Achieving Universal Health Care in the United States Using International Models

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The perfect is the enemy of the good.

- Voltaire, *La Bégueule* (1772)
ABSTRACT

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by Jessica A. Hohman

Despite its reputation as a leader in groundbreaking biomedical technology and innovative life-extending procedures, the United States today finds itself plagued by a national health care system in dire need of reform. With the number of uninsured Americans burgeoning to over 45 million, policymakers are struggling to ensure wide access, low costs, and first-rate care. With its high level of health care expenditures, the U.S. remains one of the few industrialized states without a universal health care system.

The first half of this thesis examines the financing and delivery mechanisms in the health systems of Canada, the Netherlands, France, Germany, and the United Kingdom—with a focus on how they have achieved universal health coverage. The second half of this thesis applies these models in an analysis of how the U.S. can achieve universal health care—with an emphasis on the state-led federalist approach over single-payer, population-based expansions, tax credits, and employer and individual mandate reform pathways.
Acknowledgements

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Introduction

Voltaire’s words are worth pondering today when examining the pitfalls surrounding the state of modern health care reform in the United States. In their quest to find a panacea for health care ills, it is essential that policy makers are not shortsighted in overlooking good solutions that might bring smaller—but equally significant—improvements to this country’s health system in the short-term.

Yet this struggle has not been confined to the U.S.; for industrialized countries around the globe have found themselves re-evaluating their health care priorities to balance competing needs. The last two decades have provided exceptionally ripe conditions for reform, as health care demands have risen against a backdrop of increasingly limited resources so that health expenditures now regularly outstrip growth in gross domestic product (GDP) across most countries in the Organization for Economic Cooperation and Development (OECD) [Appleby 1993]. As the baby-boomer population has aged and worker tax bases have dwindled, governments have struggled to efficiently utilize available resources in order to fund an equitable level of care for their citizenry (Appleby 1993; Blank and Burau 2004).

Understanding the nature of these struggles and the current environment for health care reform across the world requires a basic understanding of the structure of international health care systems as well as the values underlying each system:

1) Structure of international health care systems: All health care systems occupy a distinct place on the “public versus private” continuum in terms of the financing and delivery of health care (Sanders 2002). Although
distinctions blur, most systems tend to predominantly embrace a “national health service model,” “entrepreneurial model,” or “mandated insurance model.” Under a national health service (e.g. United Kingdom and Spain), universal coverage is publicly financed through taxation, hospitals are publicly owned, and medical services are primarily delivered by government-salaried physicians (Sanders 2002). In an entrepreneurial model of health care (e.g. United States), on the other hand, people voluntarily purchase employment-based or individual insurance, and the health care delivery mechanisms (providers and health care facilities) exist largely in the private sector (Sanders 2002). Between these two extremes lies the mandated insurance model, in which compulsory universal coverage is publicly financed through a payroll tax so that both employer and employee contribute to health care financing. Since health care is not primarily delivered via public mechanisms in this model, a “public/private ownership of factors of production” occurs (Sanders 26). Within this category, systems can be further classified as following a national health insurance/single-payer model (e.g. Canada and Sweden) or a multi-payer health insurance model that relies on sickness funds to provide universal health coverage (e.g. Germany and France) (OECD 2003).

2) Values underlying international health care systems. The study of international health care systems inevitably reveals stark and intriguing contrasts—contrasts that have at their root an individual country's unique
set of economic and social values. The European countries, in particular, are testaments to both the economic and social significance health care systems carry, and any health care reform effort must consequently address this central duality (Saltman and von Otter 1995). Since there is a strong ethic of social responsibility within European cultures, protecting and promoting the “public interest” is a fundamental goal. Thus, it is not surprising that despite system-wide variation, these countries share a fundamental health care vision of solidarity, mandatory participation, strict public regulation, community-based fairness, and health valued as a social good (Saltman 2002). In turn, this has produced a European focus on micro-economic efficiency based on the principle of “social entrepreneurialism”: the idea that competitive reforms tempered with the ideals of solidarity can still increase efficiency (Saltman 2002).

The following discussion focuses mainly on the structure of international health care systems, specifically those of Canada, the Netherlands, France, Germany, and the United Kingdom. Structure and organization, financing, quality/choice/access, and problems and reforms will be addressed. Although the values underlying these systems is indirectly manifest through the choices that each country has made for its system (e.g. degree of privatization, equitability, comprehensiveness), a full discussion of these values is beyond the scope of this assessment. After discussing the diverse ways by which countries have achieved universal health care and painting a picture of some of the challenges that they face in their attempts to balance increasing health care demand with limited resources, the second
part of this analysis will focus on the elements of these international health systems that could be applied to the U.S. health system to achieve universal health care in this country.

<table>
<thead>
<tr>
<th>Model</th>
<th>Financing</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>National health service</td>
<td>Predominantly public</td>
<td>Predominantly public</td>
</tr>
<tr>
<td>Entrepreneurial</td>
<td>Both public and private</td>
<td>Predominantly private</td>
</tr>
<tr>
<td>Mandated insurance</td>
<td>Predominantly public</td>
<td>Both public and private</td>
</tr>
</tbody>
</table>
International Models

Canada

**Background**

Possessing a single-payer national health insurance system, Canada combines publicly funded, mandated universal health care with largely private delivery mechanisms. Canada’s care health system reflects the decentralized nature of its government; its ten provinces and three territories are constitutionally accountable for funding, managing, and delivering health services while the national government serves a regulatory role by way of its ability to withhold federal funding to provinces when provinces/territories fail to comply with certain federally-defined criteria (Goldsmith 2002). Canada's health care system was ranked 30th by the World Health Organization in 2000 for overall system performance and 12th in level of population health (WHO 2000). Although public satisfaction with this system has fallen to 46% (Blendon, et al. 2001), Canada’s health system still remains the country’s most popular social program (Goldsmith 2002).

**Organizational Structure and Management**

**Basic Structure, Delivery, and Administration**

The Canadian model of health care ensures that its population will receive all “medically necessary hospital and physician services” (Goldsmith 2002). The 1984 Canada Health Act articulates the five fundamental principles of the Canadian health care system: public administration, universality, portability, comprehensiveness, and accessibility. Private health insurance in Canada typically exists only for those services
not publicly covered, and employers often offer supplemental health insurance as part of the benefits package. Such insurance covers prescription drugs, dental/vision care, hospital room upgrades, and nonphysician-provider services (chiropractors and physical therapists). These extended insurance plans often allow for family coverage and typically involve some form of cost-sharing in the form of co-payments or deductibles. In 1999, approximately 73% of Canadians (22.2 million) had private extended health insurance of some sort (Goldsmith 2002).

Funding and administration responsibilities are decentralized within the Canadian health system, as each province/territory administers its own insurance plan on a not-for-profit basis for residents who have lived in the area for over three months (Goldsmith 2002). The role of the federal government is to provide oversight and regulation of the provincial/territorial governments. The power of the federal government stems from its ability to withhold federal funding for health care ("transfer payments" known as the Canada Health and Social Transfer block grants) to provinces/territories that do not meet the five criteria delineated in the Canada Health Act (Goldsmith 2002).

Health care delivery occurs mainly through private providers who work either independently in solo practice or as part of a group practice. Hospitals have traditionally
been not-for-profit entities, with most being in the public sector. Nursing homes are usually privately run entities that are either for-profit or non-profit (Goldsmith 2002).

**Health care Financing Mechanisms and Health Expenditures**

**Taxation, Premiums, and Other Contributions**

The Canadian health care system is financed mainly through taxes at the provincial, territorial, and municipal levels of government. Federal taxes are the source of the national government’s transfer payments to the provincial governments for health care. Finally, private contributions also help to finance this system, representing 30.1% of all health care expenditures in 2002. Private funding represents both individual out-of-pocket expenses (55% of private health expenditures in 1996) and the cost of purchasing private health insurance (35% of private health expenditures in 1996) (Goldsmith 2002).

In a few provinces (e.g. Alberta and British Columbia), citizens also pay insurance premiums and out-of-pocket fees. According to the Canada Health Care Act of 1984, care cannot be denied to Canadians who are unable to pay these health insurance premiums; in practice, however, this has been violated, and anecdotal evidence suggests that some patients have been refused care for this reason (Goldsmith 2002).

**User Fees**

Canada has no user fees for medically necessary physician and hospital services covered under the public system, but there is cost-sharing for non-covered benefits,
particularly prescription drugs. In 1998, drug expenditures (14.8%) overtook physician services (13.9%) in share of health costs, second only to hospital services (32.9%). In recent years, provincial/territorial governments that provide some level of outpatient prescription drug coverage for residents have utilized different mechanisms to control drug expenditures, including cost-sharing for drug insurance coverage via co-payments and deductibles (Goldsmith 2002).

**Reimbursement**

Physicians in private practice are reimbursed primarily by fee-for-service mechanisms from the public insurance funds at rates negotiated with the government. Fee-for-service or per-diem (per-day) payments are also still the methods used to reimburse private for-profit hospitals, while nonprofit hospitals tend to use global or regional budgets (Goldsmith 2002).

**Quality of Benefits, Choice, and Access**

Comprehensive coverage of “all insured health services provided by hospitals and medical practitioners or dentists” by insurance plans is guaranteed in the Canada Health Act (Deber 2003). Additional services, such as dental care, home care, ambulance services, and outpatient drugs (provided for the elderly and social assistance recipients often with cost-sharing mechanisms) are also funded by the provinces/territories to varying levels. Only two provinces fail to offer residents drug insurance coverage (Goldsmith 2002). Canadians can also purchase supplemental private insurance to cover the above services.
Overall, Canadians have free choice and few financial barriers to high quality health care in their country (Deber 2003). With no user fees or deductibles for medically necessary health services provided by physicians and hospitals, they only need to display their insurance card to receive coverage. Moreover, Canadians can generally choose their physician, and typically, their hospital as well (Goldsmith 2002).

Waiting lists for elective, non-emergency procedures have become a highly symbolic and controversial issue, although the actual magnitude of the problem is unclear because the data on waiting lists is non-standardized and incomplete. Furthermore, the Canadian experience with waiting times is uneven, varying greatly by province and procedure (McDonald 1998). Nonetheless, for a significant portion of the Canadian population, waiting times for elective procedures remain a highly concerning issue.

Despite the generally good health care access for most Canadians overall, there do exist inequities in access for low-income Canadians and those living in rural areas, where there are fewer providers and health care facilities (Goldsmith 2002).

Problems and Reforms

With steadily declining levels of satisfaction with the Canadian health care system, the government has been compelled to address public concerns over waiting times, specialist availability, and nurse shortages. Many feel the problems of the health care system stem from underfunding. For instance, reductions in federal government transfer payments during the 1980s resulted in tighter hospital budgets, decreased physician reimbursement, reduced nursing staffs, an emphasis on same-day surgery, and fewer hospital beds in the 1990s (Deber 2003). There has been recent momentum
towards increased privatization of the health care system, as some believe that private sector dollars could compensate for the underfunding of the public system. Privatization, however, is controversial, as many Canadians fear it would compromise the equitability of the Canadian health care system (Deber 2003).

Canadian patients are guaranteed coverage for a wide variety of benefits, but there do remain significant gaps in public coverage, especially outpatient pharmaceutical drugs and long-term care. Provinces are free to provide additional coverage for such non-covered benefits, but those that do often charge significant user fees for such coverage (Deber 2003).

There is an ongoing tension between the federal and provincial governments as they attempt to agree upon health care organization and how comprehensive publicly financed care should be. Such tensions have sometimes erupted into pitched battles resolved only by increases in federal funding for the provinces (Deber 2003).

Finally, Canada’s relatively high expenditures on health care have prompted many efforts at cost-containment in the past few years. In 1998, Canada was the fifth highest health care spender among OECD countries, with 9.5% of the GDP spent on health care (Goldsmith 2002). The concern over high expenditures was exacerbated by Canada’s simultaneous low ranking (30th) by the WHO in 2000, although some have argued that this ranking is artificially low due to the WHO’s controversial methodology of adjusting health care systems by educational attainment (Deber 2003).

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>National health insurance (Medicare) covers medically necessary services for Canadians (13 province/territory-based insurance plans with federal oversight); many also purchase supplemental private insurance</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Combination of individual and corporate taxes at all levels of government, premiums in some provinces, and out-of-pocket fees; provinces/territories primarily fund, but federal government also makes contributions in the form of transfer payments; the public share of total health expenditure is 69.9% (2002)</td>
</tr>
<tr>
<td><strong>Budgeting</strong></td>
<td>Global budgets used</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Medically necessary physician and hospital services are publicly covered; additional coverage for services, such as dental care, home care, ambulance services, and outpatient drugs can be purchased from provincial/territorial insurance plans or private insurers; costly outpatient pharmaceuticals are financed by a combination of public and private sources</td>
</tr>
<tr>
<td><strong>User Charges</strong></td>
<td>Canada has no user fees for medically necessary physician and hospital services covered under the public system, but there is cost-sharing for non-covered benefits, particularly prescription drugs.</td>
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</table>
The Netherlands

Background

With private ownership themes strongly interwoven into the economic and cultural fabric of the Netherlands, it is perhaps not surprising that the Dutch possess a hybrid private-public health care system. The Netherlands covers roughly two-third of its population through its public health care system, and the remaining one-third (primarily civil servants and upper-income citizens who do not qualify for government-financed benefits) obtain coverage from private insurers (National Union 2002). In 2000, the Netherlands was ranked 17th for overall health system performance, 9th in level of responsiveness, and 13th for level of population health attainment by the World Health Organization (WHO 2000). Furthermore, 73.2% of the Dutch population expressed satisfaction with the Dutch health care system in 1999 (Exter, et al. 2004). The Netherlands presents an intriguing example of how universal health coverage can be equitably achieved in the presence of a strong private sector.

Organizational Structure and Management

Basic Structure, Delivery, and Administration

Conceptually, the Dutch health system has three distinct components: “Public universal insurance for so-called ‘exceptional medical expenses,’ compulsory social health insurance for the low income and voluntary private insurance for the high income, and voluntary supplementary insurance open to all” (Busse 2002). This system is dependent on employer-based insurance, and "sickness funds" (insurance plans) play an
integral role in the provision of the compulsory social health insurance component of the
Dutch health care program (National Union 2002).

The three distinct coverage schemes comprising the Dutch health care system are
as follows:

1) **AWBZ.** The Exceptional Medical Expenses Act (AWBZ) ensures that
the government will cover long-term care, as well as catastrophic care for
costly treatments often associated with serious illness/disability. Everyone
pays into this system, and everyone receives benefits from this system.

2) **ZFW.** Non-catastrophic, but medically necessary, care is provided
through the Sickness Funds Act (ZFW), civil servant health insurance
programs, substitutive voluntary health insurance (VHI), or WTZ
mandate.

- People earning under EUR 30700 (considered a middle-class income)
qualify for mandatory ZFW coverage via sickness funds (Exter, et al.
2004). In addition, those who social security benefit recipients and
who have opted into this program because they are over 65 and make
less than EUR 19550 are also eligible for ZFW coverage. ZFW alone
covered close to 66% of the population in 2001 (Busse 2002).

- Insurance schemes for groups such as civil servants accounted for 5%
of the Dutch population.

- For those who do not qualify for ZFW sickness funds because of high
income and who also are not covered under civil servant insurance
programs, there is the option to voluntarily purchase substitutive VHI from a private insurer. This is the route chosen by about 29% of the Dutch.

- For those who do not qualify for ZFW and who are denied substitutive VHI coverage by private insurers, the Health Insurance Access Act (WTZ) guarantees access to government coverage. The WTZ “standard policy” annual premium was set at EUR 1135 in 1999 for individuals under 65 and EUR 1275 for those over 65. In contrast to ZFW sickness funds, in which dependents are also insured, dependent coverage must be purchased separately under WTZ. There is also a WTZ surcharge to compensate for the disparity between WTZ costs and premiums (Busse 2002).

3) Voluntary health insurance. The last component of the Dutch health care system involves the purchase of VHI from certain sickness funds (sickness funds often offer publicly financed coverage and private options for those above the income ceiling) and private insurance companies to cover medical services that are “less necessary.” These benefits typically extend to accommodation upgrades or services such as dental care, but they do not allow for quicker access to care by bypassing waiting lines (Busse 2002).
The vast majority (90%) of hospitals in the Netherlands are private, non-profit entities (Exter, et al. 2004). Physicians are independent practitioners that exist both in the private and public sector, with a predominance of private providers (Busse 2002).

**Health care Financing Mechanisms and Health Expenditures**

**Taxation, Premiums, and Other Contributions**

The Dutch pay national, provincial, and municipal taxes to help fund health care. Although general taxes only formally account for 5.3% of health expenditures, taxes also indirectly subsidize annual federal grants to the AWBZ and ZFW (Busse 2002).

The National Insurance Financing Act requires all insured individuals to make contributions to AWBZ based on their taxable earnings. In 2001, 10.25% of the first EUR 27009 of an employee’s income was uniformly withheld from their paycheck (Busse 2002).

The ZFW is financed by two main sources. First, it is funded by a combination of employer contributions (6.25% payroll tax) and employee contributions (1.7% of income up until a ceiling of EUR 28188 in 2002, with self-employed workers and those living on social security benefits having a lower ceiling). Second, the ZFW is funded by an annual flat-rate contribution between EUR 114 and EUR 238.80 for ZFW insurees as set by the Ministry of Health (Busse 2002).
Those individuals who purchase substitutive VHI pay premiums assessed according to risk-ratings that take into account family medical history and age; the average annual premium was EUR 698 in 1999 (Keen, et al. 2001; Busse 2002). Private insurance is both renewable and portable once it is obtained (Keen, et al. 2001). In addition, there is a “MOOZ” surcharge that those with substitutive VHI pay to subsidize sickness funds that cover a high percentage of the elderly (Busse 2002).

**User Fees**

Out-of-pocket fees fund 9% of health expenditures in the Netherlands (4% for AWBZ co-pays, 2% for co-pays/deductibles in ZFW, and 3% for private complementary or supplementary VHI). Cost-sharing occurs in all three parts of the Dutch system. AWBZ co-payments apply mainly to nursing home care and take into account individuals’ circumstances; the maximum co-payment was EUR 1631 per month in 2001 (Busse 2002). ZFW insurees pay for medical costs at a 20% co-insurance rate; however, this contribution is capped, and there is no co-payment or deductible for GP visits, general dental services, or inpatient pregnancy fees (Busse 2002). Also, AWBZ assesses user fees according to income (Keen, et al. 2001).
Reimbursement

The ZFW is responsible for reimbursing GPs on a capitation basis, and specialists are reimbursed on a fee-for-service basis. Hospitals tend to operate under size-dependent global budgets. VHI funds reimburse GPs on a fee-for-service basis.

Quality of Benefits, Choice, and Access

AWBZ coverage includes psychiatric and mental health care, hospital coverage after the first year of an admission, nursing home care for those who are disabled, assistance for the mentally/physically disabled, inpatient and outpatient rehabilitation, and child immunizations, among other services. The ZFW covers acute medical/surgical services, obstetric care, hospital stays for up to a year, selective dental care, prescription drugs, home dialysis, medical aids and transport, maternity care, rehabilitation, and various other services. Substitutive VHI policies offer variable benefit packages, while the complementary and supplementary VHI provided by private insurers and by most sickness funds (i.e. the third component of the Dutch system) often covers additional health expenses such as dental and eye care (Busse 2002).

With 22 sickness funds, the Dutch not only have the option of selecting which fund to belong to, but they also have the ability to change funds annually (Exter, et al. 2004). Moreover, they can pick their GP, who then acts as a gatekeeper for specialist
care. Dutch residents can also choose their specialist, although referrals are needed. In contrast to many other countries, GPs treat almost all ailments, and they refer patients to specialists during only 6% of all contacts (Busse 2002).

Although access to primary care physicians is unimpeded, waiting times for elective procedures and specialty care have become highly important issues to the public in recent years. On average, the waiting time for a specialist appointment is 6 weeks, and the waiting time between seeing a specialist and receiving treatment is 11 weeks (2 in internal medicine, 9 in surgery) (Busse 2002). In order to address the issue of waiting times, sickness funds have contracted with hospitals in other countries (e.g. Belgium) to provide care for their enrollees. Also, health insurers now pay hospitals according to their performance level and ability to meet goals aimed at reducing waiting times (Busse 2002).

Problems and Reforms

In part due to the income-based method of determining health care coverage and the fact that people ineligible for ZFW are not mandated to purchase substitutive VHI, 1.6% of the Dutch population lacks health care coverage. Most of the uninsured are homeless individuals or people who refuse to insure themselves on principle (Busse 2002).

There has been much debate over the inequitable nature of the Dutch health care system’s second compartment, in which there is a compulsory health insurance program for the low-income (ZFW) and a more expensive parallel private system for those above the income cutoff. As Busse writes, “Currently one Euro more or less on either side of
the threshold can more than double the contribution” (Busse 2002). A July 2001 government plan includes reforms to unify the second compartment into one scheme, and then to merge this with the AWBZ to provide for one single national insurance system administered by sickness funds and private health insurers (Busse 2002).

<table>
<thead>
<tr>
<th>The Netherlands In Brief (2000/1) European Observatory</th>
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<tbody>
<tr>
<td><strong>Coverage</strong> 100% population publicly covered by AWBZ for exceptional medical services and long-term care; 64% publicly covered through ZFW; 29% purchase substitutive private insurance; 93% of ZFW enrollees have private complementary insurance</td>
</tr>
<tr>
<td><strong>Financing</strong> Uniform employee tax contribution rate of 10.25% for AWBZ; for ZFW insurees, there is a 6.25% contribution for employers and 1.7% for employees; variation in monthly premium rates among funds, but typically falls between EUR 9.50-19.90 (2001); tax grants are also made to AWBZ and ZFW; the ceiling on contributory income for AWBZ is EUR 27,847 and is EUR 28,188 for ZFW (EUR 19,650 for self-employed and EUR 19,550 for pension recipients)</td>
</tr>
<tr>
<td><strong>Budgeting</strong> Soft global budget used; Sickness Fund Council sets budgets for ZFW funds</td>
</tr>
<tr>
<td><strong>Benefits</strong> Defined in Exceptional Medical Expenses Decree (AWBZ) and Health Insurance Decree (ZFW)</td>
</tr>
<tr>
<td><strong>User Charges</strong> No co-payments for GP, specialist, or inpatient care; consumers do, however, pay the difference between reference and actual pharmaceuticals</td>
</tr>
</tbody>
</table>
France

Background

Ranked first for overall health system performance and third for population health level attainment by the World Health Organization in 2000, France’s health care system arguably serves as the benchmark for all other world systems. Of particular note is the system's ability to provide universal care for all legal residents, choice of providers, free health programs for the poor/disabled, model child/adolescent care, and significant cost reimbursement (WHO 2000; Costich 2002). With a strong ethos of solidarity pervading its cultural history, France has attempted to balance the societal value of collectivity with the traditional French respect for the sanctity of freedom and individual choice.

Combining elements of both the public and private sectors, France possesses a multi-payer insurance system with which over 65% of the population expresses satisfaction (Blendon, et al. 2003). Moreover, France offers a considerable health safety net for its population through charitable Médecins sans Frontières organizations that supply care to illegal immigrants and through 2000 clinics that provide free consultations for health education, screening, prevention, and checkups (Costich 2002).

Organizational Structure and Management

Basic Structure, Delivery, and Administration

France’s multi-payer health insurance system is an amalgamation of Sickness Insurance Funds (SIFs) and supplementary insurers:

1) **SIFs.** Profession and geographical location determine which SIF an individual is automatically enrolled in, and people do not have the ability
to “opt out” of France’s social insurance scheme in favor of private coverage (Sandier, et al. 2002). There are three main SIFs. The National Fund for the Insurance of Employed Workers (CNMATS) covers 83% of the population—including industrial, commercial, and government workers. There is also a major SIF for farmers (9% of the population) and a major SIF for professionals, craftspersons, and small business workers (6% of the population). A small number of more specific occupation-linked SIFs also exist, with variation among the plans in terms of benefits and contributions. To address imbalances among SIFs, significant cross-subsidization takes place (Costich 2002).

2) Supplemental insurance. In addition to SIF coverage, 86% of the French obtain supplementary/complementary voluntary health insurance (VHI) through their employers, who reimburse employees for co-payments and other out-of-pocket expenses to various degrees. Moreover, in 2000 the Universal Coverage Act (CMU) provided VHI for over six million disabled, unemployed, and low-income French residents (Costich 2002). This brought the percentage of the French population with complementary VHI to 90% (Sandier, et al. 2002).

Most French physicians are in private practice, although some work for public hospitals. The majority of ambulatory care is provided by private-practice cares. Hospitals exist in both the public and private sectors (Costich 2002).


Health care Financing Mechanisms and Health Expenditures

Taxation, Premiums, and Other Contributions

The French health care system is primarily financed through general taxation and a payroll tax. Supplementary insurance and out-of-pocket payments also account for a small portion of health expenditures. Individuals pay a user fee at the point-of-service, which their insurance scheme and/or supplementary VHI will typically reimburse within 12 days (Costich 2002; Sandier, et al. 2002).

There are three main categories of earmarked national taxes for France’s health care system. First, there are general social contribution (CSG) funds drawn from a tax of 5.25% on total income (3.95% for the unemployed and social security beneficiaries). Second, there is a tax levied on pharmaceutical companies. Finally, there is a tax on tobacco and alcohol.

The social health insurance contributions from employers and employees (payroll tax) are proportional for salaried employees and regressive for farmers and the self-employed. For salaried employees, employers contribute 12.80% of employee salary, and employees contribute 0.75% of their salary for such payroll taxes. In contrast, the contribution rate ranges from 5.90% to 6.50% for the self-employed and 8.13% for
farmers. These contribution rates apply only for the first EUR 164000 of income; income above this level is not taxed (Sandier, et al. 2002).

User Fees

Out-of-pocket expenses play a small role in France’s health care financing. User fees via co-payments vary depending on the health service. Generally, French individuals are responsible for 30% of the costs of GP and specialist visits (EUR 18.50 and 22.87, respectively), an average of 35% of drug costs (0% coinsurance rate for “effective drugs” and 65% rate for drugs with questionable effectiveness), 40% for lab tests, and 20% for non-maternity hospital care during the first month (up to EUR 200). It is important to note, though, that French residents can apply for co-payment exemptions for catastrophic health incidents resulting in treatment costing over EUR 200 (in 2000). Patients also pay extra fees to see private practitioners. Many of the above costs, however, can be reimbursed through complementary VHI, which is purchased through one’s employer or on an individual basis (Sandier, et al. 2002).

Reimbursement

The majority of physicians and specialists are paid on a fee-for-service basis (with the exception of salaried public hospital doctors), but reimbursement rates vary according to whether a doctor participates in "Sector I" or "Sector II." Sector I physicians are paid
according to the national fee schedule, and in exchange, they themselves are guaranteed government benefits including free health coverage. Physicians who opt for Sector II can charge prices above the national fee schedule, but they forsake the government benefits their Sector I counterparts enjoy. In 1997, only 27% of physicians practiced in the closely regulated Sector II (Costich 2002).

Public hospitals and private not-for-profit hospitals operate via a global budget set by the regional hospital agency. Private for-profit hospitals have an itemized billing system including a per diem charge for accommodations/care, a per diem charge for drugs, and payment for the use of operating rooms, prosthetics, and other equipment (Sandier, et al. 2002).

**Quality of Benefits, Choice, and Access**

French residents are free to visit their GP, specialist, and hospital of choice without referrals, and they usually are able to make a same-day appointment to see their GP. France’s health care system also offers a wide range of benefits (Costich 2002).

Generally, medical services in the fee-for-service sector will be covered by insurance if they are prescribed by a health care professional and are on the lists of approved procedures or drugs/medical devices (list inclusion is determined by level of effectiveness). Medical treatment in public hospitals, on the other hand, is usually
covered by global budgets, but these hospitals cannot participate in certain elective procedures such as plastic surgery (Sandier, et al. 2002).

Access to health care is particularly good for school-aged children, as nurses and physicians regularly visit France’s public schools. The general population’s experience with equitable access, however, has been more uneven. 27% of French physicians charge above the national fee schedule (Sector II), creating a barrier to access for low-income populations (Costich 2002).

*Problems and Reforms*

Despite the French health care system’s high overall level of performance, problems exist in terms of rising expenditures, poor quality assurance and uniformity, health disparities by region and socioeconomic status, and over-consumption of health services. High out-of-pocket costs at the point-of-service (although reimbursed later) also can serve as an initial impediment to care for some. Additionally, there is currently a nursing shortage, which is compounded by mandatory 35-hour work week caps for nurses. There will also likely be a future physician shortage due to recently enacted medical school quotas (Costich 2002; Sandier, et al. 2002). Additionally, problems have plagued the relationship between physicians and health insurance providers because reforms in 1996 capped physician fees; this has made reaching future contractual agreements unusually difficult (Costich 2002).

Soaring health costs in France are largely attributable to drug expenditures, which account for 19% of overall health costs (dwarfing physician fees, which stand at 13%). 90% of physician consultations in France result in prescriptions. This excessive
consumption is encouraged by the French government’s restriction of pharmaceutical
prices to low levels (Costich 2002).

As the percentage of GDP spent on health care has risen to 9.7%, reforms have
been undertaken to encourage more efficient health service usage and to curb waste, such
as raising rates of coinsurance and lowering physician reimbursement levels. Such
reforms have had only mixed results, however, because physicians compensate for their
losses by ordering more services within France’s fee-for-service payment structure while
supplementary insurance often covers the higher co-payment rates (Costich 2002).

There have also been other recent attempts at widespread reform. The Juppé Plan
was a 1996 initiative aimed at reforming French health care funding and administration
by adopting yearly spending objectives, determining global budgets for hospitals, and
setting treatment guidelines; the ultimate objective of this plan was to improve the quality
of care while containing costs. The CNMATS plan that later followed built on these
initiatives while concurrently advocating greater patient involvement, available and
uniform outcome comparison data, portable medical records (smart cards), and DRG
payments, among other reforms (Costich 2002).
<table>
<thead>
<tr>
<th><strong>France In Brief (2000/1)</strong> European Observatory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong> 100% population with public/social insurance (CNAMTS, MSA, and CANAM are three main SIFs and cover 95% population) ; 90%+ with complementary private</td>
</tr>
<tr>
<td><strong>Financing</strong> 5.25% CSG income tax; 12.8% employer tax contribution; employee pays 0.75% tax on gross earnings; tobacco, alcohol, and social debt repayment (.5%) contributions</td>
</tr>
<tr>
<td><strong>Budgeting</strong> Annual global budgets</td>
</tr>
<tr>
<td><strong>Benefits</strong> Defined benefits for ambulatory care and private hospitals; reimbursement for drugs and medical devices also determined nationally</td>
</tr>
<tr>
<td><strong>User Charges</strong> 30% GP and specialist co-payment rate (Sector 2 greater); 20% co-payment for inpatient care + EUR 10.67 per diem; pharmaceutical co-insurance rate of 0%, 35%, or 65% depending on classification</td>
</tr>
</tbody>
</table>
Germany

Background

Since its inception over a century ago under the leadership of German Chancellor Otto von Bismarck, Germany’s health care system has occupied an esteemed place in history and continues to serve as the premier model for countries attempting to implement similar health programs. Germans rely on occupation-based sickness funds for compulsory health coverage, and these are financed primarily via payroll contributions shared equally between employers and employees. Although Germany’s health care system heavily depends on public funding through such taxes, Germans covered by the public program have a wide range of choices in terms of public and private providers; moreover, high earners can opt out and purchase private insurance instead.

Highlights of the German health system include cost-sharing by employers and employees, risk-sharing via large population insurance pools, a large number of doctors, patient choice in physicians, and direct access to specialists. The unique power-sharing arrangement in Germany’s health care system has allowed German patients to enjoy a greater overall level of autonomy and more options than many of their European counterparts (Busse 2002). Ranked 25th in overall health system performance by the World Health Organization in 2000, Germany’s system was 22nd in health attainment and 3rd in health expenditures per capita; roughly 58% of the current population expresses satisfaction with this present arrangement (WHO 2000; Blendon, et al. 2001).
Although the German system has long served as a health care model for other states, it now finds itself in the midst of a critical period of reform; health expenditures have risen to close to 11% of Germany’s Gross Domestic Product, and generous benefits and a lack of cost-containment measures, coupled to Germany’s high level of unemployment, have destabilized the system (Brenner and Rublee 2002).

Organizational Structure and Management

Basic Structure, Delivery, and Administration

The German social health insurance (SHI) network’s 192 statutory sickness funds (designated by occupation or region) cover approximately 88% of the population (78% compulsory enrollees and their dependants, 10% voluntary). 9% of the population opted out of SHI for private health insurance, and 2% qualified for free government care in 2002 (Appleby 1993; Busse 2002; Busse and Riesberg 2004). Employees who opt for private insurance pay risk-based premiums (an especially attractive and cheaper option for the young and healthy who earn high salaries), and their employers continue to make contributions at the same level they would if the individual was publicly insured (Brenner and Rublee 2002). In addition, all Germans have the option of obtaining complementary and supplementary VHI policies to cover services such as dentures (Busse 2002).

While the statutory sickness funds are “private in formal ownership,” they are publicly responsible and accountable (Busse and Riesberg 2004). In addition, retirees are covered under a social insurance plan if they made contributions into a sickness fund during the majority of their working life (or if their spouse did), and the government helps to fund deficits related to higher costs of care for the elderly.
While the national government passes the legislation mandating health insurance and hospital financing levels, administration/implementation tends to be more decentralized with sickness funds, the hospital association, health professionals, and state governments all playing a role. Hospital care is administered by individual hospitals, sickness funds, and Länder (state) governments; ambulatory care, on the other hand, is administered by physician associations and sickness funds (Brenner and Rublee 2002).

Ambulatory and hospital functions are distinct, and in contrast to other industrialized countries, few outpatient contacts occur in the hospital setting (Busse 2002). Ambulatory care doctors can only treat social insurance patients if they are part of the Länder medical association, which negotiates contracts with sickness funds (Brenner and Rublee 2002). Private physicians dominate the ambulatory care market within Germany, while both public and private providers are available for hospital care (Busse 2002).

**Health care Financing Mechanisms and Health Expenditures**

**Taxation, Premiums, and Other Contributions**

The German SHI system is financed mainly through a monthly payroll tax shared equally between employers and employees. This tax is compulsory for those making under EUR 3525 a month and is proportional to income (Busse and Riesberg 2004).

### Sources of Private Health Expenditure in Germany (2002)

- **Prepaid Plans (%):** 39.9
- **Out-of-Pocket Expenditure (%):** 48.2
Those who make above this amount can opt out of SHI so that they can purchase private insurance. Contributions vary among sickness funds, with the average rate being 14.2% in 2004; the employee and employer each pay half (7.1%) (Busse and Riesberg 2004). Those making under EUR 400 per month are exempt from paying this premium, but their employers must pay a 10% contribution rate on their behalf.

All in all, general taxation only accounts for 8.4% of health care expenditures (Busse 2002). General taxation is used to invest in public hospitals as well as private hospitals, both non-profit and for-profit (Brenner and Rublee 2002). The German health insurance system is further distinguished from many of its social insurance counterparts by not requiring additional contributions to cover spouses/dependents (Brenner and Rublee 2002).

Voluntary health insurance premiums diverge widely in accordance to risk and require extra fees for dependent coverage; the average substitutive premium is in the range of EUR 1790 per year (Busse 2002).

User Fees

Out-of-pocket fees account for 12.2% of German health expenditures, although co-insurance rates for pharmaceuticals, nonphysician care, the first two weeks of hospital stays, and transportation are limited to 2% of gross income for an individual (certain
groups such as low-income earners, pensioners, and minors have exemptions). The average drug co-payment is between EUR 4 and 5, while ambulance transportation typically cost EUR 13 per ride in 2002 (Busse 2002).

Reimbursement

Hospitals receive two sources of funding: investment costs through the Länder and sickness funds, which are responsible for setting each hospital’s operating budget at the regional level. Hospitals were formerly paid according to a hybrid system of prospective case-fees, procedure-fees, and per diems. The Reform Act of SHI (2000) mandated that by 2004, all hospital remuneration will be conducted according to a DRG-based scheme (Busse 2002).

German hospital physicians are salaried and generally do not bill patients. Reimbursement for ambulatory care physicians from sickness funds occurs in two steps. First, sickness funds allocate a global budget for the physician’s associations based on capitation (i.e. a certain amount is allocated per insured person). Second, the physician’s associations reimburse physicians on a fee-for-service basis according to the Uniform Evaluation Standard fee schedule. This fee schedule also makes budgetary allowances for overhead costs associated with equipping and staffing a practice (Brenner and Rublee 2002; Busse 2002).

All private practice physicians can see privately insured clients and bill them higher amounts on a fee-for-service basis. In contrast, in order to treat sickness fund insurees, ambulatory care physicians must be authorized and must agree to certain
stipulations (i.e. fees, regulation, regional medical association and chamber membership) (Busse 2002).

**Quality of Benefits, Choice, and Access**

The Social Code Book V (SGB V) defines benefits that are guaranteed by Germany’s health care system in general terms, focusing on prevention/screening, treatment, and transportation. In practice, the German health system provides an extensive array of benefits to its population, ranging from ambulatory, hospital, and preventive care to physiotherapeutic, maternity/family planning, and rehabilitation services. Prescription drugs are also covered, as are dental and eye care. Different levels of cost-sharing, however, exist for these services (Brenner and Rublee 2002).

Germans reap a high level of benefits to compensate for missed employment time due to illness; employer’s must continue to pay employees 100% of their income for the first six weeks of illness, but sickness funds take over this function after that period and pay cash benefits at 80% of income until the 78th week of illness during each period (Busse 2002).

In general, Germans find easy access to medical, dental, and hospital services, and they carry a health insurance card with a memory chip so that their chosen health care provider can effortlessly retrieve pertinent administrative information (Brenner and Rublee 2002). With the passage of the 1996 Health Care Structure Act, Germans can select their sickness fund and conditionally switch between funds (Busse 2002). Germany is oversaturated with physicians, possessing a high ratio of 3.4 physicians per 1000 people; thus, Germans can freely choose their GPs and their specialists for
ambulatory care from many available options, but hospital visits typically require physician referrals and use of the closest available hospital for non-emergency care (Brenner and Rublee 2002). Waiting times for appointments/hospital treatment are virtually nonexistent within Germany (Busse 2002).

In an attempt to empower German patients by improving their access to information, health insurance agencies offer advice through their telephone lines, which is complimented by increased use of the Internet for medical-related purposes (Coulter and Magee 2003). Germany is unique in offering such a strong self-help group presence, with over 70000 groups and 250 self-help contact points. Through German patient organization funding, these contact points help tie the self-help groups to physicians and improve access to care. Such patient groups, in turn, have the opportunity to contribute to policy making at regional health conferences (Coulter and Magee 2003). Despite these attempts to cater to consumer interests, an eight-country 2002 survey found that only 29% Germans thought doctors listened, explained, and allowed time for questions. This dissatisfaction with patient-physician relationships is particularly interesting when considering that Germany spends a higher percentage of its GDP on health care than most of its European brethren (Coulter and Magee 2003).

Problems and Reform

Despite the long history of the German health care program, German health expenditures per person are relatively high in comparison to other European countries, although this can be partly attributed to money set aside as cash benefits used to defray income losses during times of sickness (Appleby 1993). Current health care expenditures
account for close to 11% of GDP, but this statistic is deceiving; when all actual health-related expenses (sickness benefits, capital costs, out-of-pocket payments) are taken into account, this figure soars to near 15% (Brenner and Rublee 2002). Moreover, the German health care system is fraught with excessive hospital usage, disproportionate numbers of physicians, and nurse shortages.

Before 1993, the German health system tended towards overprovision of medical care, as competition was virtually non-existent among SHI funds and patients lacked both the information to demand quality improvements and the financial incentive to curtail their demand for services (Sauerland 2001). The jump in health care expenditures from 6.3% of the GDP in 1970 to present levels against the backdrop of a sputtering German economy and rising unemployment precipitated the passage of the Health Care Reform Act (1993); this law called for separate budgets for ambulatory care, inpatient treatment, and prescription drugs in the Social Code Book V. At the same time, a shift from a fee-for-service to a capitation reimbursement system helped to reign in physician tendencies toward provision of unnecessary services (Sauerland 2001). The trend towards cost-containment measures such as capitation and global budgets ultimately subjugated the health care system to the SHI cost-control agenda, and overprovision of care was replaced with under-provision (Sauerland 2001).

German health care over-consumption can be partly attributed to the strong position held by physicians trying to maximize their income and by hospitals looking to capitalize on per diem reimbursement rates by increasing hospital admissions and stay lengths; this has been partially combated by increased numbers of physicians (and a
resultant limiting of their salary potential), improved monitoring, and restrictions on referrals for hospital care (Appleby 1993; OECD 2003). Certain areas have also been closed to additional ambulatory care physicians if the location already is at 10% physician excess; at present, around 60% of Germany’s geographical areas are closed (Brenner and Rublee 2002).

<table>
<thead>
<tr>
<th>Germany In Brief (2000/1)</th>
<th>European Observatory</th>
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<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td>88% population with public/social health insurance; 9% with substitutive private insurance; 10% SHI enrollees have supplementary/complementary private insurance</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Variation among funds with an average compulsory employer contribution of 6.75% and compulsory employee contribution of 6.75%; only the employer makes contributions (10%) for those earning less than EUR 322; DEM 6525 ceiling on monthly contributory income (2001)</td>
</tr>
<tr>
<td><strong>Budgeting</strong></td>
<td>Budgets set for each sect; no global budgets</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>General benefits detailed in Social Code Book V; federal committees establish more detailed ambulatory and hospital care guidelines</td>
</tr>
<tr>
<td><strong>User Charges</strong></td>
<td>No co-insurance rate for GP and specialist care, but 15% co-payment for nonphysician services; co-payment of EUR 9 per day for up to two weeks per year for inpatient care; co-payment of EUR 13 for ambulance transportation; pharmaceutical co-payment between EUR 4-5 + 100% of difference over reference price</td>
</tr>
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</table>
The United Kingdom

Background

Despite its reputation as a staunch advocate of free-market capitalism in its economic policies, the United Kingdom funds a strong social welfare safety net for its population that includes the National Health Service (NHS), a health system characterized by market-minimization and government ownership/control (Fried and Gaydos 2002). The U.K. NHS represents true socialized medicine in the sense that physicians work for the government and the majority of health care facilities are publicly owned; that is, both the financing and delivery of health care is predominantly public.

The NHS was ranked 18th for overall health system performance and 14th in health level attainment by the World Health Organization in 2000 (Gaydos and Fried 2002; WHO 2000). NHS costs represent a significantly smaller percentage of the U.K.’s GDP at 7.7% than the health systems of many of its European counterparts (WHO 2005; Dixon and Robinson 2002). Despite this, the NHS continues to be plagued by chronic underfunding, as it is perpetually caught in an “efficiency trap”: its vaunted cost-effectiveness allows more patients to be treated, but the increased number of patients simultaneously creates higher costs and a need for greater funding (Appleby 1993). Moreover, the NHS has experienced problems with long waiting times, restricted choice, poor access to specialists, and outdated facilities (Appleby 1993; Ranade 1998). Yet in the face of this growing list of complaints, the NHS still enjoys an unprecedented level of public support (57%) and has been relatively successful at keeping escalations in health spending in line with GDP growth (Anderson and Poullier 1999; Blendon, et al. 2001).
Organizational Structure and Management

Basic Structure, Delivery, and Administration

Established in 1948 in the aftermath of World War II, the NHS has been guided by the principles of equity, comprehensiveness, and free access at the point-of-service since its inception (Gaydos and Fried 2002). While a small private insurance sector does exist in the British health care system, the NHS provides the majority of care for the U.K.’s inhabitants via government-salaried physicians and public hospitals. The private insurance sector, which has grown significantly in recent years, is generally sought to improve access to elective procedures and ease waiting times, but even these private insurees are still entitled to NHS care (Gaydos and Fried 2002).

Much of the actual administration of care is in the hands of county health authorities funded by the government. These authorities identify the local population’s health needs and purchase services from providers including GPs and NHS hospital trusts (Gaydos and Fried 2002). Recently, administrative duties have increasingly fallen in the hands of so-called “primary care groups” or “primary care trusts”, which are groups of GPs and other health care professionals that are given funding to plan health services for their local communities – a responsibility that traditionally had been in the domain of the county health authorities (Gaydos and Fried 2002; Dixon and Robinson 2002).

For primary care, delivery occurs through public GPs that either work alone or in a group. The average GP is responsible for a patient list of 1900 enrollees, and every U.K. citizen has the right to register with a GP. GPs provide free primary care consultations to NHS-registered U.K. citizens and serve as gatekeepers to specialist care
Gaydos and Fried 2002). GPs are prevented from treating patients on their NHS-registered list on a private basis and only approximately 200 private GPs exist in all of the U.K., most of them in London (Dixon and Robinson 2002).

NHS walk-in centers provide similar services to GPs (Gaydos and Fried 2002). Hospitals in the U.K. typically exist as part of independent, self-governing entities (“NHS trusts”) that provide a wide range of medical services, from emergency to long-term care (Gaydos and Fried 2002). NHS trusts employ the majority of the NHS workforce.

**Health care Financing Mechanisms and Health Expenditures**

**Taxation, Premiums, and Other Contributions**

General taxation funds approximately 80% of NHS costs, with additional contributions coming from national insurance contributions (12% of NHS costs), patient fees (4% of NHS costs), and miscellaneous (4% of NHS costs) (Dixon and Robinson 2002). General taxation includes a 17.5% value added tax, as well as
a direct general tax of 10% on the first Great British Pound (GBP) 1880 of taxable income, 22% of remaining income up to GBP 29400, and 40% on any income left above that amount (Dixon and Robinson 2002). The U.K. National Insurance contributions additionally require employees to pay 10% of their weekly taxable income between GBP 87-575 and employers to pay an 11.9% payroll tax for earnings over GBP 87 (Dixon and Robinson 2002).

Premiums for private medical insurance are risk-rated and vary between group policies (e.g. employer-bought private insurance) and individual policies, with the latter being generally more expensive. Approximately two-third of private medical insurance is bought by employers as part of an employee’s benefits package (Dixon and Robinson 2002).

*User Fees*

Although most medical needs are met freely at the point-of-service with no charges for GP consultations or inpatient hospital stays, the population often must pay out-of-pocket for long-term and private care, pharmaceuticals, dental care, and eye services (Gaydos and Fried 2002). For example, the prescription drug co-payment was GBP 6.20 in 2002. However, 85% of all prescriptions end up being exempt from this co-payment because they fit into one of the exception categories (e.g. pensioners, students, low-income populations, STD clinic visitors, etc.). Segments of the population who frequently require prescription drugs are able to pay for four-month or annual prescription certificates at GBP 31.90 and 87.60, respectively; these certificates cover their drug costs for that time interval. Eye exams cost between GBP 10-20, while
consumers pay 80% of the costs of dental services, up to a cap of GBP 354 (Dixon and Robinson 2002).

*Reimbursement*

Remuneration schemes for medical services vary within the U.K.'s health care system. While hospital physicians are salaried government employees, GPs are reimbursed by capitation in accordance to the number of patients enrolled in a practice and also the number of services rendered. Privately insured patients are typically billed on a fee-for-service basis (Dixon and Robinson 2002).

*Quality of Benefits, Choice, and Access*

There is no enumerated list of guaranteed benefits within the NHS, but the Secretary of State is accountable for providing necessary benefits based on the recommendations of the National Institute of Clinical Excellence (NICE). The so-called "British National Formulary" allows U.K. residents to look up which drugs are not covered by the NHS due to excessive costs or questionable benefits (Dixon and Robinson 2002).

Although the NHS consistently receives high marks for public funding of health care, population coverage, and cost control, it typically is ranked low in terms of rapid access to medical technology and patient responsiveness (Blank and Burau 2004). The
U.K. has a low ratio of both hospital beds and physicians per 1000 population relative to the U.K.’s European counterparts (Fried and Gaydos 2002). With GPs spending under 10 minutes with each patient on average, poor communication and strained, impersonal relationships are a growing consumer complaint (Coulter and Magee 2003).

Moreover, in an era where patients are seizing personal control of their health, the NHS is plagued by long waiting times after GP referrals for specialist appointments (average 2.5 months) and elective hospital procedures/treatment (average 3 months). It is worth noting, however, that first-contact access to primary care is good, as appointments can usually be made for the same day in extreme circumstances and within a week for normal requests. Nonetheless, in order to compensate for some of these access issues, recent attempts have been made to reduce waiting times for elective procedures by contracting with private, for-profit hospitals in France; similarly, U.K. residents also recently have had the opportunity to receive necessary treatments abroad in a more timely manner under three pilot programs (Dixon and Robinson 2002).

**Problems and Reform**

The NHS has been in a continual state of flux during the past two decades, with reforms yielding mixed results. On the positive side, recent NHS reforms have prompted a shift away from acute hospital-based medicine towards primary care and community health initiatives; with this new emphasis on prevention and education, GPs have found their roles enhanced at the expense of hospital-based specialists (Ham 1997). The transformation of British health care has also had negative effects, such as increased administrative costs due to the fragmentation of the purchaser role between GP
fundholders (now replaced by primary care trusts) and health authorities (Saltman and von Otter 1995). Additionally, the introduction of primary care trusts created a high number of small purchasers of health care, which in turn reduced the bargaining power used to obtain lower prices and wage costs (Appleby 1993). In recent years, the Labour government has enacted reforms that have reversed the trends towards greater competition in favor of increased cooperation between purchasers and providers. These reforms aim to create an environment conducive to the formation of innovative partnerships between primary and secondary care providers (Ham 1997).

The NHS continues to struggle with underfunding in the face of rising health care expenditures. Recently, the government committed to increasing levels of funding for health care with its 19 billion GBP “NHS plan” of 2000. This plan represents a 10-year effort to modernize and improve the NHS system, including increasing the number of doctors/nurses/hospitals, decreasing waiting times, upgrading health care facilities, and improving care for the elderly. The plan will be implemented by ten Department of Health task forces and a new Modernization Agency, which will work with NHS trusts and others to insure maximal community responsiveness (Gaydos and Fried 2002).

Finally, health disparities continue to plague the U.K.’s health care system. While the magnitude of gradients might vary depending on the measure and method used (i.e. occupational class, education, income, or ecological index to examine mortality, birth weight, morbidity, height, etc.), studies have consistently shown that individuals in lower social classes tend to die younger and suffer from a higher rate of disability during their lifetimes (MacIntyre 1997). Significant variations also exist according to geographical
location and gender. Eliminating these inequities has become a more pressing concern, as the health disparities between higher and lower social classes are increasing today despite advances in medicine and science. The social class gradient in mortality and morbidity is getting steeper largely because the professional, non-manual labor classes are experiencing a faster rate of decrease in mortality rates than the lower, manual labor classes (MacIntyre 1997). Although life expectancies were improving for all five social classes during the period from 1931 to 1991, males from professional families were found to live almost 10 years longer than their counterparts born to parents who were unskilled laborers according to a 1992-96 study. Even more disturbing, during the 1980s individuals from the poorest regions experienced a 27% increase in “likelihood of death,” which then ballooned to 34% as compared to the rest of the population in the 1990s (Mackenbach and Bakker 2002).

The United Kingdom In Brief (2000/1) European Observatory

- **Coverage**: 100% population publicly covered by NHS; 11.5% population obtain private complementary and supplementary insurance
- **Financing**: Funded primarily by the 17.5% VAT and income tax ranges of 10%, 22%, and 40%; national insurance contributions where employers pay 11.9% and employees 10% of earnings also contribute; lower limit on employee national insurance contribution income set at GBP 87 and upper is set at GBP 575; no employer ceiling on contributory income for national insurance, but lower limit is GBP 87
- **Budgeting**: Global budget set every three years
- **Benefits**: Negative drug list; medical care benefits not explicitly defined except in cases where NICE has intervened and mandated coverage of certain drugs/services
- **User Charges**: No co-payments for GP, specialist, or inpatient services; co-payment of GBP 6.20 for pharmaceuticals (2002)
The United States

Background

The U.S. fuses a heavy reliance on private, voluntary insurance obtained primarily through employers with a public system that provides services through Medicare and Medicaid (Sanders 2004). Despite being a leader in groundbreaking biomedical technology and innovative life-extending procedures, the U.S. entered the new millennium with a health care system characterized by skyrocketing costs, administrative inefficiency, and significant health disparities by race and income. Perhaps most visibly from an international standpoint, the U.S. remains the only industrialized country in the world without guaranteed health care for its citizens, as the number of uninsured Americans rose to 45 million (15.6%) in 2003. Recent economic recessions have aroused middle-class fears over the tenuous nature of their health insurance, particularly as escalating costs prompt increasing numbers of employers to drop coverage (Ham 1997; Marmor 1998).

Ranked 37th for overall health system performance, 24th in overall health attainment, and 55th for fairness in financial contribution by the World Health Organization, the U.S. health care system performs unevenly on various health indicators, which is significant given that the U.S. spends far more per capita on health care than any other country in the world (WHO 2005). Among the 30 OECD countries, the U.S. ranked 7th worst in infant mortality rate and 9th worst in life expectancy (Department of Commerce 2004; OECD 2003). In contrast, the U.S. excels on other indicators, such as its high level of consumer responsiveness (ranked first in the world by the WHO) and
easy access to technology; indeed, with the exception of Japan, the U.S. possesses more 
magnetic resonance imaging (MRI) units per capita, as well as more computed 
tomography (CT) scanners per million population (Anderson and Poullier 1999).

The unevenness of the U.S. system's performance on these health indicators, the 
decline in satisfaction with the U.S. system to levels hovering around 40%, and the 
increasing drag on the economy caused by skyrocketing health expenditures have created 
a political environment geared towards reform of the health care system. It remains to be 
seen whether the problems of the U.S. health care system can be successfully addressed 
by incremental reforms that keep the current structure in place, or whether the problems 
can only be solved through fundamental reform of the system.

Organizational Structure and Management

Basic Structure, Delivery, and Administration

The U.S. health care system relies on a combination of private and public 
insurance. The majority of Americans purchase private health insurance (63% in 1999) 
through their employer (58%) or on an individual basis (5%) (Upshaw and Deal 2002). 
An employer may purchase insurance coverage for an employee, cover them through the 
employer’s own insurance company (self-funded plans), or help pay for health insurance 
coverage for the employee.

The public insurance system includes entities such as Medicare and Medicaid. 
Covering 11% of the population in 1999, Medicare provides health insurance for 65 and 
over Americans and is funded through payroll tax contributions. Medicaid is an income-
based health insurance program jointly administered by the states and federal government
that covers approximately 10% of the population, including low-income populations, the disabled, and the elderly. Other publicly funded programs such as the Veterans Health Administration and workers’ compensation fund health services for veterans and those who are unable to work due to occupation-related disability, respectively (Upshaw and Deal 2002).

Both for-profit and not-for-profit private insurance companies operate within the U.S. In general, health services are delivered in both public and private settings, with a predominance of physicians and hospitals in the private sector.

**Health care Financing Mechanisms and Health Expenditures**

**Taxation, Premiums, and Other Contributions**

Contributions to health care funding in the U.S. are made by individuals, employers, federal and state governments, and charitable organizations (Upshaw and Deal 2002). In 2002, government expenditures accounted for 44.9% of health care costs, and private expenditures represented the remaining 55.1% in the form of prepaid plans (65.7%) and out-of-pocket expenses (25.4%) (Sanders 2004; WHO 2005).
The government finances Medicare, Medicaid, the Veterans Health Administration, and workers’ compensation largely out of general federal/state/local taxes (Upshaw and Deal 2002). Medicare is financed both through a Social security payroll tax and premiums (for Medicare Part B). Both state and federal governments finance Medicaid, with the federal government providing states with matching funds for Medicaid expenditures according to a set formula (Upshaw and Deal 2002).

User Fees

48% of Americans covered by private employer-based insurance obtain coverage through preferred-provider organizations (PPOs), which typically offer incentives to enrollees to choose certain contracted providers in the form of lower coinsurance rates. 23% of those covered by employer-based health insurance are enrolled in health maintenance organizations (HMO’s), which subject enrollees to monthly premiums and co-payments (average $10) when they visit their physician. 22% are covered by point-of-service/indemnity plans that allow free choice of providers, although choosing contracted providers is usually rewarded in the form of more extensive benefit coverage. Finally, 7% have traditional fee-for-service plans that require enrollees to pay a monthly premium (often with employer contributions). Their insurance company then pays providers for services rendered each month. These plans, however, often have deductibles ranging from $250-500 as well as co-insurance requirements (Upshaw and Deal 2002).

By federal law, states are not allowed to charge premiums to most Medicaid beneficiaries, but recently, states have been obtaining waivers that allow them to charge higher premiums to an expanded number of Medicaid beneficiaries. Cost-sharing in the
form of deductibles, co-payments, or co-insurance has also increased recently. Certain
groups of individuals are not allowed to be targeted for cost-sharing (e.g. children and
pregnant women). Nonetheless, a total of 29 states imposed new or higher co-payments
in Medicaid in fiscal years 2004 and 2005 for other groups (Artiga and O’Malley 2005).

Reimbursement

Reimbursement within the U.S. health care system occurs via several different
mechanisms: fee-for-service, capitation, and prospective payment. Indemnity plans tend
to favor fee-for-service remuneration, while managed care plans often rely on capitation.
Prospective payment mechanisms are also favored by health maintenance organizations
(Upshaw and Deal 2002).

Quality of Benefits, Choice, and Access

Medicare Part A provides for limited hospitalization and home health costs for all
Medicare enrollees who have made payroll contributions throughout their lifetime;
Medicare Part B, on the other hand, offers a more generous benefits package extending to
certain outpatient services and medical equipment (Upshaw and Deal 2002). Medicaid
enrollee benefits vary by state, but the federal government mandates that certain medical
services be covered, with other services (such as dental services) left to the state’s
discretion (Upshaw and Deal 2002).

The tradeoff between virtually unlimited high-technology options for those who
can afford them and guaranteed access for all has produced large disparities in care
according to gender, race, age, region, education, and socioeconomic status. The tradeoff
has also created a system simultaneously plagued by both overprovision for the insured
and under-provision for the uninsured and underinsured (Schuster, et al. 1998). Despite possessing a large number of physicians (particularly specialists), 46 million Americans resided in areas experiencing primary health care professional shortages in 2000 (Upshaw and Deal 2002). Within the U.S. health care system, there exists inequitable and poorly distributed access, a low commitment to public health, many concerns over quality, over-consumption, medical cost inflation, and inefficiency: by-products of a system that relies on financing through direct payments (33%) and private insurance (28%) (Appleby 1993). According to the Institute Of Medicine, moreover, there are 18,000 preventable deaths a year related to a lack of health insurance coverage (IOM 2004).

Even with these barriers to access, U.S. patients are generally informed, savvy consumers of health care in comparison to many of their European counterparts. Particularly in today’s Information Age, patients are finding a wealth of information at their fingertips. Conversely, the increasingly specialized medical profession is struggling to stay up-to-date with recent developments; thus, physicians rarely possess more than a topical knowledge of areas outside of their specialty, which serves to level the playing field between doctors and the information-armed patients and to promote mutual participation in the decision-making process (Freidson 2004). Here the high level of health system responsiveness, in part, earned the U.S. a top ranking by the WHO in 2000 for this category (WHO 2000).

Problems and Reform

The U.S. is plagued by high administrative costs, and studies have estimated as much as 31% of all health care costs in the U.S. go to administration (Woolhandler, et al.
Health insurance premiums continued to grow at unsustainable rates; from 2003 to 2004, premiums increased 11.2% -- a much faster rate than inflation (2.3%) and wage increases (2.2%). Overall, the U.S. devoted 14.6% of GDP to health care in 2002, which is significantly higher than the OECD average of 8.1% (Reinhart, et. al 2004).

With such a strong reliance on employer-based health insurance, it is noteworthy that only 63% of jobs offered workers health insurance such that by 2003, 17.5% of full-time workers had no health insurance (Kaiser Family Foundation 2004).

The U.S. has embraced an element of planning/regulation during the past two decades, transforming itself from a fee-for-service system to one in which over 50% of the population is now part of a managed health care organization (MHO) (Appleby 1993). Although HMOs have achieved a degree of success in reducing unnecessary treatments and increasing consumer/provider accountability through deductibles and incentives, these accomplishments have often been at the expense of low-income populations, the elderly, and people with pre-existing health conditions; thus, coverage has improved little in the U.S. during this era of managed care because HMOs cannot afford to take on such high-risk populations (Appleby 1993; Saltman and Otter 1995).

Even the rise of managed care and the subsequent shift from fee-for-service to the prospective payment system’s use of DRGs has failed to produce significant quality improvements (Brook, et al. 2000). In fact, various studies have shown that not only are a mere two-thirds of acute/chronic patients receiving proper care in the U.S., but American patients receive many unnecessarily “intensive treatments” that fail to produce appreciable gains in health outcomes on a consistent basis (OECD 2003; McLoughlin and
Leatherman 2003). These problems are further compounded by the continued use of treatments proven ineffective by research studies, such as the prescription of antibiotics for viral infections, as well as the extensive underuse of necessary treatments, such as the under-prescribing of $\beta$ blockers to decrease the likelihood of future attacks in heart attack patients (McLoughlin and Leatherman 2003; Schuster, et al. 1998).

The U.S. has effectively embraced health technology, spurred research and development, and witnessed employers efficiently adopting utilization reviews and disease management to cap their spending (Sanders 2004). Despite these positive developments for the insured segment of the American population, many impediments to future reform efforts that would extend health coverage to all remain. As evidenced in the political war that doomed the passage of President Bill Clinton’s Health Security Act and more recent struggles over expanding Medicaid and Medicare coverage, interest groups representing doctors, insurers, lawyers, and corporations will mount sensationalistic attacks in the media in order to preserve the status quo system of employer-sponsored insurance coverage and tax incentives (Appleby 1993). Although first-class medical care and cutting-edge breakthroughs in treatment are available to well-insured Americans, the central challenge facing this generation of aspiring U.S. health leaders is to learn from international models of extending comprehensive care to all citizens, not just those who can afford it.
<table>
<thead>
<tr>
<th>Coverage</th>
<th>15.6% (45 million) uninsured; 11% of the population 65 and over is covered by Medicare (1999); Medicaid is a means-tested health insurance program covering approximately 10% of the population (1999); 63% purchase private insurance (1999); Veterans Health Administration and Workers Compensation are public programs covering a small segment of the population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
<td>US government funded 44.9% of healthcare costs, and private expenditures represented the remaining 55.1% of health outlays (2002); the government finances Medicare, Medicaid, the Veterans Health Administration, and workers’ compensation out of general federal/state/local taxes, as well as payroll taxes</td>
</tr>
<tr>
<td>Budgeting</td>
<td>Rising use of budgets as managed care expands</td>
</tr>
<tr>
<td>Benefits</td>
<td>Medicare Part A covers limited hospitalization and home health costs for all Medicare enrollees; Medicare Part B covers certain outpatient services and medical equipment for those who choose to pay the monthly premium ($45.50 in 2000); Medicaid enrollee benefits vary by state although certain basic medical services are federally stipulated</td>
</tr>
<tr>
<td>User Charges</td>
<td>Co-payments and premiums vary significantly among private plans; risk-rating</td>
</tr>
<tr>
<td>Category</td>
<td>U.S.</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Health Expenditure as % of GDP (2002/3)</td>
<td>15</td>
</tr>
<tr>
<td>Per Capita Health Expenditure (U.S.$, 2001/2)</td>
<td>5274</td>
</tr>
<tr>
<td>Life Expectancy at Birth (years, 2003)</td>
<td>77</td>
</tr>
<tr>
<td>Healthy Life Expectancy at Birth (years, 2002)</td>
<td>69.3</td>
</tr>
<tr>
<td>WHO Health Level Attainment Ranking by Disability-Adjusted Life Expectancy (2000)</td>
<td>24</td>
</tr>
<tr>
<td>WHO Level of Responsiveness Attainment Ranking (2000)</td>
<td>1</td>
</tr>
<tr>
<td>WHO Fairness in Financial Contribution Ranking (2000)</td>
<td>54--55</td>
</tr>
<tr>
<td>WHO Overall System Performance Ranking (2000)</td>
<td>37</td>
</tr>
<tr>
<td>Infant Mortality Rate (deaths per 1000 live births, 2003)</td>
<td>7</td>
</tr>
<tr>
<td>Hospitals per 100000 (2002)</td>
<td>n/a</td>
</tr>
<tr>
<td>Percent of Population with Government-Assured Health Insurance (1997)</td>
<td>33.3</td>
</tr>
<tr>
<td>Average Growth Rate of Total Health Expenditure, 1998-2002/3</td>
<td>4.6</td>
</tr>
<tr>
<td>Drug Spending Per Capita (1996)</td>
<td>344</td>
</tr>
<tr>
<td>Expenditure on Pharmaceuticals as % of Total Health Expenditure (2000)</td>
<td>11.9</td>
</tr>
<tr>
<td>CT Scanners Per Million Population (2002 or most recent available)*</td>
<td>13.1</td>
</tr>
<tr>
<td>MRI Units Per Million Population (2003 or most recent available)*</td>
<td>8.6</td>
</tr>
<tr>
<td>Practicing Physicians per 1000 Population (2003)</td>
<td>2.3</td>
</tr>
<tr>
<td>Acute Care Beds Per 1000 Population (2003)</td>
<td>2.8</td>
</tr>
<tr>
<td>Per Capita Spending on Hospitals (1996)</td>
<td>1646</td>
</tr>
<tr>
<td>Per Capita Spending on Physician Services (1996)</td>
<td>761</td>
</tr>
<tr>
<td>Percent of Population with Inpatient Admissions (1996)</td>
<td>12.2</td>
</tr>
<tr>
<td>Average Length-Of-Stay (days, 1996)</td>
<td>7.8</td>
</tr>
</tbody>
</table>

*This U.S. figures are below the real number of CT scanners and MRI units because the estimates do not account for devices in non-hospital locations or multiple CT scanners in a hospital.
Applications of These Models: Achieving Universal Health Care in the U.S.

Background: Past Reform Attempts to Achieve Universal Health Care

With each passing year, it becomes increasingly clear that significant structural changes are necessary in the U.S. health system—particularly as employment-sponsored insurance declines, health care costs climb, and the number of uninsured soars to over 45 million (McNamee 2004). As a result, American companies are struggling to remain competitive on global markets under the burden of large employee health costs, and insured Americans are both directly and indirectly absorbing the health care costs of the uninsured. According to the Kaiser Commission on Medicaid and the Uninsured, achieving universal health care in this country would cost about $69 billion annually, which translates into a six percent increase in yearly health care expenditures (McNamee 2004).

With surveys and polls consistently showing that over six in ten Americans define health care as a right and support making it available to all, the question that naturally emerges is why no system of universal health care has yet to be implemented in the U.S. Undoubtedly, the very idea of universal health care reform is not new to this country; but cultural values, vested interests in the health industry, and a general lack of urgency among the public and government have thus far thwarted this goal. Efforts to achieve health care for all Americans date back to President Harry S. Truman, whose attempt at doing so was easily defeated in the 1940s (McNamee 2004). During the 1960s, President Lyndon S. Johnson realized that he would not be able to enact sweeping
reform on the magnitude Truman had once envisioned, so he instead embraced incremental expansions of the U.S. health system to cover the poor and elderly through Medicaid and Medicare, respectively.

The most recent attempt to implement universal health care in this country occurred in 1993 under the Clinton Administration, and the memories of this failure continue to haunt politicians today. The economic recession of the early 1990s had aroused middle-class fears over the tenuous nature of their health insurance, particularly as escalating costs prompted more employers to drop coverage (Ham 1997; Marmor 1998). To cope with financial pressures, states resorted to reducing Medicaid eligibility, private for-profit insurance companies avoided high-risk candidates and replaced community ratings with experience ones, and large corporations moved towards self-insurance—often at the expense of small businesses who could not afford to do so (Kirkman-Liff 1997). Such events further eroded public faith in the medical professional class, and patient dissatisfaction sharply rose as medicine became viewed as more of a business than an altruistic calling (Marmor 1998). The public outcry and consequent political pressure to rein in medical expenditures allowed Clinton to take office with a virtual popular mandate to make significant coverage and financing reforms to the U.S. health care system—bridging Democratic hopes for “universal coverage” and Republican desires for cost control (Kirkman-Liff 1997; Marmor 1998).

It was within this context that Clinton’s Health Task Force began formulating The Health Security Act—a 1342-page document not finished until 1994 that chronicled plans for “compulsory workplace insurance” and for several available managed care plan
options (Kirkman-Liff 1997). Yet in taking two years to finalize the details of this health care proposal which would have guaranteed lifelong insurance coverage in the U.S., the Clinton administration managed to squander its political capital and subsequently suffered an embarrassing defeat at the hands of the newly elected Republican Congress in 1994 (Marmor 1998). The lengthy and convoluted Health Security Act fell victim to interest group attacks, media distortions, and partisan politics. In order to preserve the status quo system of employer-sponsored insurance coverage and tax incentives, interest groups representing doctors, insurers, lawyers, and corporations mounted sensational attacks in the press, scaring the American public into believing that the bill called for socialized medicine devoid of patient choice (Appleby 1993). Permanently ingraining irrational fears of socialized medicine devoid of patient freedom in the minds of Americans, the Clinton health care debacle ensured the further entrenchment of this country’s current three-tiered health care system—composed of the uninsured, underinsured, and adequately insured (Blank and Burau 2004; Kirkman-Liff 1997). In a twist of irony, the stifling of competition and limiting of health care options that so concerned critics of the Clinton plan in 1994 have actually become realities in the aftermath of the bill’s defeat; as 70% of Americans are now enrolled in managed care plans, they are finding themselves with even fewer choices than the Clinton proposal offered (Appleby 1993).

Since Clinton’s failed attempt at achieving universal health care in 1993, recent efforts to expand U.S. health coverage have centered on incremental reforms that have extended Medicaid coverage to more children, added prescription drug coverage to
Medicare, and promoted increased usage of Medical Savings Accounts (McNamee 2004). Both federal and state policy makers have examined how the countries discussed above have adopted national health service, mandated social insurance, and entrepreneurial health systems to achieve close to 100% population coverage while balancing both public- and private-sector demands. Yet the difficulty in their task lies in determining what the appropriate blend of financing and delivery methods is for this country so that health care can be guaranteed for all Americans.

*Universal Health Care Reform Pathways*

The experiences of other industrialized states have shown that there are many models of achieving universal health care. Although the majority of Americans support the idea of extending health coverage to all, determining which approach would be best-suited to the U.S. health system is contentious and controversial. Of particular worthiness for consideration, however, are strategies that involve the creation of a single-payer system, population-based expansions, the federalist state-led approach, tax credits, employer mandates, and individual mandate (Chua 2005).
Introduction of a Single-Payer System

Summary of the Reforms

Single-payer reforms have the potential to create the most efficient U.S. health system, but they would also entail the most significant restructuring and likely would encounter the most public and political resistance. With the federal government assuming responsibility for the financing of health care in this approach, private insurers would find their long-held dominant position in the U.S. health care market greatly diminished since their role would be reduced to offering only extra service coverage beyond what would be covered by the public health system (Chua 2005).

Advantages

Creating a single-payer system would significantly improve the efficiency of the current U.S. health system because it would eliminate the estimated $200-300 billion spent on administrative costs each year by the private insurance sector. After initial restructuring costs were recovered, moreover, a single-payer system would result in long-term savings (Chua 2005). In addition, the government would have enhanced power to negotiate lower prices for pharmaceuticals, health equipments, and other services. Finally, Americans would find unexpectedly greater freedom to choose their physician since preferred provider networks would no longer be in existence.

Disadvantages

With 85% of the American voting electorate insured and the majority of Americans supportive of the principle of private health insurance, single-payer reforms would likely encounter significant resistance since they would involve a radical departure
from this country’s present health system; thus, many Americans still view this as an “extreme solution” (Chua 2005). Moreover, this strategy would be difficult to achieve in the current political atmosphere, which is rife with partisanship.

Americans tend to (incorrectly) associate single-payer health systems with socialized medicine, restricted choice, and government inefficiency. Therefore, this approach would also require significant educational and informational components to combat these misperceptions. Conservatives are particularly opposed to single-payer proposals because all individuals would be forced to have the same basic insurance plan (and thus would lose the freedom to choose the type of coverage they wanted from a variety of options). They also feel that a government monopoly and a lack of private sector competition would lead to increased inefficiency and higher prices in health care (Chua 2005).

Population-Based Expansions

Summary of the Reforms

To some extent, population-based reforms are already occurring in the U.S. The decade of the 1990s was characterized by incremental reforms that extended health coverage to more segments of the population. For instance, the State Children’s Health Insurance Program (SCHIP) was created to provide health insurance for children from low-income families, while Medicaid also underwent expansions to cover more pregnant women and children. Universal health advocates hope that by taking health care programs already in place and then “expanding coverage upwards to cover the young and
downwards to cover those who are old (pincer strategy),” universal health care will be achieved in this country (Chua 2005).

Advantages

The principle advantage of this reform approach is that it has already proven politically feasible on a smaller level; for it builds on public health programs (e.g. Medicaid, SCHIP, and Medicare) that have already been established so that no major structural or administrative overhauls of the U.S. health system would need to occur to achieve universal health care with this model.

Disadvantages

One of the major criticisms of population-based expansions of coverage is that this reform approach is too incremental. According this school of thought, the minor health care improvements from this strategy would reduce the number of uninsured Americans and therefore decrease public pressure for more substantial reform. These critics tend to decry incremental reform attempts, believing that reforms short of achieving their desired universal health care system should not be accepted since they will be counterproductive and detrimental to realizing the ultimate goal of care for all (Chua 2005).

Moreover, it is worth noting that many Americans who qualify for Medicaid and SCHIP do not receive the benefits they are entitled too because they lack knowledge/information, failed to register, or encountered some other barrier to enrollment. Thus, extending universal coverage to all Americans based on expansions of
these programs also would require significant investments in eliminating barriers to enrollment.

**Federalist State-Led Approach**

*Summary of the Reforms*

The federal-state partnership approach to achieving universal health care involves the federal government financing state efforts to develop their own individualized programs that would provide their populations with care. The level of care would be regulated by certain federal stipulations, but states would have the freedom and flexibility to be responsive to their environment and population needs.

*Advantages*

The political feasibility of this approach is one of its greatest assets. At the federal level, discord among universal health care advocates—who disagree over what model should be implemented in the U.S.—can be alleviated by removing that question from the federal discourse and reframing the discussion as one of whether the general principle of universal health care has public support in the U.S. Allowing states to develop their own universal health care programs thereby circumvents the highly partisan federal deadlock on what method is best, leaving that for states to decide. In many ways, the federalist state-led approach caters to both progressives and conservatives; for it holds the promise of achieving the long-held progressive goal of universal health care, yet also realizes the conservative principle of enhanced local and state power. Finally, since
different experimentations would occur in each state, empirical data and anecdotal experiences would be readily available for other states to learn (Chua 2005).

Disadvantages

Perhaps the most troubling disadvantage of this strategy for achieving universal health care is that it will likely produce significant inequities in coverage among states. Not only does that raise questions about health care insurance portability across state lines, but it also brings up concerns as to whether individuals will flock to states with more favorable health care programs. Moreover, the model of universal health care will be defined differently by each state—rendering their individual health systems especially vulnerable to changing political and economic conditions at the state level. Finally, there is no guarantee that resolving the question of how universal health care should be achieved will be any easier at the state level, or that it will generate higher levels of bipartisan cooperation locally (Chua 2005).

Tax Credits

Summary of the Reforms

The favored approach of the present Bush administration and many other conservatives, tax credits can also be used to achieve universal health care. Tax credits, which would likely be assessed based on an individual’s income, would be extended to those Americans who do not receive health coverage through their employer. This would then allow these people to individually purchase their own private health insurance (Chua 2005). A variant of this approach would be the extension of tax incentives to Health
Savings Accounts, which would allow employers and/or employees to set aside money in an account to be used to pay for their health expenses on a tax-free basis (Hubbard 2006).

**Advantages**

Advocates of increased personal responsibility and consumer choice are particularly supportive of this strategy. Tax credits are designed to empower the consumer, allowing him to increase his purchasing power and enhancing his individual choice over what type of health insurance he needs. In addition, free-market economists believe that since tax credits give consumers more economic freedom to choose among plans, greater competition will ensue among private insurers—which in turn will produce higher quality, greater efficiency, and lower prices in health care (Chua 2005).

Moreover, tax-friendly plans such as Health Savings Accounts have grown in popularity in recent years, with over three million people now participating; many view such tax incentives as a means of increasing personal restraint and accountability over health spending (Hubbard 2006).

**Disadvantages**

Not only will tax credits likely result in higher administrative costs, but they also do not guarantee that universal health care will be achieved since tax credits do not obligate Americans to purchase health coverage. Moreover, even though tax credits would be able to help individuals afford to purchase health coverage when not insured through their employers, they would not necessarily ensure access to care; for people might still be unable to afford to pay the premiums or co-payments at the point-of-service (that would later be refunded via rebate). It is particularly important to note that in the
past five years, premiums for private insurance coverage have increased by 73% (Hubbard 2006).

Equally as concerning, tax credits rely on individual markets, which tend to be more costly since groups often use their bargaining power to negotiate discounted prices (Chua 2005). Finally, plans involving Health Savings Accounts tend to favor the healthy and better-off segments of society, leaving the impoverished—who generally have lower health levels—to fend for themselves in purchasing private insurance from a discriminating free market.

Employer Mandates

Summary of Reforms

The fundamental principle behind this reform approach is that employers would be responsible for health benefits for their employees—whether by offering health plans to insure them or by paying a payroll tax that funds public programs that provide coverage (“pay or play”). This strategy has recently become a hot topic for debate on the federal level, especially following the introduction of the Health Care Accountability Act in June 2005. This bill would require states to record the names of companies with 50 or greater employees that did not provide health coverage. Its particular goal is to force Wal-Mart (and other large companies) to cover their 600,000 uninsured employees instead of pushing them onto the public dole (Joyce 2005).
**Advantages**

Companies that do not provide health insurance for their employees would no longer be able to enjoy a “free ride” on public tax dollars. This would thus benefit both tax payers and employees. The employer-mandate strategy would force businesses to either cover employees with health plans or pay for public coverage via a payroll tax. Moreover, employer mandates may be more acceptable to the public since the increased costs of universal coverage would not come in the form of a new tax (Chua 2005).

**Disadvantages**

This approach would encounter severe opposition from the business community, which abhors the idea of additional taxes or benefit provision requirements and would use its well-financed lobbyists to fiercely resist such proposals (Symonds, et al. 2005). Many still vividly recall the full-blown media attack these forces launched against the employer-mandate proposal set forth under Clinton, and their resistance was largely responsible for its failure in 1993-1994.

Businesses believe that the extra monetary strain imposed by an employer-mandate would decrease their competitiveness on the global market and result in a loss of jobs. In particular, small businesses would likely struggle to afford such additional costs. It is important to note, moreover, that universal health care is not guaranteed by an employer mandate alone. An individual mandate requiring the purchase of insurance and/or expansions of public health care programs must also occur to ensure that all receive health insurance (Chua 2005).
Individual Mandate

Summary of Reforms

Based on the auto insurance requirement for all drivers, the individual mandate would compel all Americans to purchase health insurance—whether through their employer, the individual market, or public coverage.

Advantages

The individual mandate strategy is a highly touted approach by many conservatives who feel that it offers the perfect solution to America’s health crisis: preserving the celebrated U.S free-market system while also guaranteeing that everyone has health insurance (Klein 2005). One of the advantages of this proposal is that it would force everyone to obtain health coverage so that the cost of care for uninsured individuals no longer would have to be absorbed by other insured Americans in the form of higher taxes or insurance premiums. Advocates of this strategy cite it as a method of increasing personal responsibility in health care spending (Chua 2005).

Disadvantages

The most significant drawback of this approach is that those impoverished individuals with incomes too high to qualify for public assistance yet who still do not have the means to purchase expensive health insurance would be unfairly targeted; significant subsidies must exist to guarantee that this segment of the population can afford to purchase coverage. Moreover, this strategy of guaranteeing universal health care would likely result in higher administrative costs in order to make sure that all Americans purchases health insurance (Chua 2005).
Both conservatives and liberals have their qualms about individual-mandate plans. Conservatives detest the idea that individuals would lose the choice of whether to purchase health coverage or not in the name of public fairness (this element particularly targets young, healthy individuals who refuse to purchase insurance), while progressives worry about the difficulties low-income individuals will encounter as they try to reasonably obtain coverage on the largely preserved, complex free market system (Klein 2005).

<table>
<thead>
<tr>
<th>Reform Strategies</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single-Payer System</strong></td>
<td>Administrative efficiency; government bargaining power; lower pharmaceutical prices; choice; cost control</td>
<td>Significant costs associated with initial structural changes; viewed by most Americans as extreme solution; private insurance industry would strongly oppose; not politically feasible at present</td>
</tr>
<tr>
<td><strong>Population-Based Expansion</strong></td>
<td>Public and political support for these incremental reforms; based on already established public health programs</td>
<td>Requires concurrent commitment to improve enrollment in public programs; incremental approach may erode public pressure for more far-reaching reforms; does not directly address cost containment</td>
</tr>
<tr>
<td><strong>Federalist State-Driven</strong></td>
<td>Allows for state flexibility and responsiveness; individualized approach; experimentation to determine best method to achieve universal health care; success could generate national momentum for federal legislation for universal health care</td>
<td>Dependent on federal funding; inequity among states; health insurance portability problems; could still encounter partisan gridlock at the state level over best route to achieve universal health care</td>
</tr>
<tr>
<td><strong>Tax Credits</strong></td>
<td>Conservatives have long loved this method of increasing personal responsibility; enhanced consumer freedom to choose their health plan; greater competition and better options</td>
<td>Inefficiency; greater administrative costs; do not control health costs; point-of-service fees could still serve as barrier to care; relies on individual markets that tend to be more expensive and inefficient</td>
</tr>
<tr>
<td><strong>Employer Mandates</strong></td>
<td>Levels the corporate &quot;playing field&quot;; stops businesses from free-loading off the public health system</td>
<td>Could hurt American businesses; could result in job losses and lowered compensation in other areas; could be especially difficult for small businesses</td>
</tr>
<tr>
<td><strong>Individual Mandate</strong></td>
<td>All required to purchase health insurance; auto insurance industry model; no more free-loading off of the public system</td>
<td>Unfair burden on those unable to afford costly coverage if not high enough levels of subsidization; high administrative costs</td>
</tr>
</tbody>
</table>
Conclusion

Although the federal government has legislated population-based expansions of coverage through Medicaid, Medicare, and SCHIP during the past decade, states are becoming the significant drivers behind the push towards universal health care in this country. Consequently, much potential lies in the federalist, state-led approach to guarantee care for all Americans.

States have individually experimented with many of the strategies discussed above. Particularly when considering the partisan gridlock and discord that exists over major health care reform at the federal level, it appears more probable that states would first lead the way in experimenting with universal health care systems. The hope is that the public momentum generated by successful state programs would spread and eventually compel the federal government to enact legislation to guarantee universal health care at the national level. This route towards universal health care would closely mimic Canada’s experience, where the provinces adopted universal health care before the federal government came on board.

Although the U.S. could feasibly follow Canada’s bottom-up path towards universal health care, it appears unlikely that the U.S. would adopt its single-payer model of health insurance provision because significant public resistance exists to such drastic restructuring in this country. Since the segment of the population that remains uninsured is not politically mobilized, moreover, the majority of Americans—although troubled by reductions in insurance benefits and higher costs—“have a strong vested interest in their employer-based insurance” and tend to favor more incremental changes that would
preserve the core of the U.S. health system (i.e. expansions in Medicaid or employer mandates) [McNamee 2004]. Thus, it is more probable that the U.S. would adopt a hybrid of other European models and strategies that would preserve the role of a strong private insurance sector as in the Netherlands.

At the federal level, policy makers continue to fail to reach a consensus on the best method of achieving universal health care. As a result, no significant nationally dictated restructurings are probable given the present level of partisan clashing and special interest/lobby influence. As such, the role of the states emerges as central to the process of bringing universal health care to Americans. Although state policy makers also vary in their attitudes towards universal health care and how best to achieve it, they have nonetheless found enough common ground to make some notable progress. States have experimented with various international strategies—from mandates to single-payer reforms—to achieve this goal. For instance, Maine’s Dirigo Health Plan aims to provide universal health care by 2009. Meanwhile, Governor Rod Blagojevich of Illinois just signed the first law to guarantee health coverage for all children in the state through a new health plan called All Kids (Symonds, et al. 2005). This is not to say that states have not encountered pitfalls in implementing universal health care reforms in the past—most notably demonstrated by the 12% of Hawaii’s population left uninsured today even after the passing of its 1974 employer mandate and by California’s recent failure to pass an employer mandate due to intense public pressure (Symonds, et al. 2005).

Nonetheless, states have forged ahead, learning from past mistakes and successes in their attempts to extend health care to all residents. Today, Massachusetts presents a
relevant case study for the nation on gaining bipartisan support for hybrid models of achieving universal health coverage. Governor Mitt Romney has tried to find a middle ground between Democrats and Republicans in the creation of a health plan to cover the 500,000 uninsured state residents through a low-premium, high-deductible ($250-$1000 per year) plan (Rowland 2005). While this plan would increase out-of-pocket expenses and could consequently create new barriers to routine and preventive care for the poor unless subsidies are high enough, it is nevertheless a proposal that businesses, state HMOs, and employees support. Part of its broad appeal lies in how it would relieve companies of rapidly increasing premiums and employees would be able to have insurance portability from job to job (Rowland 2005).

The nation will be closely watching the Massachusetts experiment in universal health care, as well as those being implemented by other states throughout the country. States have learned from their European and Canadian counterparts that there are many diverse methods of achieving universal care. As long as states remember to not let the perfect be the enemy of the good, their momentum towards extending health coverage to all Americans could bring about this reality on the national level.
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