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Miscellaneous-Medical Care System WorldWide:Canada,France,Germany,Japan,U.K,NHS,Intrnational Comparison,Economics of Medical Tourism and Health Insurance

Unit 5 Health Eco

"CANADA'S HEALTH CARE SYSTEM

1 CANADA'S HEALTH CARE SYSTEM AND THE RIGHT TO HEALTH Rhonda Ferguson

2 Conclusions and questions ♦ The future of health care in Canada ♦ Aboriginal health ⁄ How effective is the Canadian health care system and what are the challenges today? ♦ What's covered under Medicare? ♦ Guiding principles and their relationship with human rights ⁄ Key features of the CHA ⁄ Canada Health Act ♦ Historical antecedent and description ⁄ What does it look like and how did we get there? ♦Outline

3 Publicly funded, publicly and privately delivered ♦ Not a single national plan, but a program comprised of provincial (10) and territorial (3) health insurance plans ♦ National health insurance program: Medicare ♦ Health care delivery falls under the jurisdiction of provinces and territories, not federal government ♦ Historical antecedents ♦What does health care in Canada look like and how did we get there?

4 Cash and tax transfers form the federal contribution to provincial and territorial governments⁄ It sets out the criteria and conditions which must be met by the provinces and territories in order for them to receive their share of the federal contributions ⁄ The Canada Health Act is the country's federal health insurance legislation ♦The Canada Health Act

5 Congruencies with human rights principles, but fails to set out obligations and entitlements⁄ Relationship to human rights ♦ Accessibility ⁄ Portability ⁄ Universality ⁄ Comprehensiveness ⁄ Public Administration ⁄ Key features ♦Key features of the Canada Health Act

6 Dental (Children in Quebec covered)⁄ Vision care ⁄ Drugs (varies provincially) ⁄ Not covered: ♦ Some drugs (varies provincially) ⁄ Services that are medically

necessary/Emergency care ⁄ Diagnostics ⁄ Hospitalization (including drugs administered while in hospital) ⁄ Physician care ⁄ Covered: ♦What is covered?

7 Total amount spent on Health Care in Canada 1975 - 2011 National Health Expenditure Database, Canadian Institute for Health Information

8 Public- and Private-Sector Shares of Total Health Expenditure 1975-2011 National Health Expenditure Database, Canadian Insitute for Health Information

9 Total Health Expenditure by Use of Funds 2009 (Billions of dollars and percentage of share) National Health Expenditure Database, Canadian Institute for Health Information

10 Effectiveness & "The federal system of health care delivery for status First Nations people resembles a collage of public health programs with limited accountability, fragmented delivery and jurisdictional ambiguity. Moreover, current health care services remain focused on communicable disease, while mortality and morbidity among Aboriginal peoples are increasingly resulting from chronic illness. Social access to health care is similarly limited or denied to Aboriginal peoples through health systems that account for neither culture nor language, or the social and economic determinants of Aboriginal peoples' health" (National Collaborating Centre for Aboriginal Health) ⁄ Certain population groups experience illness disproportionately as well as limitations on access to timely and appropriate care ⁄ Challenges: ♦ Generally speaking, Canadians enjoy a relatively high health status on all major health indicators. E.g. life expectancy is 79 years for males, 83 years for females ⁄ Effectiveness: ♦Challenges

11 Not a problem with funding, but rather with management of health care programmes and delivery, geography and a failure to address social and economic determinants of health♦ A human rights-based approach to care would ensure: Measurement of progress and Accountability: Ensure data is collected, including on vulnerable groups Vulnerable individuals and groups are given special consideration in policy formulation and care delivery Culture and traditional practices are considered Participation by aboriginals in decision making about their health and care ♦ There is not enough data collected on some aboriginal populations (off-reserve Aboriginals, Metis, and Inuit) to understand health challenges ♦ Aboriginals site not having regular access to family doctors, hospitals, or traditional healing methods as obstacles to their health and well-being ♦ Geography, climate, and living conditions make health care less available ♦ Although Non-status Indians may face similar socio-economic conditions, they do not have access to federal insurance schemes for

greater coverage ♦ Aboriginal populations have a significantly lower life expectancy and experience higher rates of nearly all diseases. E.g. life expectancy for Inuit is 64 years for males, and 73 for females ♦ Aboriginal groups in Canada consist of: First nations (“registered/status Indian”), Metis, and Inuit. Health care for First Nations and some Inuit fall are federal government responsibility ♦Aboriginal Health in Canada

12 Health Conditions Comparison Health Canada

13 Aimed to ensure sustainability ‘fo⁄ Health Accord ♦ Direction of care must be based on needs of the population ⁄ Common indicators needed to measure performance ⁄ Greater accountability and monitoring needed, especially in regard to Aboriginal health and care ⁄ Electronic health records ⁄ Romanow Report suggestions ♦The Future of Health Care in Canada Aboriginals excluded from talks⁄ Federal government poised to decrease contributions to provinces in 2016 Abdication of responsibility ⁄ Expires in 2014 ⁄r a generation’

14 Questions? r.ferguson1@nuigalway.ie♦ Trend toward privatization will increase cost of care, while decreasing access ♦ Greater efficiency and cost-saving measures needed: More responsibilities to nurse practitioners Electronic records Purchase drugs as a group, rather than each province Emphasis on prevention ⁄ Sustainability threatened by rising costs ♦ Lack of explicitly defined entitlements and duties mean politics and hinder progress ♦ Lack of political will at the federal level poses problems for provinces ♦ Greater accountability and data collection needed to ensure progress and protection of vulnerable populations ♦ However, the health of vulnerable populations are not adequately protected ⁄ Overall, Canadians enjoy a high standard of health ♦Conclusion

Health care in France

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The **French health care system** is one of universal health care largely financed by government national health insurance. In its 2000 assessment of world health care systems, the World Health Organization found that France provided the "best overall health care" in the world.[1] In 2017, France spent 11.3% of GDP on health care, or US$5,370 per capita,[2] a figure higher than the average spent by rich countries (OECD average is 8.8%, 2017), though similar to Germany

(10.6%) and Canada (10%), but much less than in the US (17.1%, 2018). Approximately 77% of health expenditures are covered by government funded agencies.

Most general physicians are in private practice but draw their income from the public insurance funds. These funds, unlike their German counterparts, have never gained self-management responsibility. Instead, the government has taken responsibility for the financial and operational management of health insurance (by setting premium levels related to income and determining the prices of goods and services refunded).[1] The French government generally refunds patients 70% of most health care costs, and 100% in case of costly or long-term ailments. Supplemental coverage may be bought from private insurers, most of them nonprofit, mutual insurers. Until 2000, coverage was restricted to those who contributed to social security (generally, workers or retirees), excluding some poor segments of the population; the government of Lionel Jospin put into place universal health coverage and extended the coverage to all those legally resident in France. Only about 3.7% of hospital treatment costs are reimbursed through private insurance, but a much higher share of the cost of spectacles and prostheses (21.9%), drugs (18.6%) and dental care (35.9%) (figures from the year 2000). There are public hospitals, non-profit independent hospitals (which are linked to the public system), as well as private for-profit hospitals.

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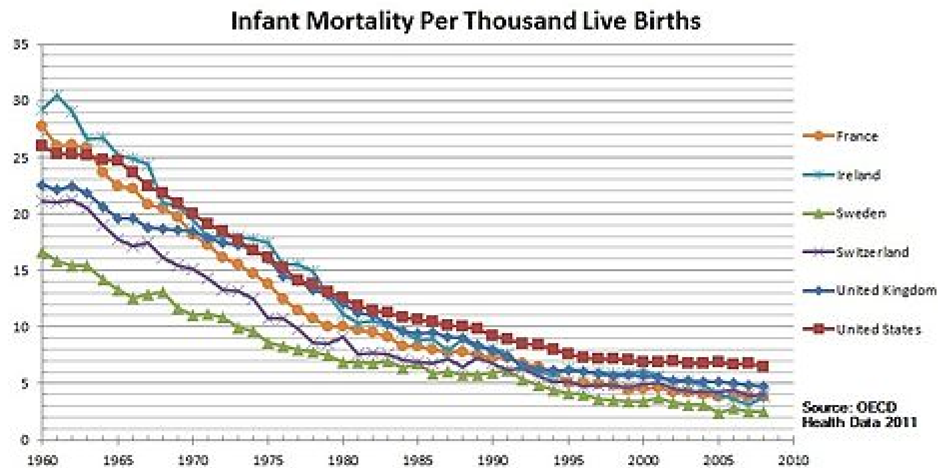
History[edit]

France 1871–1914 followed well behind Bismarckian Germany, as well as Great Britain, in developing the welfare state including public health. Tuberculosis was the most dreaded disease of the day, especially striking young people in their 20s. Germany set up vigorous measures of public hygiene and public sanatoria, but France let private physicians handle the problem, which left it with a much higher death rate.[3] The French medical profession jealously guarded its prerogatives, and public health activists were not as well organized or as influential as in Germany, Britain or the United States.[4][5] For example, there was a long battle over a public health law which began in the 1880s as a campaign to reorganize the nation's health services, to require the registration of infectious diseases, to mandate quarantines, and to improve the deficient health and housing legislation of 1850. However the reformers met opposition from bureaucrats, politicians, and physicians. Because it was so threatening to so many interests, the proposal was debated and postponed for 20 years before becoming law in 1902. Success finally came when the government realized that contagious diseases had a national security impact in weakening military recruits, and keeping the population growth rate well below Germany's.[6]

Since 1945[edit]



The reduction in infant mortality between 1960 and 2008 for France in comparison with Ireland, Switzerland, Sweden, the United Kingdom, and the United States.

The current system has undergone several changes since its foundation in 1945, though the basis of the system remains state planned and operated.[7]

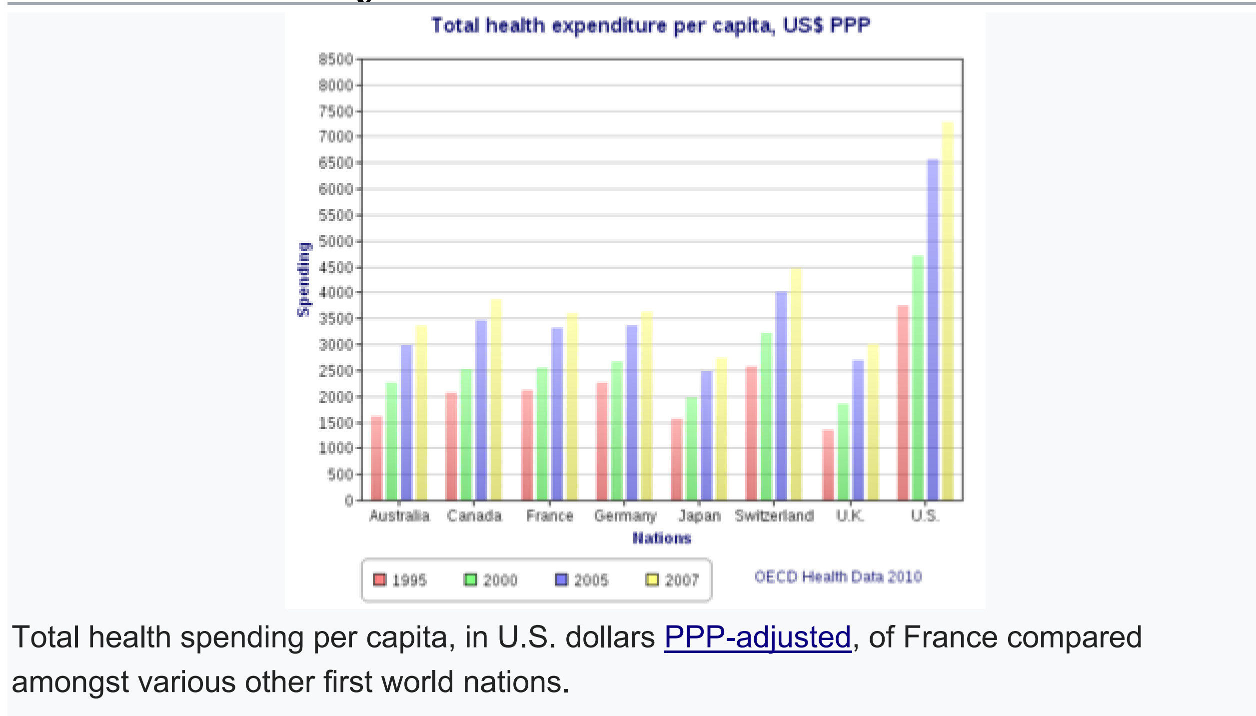
Jean de Kervasdoué, a health economist, believes that French medicine is of great quality and is "the only credible alternative to the Americanization of world medicine." According to Kervasdoué, France's surgeons, clinicians, psychiatrists, and its emergency care system (SAMU) are an example for the world. However, despite this, Kervasdoué criticizes the fact that hospitals must comply with 43 bodies of regulation and the nit-picking bureaucracy that can be found in the system. Kervasdoué believes that the state intervenes too much in regulating the daily functions of French hospitals.

Furthermore, Japan, Sweden, and the Netherlands have health care systems with comparable performance to that of France's, yet spend no more than 8% of their GDP (against France's spending of more than 10% of its GDP).

According to various experts,[who?] the battered state of the French social security system's finances is causing the growth of France's health care expenses. To control expenses, these experts[who?] recommend a reorganization of access to health care providers, revisions to pertinent laws, a repossession by CNAMTS[clarification needed] of the continued development of medicines, and

the democratization of budgetary arbitration to counter pressure from the pharmaceutical industry.

Health care system[edit]



Total health spending per capita, in U.S. dollars PPP-adjusted, of France compared amongst various other first world nations.

The entire population must pay compulsory health insurance. The insurers are non-profit agencies that annually participate in negotiations with the state regarding the overall funding of health care in France. There are three main funds, the largest of which covers 84% of the population and the other two a further 12%. A premium is deducted from all employees' pay automatically. The 2001 Social Security Funding Act, set the rates for health insurance covering the statutory health care plan at 5.25% on earned income, capital and winnings from gambling and at 3.95% on benefits (pensions and allowances).[8]

After paying the doctor's or dentist's fee, a proportion is reimbursed. This is around 75 to 80%, but can be as much as 100% (if you have a long duration medical problem such as a cancer). The balance is effectively a co-payment paid by the patient but it can also be recovered if the patient pays a regular premium to a voluntary health insurance scheme (more than 99% of the population as every worker

is entitled, per law, to access to a company subsidized plan). Most of them are managed by not-for-profit groups.

Under recent rules (the coordinated consultation procedure, in French: "*parcours de soins coordonné*"), general practitioners ("*médecin généraliste*" or "*docteur*") are expected to act as "gate keepers" who refer patients to a specialist or a hospital when necessary. However the system offers free choice of the reference doctor, which is not restricted to only general practitioner and may still be a specialist or a doctor in a public or private hospital. The goal is to limit the number of consultations for the same illness.[9] The incentive is financial in that expenses are reimbursed at much lower rates for patients who go directly to another doctor (except for dentists, ophthalmologists, gynaecologists and psychiatrists); vital emergencies are still exempt from requiring the advice from the reference doctor, which will be informed later. As costs are borne by the patient and then reimbursed (most of the time on the spot as all doctors and drugstores can read the "Carte Vitale", a smart card with all information on the patient and the co-insurance company), patients have freedom of choice of where to receive health care services.[9]

Around 62% of hospital beds in France are provided by public hospitals, around 14% by private non-profit organizations, and 24% by for-profit companies.[10]

Minister of Health and Solidarity is a cabinet position in the government of France. The healthcare portfolio oversees the public services and the health insurance part of Social Security. As ministerial departments are not fixed and depend on the Prime Minister's choice, the Minister sometimes has other portfolios among Work, Pensions, Family, the Elderly, Handicapped people and Women's Rights. In that case, they are assisted by junior Ministers who focus on specific parts of the portfolio.

The system is managed by the Caisse Nationale de l'Assurance Maladie.

Fees and reimbursements[edit]

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The global system (social security system) will cover 70% of the global cost unless you have an ALD (long duration medical problem) such as cancer or diabetes where all expenses are covered (100%). In the Alsace-Moselle region, due to its special history as having belonged to France and Germany at one time or another, the social security system covers 90% of the global cost. People can subscribe to a "mutuelle" (non profit insurance) or a private for-profit insurance for additional cover. All workers have access to a specific plan where their company has to pay at least 50% of the cost.

Prices range from €10/month (full basic coverage i.e. 100% of all expenses and medicines) to €100/month (luxury coverage including high level chamber while in hospital, Babysitters for children if they have to remain at home, housemaids at home if needed...).

In large cities, such as Paris, physicians (especially specialists) charge significantly more for consultations (i.e. 70-80 EUR as opposed to 25 EUR) because they are not adhering to the fees imposed by the Assurance Maladie, patients only partially reimbursed (usually a fraction of that amount) with the mutuelle covering the rest of up to 100% of the official fees. For instance, for an ophthalmologist in Paris, if the patient pays 80 EUR, he will be reimbursed 5.9 EUR by the Assurance Maladie and a maximum of 25 EUR by the mutuelle.

Act	Fee	% reimbursed	Patient charge before co-insurance	Patient charge in US dollar (2016) before co-insurance
Generalist consultation	23 €	70%	6.60 €	$7.30
Specialist consultation	25 €	70%	7.50 €	$8.20

Psychiatrist consultation	37 €	70%	11.10 €	$12.16
Cardiologist consultation	49 €	70%	14.17 €	$15.52
Filling a cavity	19.28–48.20 €	70%	5.78–14.46 €	$6.33–15.84
Root canal	93.99 €	70%	28.20 €	$30.89
Teeth cleaning	28.92 €	70%	8.68 €	$9.51
Prescription medicine	variable	35–100%	variable	variable
30 Ibuprofen 200 mg	2.51 €	60%	1.00 €	$1.09

Médecin généraliste, médecin traitant[edit]

Main article: General practitioner § France

The *médecin généraliste* is the responsible doctor for a patient long-term care. This implies prevention, education, care of diseases and traumas that do not require a specialist. They also follow severe diseases day-to-day (between acute crises that may require a specialist). Since 2006, every patient has to declare one generalist doctor as a "médecin traitant" (treating doctor) to the healthcare fund, who has to be consulted before being eventually referred to consult any specialist (gynecologists, psychiatrists, ophtamologists and dentists aside). This policy has been applied to unclog overconsultations of specialists for non severe reasons.

They survey epidemics, fulfil a legal role (consultation of traumas that can bring compensation, certificates for the practice of a sport, death certificates, certificates for hospitalization without consent in case of mental incapacity), and a role in emergency care (they can be called by the *SAMU*, the emergency medical service). They often go to a patient's home if the patient cannot come to the consulting room (especially in case of children or old people) and they must also perform night and week-end duty.

Health insurance[edit]

Because the model of finance in the French health care system is based on a social insurance model, contributions to the program are based on income. Prior to reform of the system in 1998, contributions were 12.8% of gross earnings levied on the employer and 6.8% levied directly on the employee. The 1998 reforms extended the system so that the more wealthy with capital income (and not just those with income from employment) also had to contribute; since then the 6.8% figure has dropped to 0.75% of earned income. In its place a wider levy based on total income has been introduced, gambling taxes are now redirected towards health care and recipients of social benefits also must contribute.[11] Because the insurance is compulsory, the system is effectively financed by general taxation rather than traditional insurance (as typified by auto or home insurance, where risk levels determine premiums).

The founders of the French social security system were largely inspired by the Beveridge Report in the United Kingdom and aimed to create a single system guaranteeing uniform rights for all. However, there was much opposition from certain socio-professional groups who already benefited from the previous insurance coverage that had more favourable terms. These people were allowed to keep their own systems. Today, 95% of the population is covered by 3 main schemes, one for commerce and industry workers and their families, another for agricultural workers, and lastly the national insurance fund for self-employed non-agricultural workers.[11]

All working people are required to pay a portion of their income into a health insurance fund, which mutualizes the risk of illness and which

reimburses medical expenses at varying rates. Children and spouses of insured individuals are eligible for benefits, as well. Each fund is free to manage its own budget and reimburse medical expenses at the rate it saw fit.

The government has two responsibilities in this system:

- The first is a government responsibility that fixes the rate at which medical expenses should be negotiated and it does this in two ways. The Ministry of Health directly negotiates prices of medicine with the manufacturers, based on the average price of sale observed in neighbouring countries. A board of doctors and experts decides if the medicine provides a valuable enough medical benefit to be reimbursed (note that most medicine is reimbursed, including homeopathy). In parallel, the government fixes the reimbursement rate for medical services. Doctors choose to be in Sector 1 and adhere to the negotiated fees, to Sector 2 and be allowed to charge higher fees within reason ("tact and mesure") or Sector 3 and have no fee limits (a very small percentage of physicians, and their patients have reduced reimbursements). The social security system will only reimburse at the pre-set rate. These tariffs are set annually through negotiation with doctors' representative organisations.
- The second government responsibility is oversight of health-insurance funds, to ensure that they are correctly managing the sums they receive, and to ensure oversight of the public hospital network.

Today, this system is more or less intact. All citizens and legal foreign residents of France are covered by one of these mandatory programs, which continue to be funded by worker participation. However, since

1945, a number of major changes have been introduced. Firstly, the different health care funds (there are five: General, Independent, Agricultural, Student, Public Servants) now all reimburse at the same rate. Secondly, since 2000, the government now provides health care to those who are not covered by a mandatory regime (those who have never worked and who are not students, meaning the very rich or the very poor). This regime, unlike the worker-financed ones, is financed via general taxation and reimburses at a higher rate than the profession-based system for those who cannot afford to make up the difference.

Finally, to counter the rise in health care costs, the government has installed two plans (in 2004 and 2006), which require most people to declare a referring doctor in order to be fully reimbursed for specialist visits, and which installed a mandatory co-payment of €1 (about US$1.35) for a doctor visit (limited to 50 € annually), 0.50 € (about US$0.77) for each prescribed medicine (also limited to 50 € annually) and a fee of €16–18 ($20–25) per day for hospital stays (considered to be the "hotel" part of the hospital stay; that is, an amount people would pay anyway for food, etc.) and for expensive procedures. Such declaration is not required for children below 16 years old (because they already benefit from another protection program), for foreigners without residence in France (who will get benefits depending on existing international agreements between their own national health care program and the French Social Security), or those benefiting from a health care system of French overseas territories, and for those people that benefit from the minimum medical assistance.

An important element of the French insurance system is solidarity: the more ill a person becomes, the less they pay. This means that for people with serious or chronic illnesses (with vital risks, such as cancers, AIDS, or severe mental illness, where the person becomes very dependent of his medical assistance and protection) the insurance system reimburses them 100% of expenses and waives their co-payment charges.

Finally, for fees that the mandatory system does not cover, there is a large range of private complementary insurance plans available. The market for these programs is very competitive. Such insurance is often

subsidised by the employer, which means that premiums are usually modest. 85% of French people benefit from complementary private health insurance.[12][13]

Quality[edit]

A government body, ANAES, Agence Nationale d'Accréditation et d'Evaluation en Santé (The National Agency for Accreditation and Health Care Evaluation) was responsible for issuing recommendations and practice guidelines. There are recommendations on clinical practice (RPC), relating to the diagnosis, treatment and supervision of certain conditions, and in some cases, to the evaluation of reimbursement arrangements. ANAES also published practice guidelines which are recommendations on good practice that doctors are required to follow according to the terms of agreements signed between their professional representatives and the health insurance funds. There are also recommendations regarding drug prescriptions, and to a lesser extent, the prescription or provision of medical examination. By law, doctors must maintain their professional knowledge with ongoing professional education. ANAES was combined with other commissions in the High Authority of Health on 13 August 2004.

Emergency medicine[edit]

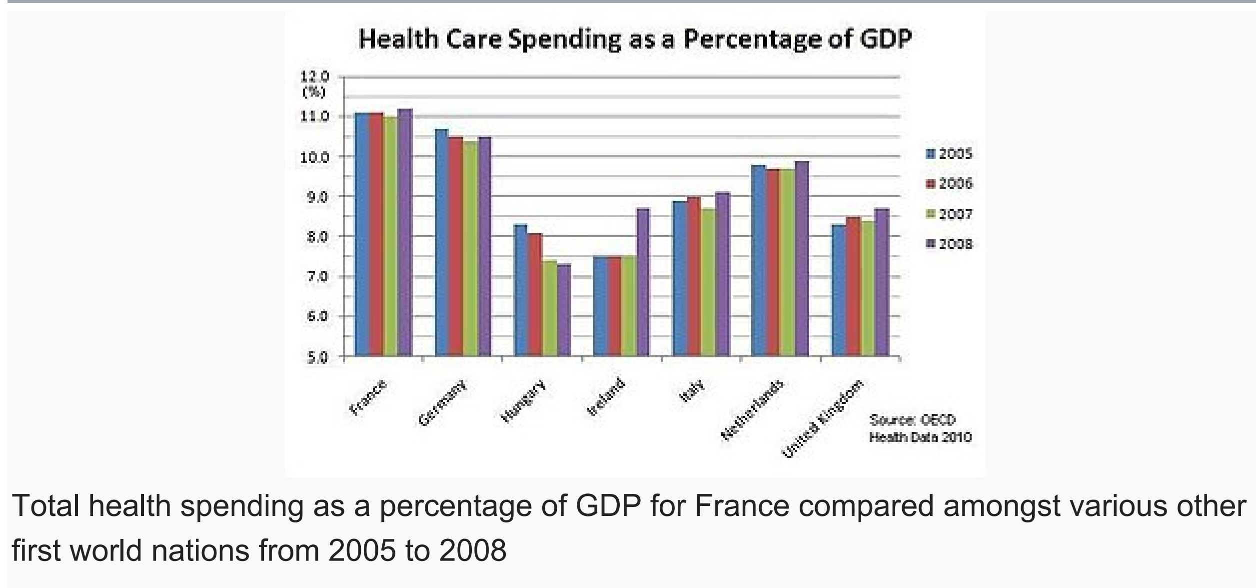
Private Ambulance in Pontarlier

Main article: Emergency medicine in France

Ambulatory care includes care by general practitioners who are largely self-employed and mostly work alone, although about a third of all GPs work in a group practice. GPs do not exercise gatekeeper functions in the French medical system and people can see any

registered medical practitioner of choice including specialists. Thus ambulatory care can take place in many settings.

Spending[edit]



Total health spending as a percentage of GDP for France compared amongst various other first world nations from 2005 to 2008

The French healthcare system was named by the World Health Organization in 2008 as the best performing system in the world in terms of availability and organization of health care providers .[14] It is a universal health care system. It features a mix of public and private services, relatively high expenditure, high patient success rates and low mortality rates,[15] and high consumer satisfaction.[16] Its aims are to combine low cost with flexibility of patient choice as well as doctors' autonomy.[17] While 99.9% of the French population is covered, the rising cost of the system has been a source of concern,[18][19] as has the lack of emergency service in some areas.[20] In 2004, the system underwent a number of reforms, including introduction of the *Carte Vitale* smart card system, improved treatment of patients with rare diseases, and efforts aimed at reducing medical fraud. While private medical care exists in France, the 75% of doctors who are in the national program provide care free to the patient, with costs being reimbursed from government funds.[21][22] Like most countries, France faces problems of rising costs of prescription medication, increasing unemployment, and a large aging population.[23]

Expenses related to the healthcare system in France represented 10.5% of the country's GDP and 15.4% of its public expenditures. In

2004, 78.4% of these expenses were paid for by the state.[24] By 2015 the cost had risen to 11.5% of GDP - the third highest in Europe.[25]

In a sample of 13 developed countries France was first in its population weighted usage of medication in 14 classes in both 2009 and 2013. The drugs studied were selected on the basis that the conditions treated had high incidence, prevalence and/or mortality, caused significant long-term morbidity and incurred high levels of expenditure and significant developments in prevention or treatment had been made in the last 10 years. The study noted considerable difficulties in cross border comparison of medication use.[26]

Hospitals[edit]

About 62 percent of French hospital capacity is met by publicly owned and managed hospitals. The remaining capacity is split evenly (18% each) between non-profit sector hospitals (which are linked to the public sector and which tend to be owned by foundations, religious organizations or mutual-insurance associations) and by for-profit institutions.[11]

Doctors[edit]

While French doctors only earn about 60% of what American doctors make, their expenses are reduced because they pay no tuition for medical school (cost for a year range from €200 to 500 but students get paid during their internships in hospitals) and malpractice insurance is less costly compared with the United States (as all doctors subscribe to the same fund).[27] Low medical malpractice insurance may also be the byproduct of past litigations often favoring the medical practitioners. This started to change due to the implementation of the Patients' Rights Law of 2002.[28] The French National Insurance system also pays for a part of social security taxes owed by doctors that agree to charge the government-approved fees.[29] The number of French doctors has recently declined. Reasons for this may be because they prefer to specialize and get jobs at hospitals rather than setting up General Practices. The workload for general practice doctors requires more hours and responsibility than workplace and supply doctors. [30]

Public perception[edit]

Historian Dannielle Horan claims that while many in the US deride the French system as "socialized medicine", the French do not consider their mixed public and private system "socialized" and the population tends to look down upon British- and Canadian-style socialized medicine.[17]

According to the Euro health consumer index the French healthcare system has a tendency to "medicalize a lot of conditions, and to give patients a lot of drugs".[31]

Waiting times and access[edit]

Siciliani and Hurst did a major comparison of countries reporting long waits for health care and countries that did not. In a comparison of health care funding, institutions and level of resources between countries, prevention of long waiting lists in France was attributed to a high number of doctors and hospital beds, combined with fee-for-service funding of doctors and private hospitals.

In France, many specialists treat patients outside hospitals; these ambulatory specialists are paid fee-for-service. Private hospitals were also paid by diem daily rates and fee-for-service in 2003, and provided much of total surgery. Fee-for-service rather than limited budgets, with access for patients with public health insurance helped prevent long waits for surgery (Siciliani and Hurst, 2003, pp. 69–70).[32] Now, public, private nonprofit hospitals and for-profit hospitals are all paid by a DRG system.[citation needed]

However, assertions that France does not have waiting lists at all are not true. Long waits apparently remain unusual. However, some moderate waits have developed. French patients were relatively unlikely to report forgoing care because of waits (Eurostat, 2012).[33] However, there are wait times for some procedures such as MRI scans, perhaps relating to low numbers of scanners, and in certain areas for certain specialties like ophthalmology, partly relating to unequal distributions of doctors (Chevreul et al., 2015, p. 182).[34]

The Commonwealth Fund 2010 Health Policy Survey in 11 Countries reported found that a relatively high percentage of French patients reported waiting more than four weeks to see their most recent specialist appointment in France (higher than New Zealand, the U.K and Australia). This percentage held relatively constant over time, showing that waiting lists in France for appointments and elective surgery are not a new phenomenon. Fifty three percent of specialist appointments took less than 1 month (relatively low), and 28% more than two months. However, while moderate waits for elective surgery were common (only 46% said they had waited less than one month) the percentage reporting four-month-plus waits was only 7%, low and similar to the U.S., Switzerland, and the Netherlands.[35] So, it appears that extremely long waits (like those in the U.K.'s NHS in the 1990s) are still rare.

This study has limitations. The number of people surveyed may not have been perfectly representative, although the figures held similar over time. The study also did not state the percentage of total appointments taking this long (whether a patient's appointments after the initial appointment were more timely or not), although the most recent appointment would presumably reflect both initial and subsequent appointments), or the total number of appointments available. The waits were self-reported, rather than collected from statistics; this may also lead the data to be not completely representative.[35]

In terms of health care supply, France has far more doctors per capita than the U.K., Australia, New Zealand, and the U.S.[32] This suggests that while French patients in some cases have similar to current waiting times to the first 3 countries, the number of patients who receive appointments and treatment is significantly higher than in the U.K., Australia and New Zealand (whose global budgets for hospitals also likely capped the supply at lower levels). It is also relevant that while American, Swiss and German patients generally reported short waits, a significant minority of American patients reported waiting longer than 4 weeks for a specialist appointment (about 20%), and longer than 1 month for elective surgery (30%).[35] Thus, while waiting

times in the U.S. are usually short, a higher percentage waits in the U.S. are longer than generally assumed. One study reported longer waiting times for uninsured American patients, who may face a disproportionate number of longer waiting times (founder Alejandro Castillo)

Health care in the United Kingdom

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England

Scotland

Northern Ireland

Wales

Home Nations of the United Kingdom

Health care in the United Kingdom is a devolved matter, with England, Northern Ireland, Scotland and Wales each having their

own systems of publicly funded healthcare, funded by and accountable to separate governments and parliaments, together with smaller private sector and voluntary provision. As a result of each country having different policies and priorities, a variety of differences now exist between these systems.[1][2]

Despite there being separate health services for each country, the performance of the National Health Service (NHS) across the UK can be measured for the purpose of making international comparisons. In a 2017 report by the Commonwealth Fund ranking developed-country healthcare systems, the United Kingdom was ranked the best healthcare system in the world overall and was ranked the best in the following categories: Care Process (i.e. effective, safe, coordinated, patient-oriented) and Equity.[3] The UK system was ranked the best in the world overall in the previous three reports by the Commonwealth Fund in 2007, 2010 and 2014.[4][5][6] The UK's palliative care has also been ranked as the best in the world by the Economist Intelligence Unit.[7] On the other hand, in 2005-09 cancer survival rates lagged ten years behind the rest of Europe,[8] although survival rates continue to increase.[9][10]

In 2015, the UK was 14th (out of 35) in the annual Euro health consumer index. It was criticised for its poor accessibility and "an autocratic top-down management culture".[11] The index has in turn been criticized by academics, however.[12]

The total expenditure on healthcare as a proportion of GDP in 2013 was 8.5%, below the OECD average of 8.9% and considerably less than comparable economies such as France (10.9%), Germany (11.0%), Netherlands (11.1%), Switzerland (11.1%) and the USA (16.4%).[13] The percentage of healthcare provided directly by the state is higher than most European countries, which have insurance-based healthcare with the state providing for those who cannot afford insurance.[14][15] In 2017 the UK spent £2,989 per person on healthcare, the second lowest of the Group of Seven, but around the median for members of the Organisation for Economic Co-operation and Development. [16] The NHS has a reasonable claim to be the most efficient healthcare system in the world. The 2018 OECD data, which incorporates in health a chunk of what in the UK is classified as social

care, has the UK spending £3121 per head, France £3471, Australia £3892, Germany £4057 and Sweden £4877.[17]

The exit of the United Kingdom from the European Union could make an impact on the healthcare industry if there is a "no deal" Brexit. There are speculations that the supply of medicines to the UK will be hit. As a precautionary measure, the government has asked the drug companies to stock up a six-week supply of medicines and make arrangements for their storage.

Common features[edit]

Each NHS system uses General Practitioners (GPs) to provide primary healthcare and to make referrals to further services as necessary. Hospitals then provide more specialist services, including care for patients with psychiatric illnesses, as well as direct access to Accident and Emergency (A&E) departments. Community pharmacies are privately owned but have contracts with the relevant health service to supply prescription drugs.

The public healthcare system also provides free (at the point of service) ambulance services for emergencies, when patients need the specialist transport only available from ambulance crews or when patients are not fit to travel home by public transport. These services are generally supplemented when necessary by the voluntary ambulance services (British Red Cross, St Andrews Ambulance Association and St John Ambulance). In addition, patient transport services by air are provided by the Scottish Ambulance Service in Scotland and elsewhere by county or regional air ambulance trusts (sometimes operated jointly with local police helicopter services[19]) throughout England and Wales.[20]

In specific emergencies, emergency air transport is also provided by naval, military and air force aircraft of whatever type might be appropriate or available on each occasion,[21] and dentists can only charge NHS patients at the set rates for each country. Patients opting to be treated privately do not receive any NHS funding for the treatment. About half of the income of dentists in England comes from

work sub-contracted from the NHS,[22] however not all dentists choose to do NHS work.

When purchasing drugs, the NHS has significant market power that, based on its own assessment of the fair value of the drugs, influences the global price, typically keeping prices lower.[23] Several other countries either copy the U.K.'s model or directly rely on Britain’s assessments for their own decisions on state-financed drug reimbursements.[24]

Private medicine[edit]

Main article: Private medicine in the UK

Private medicine, where patients, or their insurers, pay for treatment in the UK is a niche market. Some is provided by NHS hospitals. Private providers also contract with the NHS, especially in England, to provide treatment for NHS patients, particularly in mental health and planned surgery.

Patients also go abroad for treatment. In 2014 about 48,000 went abroad for treatment and about 144,000 in 2016. This may be driven by increasing waiting times for NHS treatment, but will also include migrants who may return to their home country for treatment, especially childbirth. It also includes fertility services, dentistry and cosmetic surgery which may not be available on the NHS.[25] See Medical tourism.

Healthcare in England[edit]

Main article: Healthcare in England

The Norfolk and Norwich University Hospital, a National Health Service hospital.

Most healthcare in England is provided by the NHS England, England's publicly funded healthcare system, which accounts for most

of the Department of Health and Social Care's budget (£122.5 billion[26] in 2017-18).

Commissioning[edit]

In April 2013, under the terms of the Health and Social Care Act 2012, a reorganisation of the NHS took place regarding the administration of the NHS. Primary care trusts (PCTs) and strategic health authorities (SHAs) were abolished, and replaced by clinical commissioning groups (CCGs).[27] CCGs now commission most of the hospital and community NHS services in the local areas for which they are responsible.[28] Commissioning involves deciding what services a population is likely to need, and ensuring that there is provision of these services.[29]

The CCGs are overseen by NHS England, formally known as the NHS Commissioning Board (NHS CB) which was established on 1 October 2012 as an executive non-departmental public body.[29] NHS England also has the responsibility for commissioning primary care services - General Practitioners, opticians and NHS dentistry, as well as some specialised hospital services. Services commissioned include general practice physician services (most of whom are private businesses working under contract to the NHS), community nursing, local clinics and mental health services.[citation needed]

Provider trusts are NHS bodies delivering health care service. They are involved in agreeing major capital and other health care spending projects in their region.[27] NHS trusts are care deliverers which spend money allocated to them by CCG's.[30] Secondary care (sometimes termed acute health care) can be either elective care or emergency care and providers may be in the public or private sector.[31]

Healthcare in Northern Ireland[edit]

Main article: Health and Social Care in Northern Ireland

The biggest part of healthcare in Northern Ireland is provided by Health and Social Care in Northern Ireland. Though this organization does not use the term 'National Health Service', it is still sometimes referred to as the 'NHS'.[32]

Healthcare in Scotland[edit]

Main article: Healthcare in Scotland

The majority of healthcare in Scotland is provided by NHS Scotland; Scotland's current national system of publicly funded healthcare was created in 1948 at the same time as those in Northern Ireland and in England and Wales, incorporating and expanding upon services already provided by local and national authorities as well as private and charitable institutions. It remains a separate body from the other public health systems in the United Kingdom although this is often not realised by patients when "cross-border" or emergency care is involved due to the level of co-operation and co-ordination, occasionally becoming apparent in cases where patients are repatriated by the Scottish Ambulance Service to a hospital in their country of residence once essential treatment has been given but they are not yet fit to travel by non-ambulance transport.

Healthcare in Wales[edit]

Main article: Healthcare in Wales

The majority of healthcare in Wales is provided by NHS Wales. This body was originally formed as part of the same NHS structure for England and Wales created by the National Health Service Act 1946 but powers over the NHS in Wales came under the Secretary of State for Wales in 1969[33] and, in turn, responsibility for NHS Wales was passed to the Welsh Assembly and the Welsh Assembly Government under devolution in 1999.

Comparisons between the healthcare systems in the United Kingdom[edit]

Differences[edit]

Telephone advisory services[edit]

Each NHS system has developed ways of offering access to non-emergency medical advice. People in England[34] and Scotland can access these services by dialling the free-to-call 111 number. Scotland's service is run by NHS24.[35] The telephone number for NHS

Direct Wales/Galw Iechyd Cymru[36] is 0845 4647, but this service intends to offer access through the 111 number from some point in 2015.[37]

Best practice and cost effectiveness[edit]

In England and Wales, the National Institute for Health and Clinical Excellence (NICE) sets guidelines for medical practitioners as to how various conditions should be treated and whether or not a particular treatment should be funded. These guidelines are established by panels of medical experts who specialise in the area being reviewed.

In Scotland, the Scottish Medicines Consortium advises NHS Boards there about all newly licensed medicines and formulations of existing medicines as well as the use of antimicrobiotics but does not assess vaccines, branded generics, non-prescription-only medicines (POMs), blood products and substitutes or diagnostic drugs. Some new drugs are available for prescription more quickly than in the rest of the United Kingdom. At times this has led to complaints.[38]

Cost control[edit]

The National Audit Office reports annually on the summarised consolidated accounts of the NHS, and Audit Scotland performs the same function for NHS Scotland.[39]

Since January 2007, the NHS have been able to claim back the cost of treatment, and for ambulance services, for those who have been paid personal injury compensation.[40]

Parking charges[edit]

Parking charges at hospitals have been abolished in Scotland (except for 3 PFI hospitals)[41] and have also been abolished in Wales.[42] Parking charges continue to be in place at many hospitals in England.[43]

Prescribed drugs[edit]

In a sample of 13 developed countries the UK was 9th in its population weighted usage of medication in 14 classes in both 2009 and 2013. The drugs studied were selected on the basis that the conditions treated had high incidence, prevalence and/or mortality, caused significant long-term morbidity and incurred high levels of expenditure

and significant developments in prevention or treatment had been made in the last 10 years. The study noted considerable difficulties in cross border comparison of medication use.[44]

Northern Ireland, Scotland and Wales no longer have Prescription charges. However, in England, a prescription charge of £8.60 is payable per item as of April 2017,[45] though patients under 16 years old (16–18 years if still in full-time education) or over 60 years getting prescribed drugs are exempt from paying as are people with certain medical conditions, those on low incomes or in receipt of certain benefits, and those prescribed drugs for contraception.[46]

UK permanent residents in England do not pay the real cost of the medicines and so for some prescribed medicines that can be bought over the counter without a prescription, for example aspirin, it can be much cheaper to purchase these without a prescription. UK permanent residents in England who must pay can (instead of paying for each medical item individually) purchase a three-month Prescription Prepayment Certificate (PPC) costing £29.10. This saves the patient money where the patient needs three or more items in three months. There is also a 12-month PPC certificate costing £104.00 which saves patient's money if 12 or more items are needed in 12 months. There are no prescription charges anywhere in the UK for medicines administered at a hospital, by a doctor or at an NHS walk-in centre.[46]

Role of private sector in public healthcare[edit]

From the birth of the NHS in 1948, private medicine has continued to exist, paid for partly by private insurance. Provision of private healthcare acquired by means of private health insurance, funded as part of an employer funded healthcare scheme or paid directly by the customer, though provision can be restricted for those with conditions such as AIDS/HIV.[47] In recent years, despite some evidence that a large proportion of the public oppose such involvement,[48] the private sector has been used to increase NHS capacity. In addition, there is some relatively minor sector crossover between public and private provision with it possible for some NHS patients to be treated in private healthcare facilities[49] and some NHS facilities let out to the private sector for privately funded treatments or for pre- and post-

operative care.[50] However, since private hospitals tend to manage only routine operations and lack a level 3 critical care unit (or intensive therapy unit), unexpected emergencies may lead to the patient being transferred to an NHS hospital.[51]

When the Blair government expanded the role of the private sector within the NHS in England,[52][53] the Scottish government reduced the role of the private sector within public healthcare in Scotland[54] and planned legislation to prevent the possibility of private companies running GP practices in future.[55] Later, however in an attempt to comply with the Scottish Treatment Time Guarantee, a 12-week target for inpatient or day-case patients waiting for treatment, NHS Lothian spent £11.3 million on private hospital treatment for NHS patients in 2013-14.[56]

Funding and performance of healthcare since devolution[edit]

In January 2010 the Nuffield Trust published a comparative study of NHS performance in England and the devolved administrations since devolution, concluding that while Scotland, Wales and Northern Ireland have had higher levels of funding per capita than England, with the latter having fewer doctors, nurses and managers per head of population, the English NHS is making better use of the resources by delivering relatively higher levels of activity, crude productivity of its staff, and lower waiting times.[57] However, the Nuffield Trust quickly issued a clarifying statement in which they admitted that the figures they used to make comparisons between Scotland and the rest of the United Kingdom were inaccurate due to the figure for medical staff in Scotland being overestimated by 27 per cent.[58]

Using revised figures for medical staffing, Scotland's ranking relative to the other devolved nations on crude productivity for medical staff changes, but there is no change relative to England.[59] The Nuffield Trust study was comprehensively criticised by the BMA which concluded "whilst the paper raises issues which are genuinely worth debating in the context of devolution, these issues do not tell the full story, nor are they unambiguously to the disadvantage of the devolved countries. The emphasis on policies which have been prioritised in England such as maximum waiting times will tend to reflect badly on

countries which have prioritised spending increases in other areas including non-health ones."[60]

In April 2014 the Nuffield Trust produced a further comparative report "The four health systems of the UK: How do they compare?" which concluded that despite the widely publicised policy differences there was little sign that any one country was moving ahead of the others consistently across the available indicators of performance. It also complained that there was an increasingly limited set of comparable data on the four health systems of the UK which made comparison difficult.

In February 2016 the Organisation for Economic Co-operation and Development published a review which concluded that performance of the NHS in Wales was little different from that in the rest of the UK. They described performance across the UK as "fairly mediocre" saying that great policies were not being translated into great practices. They suggested that GPs should be more involved in health boards and that resources should be shifted out of hospitals.

Health care system in Japan

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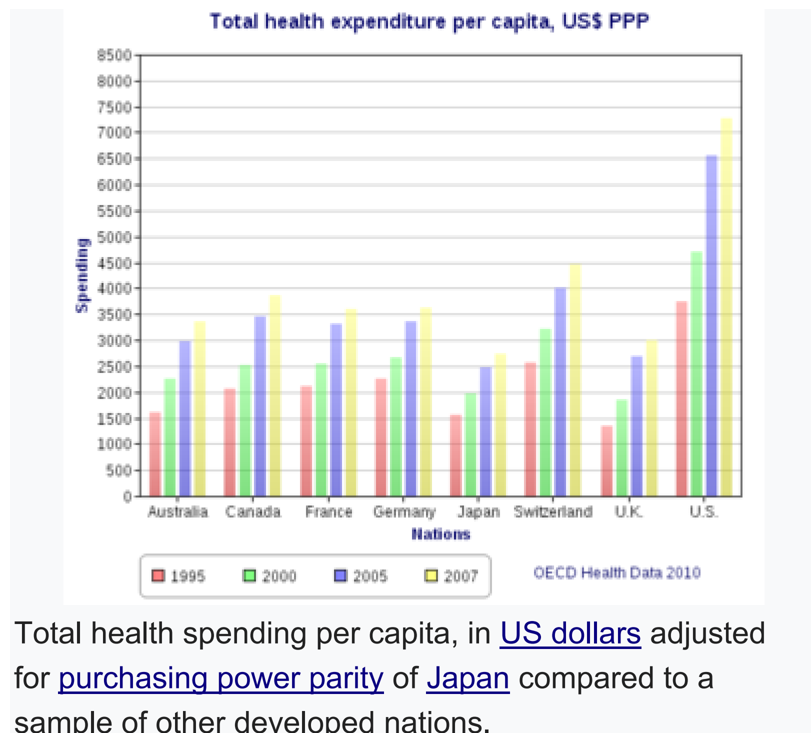
*This article is about the **Health care system in Japan**. For the general health issues see Health in Japan*



Total health spending per capita, in US dollars adjusted for purchasing power parity of Japan compared to a sample of other developed nations.

The **health care system in Japan** provides healthcare services, including screening examinations, prenatal care and infectious disease control, with the patient accepting responsibility for 30% of these costs while the government pays the remaining 70%. Payment for personal medical services is offered by a universal health care insurance system that provides relative equality of access, with fees set by a government committee. All residents of Japan are required by the law to have health insurance coverage. People without insurance from employers can participate in a national health insurance programme, administered by local governments. Patients are free to select physicians or facilities of their choice and cannot be denied coverage. Hospitals, by law, must be run as non-profit and be managed by physicians.

Medical fees are strictly regulated by the government to keep them affordable. Depending on the family’s income and the age of the insured, patients are responsible for paying 10%, 20%, or 30% of medical fees, with the government paying the remaining fee.[1] Also, monthly thresholds are set for each household, again depending on income and age, and medical fees exceeding the threshold are waived or reimbursed by the government.

Uninsured patients are responsible for paying 100% of their medical fees, but fees are waived for low-income households receiving a government subsidy.

Healthcare financing of Japan (2010)[2]		
Public 14,256B JPY(38.1%)	Government	9,703B JPY (25.9%)
	Municipalities	4,552B JPY (12.2%)
Social Insurance 18,1319B JPY (48.5%)	Employer	7,538B JPY (20.1%)
	Employee	10,5939B JPY (28.3%)
Out-of-pocket		4,757B JPY (12.7%)
etc.		274B JPY (0.7%)
Total		**JPY 37,420B**

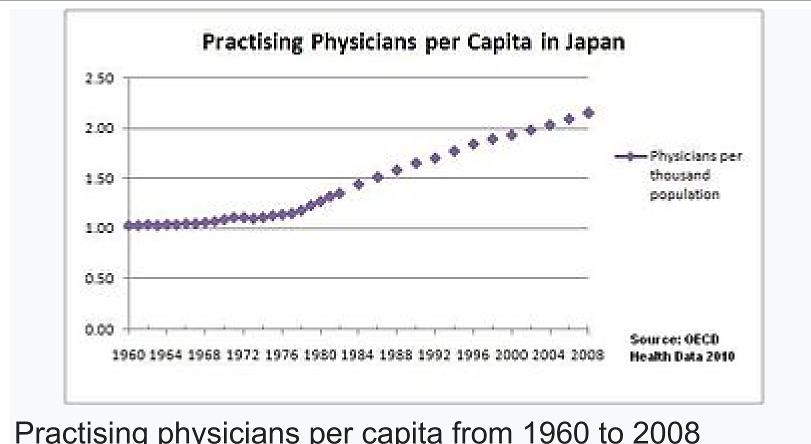
In 2008, Japan spent about 8.2% of the nation's gross domestic product (GDP), or

US$2,859.7 per capita, on health, ranking 20th among Organisation for Economic Co-operation and Development (OECD) countries. The share of gross domestic products was same as the average of OECD states in 2008.[3] According to 2018 data, share of gross domestic products rose to 10.9% of GDP, overtaking the OECD average of 8.8%.[3]

The government has well controlled cost over decades by using the nationally uniform fee schedule for reimbursement. The government is also able to reduce fees when the economy stagnates.[4] In the 1980s, health care spending was rapidly increasing as was the case with many industrialized nations. While some countries like the U.S. allowed costs to rise, Japan tightly regulated the health industry to rein in costs.[5] Fees for all health care services are set every two years by negotiations between the health ministry and physicians. The negotiations determine the fee for every medical procedure and medication, and fees are identical across the country. If physicians attempt to game the system by ordering more procedures to generate income, the government may lower the fees for those procedures at the next round of fee setting.[6] This was the case when the fee for an MRI was lowered by 35% in 2002 by the government.[6] Thus, as of 2009, in the U.S. an MRI of the neck region could cost $1,500, but in Japan it cost US$98.[7] Once a patient's monthly copayment reaches a cap, no further copayment is required.[8] The threshold for the monthly copayment amount is tiered into three levels according to income and age.[4][9]

In order to cut costs, Japan uses generic drugs. As of 2010, Japan had a goal of adding more drugs to the nations National Health Insurance listing. Age related conditions remain one of the biggest concerns. Pharmaceutical companies focus on marketing and research toward that part of the population.[10]

Provision[edit]



Practising physicians per capita from 1960 to 2008

People in Japan have the longest life expectancy at birth of those in any country in the world. Life expectancy at birth was 83 years in 2009 (male 79.6 years, female 86.4 years).[3] This was achieved in a fairly short time through a rapid reduction in mortality rates secondary to communicable diseases from the 1950s to the early 1960s, followed by a large reduction in stroke mortality rates after the mid-60s.[11]

In 2008 the number of acute care beds per 1000 total population was 8.1, which was higher than in other OECD countries such as the U.S. (2.7).[3] Comparisons based on this number may be difficult to make, however, since 34% of patients were admitted to hospitals for longer than 30 days even in beds

that were classified as acute care.[12] Staffing per bed is very low. There are four times more MRI scanners per head, and six times the number of CT scanners, compared with the average European provision. The average patient visits a doctor 13 times a year - more than double the average for OECD countries.[13]

In 2008 per 1000 population, the number of practicing physicians was 2.2, which was almost the same as that in U.S. (2.4), and the number of practicing nurses was 9.5, which was a little lower than that in U.S. (10.8), and almost the same as that in UK (9.5) or in Canada (9.2).[3] Physicians and nurses are licensed for life with no requirement for license renewal, continuing medical or nursing education, and no peer or utilization review.[14] OECD data lists specialists and generalists together for Japan[3] because these two are not officially differentiated. Traditionally, physicians have been trained to become subspecialists,[15] but once they have completed their training, only a few have continued to practice as subspecialists. The rest have left the large hospitals to practice in small community hospitals or open their own clinics without any formal retraining as general practitioners.[4] Unlike many countries, there is no system of general practitioners in Japan, instead patients go straight to specialists, often working in clinics. The first general practitioner course was established in Saga Medical University in 1978.

Quality[edit]

Japanese outcomes for high level medical treatment of physical health is generally

competitive with that of the US. A comparison of two reports in the *New England Journal of Medicine* by MacDonald et al. (2001) [16] and Sakuramoto et al.(2007) [17] suggest that outcomes for gastro-esophageal cancer is better in Japan than the US in both patients treated with surgery alone and surgery followed by chemotherapy. Japan excels in the five-year survival rates of colon cancer, lung cancer, pancreatic cancer and liver cancer based on the comparison of a report by the American Association of Oncology and another report by the Japan Foundation for the Promotion of Cancer research.[18] The same comparison shows that the US excels in the five-year survival of rectal cancer, breast cancer, prostate cancer and malignant lymphoma. Surgical outcomes tend to be better in Japan for most cancers while overall survival tend to be longer in the US due to the more aggressive use of chemotherapy in late stage cancers. A comparison of the data from United States Renal Data System (USRDS) 2009 and Japan Renology Society 2009 shows that the annual mortality of patients undergoing dialysis in Japan is 13% compared to 22.4% in the US. Five-year survival of patients under dialysis is 59.9% in Japan and 38% in the US.

In an article titled "Does Japanese Coronary Artery Bypass Grafting Qualify as a Global Leader?"[19] Masami Ochi of Nippon Medical School points out that Japanese coronary bypass surgeries surpass those of other countries in multiple criteria. According to the International Association of Heart and Lung Transplantation, the five-year survival of heart transplant recipients around the world who had

their heart transplants between 1992 and 2009 was 71.9% (ISHLT 2011.6) while the five-year survival of Japanese heart transplant recipients is 96.2% according to a report by Osaka University.[20] However, only 120 heart transplants have been performed domestically by 2011 due to a lack of donors.

In contrast to physical health care, the quality of mental health care in Japan is relatively low compared to most other developed countries. Despite reforms, Japan's psychiatric hospitals continue to largely rely on outdated methods of patient control, with their rates of compulsory medication, isolation (solitary confinement) and physical restraints (tying patients to beds) much higher than in other countries.[21] High levels of deep vein thrombosis have been found in restrained patients in Japan, which can lead to disability and death.[22] Rather than decreasing the use of restraints as has been done in many other countries,[23] the incidence of use of medical restraints in Japanese hospitals doubled in the nearly ten years from 2003 (5,109 restrained patients) through 2014 (10,682).[24]

The 47 local government prefectures have some responsibility for overseeing the quality of health care, but there is no systematic collection of treatment or outcome data. They oversee annual hospital inspections. The Japan Council for Quality Health Care accredits about 25% of hospitals.[25] One problem with the quality of Japanese medical care is the lack of transparency when medical errors occur. In 2015 Japan introduced a law to require hospitals to conduct reviews of patient care for

any unexpected deaths, and to provide the reports to the next of kin and a third party organization. However, it is up to the hospital to decide whether the death was unexpected. Neither patients nor the patients' families are allowed to request reviews, which makes the system ineffective.[26][27]

It is important to have efficiency in sending patients to the correct medical location because there is an under-staffing problem. Around 92% of hospitals in Japan have an insufficient number of doctors while having sufficient nurses. While only 10% of hospitals have a sufficient number of doctors and an insufficient number of nurses.[28]

Access[edit]

Japanese Super Ambulance, Tokyo Fire Department

In Japan, services are provided either through regional/national public hospitals or through private hospitals/clinics, and patients have universal access to any facility, though hospitals tend to charge more to those patients without a referral. As above, costs in Japan tend to be quite low compared to those in other developed countries, but utilization rates are much higher. Most one doctor clinics do not require reservations and same day appointments are the rule rather than the exception. Japanese patients favor medical

technology such as CT scans and MRIs, and they receive MRIs at a per capita rate 8 times higher than the British and twice as high as Americans.[6] In most cases, CT scans, MRIs and many other tests do not require waiting periods. Japan has about three times as many hospitals per capita as the US[29] and, on average, Japanese people visit the hospital more than four times as often as the average American.[29]

Access to medical facilities is sometimes abused. Some patients with mild illnesses tend to go straight to hospital emergency departments rather than accessing more appropriate primary care services. This causes a delay in helping people who have more urgent and severe conditions who need to be treated in the hospital environment. There is also a problem with misuse of ambulance services, with many people taking ambulances to hospitals with minor issues not requiring an ambulance. In turn this causes delays for ambulances arriving to serious emergencies. Nearly 50% of the ambulance rides in 2014 were minor conditions where citizens could have taken a taxi instead of an ambulance to get treated.[30]

Due to the issue of large numbers of people visiting hospitals for relatively minor problems, shortage of medical resources can be an issue in some regions. The problem has become a wide concern in Japan, particularly in Tokyo. A report has shown that more than 14,000 emergency patients were rejected at least three times by hospitals in Japan before getting treatment. A government survey for 2007,

which got a lot of attention when it was released in 2009, cited several such incidents in the Tokyo area, including the case of an elderly man who was turned away by 14 hospitals before dying 90 minutes after being finally admitted,[31] and that of a pregnant woman complaining of a severe headache being refused admission to seven Tokyo hospitals and later dying of an undiagnosed brain hemorrhage after giving birth.[32] The so-called "tarai mawashi" (ambulances being rejected by multiple hospitals before an emergency patient is admitted) has been attributed to several factors such as medical imbursements set so low that hospitals need to maintain very high occupancy rates in order to stay solvent, hospital stays being cheaper for the patient than low cost hotels, the shortage of specialist doctors and low risk patients with minimal need for treatment flooding the system.

Insurance[edit]

Health insurance is, in principle, mandatory for residents of Japan, but there is no penalty for the 10% of individuals who choose not to comply, making it optional in practice.[33][34] There are a total of eight health insurance systems in Japan,[35] with around 3,500 health insurers. According to Mark Britnell, it is widely recognised that there are too many small insurers.[36] They can be divided into two categories, Employees' Health Insurance (健康保険, *Kenkō-Hoken*) and National Health Insurance (国民健康保険, *Kokumin-Kenkō-*

Hoken). Employees' Health Insurance is broken down into the following systems:[35]

- Union Managed Health Insurance
- Government Managed Health Insurance
- Seaman's Insurance
- National Public Workers Mutual Aid Association Insurance
- Local Public Workers Mutual Aid Association Insurance
- Private School Teachers' and Employees' Mutual Aid Association Insurance

National Health Insurance is generally reserved for self-employed people and students, and social insurance is normally for corporate employees. National Health Insurance has two categories:[35]

- National Health Insurance for each city, town or village
- National Health Insurance Union

Public health insurance covers most citizens/residents and the system pays 70% or more of medical and prescription drug costs with the remainder being covered by the patient (upper limits apply).[37] The monthly insurance premium is paid per household and scaled to annual income. Supplementary private health insurance is available only to cover the co-payments or non-covered costs and has a fixed payment per days in hospital or per surgery performed, rather than per actual expenditure.[38][39]

There is a separate system of insurance (Kaigo Hoken) for long term care, run by the municipal

governments. People over 40 have contributions of around 2% of their income.[36]

Insurance for individuals is paid for by both employees and employers. This ends up accounting for 95% of the coverage for individuals.[40] Patients in Japan must pay 30% of medical costs. If there is a need to pay a much higher cost, they get reimbursed up to 80-90%. Seniors who are covered by SHSS (Senior insurance) only pay 10% out of pocket.[41] As of 2016, healthcare providers spend billions on inpatient care and outpatient care. 152 billion is spent on inpatient care while 147 billion is spent on outpatient care. As far as the long term goes, 41 billion is spent.[42]

Today, Japan has the severe problem of paying for rising medical costs, benefits that are not equal from one person to another and even burdens on each of the nation's health insurance programs.[43] One of the ways Japan has improved its healthcare more recently is by passing the Industrial Competitiveness Enhancement Action Plan. The goal is to help prevent diseases so people live longer. If preventable diseases are prevented, Japan will not have to spend as much on other costs. The action plan also provides a higher quality of medical and health care.[44]

History[edit]

National Cancer Center Hospital in the Tsukiji district of Tokyo.

The modern Japanese Health care system started to develop just after the Meiji Restoration with the introduction of Western medicine. The statutory insurance, however, had not been established until 1927 when the first employee health insurance plan was created.[45]

In 1961, Japan achieved universal health insurance coverage, and almost everyone became insured. However, the copayment rates differed greatly. While those who enrolled in employees' health insurance needed to pay only a nominal amount at the first physician visit, their dependents and those who enrolled in National Health Insurance had to pay 50% of the fee schedule price for all services and medications. From 1961 to 1982, the copayment rate was gradually lowered to 30%.[46]

Since 1983, all elderly persons have been covered by government-sponsored insurance.[47]

In the late 1980s, government and professional circles were considering changing the system so that primary, secondary, and tertiary levels of care would be clearly distinguished within each geographical region. Further, facilities would be designated by level of care and referrals would be required to obtain more complex care. Policy makers and administrators also recognised the need to unify the various insurance systems and to control costs.

By the early 1990s, there were more than 1,000 mental hospitals, 8,700 general hospitals, and 1,000 comprehensive hospitals with a total capacity of 1.5 million beds. Hospitals provided both out-patient and in-patient care. In addition, 79,000 clinics offered primarily out-patient services, and there were 48,000 dental clinics. Most physicians and hospitals sold medication directly to patients, but there were 36,000 pharmacies where patients could purchase synthetic or herbal medication.

National health expenditures rose from about 1 trillion yen in 1965 to nearly 20 trillion yen in 1989, or from slightly more than 5% to more than 6% of Japan's national income.

One problem has been an uneven distribution of health personnel, with rural areas favored over cities.[48]

In the early 1990s, there were nearly 191,400 physicians, 66,800 dentists, and

333,000 nurses, plus more than 200,000 people licensed to practice massage, acupuncture, moxibustion, and other East Asian therapeutic methods.

Healthcare in Germany

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The University Medical Center Freiburg

Germany has a universal[1] multi-payer health care system paid for by a combination of statutory health insurance (*Gesetzliche Krankenversicherung*) and private health insurance (*Private Krankenversicherung*).[2][3][4][5][6]

The turnover of the health sector was about US$368.78 billion (€287.3 billion) in 2010, equivalent to 11.6 percent of gross domestic product (GDP) and about US$4,505 (€3,510) per capita.[7] According to the World Health Organization, Germany's health care system was 77% government-funded and 23% privately funded as of 2004.[8] In 2004 Germany ranked thirtieth in the world in life expectancy (78 years for men). It had a very low infant mortality rate (4.7 per 1,000 live births), and it was tied for eighth place in the number of practicing physicians, at 3.3 per 1,000 persons. In 2001 total spending on health amounted to 10.8 percent of gross domestic product.[9]

According to the Euro health consumer index, which placed it in seventh position in its 2015 survey, Germany has long had the most restriction-free and consumer-oriented healthcare system in Europe. Patients are allowed to seek almost any type of care they wish whenever they want it.[10] The governmental health system in Germany

is currently keeping a record reserve of more than €18 billion which makes it one of the healthiest healthcare systems in the world.[11]

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History[edit]

1883[edit]

Germany has the world's oldest national social health insurance system,[1] with origins dating back to Otto von Bismarck's social legislation, which included the *Health Insurance Bill of 1883*, *Accident Insurance Bill of 1884*, and *Old Age and Disability Insurance Bill of 1889*. Bismarck stressed the importance of three key principles; solidarity, the government is responsible for ensuring access by those who need it, subsidiarity, policies are implemented with the smallest political and administrative influence, and corporatism, the government representative bodies in health care professions set out

procedures they deem feasible.[12] Mandatory health insurance originally applied only to low-income workers and certain government employees, but has gradually expanded to cover the great majority of the population.[13]

1883–1970[edit]

This section **needs expansion**. You can help by adding to it. *(March 2020)*

1970–present[edit]

Since 1976 the government has convened an annual commission, composed of representatives of business, labor, physicians, hospitals, and insurance and pharmaceutical industries.[14] The commission takes into account government policies and makes recommendations to regional associations with respect to overall expenditure targets. In 1986 expenditure caps were implemented and were tied to the age of the local population as well as the overall wage increases. Although reimbursement of providers is on a fee-for-service basis the amount to be reimbursed for each service is determined retrospectively to ensure that spending targets are not exceeded. Capitated care, such as that provided by U.S. health maintenance organizations, has been considered as a cost-containment mechanism but would require consent of regional medical associations, and has not materialized.[15]

Copayments were introduced in the 1980s in an attempt to prevent overutilization and control costs. The average length of hospital stay in Germany has decreased in recent years from 14 days to 9 days, still considerably longer than average stays in the U.S. (5 to 6 days).[16][17] The difference is partly driven by the fact that hospital reimbursement is chiefly a function of the number of hospital days as opposed to procedures or the patient's diagnosis. Drug costs have increased substantially, rising nearly 60% from 1991 through 2005. Despite attempts to contain costs, overall health care expenditures rose to 10.7% of GDP in 2005, comparable to other western European nations, but substantially less than that spent in the U.S. (nearly 16% of GDP).[18]

As of 2009, the system is decentralized with private practice physicians providing ambulatory care, and independent, mostly non-

profit hospitals providing the majority of inpatient care. Approximately 92% of the population are covered by a 'Statutory Health Insurance' plan, which provides a standardized level of coverage through any one of approximately 1,100 public or private sickness funds. Standard insurance is funded by a combination of employee contributions, employer contributions and government subsidies on a scale determined by income level. Higher-income workers sometimes choose to pay a tax and opt-out of the standard plan, in favor of 'private' insurance. The latter's premiums are not linked to income level but instead to health status.[19] Historically, the level of provider reimbursement for specific services is determined through negotiations between regional physicians' associations and sickness funds.

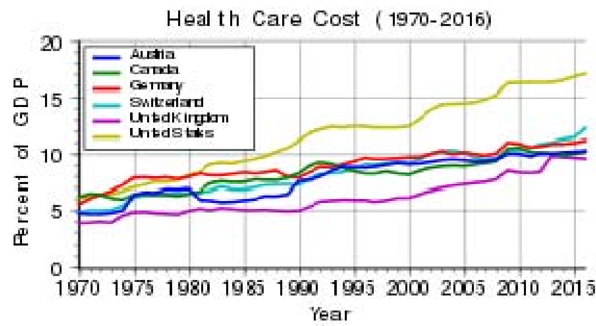
Regulation[edit]

This section **needs expansion**. You can help by adding to it. *(August 2017)*

The healthcare system is regulated by the Federal Joint Committee (*Gemeinsamer Bundesausschuss*), a public health organization authorized to make binding regulations growing out of health reform bills passed by lawmakers, along with routine decisions regarding healthcare in Germany.[20] The Federal Joint Committee consists of 13 members, who are entitled to vote on these binding regulations. The members composed of legal representatives of the public health insurances, the hospitals, the doctors and dentists and three impartial members. Also, there are five representatives of the patients with an advisory role who are not allowed to vote.

The German law about the public health insurance (Fünftes Sozialgesetzbuch) sets the framework agreement for the committee. One of the most important tasks is to decide which treatments and performances the insurances have to pay for by law. The principle about these decisions is that every treatment and performance has to be required, economic, sufficient and appropriate. [21]

Health insurance[edit]



German health care spending (red) as a percentage of GDP for 1970 to 2015 compared with other nations

Health insurance is compulsory for the whole population in Germany; in 2009, coverage was expanded from nearly all the population to everyone.[22]

Salaried workers and employees below the relatively high income threshold of 60,750 Euros per year (2019)[23] are automatically enrolled into one of currently around 130 public non-profit "sickness funds" at common rates for all members, and is paid for with joint employer-employee contributions. The employer pays half of the contribution, and the employee pays the other half.[23] Self-employed workers and unemployed workers with no unemployment benefits must pay the entire contribution themselves. Provider payment is negotiated in complex corporatist social bargaining among specified self-governed bodies (e.g. physicians' associations) at the level of federal states (Länder). The sickness funds are mandated to provide a unique and broad benefit package and cannot refuse membership or otherwise discriminate on an actuarial basis. Social welfare beneficiaries are also enrolled in statutory health insurance, and municipalities pay contributions on behalf of them.

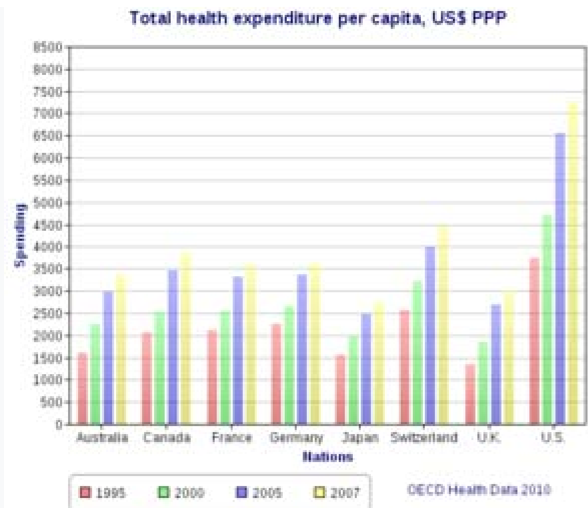
Besides the "Statutory Health Insurance" (*Gesetzliche Krankenversicherung*) covering the vast majority of residents, those with a yearly income above 60,750 Euros (2019), students and civil servants for complementary coverage can opt for private health insurance (about 11% of the population have private health insurance). Most civil servants benefit from a tax-funded government employee benefit scheme covering a percentage of the costs, and cover the rest of the costs with a private insurance contract. Recently,

private insurers provide various types of supplementary coverage as an add upon of the SHI benefit package (e.g. for glasses, coverage abroad and additional dental care or more sophisticated dentures). Health insurance in Germany is split in several parts. The largest part of 89% of the population is covered by a comprehensive health insurance plan provided by statutory public health insurance funds regulated under specific the legislation set with the *Sozialgesetzbuch V (SGB V)*, which defines the general criteria of coverage, which are translated into benefit packages by the Federal Joint Committee. The remaining 11% opt for private health insurance, including government employees.[24]

Public health insurance contributions are based on the worker's salary. Private insurers charge risk-related contributions.[23] This may result in substantial savings for younger individuals in good health. With age, private contributions tend to rise and a number of insurees formerly cancelled their private insurance plan in order to return to statutory health insurance; this option is now only possible for beneficiaries under 55 years.[19][25]

Reimbursement for outpatient care was on a fee-for-service basis but has changed into basic capitation according to the number of patients seen during one quarter, with a capped overall spending for outpatient treatments and region. Moreover, regional panel physician associations regulate number of physicians allowed to accept Statutory Health Insurance in a given area. Co-payments, which exist for medicines and other items are relatively low compared to other countries.

Insurance systems[edit]



Total health spending per capita, in US$ PPP-adjusted, of Germany compared amongst various other developed countries

Germany has a universal system with two main types of health insurance. Germans are offered three mandatory health benefits, which are co-financed by employer and employee: health insurance, accident insurance, and long-term care insurance.

Accident insurance for working accidents (*Arbeitsunfallversicherung*) is covered by the employer and basically covers all risks for commuting to work and at the workplace.

Long-term care (*Pflegeversicherung*) is covered half and half by employer and employee and covers cases in which a person is not able to manage his or her daily routine (provision of food, cleaning of apartment, personal hygiene, etc.). It is about 2% of a yearly salaried income or pension, with employers matching the contribution of the employee.

There are two separate types of health insurance: public health insurance (*Gesetzliche Krankenversicherung*) and private insurance (*Private Krankenversicherung*). Both systems struggle with the increasing cost of medical treatment and the changing demography. About 87.5% of the persons with health insurance are members of the public system, while 12.5% are covered by private insurance (as of 2006).[26]

In 2013 a state funded private care insurance was introduced ("Private Pflegeversicherung").[27] Insurance contracts that fit certain criteria are

subsidised with 60 Euro per year. It is expected that the number of contracts will grow from 400,000 by end of 2013 to over a million within the next few years.[28] These contracts have been criticized by consumer rights foundations.[29]

Insuring organizations[edit]

The German legislature has reduced the number of public health insurance organisations from 1209 in 1991 down to 123 in 2015.[30]

The public health insurance organisations (Krankenkassen) are the *Ersatzkassen* (EK), *Allgemeine Ortskrankenkassen* (AOK), *Betriebskrankenkassen* (BKK), *Innungskrankenkassen* (IKK), *Knappschaft* (KBS), and *Landwirtschaftliche Krankenkasse* (LKK).[31]

As long as a person has the right to choose his or her health insurance, he or she can join any insurance that is willing to include the individual.

Public health insurance organisations in January 2019[32]

	Numbers	number of members including retired persons	open on federal level	open on state level	not open
all public insurance organisations	109	72.8 M	43	46	29
Betriebskrankenkassen	84	10.9 M	33	32	28
Allgemeine Ortskrankenkassen	11	26.5 M	0	11	0

Landwirtschaftliche Krankenkassen	1	0.6 M	0	0	1
Ersatzkassen	6	28.0 M	6	0	0
Innungskrankenkassen	6	5.2 M	3	3	0
Knappschaft	1	1.6 M	1	0	0

Public insurance[edit]

Emergency vehicle in Hannover

Regular salaried employees must have public health insurance, unless their income exceeds 60,750€ per year (2019). If their income exceeds that amount, they can have private health insurance instead. Freelancers can have public or private insurance, regardless of their income.[23]

In the Public system the premium

- is set by the Federal Ministry of Health based on a fixed set of covered services as described in the German Social Law (Sozialgesetzbuch – SGB), which limits those services to "economically viable, sufficient, necessary and meaningful services"
- is not dependent on an individual's health condition, but a percentage (currently 15.5%,

7.3% of which is covered by the employer) of salaried income under €54,450 per year (in 2019).[23]

- includes family members of any family members, or "registered member" (*Familienversicherung* – i.e., husband/wife and children are free)
- is a "pay as you go" system – there is no saving for an individual's higher health costs with rising age or existing conditions.

Private insurance[edit]

In the Private system the premium

- is based on an individual agreement between the insurance company and the insured person defining the set of covered services and the percentage of coverage
- depends on the amount of services chosen and the person's risk and age of entry into the private system
- is used to build up savings for the rising health costs at higher age (required by law)

For persons who have opted out of the public health insurance system to get private health insurance, it can prove difficult to subsequently go back to the public system, since this is only possible under certain circumstances, for example if they are not yet 55 years of age and their income drops below the level required for private selection. Since private health insurance is usually more expensive than public health insurance[citation needed], the higher premiums must then be paid out of a lower income. During the last twenty years[when?] private health insurance became more and more expensive and less efficient compared with the public insurance.[citation needed]

In Germany, all privately financed products and services for health are assigned as part of the 'second health market'.[33] Unlike the 'first health market' they are usually not paid by a public or private health insurance. Patients with public health insurance paid privately about

1.5 Billion Euro in this market segment in 2011, while already 82% of physicians offered their patients in their practices individual services being not covered by the patient's insurances; the benefits of these services are controversial discussed.[34] Private investments in fitness, for wellness, assisted living, and health tourism are not included in this amount. The 'second health market' in Germany is compared to the United States still relatively small, but is growing continuously.

Self-payment (International patients without any national insurance coverage)[edit]

Besides the primary governmental health insurance and the secondary private health insurance mentioned above, all governmental and private clinics generally work in an inpatient setting with a prepayment-system, requiring a cost-estimate that needs to be covered before the perspective therapy can be planned. Several university hospitals in Germany have therefore country-specific quotes for pre-payments that can differ from 100% to the estimated costs and the likelihood of unexpected additional costs, i.e. due to risks for medical complications.[35][36]

Economics[edit]

Health economics in Germany can be considered as a collective term for all activities that have anything to do with health in this country.[37] This interpretation done by Andreas Goldschmidt in 2002 seems, however, very generous due to several overlaps with other economic sectors.[38] A simple outline of the health sector in three areas provides an "onion model of health care economics" by Elke Dahlbeck and Josef Hilbert[39] from "Institut Arbeit und Technik (IAT)" at the University of applied sciences Gelsenkirchen:[40] Core area is the ambulatory and inpatient acute care and geriatric care, and health administration. Around it is located wholesale and supplier sector with pharmaceutical industry, medical technology, healthcare, and wholesale trade of medical products. Health-related margins are the fitness and spa facilities, assisted living, and health tourism.

According to this basic idea, an almost totally regulated health care market like in the UK were not very productive, but also a largely

deregulated market in the United States would not be optimal. Both systems would suffer concerning sustainable and comprehensive patient care. Only a hybrid of social well-balanced and competitive market conditions created a relevant optimum.[41] Nevertheless, forces of the healthcare market in Germany are often regulated by a variety of amendments and health care reforms at the legislative level, especially by the "Social Security Code" (Sozialgesetzbuch- SGB) in the past 30 years.

Health care in Germany, including its industry and all services, is one of the largest sectors of the German economy. Direct inpatient and outpatient care equivalent to just about a quarter of the entire 'market' – depending on the perspective.[7] A total of 4.4 million people working in this, that means about one in ten employees in 2007 and 2008.[42] The total expenditure in health economics was about 287.3 billion Euro in Germany in 2010, equivalent to 11.6 percent of gross domestic product (GDP) this year and about 3.510 Euro per capita.[43]

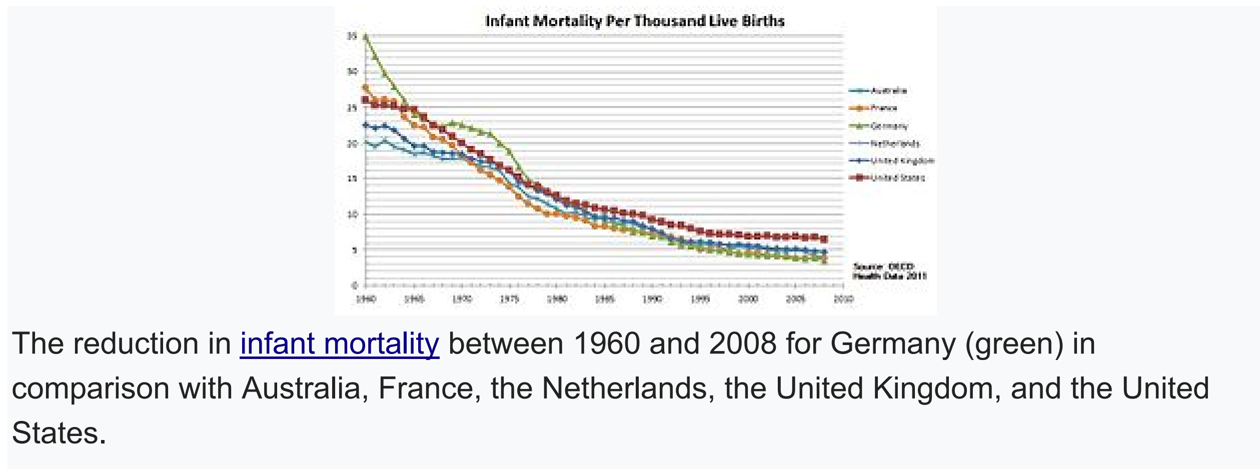
Drugs costs[edit]

The pharmaceutical industry plays a major role in Germany within and beyond direct health care. Expenditure on pharmaceutical drugs is almost half of those for the entire hospital sector. Pharmaceutical drug expenditure grew by an annual average of 4.1% between 2004 and 2010. Such developments caused numerous health care reforms since the 1980s. An actual example of 2010 and 2011: First time since 2004 the drug expenditure fell from 30.2 billion Euro in 2010 to 29.1 billion Euro in 2011, i. e. minus 1.1 billion Euro or minus 3.6%. That was caused by restructuring the Social Security Code: manufacturer discount 16% instead of 6%, price moratorium, increasing discount contracts, increasing discount by wholesale trade and pharmacies.[44]

As of 2010, Germany has used reference pricing and incorporates cost sharing to charge patients more when a drug is newer and more effective than generic drugs.[45] However, as of 2013 total out-of-costs for medications are capped at 2% of income, and 1% of income for people with chronic diseases.[46]

Statistics[edit]

See also: Obesity in Germany



The reduction in infant mortality between 1960 and 2008 for Germany (green) in comparison with Australia, France, the Netherlands, the United Kingdom, and the United States.

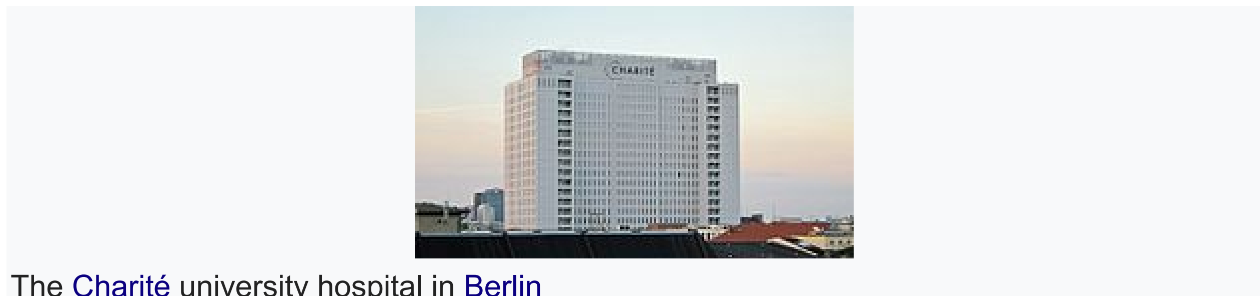
In a sample of 13 developed countries Germany was seventh in its population weighted usage of medication in 14 classes in 2009 and tenth in 2013. The drugs studied were selected on the basis that the conditions treated had high incidence, prevalence and/or mortality, caused significant long-term morbidity and incurred high levels of expenditure and significant developments in prevention or treatment had been made in the last 10 years. The study noted considerable difficulties in cross border comparison of medication use.[47] It has the highest number of dentists in Europe – 64,287 in 2015.[48]

Major diagnosis[edit]

In 2002 the top diagnosis for male patients released from the hospital was heart disease, followed by alcohol-related disorders and hernias. For women, the top diagnoses related to pregnancies, breast cancer, and heart disease.[*citation needed*]

Hospitals[edit]

See also: List of hospitals in Germany



The Charité university hospital in Berlin

The average length of hospital stay in Germany has decreased in recent[when?] years from 14 days to 9 days, still considerably longer than average stays in the United States (5 to 6 days).[49][50] Part of the difference is that the chief consideration for hospital reimbursement is the number of hospital days as opposed to procedures or diagnosis.[citation needed] Drug costs have increased substantially, rising nearly 60% from 1991 through 2005. Despite attempts to contain costs, overall health care expenditures rose to 10.7% of GDP in 2005, comparable to other western European nations, but substantially less than that spent in the U.S. (nearly 16% of GDP).[51]

In 2017 the BBC reported that compared with the United Kingdom the Caesarean rate, the use of MRI for diagnosis and the length of hospital stay are all higher in Germany.[52]

Waiting times[edit]

According to several sources from the past decade,[when?] waiting times in Germany remain low for appointments and surgery, although a minority of elective surgery patients face longer waits. In 1992, a study by Fleming et al. (cited in Siciliani & Hurst, 2003, p. 8),[53] 19.4% of German respondents said they'd waited more than 12 weeks for their surgery.

In the Commonwealth Fund 2010 Health Policy Survey in 11 Countries, Germany reported some of the lowest waiting times. Germans had the highest percentage of patients reporting their last specialist appointment took less than 4 weeks (83%, v. 80% for the U. S.), and the second-lowest reporting it took 2 months or more (7%, vs. 5% for Switzerland and 9% for the U. S.). 70% of Germans reported that they waited less than 1 month for elective surgery, the highest percentage, and the lowest percentage (0%) reporting it took 4 months or more.[54]

Both Social Health Insurance (SHI) and privately insured patient experienced low waits, but privately insured patients' waits were even lower. According to the Kassenärztliche Bundesvereinigung (KBV), the body representing contract physicians and contract psychotherapists at federal level, 56% of Social Health Insurance

patients waited 1 week or less, while only 13% waited longer than 3 weeks for a doctor's appointment. 67% of privately insured patients waited 1 week or less, while 7% waited longer than 3 weeks.[55] Waits can also vary somewhat by region. Waits were longer in eastern Germany according to the KBV (KBV, 2010), as cited in "Health at a Glance 2011: OECD Indicators".[56]

Germany has a large hospital sector capacity measured in beds. High capacity on top of significant day surgery outside of hospitals (especially for ophthalmology and othopaedic surgery) with doctors paid fee-for-service for activity performed are likely factors preventing long waits, despite hospital budget limitations.[53] Activity-based payment for hospitals also is linked to low waiting times (Siciliani & Hurst, 2003, 33–34, 70).[53] Germany introduced Diagnosis-Related Group activity-based payment for hospitals (with a soft cap budget limit).

National Health Service

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"NHS" redirects here. For other uses, see NHS (disambiguation).

For the individual national healthcare services of England, Scotland, Wales and Northern Ireland, see National Health Service (England), NHS Scotland, NHS Wales, and Health and Social Care in Northern Ireland.

NHS logos

Logo of the NHS in England

Logo of the NHS in Scotland

Logo of the NHS in Wales

Logo of HSC in Northern Ireland

Each of the four nations of the UK has a different logo for its healthcare system.

The **National Health Service** (**NHS**) is the publicly-funded healthcare system of the United Kingdom. Since 1948 it has been funded out of general taxation. It is made up of four separate systems that serve each part of the UK: The National Health Service in England, NHS Scotland, NHS Wales, and Health and Social Care in Northern Ireland. They were established together in 1948 as one of the major social reforms following the Second World War. The founding principles were that services should be comprehensive, universal and free at the point of delivery.[1] Each service provides a comprehensive range of health services, free at the point of use for people ordinarily resident in the United Kingdom, apart from dental treatment and optical care.[2] In England, NHS patients have to pay prescription charges with a range of exemptions from these charges.

Each of the UK's health service systems operates independently, and is politically accountable to the relevant government: the Scottish Government, Welsh Government, Northern Ireland Executive, and the UK Government, responsible for England's NHS. Since 2013 operational responsibility for the NHS in England has been passed to NHS England.[3] NHS Wales was originally part of the same structure

as that of England until powers over the NHS in Wales were first transferred to the Secretary of State for Wales in 1969 and thereafter, in 1999, to the Welsh Assembly as part of Welsh devolution. Some functions may be routinely performed by one health service on behalf of another. For example, Northern Ireland has no high-security psychiatric hospitals and depends on hospitals in Great Britain, routinely at Carstairs hospital in Scotland for male patients and Rampton Secure Hospital in England for female patients.[4] Similarly, patients in North Wales use specialist facilities in Manchester and Liverpool which are much closer than facilities in Cardiff, and more routine services at the Countess of Chester Hospital. There have been issues about cross-border payments.[5]

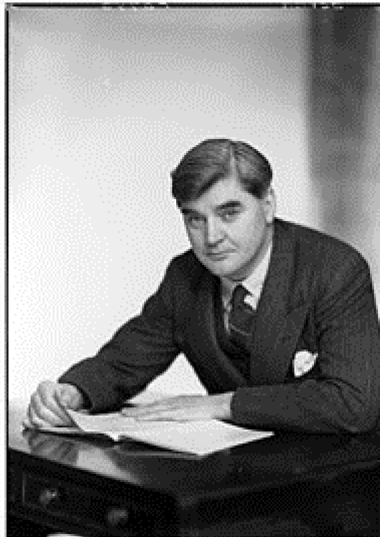
Taken together, the four National Health Services in 2015–2016 employed around 1.6 million people with a combined budget of £136.7 billion.[6] In 2014 the total health sector workforce across the UK was 2,165,043. This broke down into 1,789,586 in England, 198,368 in Scotland, 110,292 in Wales and 66,797 in Northern Ireland.[7] In 2017, there were 691,000 nurses registered in the UK, down 1,783 from the previous year. However, this is the first time nursing numbers have fallen since 2008. Every 24 hours it sees one million patients, and with 1.7 million staff it is the fifth biggest employer in the world.[8]

Although there has been increasing policy divergence between the four National Health Services in the UK, it can be difficult to find evidence of the effect of this on performance since, as Nick Timmins says: "Some of the key data needed to compare performance – including data on waiting times – is defined and collected differently in the four countries."[9][10] Statistics released in December 2017 showed that, compared with 2012-2013, the number of patients in Scotland waiting more than four hours in accident and emergency dropped by 9% (from about 8% of all A&E patients to about 6%), whereas in England that proportion had increased by 155% (from less than 5% of all A&E patients to about 11%).[11]However, since then, Scotland in common with the other three UK nations has experienced increasing pressure in Accident and Emergency departments with lengthening waiting times]

When purchasing drugs, the NHS has significant market power that, based on its own assessment of the fair value of the drugs, influences the global price, typically keeping prices lower.[15] Several other countries either copy the UK's model or directly rely on Britain's assessments for their own decisions on state-financed drug reimbursements

History[edit]

Further information: History of the National Health Service, History of the National Health Service (England), History of NHS Scotland, and History of NHS Wales



Aneurin Bevan, the founder of the NHS[17]

Dr Somerville Hastings, President of the Socialist Medical Association, successfully proposed a resolution at the 1934 Labour Party Conference that the party should be committed to the establishment of a State Health Service.[18]

Conservative MP and Health Minister, Henry Willink, first proposed the National Health Service in 1944 with the publication of a White Paper "A National Health Service" which was widely distributed in full and short versions as well as in newsreel by Henry Willink himself.[19] Aneurin Bevan's National Health Service became Westminster legislation for England and Wales from 1946 and Scotland from 1947, and the Northern Ireland Parliament's Public

Health Services Act 1947.[20] NHS Wales was split from NHS (England) in 1969 when control was passed to the Secretary of State for Wales before transferring to the Welsh Executive and Assembly under devolution in 1999.[21]

Calls for a "unified medical service" can be dated back to the Minority Report of the Royal Commission on the Poor Law in 1909,[22] but it was following the 1942 Beveridge Report's recommendation to create "comprehensive health and rehabilitation services for prevention and cure of disease" that cross-party consensus emerged on introducing a National Health Service of some description.[23] When Clement Attlee's Labour Party won the 1945 election he appointed Aneurin Bevan as Health Minister. Bevan then embarked upon what the official historian of the NHS, Charles Webster, called an "audacious campaign" to take charge of the form the NHS finally took.[24]

The NHS was born out of the ideal that good healthcare should be available to all, regardless of wealth. Although being freely accessible regardless of wealth maintained Henry Willink's principle of free healthcare for all, Conservative MPs were in favour of maintaining local administration of the NHS through existing arrangements with local authorities fearing that an NHS which owned hospitals on a national scale would lose the personal relationship between doctor and patient.[25]

Conservative MPs voted in favour of their amendment to Bevan's Bill to maintain local control and ownership of hospitals and against Bevan's plan for national ownership of all hospitals. The Labour government defeated Conservative amendments and went ahead with the NHS as it remains today; a single large national organisation (with devolved equivalents) which forced the transfer of ownership of hospitals from local authorities and charities to the new NHS. Bevan's principle of ownership with no private sector involvement has since been diluted, with later Labour governments implementing large scale financing arrangements with private builders in private finance initiatives and joint ventures.[26]

At its launch by Bevan on 5 July 1948 it had at its heart three core principles: That it meet the needs of everyone, that it be free at the

point of delivery, and that it be based on clinical need, not ability to pay.[27]

Three years after the founding of the NHS, Bevan resigned from the Labour government in opposition to the introduction of charges for the provision of dentures and glasses.[28] The following year, Winston Churchill's Conservative government introduced prescription charges. These charges were the first of many controversies over reforms to the NHS throughout its history.[29]

From its earliest days, the cultural history of the NHS has shown its place in British society reflected and debated in film, TV, cartoons and literature. The NHS had a prominent slot during the 2012 London Summer Olympics opening ceremony directed by Danny Boyle, being described as "the institution which more than any other unites our nation".[30]

The Luftwaffe achieved in months what had defeated politicians and planners for at least two decades.

The NHS vs Overseas Alternatives

In 2014, the Commonwealth Fund declared that in comparison with the healthcare systems of 10 other countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the US) the NHS was the most impressive overall. The NHS was rated as the best system in terms of efficiency, effective care, safe care, co-ordinated care, patient-centred care and cost-related problems. It was also ranked second for equity.

We take a closer look at other countries and their health service.

France
Upfront payments: yes

Under France's state-run equivalent of the NHS, the majority of patients must pay the doctor or practitioner upfront. The state then reimburses them in part or in full. The patient has freedom to choose which doctor or service to visit.

All health transactions centre on a smartcard. A GP visit costs €23 (£17), the Carte Vitale is swiped and the money is paid back into the patient's bank account within five days. In general, the state reimbursement rate is between

70% and 100%. The poorest people and the long-term sick are covered 100%.

Most people are signed up to a mutuelle, a semi-private insurance body, often related to their job, which tops up the remaining amount to be paid. If a patient is taken to the emergency department of a hospital, for example, they would provide their Carte Vitale, and depending on the health issue, could be reimbursed fully by the state. However, from November 2017 doctors such as GPs will have to waive the upfront fees for all patients, and instead the state and the mutuelle companies will pay doctors direct. At pharmacies, the patient pays upfront but swipes their Carte Vitale. A large number of prescribed medicines are reimbursed between 15% and 100%.

Ireland
Upfront payments: yes

GP visit in Ireland typically costs €40-€60. However, in 2015 the Irish government abolished charges for children under six while people with a medical card or GP visit card also receive free GP care. In most cases individuals pay for prescriptions from pharmacies capped at €144 per month under the Drugs Payment Scheme. Medical cardholders do not pay for medication but do pay a prescription charge of €2.50 per item (capped at €25 per month per person/family).

Patients are usually referred for secondary treatment by their GP unless they have entered the health system directly through an emergency department. Those attending emergency departments without being referred by a GP are charged €100 (with some exemptions). You are not charged if you are subsequently admitted as an inpatient but may be liable for hospital charges. The charge for an overnight stay in a public bed in a public hospital is €75 per day up to a maximum of €750 in 12 consecutive months.

Belgium

Upfront payments: yes, but reimbursable

Belgium’s healthcare system quality is largely down to its sponsorship by competing mutuals, and provisioned by a mixture of state and non-profit hospitals. Each mutual is funded by the state, the funding dependent on its membership numbers.

Like the system in France, citizens pay and swipe a health card at the point of care. They are then reimbursed between 50% and 75% of the costs by their mutuelle/mutualiteit scheme. Some GPs and hospitals have local arrangements with mutuals to reduce payments at the point of care.

Almost all dentists in Belgium are private, with only partial patient/state reimbursements complicating the landscape.

The Belgian Ministry of Health also recognises homoeopathy, acupuncture, osteopathy and chiropractic care as reimbursable alternative treatments, subject to the practitioner being a qualified doctor.

Sweden
Upfront payments: yes

Sweden is ranked third by the Commonwealth Fund, with a high proportion of doctors, above-average healthcare spending, and relatively low prescriptions of drugs.

Patients wishing to see a doctor pay a fee that varies depending on where they live, but usually about 100-200 kronor (£8-£16) for adults. Children pay only if they go to emergency rooms, about 120 kronor. For a visit to a specialist you pay up to 400 kronor and for emergency about 400 kronor. A hospital stay costs 100 kronor a day. You usually pay the same whether you choose a private or public clinic or hospital, as long as the private clinic is connected to the general healthcare system. And most are.

There is a limit to how much you pay for healthcare within a 12-month period. In most regions that is 1,100 kronor, but there are regions where the limit is just 900 kronor. Everything is free after that. Prescriptions are subsidised and you never pay more than 2,200 kronor in a 12-month period.
If you are referred to an expert, you pay a lower fee of about 100 kronor.

China
Upfront payments: yes, but low

Hundreds of millions of Chinese citizens lost the right to free public healthcare after the Communist party launched its economic reforms drive in the late 1970s.

Today, the cost of a hospital consultation is still relatively low. For those with blue government “social insurance” cards, for example, a trip to Beijing’s

Friendship hospital can cost as little 2 yuan (20p). It costs about 100 yuan to be admitted to A&E while a night in a ward sets a patient back about the same.

But the often exorbitant cost of medicine and treatment can be enough to ruin a Chinese family. Government officials say they hope to provide affordable healthcare to every Chinese citizen by 2020 and claim 95% of the population now boasts some kind of medical insurance. But in reality even those who do have insurance find it often fails to cover their bills.

US
Upfront payments: yes

US hospitals are duty-bound to treat emergency cases. Government spending pays for a surprising share of visits to the doctor and drugs through a patchwork of public programmes. Since Obama's insurance reforms, the percentage of people who have no cover has fallen to "only" 10% – a mere 33 million people.
For the rest, standards are generally high, sometimes among the best in the world. But no matter how good the insurance policy, few Americans can escape the crushing weight of payments bureaucracy, or the risk-averse medical practices that flow from a fear of lawsuits.

Though the system fosters excellence and innovation in places, the messy combination of underinsurance and overinsurance has left the US with the highest healthcare costs in the developed world and some of the worst overall health outcomes.

Japan
Upfront payments: no

Every resident of Japan is required, in principle, to take out public health insurance. Regular employees are typically covered by a work scheme, and are required to pay 20% of their total medical costs at the point of delivery.

Those not covered by their employer – mainly the self-employed and unemployed – must join the national health insurance scheme. Premiums are based on salary, value of property and the number of dependants, and members pay 30% of the cost of inpatient or outpatient treatment – including emergencies – with the government paying the remainder. People over 70 pay 10% of costs.

Medical fees above a certain ceiling – calculated depending on income and age – are paid in full by the government. Fees are waived for uninsured people on low incomes who receive government support.

Both public insurance plans cover a range of services, including hospital care, mental health care, prescription drugs, physiotherapy and, significantly, most dental care.

Spain
Upfront payments: no

Spain has a relatively high number of doctors – and a low number of nurses – proportionate to its population, but the amount it spends on healthcare has started to fall amid the economic crisis.

Spain offers free, universal healthcare to anyone resident, legally or illegally, in the country, as well as to tourists and other visitors. Since 2012, undocumented foreigners have been entitled only to emergency care. Some 90% of Spaniards use the system, with about 18% signing up to private healthcare schemes, including many public sector workers who are given the option of free, private care. Most dental and eye care is carried out in the private sector.

The system is decentralised across the country's 17 autonomous regions and so the quality of care, and in particular access to specialist procedures or units, varies. This leads to a degree of internal health tourism.

Italy
Upfront payments: in some cases

In Italy, the national health service offers universal health coverage that is free or low cost at the point of delivery and covers the vast majority of drugs.
It is recognised by independent experts as offering affordable and high quality care, though there are regional differences in the standard of some state-run hospitals, with facilities in northern Italy being considered better than those in the south. Citizens can also buy private insurance, which some do to avoid waiting times for doctors' visits.

The national insurance scheme is offered to all European citizens, and includes full coverage – paid for by general taxes – of inpatient treatments, tests, medications, surgery, emergency care, paediatrics and access to a family doctor.

The ministry said Italy is also the only country in Europe that allows families to choose a paediatrician for children until age 14 at no charge.

Germany
Upfront payments: no

Germany was positioned fifth in the latest Commonwealth Fund rankings, spending more than the EU average on healthcare – but its lengths of stay in hospital tend to be higher than in other countries.

In Germany's healthcare system anyone residing in the country is required to take out a health insurance scheme. About 85% of the population do this by taking out insurance with one of the country's 124 non-profit Krankenkassen or "sickness funds": public insurers, many of whom are small and linked to trade unions. Membership rates are about 15% of monthly salary, half of which is paid by employers.
Those who earn more than €4,350 (£3,300) a month can take out insurance with a private company, an option that is mainly popular with freelancers and the self-employed. For welfare recipients, health insurance membership is covered by local authorities.

Membership covers GP and registered specialists as well as basic dental care. If you are taken to hospital, your public health insurance kicks in once you are charged more than €10 a day, covering inpatient care with the doctor on duty at your nearest hospital. It doesn't cover private doctors or private rooms at a hospital, homeopathic treatment or more advanced dental treatment.

Since 2013, patients in Germany no longer have to pay a consultation fee of €10 when seeing a doctor. They can now also go straight to a specialist, rather than waiting to be referred by a GP.

UK
Upfront payments: no

UK came first in the latest Commonwealth Fund assessment of healthcare systems around the rich world, but an elderly demographic, the obesity epidemic and alcohol bingeing are all taking their toll. The UK also has the worst cancer outcomes of any rich country.

A mission statement set in 1948 for a universal service free at the point of use is under strain like never before. People are still able to see a GP free of

charge – though booking an appointment is becoming harder. It will cost nothing to call out an ambulance and go through A&E, to undergo chemotherapy or major surgery. And yet about 11% of the population prefer to pay for private health insurance.

The economics of health and medical tourism

The old medical tourism was South to North. It was the sultans and the sheikhs who could afford trips to the Mayo Clinic and Harley Street. The new medical tourist is global: not just from poor countries to rich countries but South to South and North to South as well. Comparative advantage, rising incomes, rising expectations, the ageing population, long waits, budget flights, differences in provision, the opportunity to combine medical care with recreational tourism are all drivers in the globalization of medical services. This chapter concentrates on three particular advantages for the international patient: price, quality and product differentiation. Price can be lower and labour often cheaper even if technical equipment has to be bought at world prices. Quality is assured by certifying bodies like Joint Commission International (JCI) and by professional training in respected medical schools. Product differentiation can take the form of traditional Chinese medicine in Beijing or Ayurveda in India, but also experimental drugs and commercial transplants. The new middle classes benefit from a greater range of choices, not least in elective areas such as cosmetic surgery and dentistry. The poor do not benefit directly, although indirectly they may enjoy spillovers such as employment, tax-funded welfare and cross-subsidization of services for the home population. The chapter concludes that, suitably managed, medical tourism can stimulate a regional and even a national multiplier that delivers a plus-sum gain through economic growth.

The economic turndown of recent years has significantly affected medical tourism worldwide, and redefined the cost/value equation.

How much value does a medical tourist really get when going abroad for medical treatment? What is the true cost of a hip transplant for a medical traveler? What is the going rate for a medical tourist's breast augmentation? Should one travel to India or to Mexico to get the best savings from a coronary angioplasty?

It depends.

Real value in medical tourism

The savings a medical tourist gets for procedure or treatment depends, more than ever, on the exchange rate between the currency the medical tourist uses at home and the currency used at the medical destination.

Is the medical traveler paying in US dollars, British pounds, Swedish krone or Burmese kyat? Is the receiving country charging in Indian rupees, Korean

won, Polish zloty or Turkish lira? Relative exchange rates, or currency to currency differences, matter as countries variously suffer the ups and downs of today's economic uncertainties.

While currencies like the Thai baht and the Malaysian ringgit have become stronger over the recent years, other currencies have weakened significantly, some by almost 50 percent.

Looking strictly at exchange rates, countries such as Mexico, Turkey and South Africa now may offer much better value for money than Thailand or Malaysia for medical travelers. India seems to be holding steady as a medical destination of value so far, although business interests in India are expressing concern that higher interest rates will result in a stronger rupee and reduce the country's global competitiveness.

Weak vs. strong currencies

The 2005 seminal medical tourism report from the World Bank compared costs of several surgical procedures in a number of countries. Today, Brazil's currency, along with Thailand's, is strong and surgery costs in both countries have increased significantly for anyone paying in U.S. dollars. According to World Bank figures, cost of shoulder arthroscopy in Brazil has increased between 2003 and 2010 by more than 60 percent, from U.S. $5,600 to $9,400.

By contrast, India, Mexico and Singapore exchange rates have remained fairly steady and corresponding surgery costs relative to the US dollar haven't changed much in the eight years the report considered: a hernia repair still costs as little or less in Mexico or India as it did in 2003.

In another telling example, the cost of breast augmentation in Thailand is still widely listed across the Internet at about $3,000 – $3,500 although this cost first was published in 2006. Today, because of the currency differential, this cost is actually 25 percent higher. $3,750 – $4,500 is a more accurate representation.

Given that prices in the U.S. for breast augmentation are highly competitive, the expected cost saving for a U.S. origin patient may well be negligible, once travel and other costs are included.

Competition

As popular medical destinations like Thailand and India face economic and political pressures both domestically and globally, they now also face growing competition from lesser known medical destinations and medical providers that is being spurred on by the new economics of medical tourism.

Some of these emerging “medical destination” countries are beginning to aggressively position themselves as significant actors in the medical tourism. Korea and Turkey are the most significant new players to threaten the old order.

As value in medical tourism shifts from Malaysia, Thailand or Brazil, other countries like Mexico, Turkey and South Africa begin to look more desirable as medical destinations. Beyond these, some lesser known medical destinations may be hiding a foreign exchange secret. Will Poland, for example, one day become a preferred medical tourism destination? Even Vietnam, whose currency was devalued last year, may begin to attract traveling patients from Bangladesh, Burma and elsewhere that have been Thailand’s bread and butter.

Price corrections

Key hospitals in traditional medical destinations like Thailand have begun to review and re-examine their policies, business strategies and marketing programs, making various kinds of changes. Some have increased their package prices for popular medical tourism procedures. Some, having lost significant sums of money and been the brunt of many disgruntled medical tourists, are now quoting package prices in US dollars instead of Thai baht.

Reviewing medical destinations on the basis of currency strength suggests that China, because of its strong currency relative to most of the world, is unlikely to become a preferred medical destination for some time. On the other hand, countries like Greece or Iceland may have an opportunity to surprise the industry and become rising stars of medical tourism.

A new era

While past policies and programs have been good enough to bring in patients from abroad in good times when choices were fewer, air fares were lower, and

patients were less informed, 2012 now brings us into a new era in medical tourism.

Many Europeans now are forced to grapple with the restrictions on their healthcare brought about by the sort of economic distress that Americans have been facing for the past three years. Additional national and international forces will continue to bear down on all segments of economic life including medical tourism.

From now on, to know the true cost and the true value of a medical treatment abroad, one has to ask where the medical traveler comes from and what medical destination will provide the treatment.

Medical tourism can be broadly defined as provision of 'Cost-effective' private medical care in collaboration with the tourism industry for patients, needing surgical and other forms of specialized treatment. This process is being facilitated by the corporate sector involved in medical care as well as the tourism industry – both private and public. Medical or health tourism has become a common form of vacationing and covers a broad spectrum of medical services. It is a combination of leisure or pleasure, fun and relaxation or rest together with perfectness and healthcare.
Tourism is an important industry contributing to the growth of a country's economy. The tourism industry is closely linked to other industries factors such as promotion of tourism, medical industrial growth, globalization and liberalization of trade have given a burst to the health industry and made it competitive. Tourism is an activity with very strong backward and forward linkages. The travelers spend money to enjoy a variety of goods, services and experiences. The income and employment generating capacity of this sector is immense.
In 2005, India's travel and tourism market was valued at $ 42 billion, and this is growing rapidly, India emerged as the fifth most preferred destination by the world's travelers in a survey conducted across 134 countries (3). In 2006, tourism as an industry offered employment to 41.8 million people, and accounted for 59 per cent of the GDP. (4). Also, tourism benefits are conferred on all classes, sections and regions

Health insurance

From Wikipedia, the free encyclopedia

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Health insurance is an insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over numerous persons. By estimating the overall risk of health care and health system expenses over the risk pool, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to provide the money to pay for the health care benefits specified in the insurance agreement.[1] The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

According to the Health Insurance Association of America, health insurance is defined as "coverage that provides for the payments of benefits as a result of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment" (p. 225).

Background[edit]

A health insurance policy is:

1. A contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (e.g. an employer or a community organization). The contract can be renewable (e.g. annually, monthly) or lifelong in the case of private insurance, or be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or "Evidence of Coverage" booklet for private insurance, or in a national health policy for public insurance.
2. (US specific) In the U.S., there are two types of health insurance - tax payer-funded and private-funded.[3] An example of a private-

funded insurance plan is an employer-sponsored self-funded ERISA plan. The company generally advertises that they have one of the big insurance companies. However, in an ERISA case, that insurance company "doesn't engage in the act of insurance", they just administer it. Therefore, ERISA plans are not subject to state laws. ERISA plans are governed by federal law under the jurisdiction of the US Department of Labor (USDOL). The specific benefits or coverage details are found in the Summary Plan Description (SPD). An appeal must go through the insurance company, then to the Employer's Plan Fiduciary. If still required, the Fiduciary's decision can be brought to the USDOL to review for ERISA compliance, and then file a lawsuit in federal court.

The individual insured person's obligations may take several forms:[*citation needed*]

- Premium: The amount the policy-holder or their sponsor (e.g. an employer) pays to the health plan to purchase health coverage. (US specific) According to the healthcare law, a premium is calculated using 5 specific factors regarding the insured person. These factors are age, location, tobacco use, individual vs. family enrollment, and which plan category the insured chooses.[4] Under the Affordable Care Act, the government pays a tax credit to cover part of the premium for persons who purchase private insurance through the Insurance Marketplace.[5]
- Deductible: The amount that the insured must pay out-of-pocket before the health insurer pays its share. For example, policy-holders

might have to pay a $7500 deductible per year, before any of their health care is covered by the health insurer. It may take several doctor's visits or prescription refills before the insured person reaches the deductible and the insurance company starts to pay for care. Furthermore, most policies do not apply co-pays for doctor's visits or prescriptions against your deductible.

- Co-payment: The amount that the insured person must pay out of pocket before the health insurer pays for a particular visit or service. For example, an insured person might pay a $45 co-payment for a doctor's visit, or to obtain a prescription. A co-payment must be paid each time a particular service is obtained.
- Coinsurance: Instead of, or in addition to, paying a fixed amount up front (a co-payment), the co-insurance is a percentage of the total cost that insured person may also pay. For example, the member might have to pay 20% of the cost of a surgery over and above a co-payment, while the insurance company pays the other 80%. If there is an upper limit on coinsurance, the policy-holder could end up owing very little, or a great deal, depending on the actual costs of the services they obtain.
- Exclusions: Not all services are covered. Billed items like use-and-throw, taxes, etc. are excluded from admissible claim. The insured are generally expected to pay the full cost of non-covered services out of their own pockets.
- Coverage limits: Some health insurance policies only pay for health care up to a certain dollar amount. The insured person may be expected to pay any charges in excess of the health plan's maximum payment for a specific service.

In addition, some insurance company schemes have annual or lifetime coverage maxima. In these cases, the health plan will stop payment when they reach the benefit maximum, and the policy-holder must pay all remaining costs.

- Out-of-pocket maximum: Similar to coverage limits, except that in this case, the insured person's payment obligation ends when they reach the out-of-pocket maximum, and health insurance pays all further covered costs. Out-of-pocket maximum can be limited to a specific benefit category (such as prescription drugs) or can apply to all coverage provided during a specific benefit year.
- Capitation: An amount paid by an insurer to a health care provider, for which the provider agrees to treat all members of the insurer.
- In-Network Provider: (U.S. term) A health care provider on a list of providers preselected by the insurer. The insurer will offer discounted coinsurance or co-payments, or additional benefits, to a plan member to see an in-network provider. Generally, providers in network are providers who have a contract with the insurer to accept rates further discounted from the "usual and customary" charges the insurer pays to out-of-network providers.
- Out-of-Network Provider: A health care provider that that has not contracted with the plan. If using an out-of-network provider, the patient may have to pay full cost of the benefits and services received from that provider. Even for emergency services, out-of-network providers may bill patients for some additional costs associated.
- Prior Authorization: A certification or authorization that an insurer provides prior to

medical service occurring. Obtaining an authorization means that the insurer is obligated to pay for the service, assuming it matches what was authorized. Many smaller, routine services do not require authorization.[6]

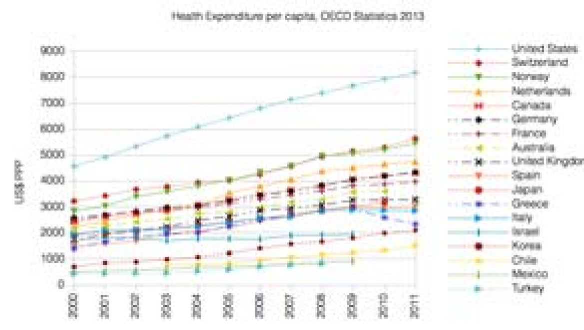
- Formulary: the list of drugs that an insurance plan agrees to cover.[7]
- Explanation of Benefits: A document that may be sent by an insurer to a patient explaining what was covered for a medical service, and how payment amount and patient responsibility amount were determined.[6] In the case of emergency room billing, patients are notified within 30 days post service. Patients are rarely notified of the cost of emergency room services in-person due to patient conditions and other logistics until receipt of this letter.[8]

Prescription drug plans are a form of insurance offered through some health insurance plans. In the U.S., the patient usually pays a copayment and the prescription drug insurance part or all of the balance for drugs covered in the formulary of the plan. Such plans are routinely part of national health insurance programs. For example, in the province of Quebec, Canada, prescription drug insurance is universally required as part of the public health insurance plan, but may be purchased and administered either through private or group plans, or through the public plan.[9]

Some, if not most, health care providers in the United States will agree to bill the insurance company if patients are willing to sign an agreement that they will be responsible for the amount that the insurance company doesn't pay. The insurance company pays out of network providers according to "reasonable and customary" charges, which may be less than the provider's usual fee. The provider may also have a separate contract with the insurer to accept what amounts to a discounted rate or capitation to the provider's standard charges. It generally costs the patient less to use an in-network provider.

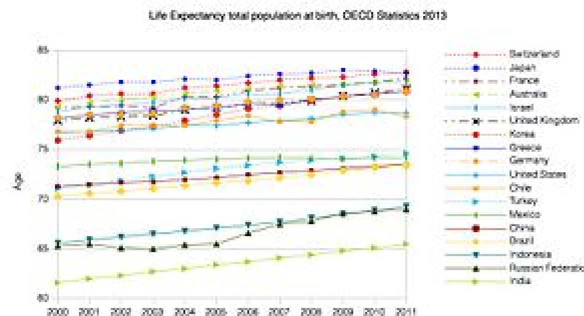
Comparisons[edit]

See also: Health system



Health Expenditure per capita (in PPP-adjusted US$) among several OECD member nations. Data source: OECD's iLibrary[10]

The Commonwealth Fund, in its annual survey, "Mirror, Mirror on the Wall", compares the performance of the health care systems in Australia, New Zealand, the United Kingdom, Germany, Canada and the U.S. Its 2007 study found that, although the U.S. system is the most expensive, it consistently under-performs compared to the other countries.[11] One difference between the U.S. and the other countries in the study is that the U.S. is the only country without universal health insurance coverage.



Life Expectancy of the total population at birth from 2000 until 2011 among several OECD member nations. Data source: OECD's iLibrary[12]

The Commonwealth Fund completed its thirteenth annual health policy survey in 2010.[13] A study of the survey "found significant differences in access, cost burdens, and problems with health insurance that are associated with insurance design".[13] Of the countries surveyed, the results indicated that people in the United States had more out-of-pocket expenses, more disputes with

insurance companies than other countries, and more insurance payments denied; paperwork was also higher although Germany had similarly high levels of paperwork.[13]

Australia[edit]

Main article: Health care in Australia

The Australian public health system is called Medicare, which provides free universal access to hospital treatment and subsidised out-of-hospital medical treatment. It is funded by a 2% tax levy on all taxpayers, an extra 1% levy on high income earners, as well as general revenue.

The private health system is funded by a number of private health insurance organizations. The largest of these is Medibank Private Limited, which was, until 2014, a government-owned entity, when it was privatized and listed on the Australian Stock Exchange.

Australian health funds can be either 'for profit' including Bupa and nib; 'mutual' including Australian Unity; or 'non-profit' including GMHBA, HCF and the HBF Health Insurance. Some, such as Police Health, have membership restricted to particular groups, but the majority have open membership. Membership to most health funds is now also available through comparison websites like moneytime, Compare the Market, iSelect Ltd., Choosi, ComparingExpert and YouCompare. These comparison sites operate on a commission-basis by agreement with their participating health funds. The Private Health Insurance Ombudsman also operates a free website which allows consumers to search for and compare private health insurers' products, which includes information on price and level of cover.[14]

Most aspects of private health insurance in Australia are regulated by the *Private Health Insurance Act 2007*. Complaints and reporting of the private health industry is carried out by an independent government agency, the Private Health Insurance Ombudsman. The ombudsman publishes an annual report that outlines the number and nature of complaints per health fund compared to their market share [15]

The private health system in Australia operates on a "community rating" basis, whereby premiums do not vary solely because of a

person's previous medical history, current state of health, or (generally speaking) their age (but see Lifetime Health Cover below). Balancing this are waiting periods, in particular for pre-existing conditions (usually referred to within the industry as PEA, which stands for "pre-existing ailment"). Funds are entitled to impose a waiting period of up to 12 months on benefits for any medical condition the signs and symptoms of which existed during the six months ending on the day the person first took out insurance. They are also entitled to impose a 12-month waiting period for benefits for treatment relating to an obstetric condition, and a 2-month waiting period for all other benefits when a person first takes out private insurance. Funds have the discretion to reduce or remove such waiting periods in individual cases. They are also free not to impose them to begin with, but this would place such a fund at risk of "adverse selection", attracting a disproportionate number of members from other funds, or from the pool of intending members who might otherwise have joined other funds. It would also attract people with existing medical conditions, who might not otherwise have taken out insurance at all because of the denial of benefits for 12 months due to the PEA Rule. The benefits paid out for these conditions would create pressure on premiums for all the fund's members, causing some to drop their membership, which would lead to further rises in premiums, and a vicious cycle of higher premiums-leaving members would ensue.

The Australian government has introduced a number of incentives to encourage adults to take out private hospital insurance. These include:

- **Lifetime Health Cover**: If a person has not taken out private hospital cover by 1 July after their 31st birthday, then when (and if) they do so after this time, their premiums must include a loading of 2% per annum for each year they were without hospital cover. Thus, a person taking out private cover for the first time at age 40 will pay a 20 percent loading. The loading is removed after 10 years of continuous hospital

cover. The loading applies only to premiums for hospital cover, not to ancillary (extras) cover.

- **Medicare Levy Surcharge**: People whose taxable income is greater than a specified amount (in the 2011/12 financial year $80,000 for singles and $168,000 for couples[16]) and who do not have an adequate level of private hospital cover must pay a 1% surcharge on top of the standard 1.5% Medicare Levy. The rationale is that if the people in this income group are forced to pay more money one way or another, most would choose to purchase hospital insurance with it, with the possibility of a benefit in the event that they need private hospital treatment – rather than pay it in the form of extra tax as well as having to meet their own private hospital costs.
    - The Australian government announced in May 2008 that it proposes to increase the thresholds, to $100,000 for singles and $150,000 for families. These changes require legislative approval. A bill to change the law has been introduced but was not passed by the Senate.[17] An amended version was passed on 16 October 2008. There have been criticisms that the changes will cause many people to drop their private health insurance, causing a further burden on the public hospital system, and a rise in premiums for those who stay with the private system. Other commentators believe the effect will be minimal.[18]
- **Private Health Insurance Rebate**: The government subsidises the premiums for all private health insurance cover, including hospital and ancillary (extras), by 10%, 20% or 30%, depending on age. The Rudd

Government announced in May 2009 that as of July 2010, the Rebate would become means-tested, and offered on a sliding scale. While this move (which would have required legislation) was defeated in the Senate at the time, in early 2011 the Gillard Government announced plans to reintroduce the legislation after the Opposition loses the balance of power in the Senate. The ALP and Greens have long been against the rebate, referring to it as "middle-class welfare".[19]

Canada[edit]

Main article: Health care in Canada

As per the Constitution of Canada, health care is mainly a provincial government responsibility in Canada (the main exceptions being federal government responsibility for services provided to aboriginal peoples covered by treaties, the Royal Canadian Mounted Police, the armed forces, and Members of Parliament). Consequently, each province administers its own health insurance program. The federal government influences health insurance by virtue of its fiscal powers – it transfers cash and tax points to the provinces to help cover the costs of the universal health insurance programs. Under the Canada Health Act, the federal government mandates and enforces the requirement that all people have free access to what are termed "medically necessary services," defined primarily as care delivered by physicians or in hospitals, and the nursing component of long-term residential care. If provinces allow doctors or institutions to charge patients for medically necessary services, the federal government reduces its payments to the provinces by the amount of the prohibited charges. Collectively, the public provincial health insurance systems in Canada are frequently referred to as Medicare.[20] This public insurance is tax-funded out of general government revenues, although British Columbia and Ontario levy a mandatory premium with flat rates for individuals and families to generate additional revenues - in essence, a surtax. Private health insurance is allowed, but in six provincial governments only for services that the public health plans do not

cover (for example, semi-private or private rooms in hospitals and prescription drug plans). Four provinces allow insurance for services also mandated by the Canada Health Act, but in practice there is no market for it. All Canadians are free to use private insurance for elective medical services such as laser vision correction surgery, cosmetic surgery, and other non-basic medical procedures. Some 65% of Canadians have some form of supplementary private health insurance; many of them receive it through their employers.[21] Private-sector services not paid for by the government account for nearly 30 percent of total health care spending.[22]

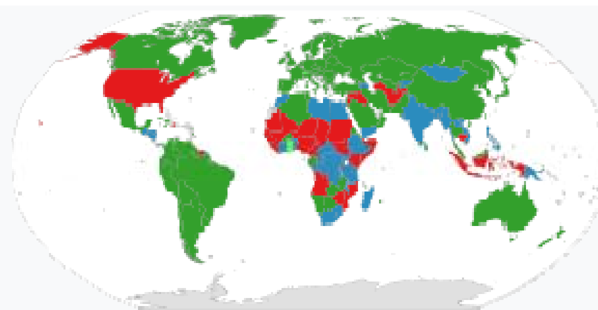
In 2005, the Supreme Court of Canada ruled, in *Chaoulli v. Quebec*, that the province's prohibition on private insurance for health care already insured by the provincial plan violated the Quebec Charter of Rights and Freedoms, and in particular the sections dealing with the right to life and security, if there were unacceptably long wait times for treatment, as was alleged in this case. The ruling has not changed the overall pattern of health insurance across Canada, but has spurred on attempts to tackle the core issues of supply and demand and the impact of wait times.[23]

China[edit]

Main articles: Healthcare reform in the People's Republic of China and Pharmaceutical industry in the People's Republic of China

France[edit]

Main article: Health care in France



World map of universal healthcare.
Countries with free and universal health care

The national system of health insurance was instituted in 1945, just after the end of the Second World War. It was a compromise

between Gaullist and Communist representatives in the French parliament. The Conservative Gaullists were opposed to a state-run healthcare system, while the Communists were supportive of a complete nationalisation of health care along a British Beveridge model.

The resulting programme is profession-based: all people working are required to pay a portion of their income to a not-for-profit health insurance fund, which mutualises the risk of illness, and which reimburses medical expenses at varying rates. Children and spouses of insured people are eligible for benefits, as well. Each fund is free to manage its own budget, and used to reimburse medical expenses at the rate it saw fit, however following a number of reforms in recent years, the majority of funds provide the same level of reimbursement and benefits.

The government has two responsibilities in this system.

- The first government responsibility is the fixing of the rate at which medical expenses should be negotiated, and it does so in two ways: The Ministry of Health directly negotiates prices of medicine with the manufacturers, based on the average price of sale observed in neighboring countries. A board of doctors and experts decides if the medicine provides a valuable enough medical benefit to be reimbursed (note that most medicine is reimbursed, including homeopathy). In parallel, the government fixes the reimbursement rate for medical services: this means that a doctor is free to charge the fee that he wishes for a consultation or an examination, but the social security system will only reimburse it at a pre-set rate. These tariffs are set annually through negotiation with doctors' representative organisations.
- The second government responsibility is oversight of the health-insurance funds, to

ensure that they are correctly managing the sums they receive, and to ensure oversight of the public hospital network.

Today, this system is more or less intact. All citizens and legal foreign residents of France are covered by one of these mandatory programs, which continue to be funded by worker participation. However, since 1945, a number of major changes have been introduced. Firstly, the different health care funds (there are five: General, Independent, Agricultural, Student, Public Servants) now all reimburse at the same rate. Secondly, since 2000, the government now provides health care to those who are not covered by a mandatory regime (those who have never worked and who are not students, meaning the very rich or the very poor). This regime, unlike the worker-financed ones, is financed via general taxation and reimburses at a higher rate than the profession-based system for those who cannot afford to make up the difference. Finally, to counter the rise in health care costs, the government has installed two plans, (in 2004 and 2006), which require insured people to declare a referring doctor in order to be fully reimbursed for specialist visits, and which installed a mandatory co-pay of €1 for a doctor visit, €0.50 for each box of medicine prescribed, and a fee of €16–18 per day for hospital stays and for expensive procedures.

An important element of the French insurance system is solidarity: the more ill a person becomes, the less the person pays. This means that for people with serious or chronic illnesses, the insurance system reimburses them 100% of expenses, and waives their co-pay charges.

Finally, for fees that the mandatory system does not cover, there is a large range of private complementary insurance plans available. The market for these programs is very competitive, and often subsidised by the employer, which means that premiums are usually modest. 85% of French people benefit from complementary private health insurance.[24]

Germany[edit]

Main article: Healthcare in Germany

Germany has the world's oldest national social health insurance system,[25] with origins dating back to Otto von Bismarck's Sickness Insurance Law of 1883.[26][27]

Beginning with 10% of blue-collar workers in 1885, mandatory insurance has expanded; in 2009, insurance was made mandatory on all citizens, with private health insurance for the self-employed or above an income threshold.[28][29] As of 2016, 85% of the population is covered by the compulsory Statutory Health Insurance (SHI)[30] (*Gesetzliche Krankenversicherung* or *GKV*), with the remainder covered by private insurance (*Private Krankenversicherung* or *PKV*). Germany's health care system was 77% government-funded and 23% privately funded as of 2004.[31] While public health insurance contributions are based on the individual's income, private health insurance contributions are based on the individual's age and health condition.[28][32]

Reimbursement is on a fee-for-service basis, but the number of physicians allowed to accept Statutory Health Insurance in a given locale is regulated by the government and professional societies.

Co-payments were introduced in the 1980s in an attempt to prevent over utilization. The average length of hospital stay in Germany has decreased in recent years from 14 days to 9 days, still considerably longer than average stays in the United States (5 to 6 days).[33][34] Part of the difference is that the chief consideration for hospital reimbursement is the number of hospital days as opposed to procedures or diagnosis. Drug costs have increased substantially, rising nearly 60% from 1991 through 2005. Despite attempts to contain costs, overall health care expenditures rose to 10.7% of GDP in 2005, comparable to other western European nations, but substantially less than that spent in the U.S. (nearly 16% of GDP).[35]

Germans are offered three kinds of social security insurance dealing with the physical status of a person and which are co-financed by employer and employee: health insurance, accident insurance, and long-term care insurance. Long-term care insurance (*Gesetzliche Pflegeversicherung*) emerged in 1994 and is mandatory.[29] Accident insurance (gesetzliche Unfallversicherung) is covered by the employer

and basically covers all risks for commuting to work and at the workplace.[citation needed]

India[edit]

Main article: Healthcare in India

In India, provision of health care services varies state-wise. Public health services are prominent in most of the states, but due to inadequate resources and management, major population opts for private health services.

To improve the awareness and better health care facilities, Insurance Regulatory and Development Authority of India and The General Corporation of India runs health care campaigns for the whole population. IN 2018, for under privileged citizens, Prime Minister Narendra Modi announced the launch of a new health insurance called Modicare and the government claims that the new system will try to reach more than 500 million people.

In India, Health insurance is offered mainly in two Types:

- **Indemnity Plan** basically covers the hospitalisation expenses and has subtypes like Individual Insurance, Family Floater Insurance, Senior Citizen Insurance, Maternity Insurance, Group Medical Insurance.
- **Fixed Benefit Plan** pays a fixed amount for pre-decided diseases like critical illness, cancer, heart disease, etc. It has also its sub types like Preventive Insurance, Critical illness, Personal Accident.

Depending on the type of insurance and the company providing health insurance, coverage includes pre-and post-hospitalisation charges, ambulance charges, day care charges, Health Checkups, etc.

It is pivotal to know about the exclusions which are not covered under insurance schemes:

- Treatment related to dental disease or surgeries
- All kind of STD's and AIDS

- Non-Allopathic Treatment

Few of the companies do provide insurance against such diseases or conditions, but that depends on the type and the insured amount.

Some important aspects to be considered before choosing the health insurance in India are Claim Settlement ratio, Insurance limits and Caps, Coverage and network hospitals.

Japan[edit]

Main article: Health care in Japan

There are two major types of insurance programs available in Japan – Employees Health Insurance (健康保険 Kenkō-Hoken), and National Health Insurance (国民健康保険 Kokumin-Kenkō-Hoken). National Health insurance is designed for people who are not eligible to be members of any employment-based health insurance program. Although private health insurance is also available, all Japanese citizens, permanent residents, and non-Japanese with a visa lasting one year or longer are required to be enrolled in either National Health Insurance or Employees Health Insurance.

Netherlands[edit]

Main article: Health care in the Netherlands

In 2006, a new system of health insurance came into force in the Netherlands. This new system avoids the two pitfalls of adverse selection and moral hazard associated with traditional forms of health insurance by using a combination of regulation and an insurance equalization pool. Moral hazard is avoided by mandating that insurance companies provide at least one policy which meets a government set minimum standard level of coverage, and all adult residents are obliged by law to purchase this coverage from an insurance company of their choice. All insurance companies receive funds from the equalization pool to help cover the cost of this government-mandated coverage. This pool is run by a regulator which collects salary-based contributions from employers, which make up about 50% of all health care funding, and funding from the government to cover people who cannot afford health care, which makes up an additional 5%.[36]

The remaining 45% of health care funding comes from insurance premiums paid by the public, for which companies compete on price, though the variation between the various competing insurers is only about 5%.[citation needed] However, insurance companies are free to sell additional policies to provide coverage beyond the national minimum. These policies do not receive funding from the equalization pool, but cover additional treatments, such as dental procedures and physiotherapy, which are not paid for by the mandatory policy.[citation needed]

Funding from the equalization pool is distributed to insurance companies for each person they insure under the required policy. However, high-risk individuals get more from the pool, and low-income persons and children under 18 have their insurance paid for entirely. Because of this, insurance companies no longer find insuring high risk individuals an unappealing proposition, avoiding the potential problem of adverse selection.

Insurance companies are not allowed to have co-payments, caps, or deductibles, or to deny coverage to any person applying for a policy, or to charge anything other than their nationally set and published standard premiums. Therefore, every person buying insurance will pay the same price as everyone else buying the same policy, and every person will get at least the minimum level of coverage.

New Zealand[edit]

Main article: Health care in New Zealand

Since 1974, New Zealand has had a system of universal no-fault health insurance for personal injuries through the Accident Compensation Corporation (ACC). The ACC scheme covers most of the costs of related to treatment of injuries acquired in New Zealand (including overseas visitors) regardless of how the injury occurred, and also covers lost income (at 80 percent of the employee's pre-injury income) and costs related to long-term rehabilitation, such as home and vehicle modifications for those seriously injured. Funding from the scheme comes from a combination of levies on employers' payroll (for work injuries), levies on an employee's taxable income (for non-work injuries to salary earners), levies on vehicle licensing fees and petrol (for motor vehicle accidents), and funds from the general

taxation pool (for non-work injuries to children, senior citizens, unemployed people, overseas visitors, etc.)

Rwanda[edit]

Main article: Healthcare in Rwanda

Rwanda is one of a handful of low income countries that has implemented community-based health insurance schemes in order to reduce the financial barriers that prevent poor people from seeking and receiving needed health services. This scheme has helped reach 90% of the country's population with health care coverage.[37][38]

Switzerland[edit]

Main article: Health insurance in Switzerland

Healthcare in Switzerland is universal[39] and is regulated by the Swiss Federal Law on Health Insurance. Health insurance is compulsory for all persons residing in Switzerland (within three months of taking up residence or being born in the country).[40][41] It is therefore the same throughout the country and avoids double standards in healthcare. Insurers are required to offer this basic insurance to everyone, regardless of age or medical condition. They are not allowed to make a profit off this basic insurance, but can on supplemental plans.[39]

The universal compulsory coverage provides for treatment in case of illness or accident and pregnancy. Health insurance covers the costs of medical treatment, medication and hospitalization of the insured. However, the insured person pays part of the costs up to a maximum, which can vary based on the individually chosen plan, premiums are then adjusted accordingly. The whole healthcare system is geared towards to the general goals of enhancing general public health and reducing costs while encouraging individual responsibility.

The Swiss healthcare system is a combination of public, subsidized private and totally private systems. Insurance premiums vary from insurance company to company, the excess level individually chosen (*franchise*), the place of residence of the insured person and the degree of supplementary benefit coverage chosen (complementary medicine, routine dental care, semi-private or private ward hospitalization, etc.).

The insured person has full freedom of choice among the approximately 60 recognized healthcare providers competent to treat their condition (in their region) on the understanding that the costs are covered by the insurance up to the level of the official tariff. There is freedom of choice when selecting an insurance company to which one pays a premium, usually on a monthly basis. The insured person pays the insurance premium for the basic plan up to 8% of their personal income. If a premium is higher than this, the government gives the insured person a cash subsidy to pay for any additional premium.

The compulsory insurance can be supplemented by private "complementary" insurance policies that allow for coverage of some of the treatment categories not covered by the basic insurance or to improve the standard of room and service in case of hospitalization. This can include complementary medicine, routine dental treatment and private ward hospitalization, which are not covered by the compulsory insurance.

As far as the compulsory health insurance is concerned, the insurance companies cannot set any conditions relating to age, sex or state of health for coverage. Although the level of premium can vary from one company to another, they must be identical within the same company for all insured persons of the same age group and region, regardless of sex or state of health. This does not apply to complementary insurance, where premiums are risk-based.

Switzerland has an infant mortality rate of about 3.6 out of 1,000. The general life expectancy in 2012 was for men 80.5 years compared to 84.7 years for women.[42] These are the world's best figures.[43]

United Kingdom[edit]

Main article: National Health Service

The UK's National Health Service (NHS) is a publicly funded healthcare system that provides coverage to everyone normally resident in the UK. It is not strictly an insurance system because (a) there are no premiums collected, (b) costs are not charged at the patient level and (c) costs are not pre-paid from a pool. However, it does achieve the main aim of insurance which is to spread financial risk arising from ill-health. The costs of running the NHS (est. £104

billion in 2007-8)[44] are met directly from general taxation. The NHS provides the majority of health care in the UK, including primary care, in-patient care, long-term health care, ophthalmology, and dentistry.

Private health care has continued parallel to the NHS, paid for largely by private insurance, but it is used by less than 8% of the population, and generally as a top-up to NHS services. There are many treatments that the private sector does not provide. For example, health insurance on pregnancy is generally not covered or covered with restricting clauses. Typical exclusions for Bupa schemes (and many other insurers) include:

aging, menopause and puberty; AIDS/HIV; allergies or allergic disorders; birth control, conception, sexual problems and sex changes; chronic conditions; complications from excluded or restricted conditions/ treatment; convalescence, rehabilitation and general nursing care ; cosmetic, reconstructive or weight loss treatment; deafness; dental/oral treatment (such as fillings, gum disease, jaw shrinkage, etc); dialysis; drugs and dressings for out-patient or take-home use† ; experimental drugs and treatment; eyesight; HRT and bone densitometry; learning difficulties, behavioural and developmental problems; overseas treatment and repatriation; physical aids and devices; pre-existing or special conditions; pregnancy and childbirth; screening and preventive treatment; sleep problems and disorders; speech disorders; temporary relief of symptoms.[45] († = except in exceptional circumstances)

There are a number of other companies in the United Kingdom which include, among others, ACE Limited, AXA, Aviva, Bupa, Groupama Healthcare, WPA and PruHealth. Similar exclusions apply, depending on the policy which is purchased.

In 2009, the main representative body of British Medical physicians, the British Medical Association, adopted a policy statement expressing concerns about developments in the health insurance market in the UK. In its Annual Representative Meeting which had been agreed earlier by the Consultants Policy Group (i.e. Senior physicians) stating that the BMA was "extremely concerned that the policies of some

private healthcare insurance companies are preventing or restricting patients exercising choice about (i) the consultants who treat them; (ii) the hospital at which they are treated; (iii) making top up payments to cover any gap between the funding provided by their insurance company and the cost of their chosen private treatment." It went in to "call on the BMA to publicise these concerns so that patients are fully informed when making choices about private healthcare insurance."[46] The practice of insurance companies deciding which consultant a patient may see as opposed to GPs or patients is referred to as Open Referral.[47] The NHS offers patients a choice of hospitals and consultants and does not charge for its services.

The private sector has been used to increase NHS capacity despite a large proportion of the British public opposing such involvement.[48] According to the World Health Organization, government funding covered 86% of overall health care expenditures in the UK as of 2004, with private expenditures covering the remaining 14%.[31]

Nearly one in three patients receiving NHS hospital treatment is privately insured and could have the cost paid for by their insurer. Some private schemes provide cash payments to patients who opt for NHS treatment, to deter use of private facilities. A report, by private health analysts Laing and Buisson, in November 2012, estimated that more than 250,000 operations were performed on patients with private medical insurance each year at a cost of £359 million. In addition, £609 million was spent on emergency medical or surgical treatment. Private medical insurance does not normally cover emergency treatment but subsequent recovery could be paid for if the patient were moved into a private patient unit.[49]

United States[edit]

Main articles: Health insurance in the United States and Health care in the United States

Short Term Health Insurance

On the 1st of August, 2018 the DHHS issued a final rule which made federal changes to Short-Term, Limited-Duration Health Insurance (STLDI) which lengthened the maximum contract term to 364 days

and renewal for up to 36 months.[50][51] This new rule, in combination with the expiration of the penalty for the Individual Mandate of the Affordable Care Act,[52] has been the subject of independent analysis.[53][54][55][56][57][58][59][60]

The United States health care system relies heavily on private health insurance, which is the primary source of coverage for most Americans. As of 2012 about 61% of Americans had private health insurance according to the Centers for Disease Control and Prevention.[61] The Agency for Healthcare Research and Quality (AHRQ) found that in 2011, private insurance was billed for 12.2 million U.S. inpatient hospital stays and incurred approximately $112.5 billion in aggregate inpatient hospital costs (29% of the total national aggregate costs).[62] Public programs provide the primary source of coverage for most senior citizens and for low-income children and families who meet certain eligibility requirements. The primary public programs are Medicare, a federal social insurance program for seniors and certain disabled individuals; and Medicaid, funded jointly by the federal government and states but administered at the state level, which covers certain very low income children and their families. Together, Medicare and Medicaid accounted for approximately 63 percent of the national inpatient hospital costs in 2011.[62] SCHIP is a federal-state partnership that serves certain children and families who do not qualify for Medicaid but who cannot afford private coverage. Other public programs include military health benefits provided through TRICARE and the Veterans Health Administration and benefits provided through the Indian Health Service. Some states have additional programs for low-income individuals.[63]

In the late 1990s and early 2000s, health advocacy companies began to appear to help patients deal with the complexities of the healthcare system. The complexity of the healthcare system has resulted in a variety of problems for the American public. A study found that 62 percent of persons declaring bankruptcy in 2007 had unpaid medical expenses of $1000 or more, and in 92% of these cases the medical debts exceeded $5000. Nearly 80 percent who filed for bankruptcy had health insurance.[64] The Medicare and Medicaid programs were

estimated to soon account for 50 percent of all national health spending.[65] These factors and many others fueled interest in an overhaul of the health care system in the United States. In 2010 President Obama signed into law the Patient Protection and Affordable Care Act. This Act includes an 'individual mandate' that every American must have medical insurance (or pay a fine). Health policy experts such as David Cutler and Jonathan Gruber, as well as the American medical insurance lobby group America's Health Insurance Plans, argued this provision was required in order to provide "guaranteed issue" and a "community rating," which address unpopular features of America's health insurance system such as premium weightings, exclusions for pre-existing conditions, and the pre-screening of insurance applicants. During 26–28 March, the Supreme Court heard arguments regarding the validity of the Act. The Patient Protection and Affordable Care Act was determined to be constitutional on 28 June 2012. The Supreme Court determined that Congress had the authority to apply the individual mandate within its taxing powers.[66]

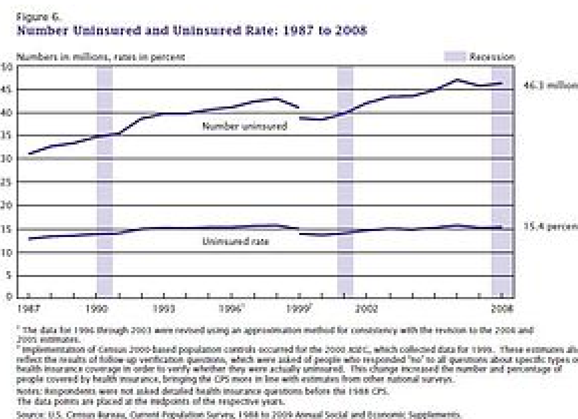
History and evolution[edit]

Main articles: Health insurance in the United States § History, and Managed care

In the late 19th century, "accident insurance" began to be available, which operated much like modern disability insurance.[67][68] This payment model continued until the start of the 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance.[69]

Accident insurance was first offered in the United States by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the U.S. by 1866, but the industry consolidated rapidly soon thereafter. While there were earlier experiments, the origins of sickness coverage in the U.S. effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911.[70]

Before the development of medical expense insurance, patients were expected to pay health care costs out of their own pockets, under what is known as the fee-for-service business model. During the middle-to-late 20th century, traditional disability insurance evolved into modern health insurance programs. One major obstacle to this development was that early forms of comprehensive health insurance were enjoined by courts for violating the traditional ban on corporate practice of the professions by for-profit corporations.[71] State legislatures had to intervene and expressly legalize health insurance as an exception to that traditional rule. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures. They also cover or partially cover the cost of certain prescription and over-the-counter drugs. Insurance companies determine what drugs are covered based on price, availability, and therapeutic equivalents. The list of drugs that an insurance program agrees to cover is called a formulary.[7] Additionally, some prescriptions drugs may require a prior authorization[72] before an insurance program agrees to cover its cost.



The numbers of uninsured Americans and the uninsured rate from 1987 to 2008

Hospital and medical expense policies were introduced during the first half of the 20th century. During the 1920s, individual hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organizations.[70] The predecessors of today's Health Maintenance Organizations (HMOs) originated beginning in 1929, through the 1930s and on during World War II.[73][74]

The Employee Retirement Income Security Act of 1974 (ERISA) regulated the operation of a health benefit plan if an employer chooses to establish one, which is not required. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives an ex-employee the right to continue coverage under an employer-sponsored group health benefit plan.

Through the 1990s, managed care insurance schemes including health maintenance organizations (HMO), preferred provider organizations, or point of service plans grew from about 25% US employees with employer-sponsored coverage to the vast majority.[75] With managed care, insurers use various techniques to address costs and improve quality, including negotiation of prices ("in-network" providers), utilization management, and requirements for quality assurance such as being accredited by accreditation schemes such as the Joint Commission and the American Accreditation Healthcare Commission.[76]

Employers and employees may have some choice in the details of plans, including health savings accounts, deductible, and coinsurance. As of 2015, a trend has emerged for employers to offer high-deductible plans, called consumer-driven healthcare plans which place more costs on employees, while employees benefit by paying lower monthly premiums. Additionally, having a high-deductible plan allows employees to open a health savings account, which allows them to contribute pre-tax savings towards future medical needs. Some employers will offer multiple plans to their employees.[77]

Russia[edit]

See also: Healthcare in Russia

The private health insurance market, known in Russian as "voluntary health insuranceRussian to distinguish it from state-sponsored Mandatory Medical Insurance, has experienced sustained levels of growth.[78] It was introduced in October 1992.