

UNIVERSITY HONORS PROGRAM

SENIOR PROJECT - APPROVAL

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PROJECT TITLE: Comparative National Health

Care Systems

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Comparative National Health Care Systems

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December 10, 1999

Crises in health care financing and pressures on health care budgets are, of course, not new issues nor are attempts at reforms. Since the oil crisis in the early 70's, policymakers have attempted to reform some element of health care systems, to stabilize expenditures, and to pass cost containment legislation - all with varying degrees of success (Altenstetter, 10). Health care reforms of the 80's focused on the power of physicians and attempts to constrain them. With the failure of this approach, the aim became to shift health care financing from the

public sector back to private sources such as collective insurance and health maintenance organizations. From this objective came the popularity of systems of cost-control arrangements.

In an age of globalization and instantaneous global communication, health care reform theories shifted from a national to an international discussion. The 90's, particularly, have seen a proliferation of literature on comparative health care. This interest reflects the continuing quest for solutions to the seemingly intractable problem of providing health care to the modern world. Increasingly, experts within the United States have begun to look to health care systems in other countries as models for reform at home. At the risk of over-simplification, worldwide health care troubles can be related to two factors. First, the costs of health care have risen continuously as have the demands of a more sophisticated consumer base. These increasing costs stem directly from new technologies which enable doctors to treat more conditions than before, the growing needs of an aging population, and the patient's raising expectations as new, better, but often more expensive treatments are offered. Second, economic and political trends have restricted the supply of resources which governments can make available to cover

health care expenses. Rising demand and associated costs have driven governments to seek new ways of controlling their overall health care bill.

Because these problems are shared by a number of countries with well-developed health care systems, foreign systems offer a conduit for comparison and reform.

In recent years, many countries have been attempting to restructure their health care delivery systems. Germany, Israel, the Netherlands, and Brazil have introduced large-scale reforms while countries such as France, Britain, and Canada have targeted specific aspects of their systems. In Eastern Europe reforms have been largely market-driven, the result of the collapsing communist system.

Depending on the type of system, problems of inequities and constrained resources manifest themselves differently. National health care systems such as those of the UK and Italy offer coverage to all. However, budgetary shortfalls often produce waiting-lists even for essential services under this type of system. Countries operating under a social insurance scheme such as France and Germany provide prompt treatment by restricting patient choice as to the type of insurance coverage they receive. However, in such systems medical providers are often reimbursed in way that encourages the prescription of unnecessary treatments.

Both quantitative and qualitative methods are useful in making comparisons between systems. Quantitative approaches tend to focus on numerical data while neglecting the political and policy processes for a given health care system.

Qualitative approaches center on the evolution and development of a given system.

However, this method of study makes comparison across national boundaries and differing pasts very difficult due to the large number of variables. Thus, a focused comparison of a few case examples will be used to limit the number of variables.

By examining reform in selected developed countries, this paper will illustrate that evolving health care policies are increasingly leading toward a common middle ground.

Germany

In planning for the 21st century, Germany is relying on its 100-year-old national health insurance program with a few modifications. In 1883, Germany became the first country to institute nationwide insurance-based social and health programs (Powell 48). The Health Insurance Act of 1883 and the Accident Insurance Law of 1884 established the foundations that have led to the present day

relationship between social insurance-based programs, the financing of health care and labor legislation. Initially, benefits and contributions to these insurance plans were primarily earnings related and entitlements were linked to past contributions. In 1885, only 26% of the blue-collar labor force received coverage (Powell 50). Through the early 1900's benefits were extended to transport and commercial workers, agricultural employees, and domestic and civil servants. Coverage was granted to the unemployed in 1918, to seamen in 1927, and to all dependents in 1930. Finally by 1941 coverage was extended to all retired Germans. By 1997, coverage based on occupational group was ended and all German citizens received benefits.

Three principles underlie the evolution of the German system. The first of these is solidarity, i.e. the willingness of the healthy to support the sick and impoverished. German society has expressed its commitment to solidarity by offering universal coverage and comprehensive benefits to its population. Additionally, these rights have been secured by court rulings and are outlined in the German constitution. Second, the German system rests on the idea of subsidiarity. This principle imparts leaving the implementation of national policy

to the lowest feasible political unit. As a result, the health care system was built from the ground up rather than from the top down. Thus the current national policy sprang from the simple roots of decentralized, voluntary mutual aid funds known as sickness funds. From these beginnings associations of regionally organized doctors, sickness funds and hospitals have emerged as the decision-makers in German health policy. These regional bodies are responsible for providing quality health care and answer to elected officials. The third principle underlying German health policy is that of corporatist organization. This concept refers to the dual representation based on occupational groups as well as representation based on popular election. This system of representation enhances policy making by giving employers and employees a voice in decision-making. As a result, no one group can significantly influence policy.

Using a system that fosters cooperation instead of competition, Germany's health system has become the envy of many western nations. Germany has been able to offer choice of doctors while still delivering high-quality care. Currently 88.5% of the population is included under the all-payer public health insurance

program. The remainder of the population consists of affluent citizens who are not required to join the public program and instead opt for private coverage.

All German citizens earning less than ceiling incomes are required to join a sickness fund. Originally, workers were assigned to a particular fund based on occupation, geography, or employer. However, beginning in 1997, assignment to a particular fund was abolished allowing funds to compete for participants.

Contributions to these sickness funds provide the sole source of German health care expenditures. Funds are not solely operated by the government, but instead are a 50:50 mix of public and private providers. Currently there are over 1,000 sickness funds in existence, although a trend toward consolidation. Beginning in the early 80's modest copayments were instituted for hospital stays, prescription drugs, eyeglasses and dental services. However, these payments are relatively small and do not significantly contribute to covering expenses.

Costs are controlled at the fund level. When a fund can not break even, it must either raise premiums or restrict benefits. Because of the influence of employer-employee boards, funds generally opt to control costs without raising premiums. However, this practice led to wide discrepancies in contribution rates

for individual funds. To correct this inequity, the Structural Reform Act mandated contribution rates across sickness funds with adjustments for risk factors.

In Germany, the federal government has the power to set policy but has none to implement rules. These powers are reserved for the regional associations that govern the sickness funds. The Federal Association of Sickness Funds and the Federal Association of Sickness Fund Physicians negotiate general agreements based on federal guidelines for the delivery of care and agree upon the fee schedules for all medical procedures for a given fiscal year. These groups constitute a committee which sets spending limits and determines the inclusion of new reimbursable procedures and preventive services. It also sets guidelines for the distribution of medical equipment for office and hospital use throughout the country. Professional self-policing has played a significant role in curtailing cost growth in Germany. Over the past few decades, doctors have come under close scrutiny for excess billing and prescribing practices. Statistical profiling of diagnostic practices has recently been used to identify fraud cases in the general practice environment. Within hospitals, most physicians are employed on a

England

The state-run National Health Service (NHS) which is tax funded and free at the point of delivery provides most British health care. Although the option exists to belong to a fee-charging private sector alternative, the majority of citizens subscribe to the NHS. While the US currently spends 12% of its national income on health care, Britain controls costs to only 6%. And while the quality of care is high, it is usually delivered in a hostile customer service environment filled with long lines and frustration (Wall 127). Since its inception in 1948, the NHS has been notorious for responding to the desires of health care providers while ignoring those of consumers. As public expectations for medical care began to rise in the 80's and 90's, budgetary constraints on the NHS tightened even more. With new medical technologies and an aging population increasing costs, the government was prompted to review the fiscal resources of the NHS.

At the formation of the NHS, government officials envisioned a plan where doctors would be salaried state employees. But after forming a powerful lobbying body, physicians remained independent contractors paid on a capitation basis. The system was set up to be governed by local bodies called executive councils

salaries on a salaried basis and do not directly bill patients. Thus, excessive billing has been less of a concern in this sector.

The resulting level of health care quality in Germany has been high compared with the United States. In 1988, West Germany had 2.3 physicians per 1,000 citizens and averaged 11.5 physician contacts per year as compared to half of that in the US. Nevertheless, expenditures per capita amounted to only \$193 while in the US costs were nearly double (\$414). Additionally, the ratio of hospital beds per person was high at 10.9 per 1,000 persons. Germans also experienced more inpatient days per person per year than the western average. The number of admissions as a percentage of the total German population was 21.5, significantly higher than the OECD average of 16.1. The average length of stay was 16.6 days, below the OECD average but nearly double the American level. Germany spends only 8.7% of GDP on health care costs compared to 13.6% in the US as indicated by the figure below.

Table 1. Health Care Costs as a Percentage of GDP

<u>Year</u>	<u>Germany</u>	<u>Canada</u>	<u>Britain</u>	<u>US</u>	<u>OECD</u> <u>Average</u>
1970	5.9	7.1	4.5	7.4	5.4
1975	8.2	7.2	5.5	8.4	7.1
1980	8.4	7.4	5.8	9.3	7.0
1985	8.7	8.5	6.0	10.8	7.2
1990	8.3	9.4	6.2	12.6	7.6
1992	8.7	10.3	7.1	13.6	8.1

(Reproduced from Powell 371)

While the German social system has provided excellent curative medicine and health insurance, other aspects of care have been completely neglected. For example, care for the chronically ill and nursing homes for the elderly are often very costly and are not provided under the current insurance scheme. Current reform acts seek to correct these deficiencies.

consisting of half appointed lay representation and half from the medical professions (Roemer 185). Local boards provided regional responsiveness to community concerns and medical schools were established throughout the country. However, three distinct organizations were responsible for hospitals, GP services, and community care. This fragmentation undermined the idea of providing a unified governmental service. In 1974 the NHS sought to combine hospital and community care under one roof. However, primary and secondary care remained segregated. The reforms of 1974 also attempted to “promote more of a management ethos” in a system that was quickly becoming dominated by the whims of physicians (Wilding 34).

Under the Thatcher government, reform was undertaken for the first time to bring market forces such as customer satisfaction into the governmental model. By improving management, eliminating hierarchical rigidities and offering positive incentives, the Thatcher reforms attempted to transform the NHS into a more customer-driven organization.

Before reform attempts, the NHS had operated through a strong relationship between state and physicians. The state set the budgets and the doctors had

complete autonomy to decide who to treat and how within the financial confines. In fact, British doctors enjoyed more independence than even American physicians had. However, the new managerial activism threatened this freedom. Physicians responded boldly to the attempts to curb their freedom by issuing a statement in 1987 declaring that the NHS was on the verge of collapse. This response was strongly received by the Thatcher government who temporarily halted the reform plan. Other national alternatives for health care were considered such as an insurance-based model like Germany's. However, fear of dramatic change prevented such a move and Britain marched on with attempts to reform the NHS. Little changed and waiting lists for procedures such as elective surgeries soared to 1 million people instead of the usual 700,000 or so.

In response to the failed reforms, the private health care sector witnessed a significant growth. However, because private insurance does not offer an alternative for patients with chronic conditions, this growth was limited to a small segment of the population. Private policies only cover acute conditions while leaving the NHS to cope with life-threatening or chronic diseases.

Britain's current health care scheme shares many similarities to the gatekeeper motif being established in the US. Every member of the population is registered with a general practitioner (GP) and makes an average of 4 visits per year. The GP serves as the gatekeeper to hospital care and to specialists. The bill for Britain's primary care is relatively inexpensive totaling less than a third of the total NHS budget. Of this third, only 30% is paid directly to GP's and their staffs. Most of the remainder goes to cover prescription drugs.

Despite being a small percentage of the total budget, primary care was the central target of reform by Thatcher's government. Because GP's were independent contractors with the state, government officials felt justification was needed to explain GP-related expenditures. Additionally, a great deal of variability existed between GP referrals to hospitals. Some physicians were making 20 times the number of hospital referrals. In line with the Thatcher model of consumerism, legislation was introduced to make physicians accountable for their actions. Targets for immunizing, vaccinating and screening were established to track physician performance. Also the payment system was modified so that 60 rather than 46 percent of a general practitioner's salary would be capitation based.

Managerial bodies were established to monitor referral and prescription patterns and ensure they were in line with similar practices. Also, figure-heads were appointed to head each health authority and health care unit (hospital, clinic, etc).

The new positions known as district health authorities (DHAs) became responsible for performance reviews and controlling costs. Also as a result of these mandates, millions of pounds were poured into updating the NHS's primitive information system enabling it to track massive amounts of statistical information.

From this reform plan emerged the concept of the internal market. An internal market meant that, instead of central direction and formal planning, resources would be allocated based on competition between buyers (Wall 147). Thus hospitals, GPs and health authorities would barter with each other for services on behalf of patients. Such a system has resulted in a small amount of competition being introduced into the British system.

All in all the British system has been able to effectively control costs. As mentioned above, England spends approximately 6% of GDP on health care whereas the US spends nearly 12%. Some studies have demonstrated social inequities in the level of care provided to various social classes and racial groups.

However, overall, the NHS has been able to deliver quality care to the majority of the population.

Canada

In a more recent move to a national health insurance program, Canada sought to make quality health care a basic right for all in 1966. The Medical Care Act of 1966 aimed to provide care to all people regardless of pre-existing conditions, age, or other circumstances. Current opinion polls show that Canadians are highly satisfied with the quality of health care provided under this system. Additionally, in recent years the United Nations Development Program has consistently ranked Canada near the top internationally on its composite measure of social and medical progress - national income level, adult literacy, and average life expectancy.

With all of the providences having joined the national health care program by the early 1970s, the latter part of the decade was a time of expansion. The budget for healthcare grew significantly, as did the concern that the health insurance program was not established soundly philosophically. The government quickly responded by enacting four piece of legislation. First the Federal-

Provincial Established Programs Financing Act of 1977 modified the structure of federal-provincial co-financing arrangements and limited the share of the federal contribution. Under the new financing formula, the provinces received a per capita block grant linked to changes in the growth of the population and the GDP. Second, the Canada Health Act of 1984 clarified and strengthened the conditions on which federal payments to the provinces were contingent by imposing financial penalties to ensure reasonable access to health care without financial impediment. Third, the 1990 Federal-Provincial Fiscal Arrangements Act, which was reconfirmed in the 1991 federal budget, limited the per capita cash and tax transfer increases to the provinces until 1994-95 to a level well below the annual rate of growth in spending on health care. Fourth, this precedent was extended under the deficit-reducing targets of the 1995 budget, which resulted both in cutbacks and a major restructuring of transfer payments to the provinces.

During the early 90's as the percent of GDP spent on health care grew from nine to over ten percent, Canadians realized that an effort must be made to control costs. In 1993, the Health Minister announced that "it is not more money that is needed in the system; it is a different way of spending it" (Altenstetter 17).

In order to achieve this, funding was shifted from hospital services to primary care avenues and management decision were moved from provincial decision makers to regional levels. The results of this shift have been dramatic. From 1974 to 1994, the number of hospital beds and patient days per 100,000 declined by 17.1% and 23.6% respectively. Total spending on hospitals as a share of total health expenditures declined from 45% to 37.3% (Health Canada 1996).

Before the introduction of public national health insurance, the US and Canada spent approximately the same proportion of national income on health care. However, while Canada has been able to control costs, the US has seen constant increases. Supporters of the Canadian model credit provincial control for approving and funding hospital budgets as one of the primary forces in keeping costs in-line. All new capital plans, renovations, and technology acquisitions must be approved through provincial health ministries. From this control, more procedures were shifted to day surgeries and ambulatory services. Throughout this time, expenditures for physicians remained nearly constant at around 15%. This was achieved by fee negotiations between provincial governments and the setting of “hard caps.” Hard caps are a predetermined maximum annual budget for

medical care expenditures. Under hard caps, physicians have to pay back any expenditure above the cap. This budget safety net placed sole responsibility on physicians' shoulders for staying within the medicare budget. The result has been a weakening medical profession, but one that stays within budgetary confinements.

The result of the Canadian system of national health insurance has been fruitful. In fact, the national health insurance plan has become Canada's most strongly endorsed public program (Powell 144). The idea of health care without economic impediment has become a basic right in the eyes of Canadians. The reform of the 90s has shifted budgeting power to provincial levels. The result has been reduction of expenditures and increased efficiency.

Lessons for the United States

During the past 20 years, all well-developed health care systems have been strained due to an aging population that demands the latest in technology. These strains have produced the need for reform in Germany, England, and Canada as well as in the United States. In all of the countries examined in this paper, financing for health care is largely the responsibility of the government. In England, taxes fund the NHS, in Canada, a combination of national and provincial

taxes provide resources for national insurance and in Germany mandatory contributions to sickness funds ensure medical coverage for all enrolled.

The ability of governments to control costs seems to be a topic with more variability. At the mercy of the national budget, the NHS has become reputed for constantly being underfunded. In Canada, provincial governments have come to shoulder the responsibility of allocating and maintaining local health care budgets. Through the use of hard capping physicians, local governments have been able to successfully fund healthcare without creating budget deficits. And in Germany, negotiations between physicians and sickness fund representatives have resulted in payroll contributions that approximate medical expenses.

In both Germany and Canada, health systems reimburse physicians for ambulatory care using a fee-for-service system. In Germany, hospital care was traditionally financed through negotiations for cost of care. This methodology placed controls post hoc. As costs increased, Germany sought to reform this system by a series of acts in 1993. The result of this legislation was increased control of sickness plans by the government and increased dissatisfaction levels among consumers and providers. The current direction of the German system will

probably include modification of the acts to decrease government control. In Canada however, the government has done little to restrain health care costs beyond limiting its contributions to the provinces. The result has been a clash between federal and provincial governments. Individually, the provinces have controlled costs to varying degrees and by employing various methods. Because of the control of the federal budget in England, reform has focused on gaining greater efficiency and meeting the expectations of public demands. Whereas the push in Germany and Canada has been toward increased governmental regulation of the health care system, Britain's efforts aimed to create an internal market and introduce a level of competition.

As the US examines models for reform, a common question has arisen concerning the level of decentralization necessary to implement an effective and efficient system that is responsive to consumer needs. Decentralization allows greater responsiveness to local needs and demands, and as a result increases efficiency. Germany and Canada offer examples of decentralization. States and provinces are given the major responsibilities for policy decisions and administering financial resources. In Germany, even federal changes in policy

require the consent of regional boards of physicians and sickness fund representatives. In Canada, conflicts between provinces and the federal government make changes in federal policy difficult. On the other hand, health care is solely a power of the federal government in England.

It is clear that the principal driving force in the health care systems presented in this paper is the need for cost containment. Though England, Germany, and Canada have varied in the degree to which budget deficits and poor economic conditions have forced action on them, all have taken action aimed at moderating the costs of medical care. The main factors contributing to increasing costs – the aging of populations, technological innovation leading to more intensive care, and heightened demands- either are uncontrollable or have been politically unassailable. As the US attempts to develop a system for such cost containment, government must consider these pressures while trying too ensure comprehensive and accessible health care coverage. Clearly, the trend over the past decade in US care has been to decrease the historical autonomy of the medical profession and its associated provider community. Evidence seems to suggest that the responsibility and authority of providers must be developed into a new

relationship of cooperation with the larger community if that autonomy is to survive. Health care reform at the end of the 20th century may be seen as a search for the institutional framework that will best facilitate this realignment.

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