Transcript  

Comparative Health Systems, Part 2  

Lecture companion to Chapter 4.  

1. Welcome to Comparative Health Systems, part 2. The lecture is a companion to Jonas & Kovner’s Health Care Delivery in the United States, Chapter 4, Comparative Health Systems.  

2. The presentation objective is to address the important concepts of healthcare systems including structure, performance, and financials for the United Kingdom, Germany, Canada, and Japan. If you want to learn more about international health systems, go to the Commonwealth Fund’s “International Profiles of Healthcare Systems, 2012.”  

3. First, let’s examine United Kingdom’s National Health Service. There is universal coverage for health insurance in the UK, which includes England, Scotland, Wales, and Northern Ireland. The National Health Service is the name of the government agency responsible for the single payer healthcare system.  

4. The United Kingdom established the National Health Service in the wake of WWII. Established in 1948, the goal was to provide universal insurance coverage and direct provision of health care to all British citizens & residents. About 85% of health care is funded through general revenues from the national government, the most of any OECD country. (Remember, the U.S. government pays almost half.) Care is free for patients at the point of use; health care taxes have already been paid, so technically it’s not free. NHS directly delivers health care, as it owns most of the hospitals. Also, NHS employs almost all health care workers, such as hospital-based doctors, nurses, dentists, pharmacists, midwives, and administrators. NHS services are not entirely free. There are extra charges for private hospital rooms, a small surcharge for prescription drugs outside the hospital setting, and copayments for some services such as dental care and eyeglasses. There is a private sector in the health care system, about 10 percent of the British purchase private health insurance.  

5. As you can see from this chart, the UK spends more per person than the average OECD country, somewhat less than Canada and Germany, but far, far less than the United States.  

6. Performance of the NHS. The effect of a system such as the NHS depends on queuing or waiting lists, where access to care is often postponed or certain services are not provided. This approach is not appealing to Americans. The waiting list is a serious shortcoming of the UK system. Universal insurance can create “queues,” as the Brits call it. Although, not all countries with universal insurance have this waiting list problem.  

The NHS devotes considerable resources on preventive services. The universal nature of the service is beneficial, as there is relatively low infant mortality rates and higher life expectancy (than U.S.). Although the UK has spent considerably less on health care than the US, by most other measures of mortality and morbidity, the UK does about as well.  

Certainly, many non-medical factors are involved in determining disease and death rates in the population, and these factors vary across countries, but still differences in outcomes remain. Despite
universal access to care in the UK, historically there have been considerable regional disparities in funding and in the use of health care. Also, the Brits do have the option to go to the private healthcare system and bypass the NHS. Evidence shows that higher income patients have received more care for a particular illness than have lower income patients. For the higher income Brits, the private system deals with quality of life issues, such as hernia repair, gallbladder surgery, and hip replacements.

7. Let’s examine a key component of the UK National Health Service: General Practitioners. This slide is intended to convey the idea that while Great Britain has a national health service, they are by no means socialists.

Brits have the freedom to pick their own doctor, this is particularly true at the General Practitioner (GP) level who serves as the guide or gatekeeper to subsequent services. This means that Patients must be referred by GPs to consultants (specialists) and hospitals. Over 35,000 GP provide care to about 90% of population. GPs are not government employees, they are self-employed and receive about half of their income from government capitation contracts.

Salaried GPs employed by the NHS clinical groups earned between $85K to $127k/year in 2013 dependent on, among other factors, length of service and experience. In the U.S., internal medicine docs make $185k. By the way, another government job, the British Prime Minister, makes about $215k/year, and according to reports, over 10% of the GPs in the UK were paid over $225k year 2011/12, and 670 GPs made over $300k.

Finally, according to Doran et al. (2006), pay-for-performance began in 2006 and was intended to increase GPs’ income by up to 25%, depending on the GPs performance with respect to 146 quality indicators relating to clinical care for 10 chronic diseases.

8. Now on to Germany. The German healthcare system is classified as a traditional sickness insurance system. In 1883 Prussian Chancellor, Otto von Bismarck, started social insurance for industrial workers. The health system model where insurance companies operate and the system is financed jointly by employers and employees through payroll deduction is called the Bismarck model.

9. Germany has mandated and almost universal coverage, as about 99.6% of the population are covered, according to Michael Tanner at the Cato Institute (2008). Health insurance is mandated in Germany. The government body, the Federal Joint Committee (G-BA) defines the benefits for what is called the statutory health insurance scheme (SHIs). The statutory health insurance scheme covers about 85% of the populations. The program is funded equally through employee and employer contributions. The public insurance operated under the “working solidarity principle.” This means that health insurance is the same costs no matter the age or sickness of the individual. Also, there are government subsidies so that if an individual has a low salary, then their health insurance payment is low.

About 10% of the population are insured through a private health insurance system. Another 5% are covered through special programs, such as police unions.

10. To understand the German healthcare system, you need to know about the Sickness Funds. Legislation requires individuals to enroll in sickness insurance funds. The sickness funds are
autonomous not-for-profit, non-governmental bodies. They compete for enrollees based on quality and plan design. These sickness funds pay the healthcare providers, just as insurance companies do in the U.S. There about 150 (non-profit) plans in the public insurance system. About 50 private plans operate in private system (some for-profit) to serve individuals with high incomes. The sickness funds are largely self-regulated, but are required by the government to meet certain quality benchmarks.

11. As mentioned above, this universal healthcare system is funded through employer and employee taxes. Patients provide out-of-pocket funding in some cases, as sickness funds can require range of cost sharing depending on their plan. This element of health plan design is part of the German health system competitive market structure.

Physicians are paid on a fee-for-service basis that are negotiated with sickness funds. Hospitals, on the other hand, are paid on prospective basis, similar to our DRGs. That is, the hospitals are paid based on the average costs associated with the diagnoses, not based on how many nights they stay or how many tests they get.

The German system also controls costs by creating overall budgets for ambulatory physicians and hospitals; the providers are penalized, if they exceed the total costs allowed.

12. Now to our neighbor to the north. The Canadian Medicare is a single payer system or a National health insurance system. The provinces have the bulk of the responsibility of running provincial and territorial health insurance plans. All of provinces share basic standards of benefit coverage established at the national level.

13. Canadian healthcare structure. Like the UK, Canada is a single-payer, universal health insurance system. Unlike the UK, the Canadian government does not own the hospitals. They are a mix of local or provincial government owned and private ownership.

Physicians are not employed by hospitals, and are usually private practice. Their salaries are less than U.S. physicians, on average. Primary-care physicians U.S. earned an average of $187k in 2008, versus $125k in Canada; orthopedic surgeon in the U.S. made $442k on average, compared to $208k in Canada.

Patients have free choice of primary care doctor, although in some areas, choices are restricted owing to limited supply, as the physician to population ratio 22% lower than United States.

14. Funding for the Canadian healthcare system is provided jointly by the federal and state governments through taxes. The federal government uses funds from general revenue to provide a block grants to each of the provinces. There is considerable nastiness in these federal-provincial negotiations, according to Theodore R. Marmor, author of “The Politics of Medicare.” Canadians pay higher taxes, but do not pay insurance premiums, deductibles or co-insurance. If US premiums and out-of-pocket expenses were added together, the cost would be more than the Canadians pay in health care taxes.
The hospitals must follow a set budget that are approved at provincial level. This is an example of the centralized planning and determination of resource allocation by a single payer system. (Remember from the ACA lecture that Sarah Palin called these “death panels”?)

Physicians work in private practice and are paid on a fee-for-service basis. Since these fees are set by a centralized agency, wages are fairly low which has led to a physician shortage.

Patients have no cost sharing, such as deductibles or copayments. In Canada, there are no complex hospital or doctor bills. In fact, usually you don’t even see a bill. The Canadian Health Act of 1984 Canada outlawed extra billing.

15. The infamous Canadian waiting times. This is the same chart from the last lecture. Look at Canada circled in red. Along with the UK, Canada has the highest percent of patients whose waiting time for a specialist appointment was four weeks or more. Wait lists are a way to ration health care. Of course, because of Canada’s proximity to the U.S., many Canadians do have the option of coming to the U.S. for treatment, but very few actually do this, according to a study by Katz, et al. (2002). These data can become more granular, and if you looked, you would find that among the various specialties, the shortest total waits are for medical oncology (4.9 weeks), radiation oncology (5.0 weeks), and elective cardiovascular surgery (8.0 weeks). Patients waited longest between a GP visit and orthopedic surgery (40.3 weeks), plastic surgery (35.4 weeks), and neurosurgery (31.7 weeks).

16. Now on to the Japanese Healthcare System. Japanese have universal health insurance coverage and spend half as much on health care as do Americans, but still they live longer. The health insurance system, or kaihoken, shouldn’t get all of the credit for their long life expectancy. The Japanese are a people who eat less and stay trimmer than the citizens of any other rich country. Kaihoken has been around for 50 years, but the system is threatened, as Japan is ageing, its population is shrinking, and its economy has been in a long period of stagnation.

17. Universal health insurance based around a mandatory, employment-based insurance (payroll taxes are split almost evenly between the employer and the employee). There are separate insurance plans for certain groups of workers; no private sector insurance companies. The Employee Health Insurance Program requires all companies with 700 of more employees to provide health insurance. The self-employed and retirees are covered by the Citizens Insurance Program administered by municipal governments (generally reserved for self-employed people and students.) In the universal health insurance system, called kaihoken. Unlike the German sickness funds, you don’t get to choose of insurance plan, but rather must use the one designated for you.

18. But patients can go to any doctor, any hospital, or any traditional healer. The market is dominated by local clinics. Patients can nearly always get in to see a doctor at a clinic within a day, but they must often wait hours for a three-minute consultation. (Waiting times are so short that most patients don’t bother to make an appointment.) However, the clinics tend to focus on quicker services, and complicated cases get too little attention. The Japanese are only a quarter as likely as the Americans or French to suffer a heart attack, but twice as likely to die if they do.
Hospitals may be private and public, but private for-profit hospitals are prohibited. Hospital-based physicians are salaried employees, but nonhospital physicians are paid on a fee-for-service basis. Private doctors earn money by running overnight clinics. In these, they make more money by keeping patients in bed, like a hotel. Simple surgery that in the West would involve no overnight stay, such as a hernia operation, entails a five-day hospital stay in Japan. Also, physicians can sell prescriptions directly to patients.

19. In 2009, 80.5 percent of total health expenditure in Japan was financed through the public health insurance system (OECD 2012). There is significant level of cost sharing, but they are capped at $677 per month for the average family. As we learned in a previous lecture, patient cost sharing helps control health care utilization. As in Canada or Germany, there is no "extra-billing" - neither physicians nor hospitals may bill their patients more than the authorized fee. However, illegal side-payments are common.

Another critical cost-containment mechanism is the fact that the Japanese government sets a reimbursement fee schedule for all healthcare services. All health insurers in the public health insurance system pay providers according to a national fee schedule. Politicians are unwilling to raise taxes, so they pressure on healthcare suppliers instead.

About half of the hospitals are fully public, and more than a three quarters of these hospitals operate at a loss. Being Japan, technology is prevalent and cheap. While an MRI scan of the neck region costs about $1,500 in the United States, in Japan, the same scan costs $98, according to author T.R. Reid. Doctors work hard for relatively low pay (around $125,000 a year at mid-career).

Finally, the costs are well controlled in Japan. If spending in a specific service, such as hip replacements, seems to be growing faster than projected, they lower fees for that service.

20. As you can see, these cost control mechanisms work. Japan spends less on healthcare per person than the average OECD country. Government control of price lists is a main reason.

21. We’ve reviewed only four healthcare system in the world. These systems offer parallels to elements of our complicated healthcare system. For example, our Veterans Health Administration (VHA) system is similar to the health care system in the UK. The VHA is a single payer system where providers are employed directly by the VHA, just like in Great Britain.

Just like in Canada, American Medicare is a single payer system, where the providers (i.e., physicians) are not directly employed by the government.

The German “sickness funds” are very similar to the employer-provided health insurance under which most employed Americans are covered. With ACA, now there is a mandated approach with standardized comprehensive coverage found in the Health Insurance Marketplaces. The Japanese system, typified by tightly control healthcare service prices is similar to our state-based Medicaid insurance programs. Each state-based Medicaid sets prices and, in an effort to control cost, the prices are typically very low.