy matters. The government decides on an annual budget for the NHS, which is administered by the NHS executive, regional, and district health authorities. The NHS is funded by general taxation and national insurance contributions and accounts for 88% of health expenditures. Complementary private insurance, which involves both for-profit and not-for-profit insurers, covers 12% of the population and accounts for 4% of health expenditures.

Physicians are paid directly by the government via salary, capitation, and fee-for-service. GP's act as gatekeepers. Private providers set their own fee-for-service rates but are not generally reimbursed by the public system. Specialists may supplement their salary by treating private patients. Hospitals are mainly semi-autonomous, self-governing public trusts that contract with groups of purchasers on a long-term basis.

The British government this year has announced a huge funding increase for the NHS. Specifically, it will receive 6.2% more in funding every year until 2004. Current plans to improve the system over the next five years include hiring 7,500 more specialists, 2,000 GP's and 20,000 nurses; providing 7,000 more acute beds in existing hospitals and building 100 new hospitals by 2010; demanding that GPs see a patient within 48 hours of an appointment; and finally, guaranteeing that patients wait no more than three months for their first outpatient appointment with a specialist and no more than six months after that appointment for an operation.

The [Resources and Priorities for the NHS](#). A statement made by the UK's Secretary of Health.

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