REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-06)
Comparison of Selected International Health Care Systems
(June 2006)

EXECUTIVE SUMMARY

Comparisons are often made between the health care system of the United States and those of countries that rely on more centralized health care financing or delivery systems. Some argue that centralized health care systems are more cost-effective and equitable than the market-oriented system of the US. Others note that these apparent advantages come at the expense of other desirable features of an effective health care system, such as choice, innovation, and timeliness of and convenient access to care.

This report, which is presented for the information of the House of Delegates, is intended to provide a snapshot of how some countries organize their health care infrastructures, and the challenges that arise from different funding structures and delivery systems. The report highlights the financing, delivery, and coverage structures of the health care systems of the United Kingdom, Canada, Germany, and Switzerland. Although these countries have been selected in part for their similarities to the US, the size, diversity, and wealth of the US relative to the other countries presents unique challenges and opportunities for the US in organizing its health care system.

In comparing the advantages and limitations of health care systems, the Council believes it is extremely important to distinguish between *coverage* (i.e., participation in some health insurance plan), and *access* (i.e., being able to receive appropriate health care services in a timely manner). The AMA plan for health system reform attempts to maximize both of these dimensions. Currently, the US lags behind other countries in the level of coverage of US residents, but among the insured population, access to covered services is remarkably good. In contrast, the government-controlled insurance systems in the United Kingdom and Canada result in virtually universal coverage, but the health care systems have severe access problems. Excessive wait times for surgeries or specialist appointments in both countries are a frequent complaint. In addition, restrictions on treating certain categories of patients, and limited availability of the most up-to-date medical technology, compromise access to and quality of health care available to their citizens.

Germany and Switzerland have more market-based health care systems. Both countries also have almost universal coverage levels, but they appear to have fewer access problems than Canada or the UK. Although most health insurance in Germany is funded through taxes paid by employers and employees, individuals can choose from among a variety of health insurance plans, each of which operates independently. In Switzerland, individuals are responsible for obtaining private insurance from one of several insurers who offer benefits mandated by the Swiss government. Individuals who cannot afford health insurance are eligible for means-tested subsidies provided by the government.

Expanding coverage for the uninsured and increasing access to care remains one of the AMA's top advocacy agenda items for 2006. Recognizing that there are many trade-offs associated with ensuring adequate access to health care for everyone, the Council believes that it will be critical to maintain a pluralistic health care system that emphasizes patient choice.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - A-06
(June 2006)

Subject: Comparison of Selected International Health Care Systems

Presented by: Joseph P. Annis, MD, Chair

Reports of rising health care costs in the United States and increasing numbers of uninsured Americans are frequent features in the news. Comparisons are often made between the health care system of the US and those of countries that rely on more centralized health care financing or delivery systems. Some argue that centralized health care systems are more cost-effective and equitable than the market-oriented system of the US. Others note that these apparent advantages come at the expense of other desirable features of an effective health care system, such as choice, innovation, and timeliness of and convenient access to care.

This report, which is presented for the information of the House of Delegates, is intended to provide a snapshot of how some countries organize their health care infrastructures, and the challenges that arise from different funding structures and delivery systems. In preparing this report, the Council limited its scope to an examination of countries with economic, political, and social systems similar to those of the United States. Accordingly, the report presents information on the health care systems of the following countries: the United Kingdom, Canada, Germany, and Switzerland. Along with the US, these countries are among the 30 member countries of the Organization for Economic Cooperation and Development (OECD) that "share a commitment to democratic government and the market economy." The Council selected these countries because in addition to some fundamental similarities between their governmental structures and economies and those of the US, their health care systems represent a variety of frameworks that offer unique opportunities and challenges for meeting the needs of their populations.

UNIQUE CHALLENGES FOR THE UNITED STATES

Although the countries in this report have been selected in part for their similarities to the United States, it is important to acknowledge the ways in which the US is vastly different from the other countries. For example, the sheer size of the US, both in terms of population and geography, distinguishes it significantly from the other four countries (except for Canada, where the total land mass is larger than that of the US). The US population is more than 3.5 times greater than that of Germany, the next largest country, and almost 40 times greater than Switzerland's population (OECD, 2005).

Not surprisingly, the size of the US, along with its history, fosters a heterogeneity that also distinguishes it from other nations. Data from the 2000 US census indicate that racial and ethnic minorities account for approximately 30% of the population. Of the countries profiled in this report, Canada has the next largest minority population (approximately 13%) (Statistics Canada, 2001). The cultural and ethnic diversity of the population of the United States is one of the country's greatest assets. However, this diversity, combined with the sheer number of residents and their geographic spread, create some challenges that are unique to the US, especially with respect to the delivery of health care services.

Although it is difficult to quantify, the cultural values of a nation also play a significant role in determining what political or economic strategies will be most effective in that country. For example, the US, which was founded on the principles of "life, liberty, and the pursuit of happiness," tends to place a high value on individual choice and the ability of the market to accommodate a variety of preferences at a variety of price points.

The strong preference for market choices also may reflect the fact that disposable income is much higher in the US than in other countries. Per capita income in the US is almost 20% higher than that of the next closest countries (Canada and Switzerland), about 23% greater than in Great Britain, and nearly 30% higher than in Germany (OECD, 2005). Interestingly, despite the overall wealth of the US, relative poverty rates and child poverty rates are significantly higher in the US than in the other countries. This asymmetry in wealth distribution also has implications for the health care needs of the US population, as well as for identifying effective and efficient ways of meeting these needs.

Although not the explicit focus of this report, per capita health expenditures are dramatically higher in the US than in the other counties. While many sociological factors contribute to higher US spending rates, two economic factors that are often cited as contributing to the higher costs are the higher cost of living in the US, and the country's professional liability climate. Studies have shown that Americans' "ability to pay" (as reflected in higher per capita incomes) helps explain overall higher prices for health care services (Reinhardt et al, 2004). The relatively aggressive professional liability climate in the US also contributes to higher levels of health care spending, with the sector absorbing the additional costs associated with professional liability insurance, defending against non-meritorious lawsuits, and increased consumption associated with the practice of defensive medicine (Anderson et al, 2005). Council on Medical Service Report 1 (A-06), "Health System Expenditures," which is also before the House at this meeting, provides an in-depth analysis of some key elements of health care spending in the US.

HEALTH CARE SYSTEM COMPARISONS

The following sections of this report provide an overview of key elements of the health care systems of the United States, the United Kingdom, Canada, Germany, and Switzerland. The appendix presents a grid comparing the health care system of each country in terms of some key features. Although estimates of features such as per capita health expenditures and percentage of gross domestic product are cited, it is important to note that comparing these data may not give an accurate picture of expenditures in other countries. In many cases – including US data – it is difficult to determine what factors are included in health care statistics. For example, services for the disabled may be included as health care costs, or as separate social service costs. Similarly, long-term care services may be considered part of overall health spending, or treated as a distinct service category.

Key Elements of the United States Health Care System

The constellation of institutions that make up the US health care system has its origins in the 1930s with the introduction of Blue Cross and Blue Shield health insurance. Following the implementation of wage controls during World War II, employer-sponsored health insurance began to dominate the market. The Medicare and Medicaid programs were authorized in 1965 (Moran, 2005).

In 2003, total health spending in the US accounted for 15% of the Gross Domestic Product (GDP), higher than the 11% average of the five countries presented in this report, and the highest of all OECD member countries. Per capita health expenditure in the US was $5,635, with a growth rate of 4.6% between 1998 and 2003 (OECD, 2005).

Financing. Health care in the US is financed through a combination of public and private sources. The government funds approximately 45% of health expenditures, through programs such as Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) (Centers for Medicare and Medicaid Services, 2003). Private insurance accounts for 36% of total health care spending. Of those individuals who have private health insurance coverage, the vast majority (86%) obtain it through their employers (US Census Bureau, 2004). The Centers for Medicare and Medicaid Services (CMS) estimates that patient out-of-pocket costs account for 14% of US health expenditures. These include premiums and co-payments/co-insurance (which are applicable in both public and private insurance programs), as well as costs for products and services that are not otherwise covered by insurance. The remaining 5% of health care financing is attributable to other non-patient sources, such as philanthropy.

Delivery. Health care in the US is delivered primarily through the private sector. Physicians, hospitals, labs, and other related services generally operate independently, on a for-profit or not-for-profit basis. Since approximately 68% of the population is covered by private health insurance (US Census Bureau, 2004), insurance companies exert significant influence over the delivery of most health care services. The demand for many health care services and procedures is closely linked to coverage policies and payment rates. Many insurance policies encourage or require patients to work through a primary care physician in order to receive care. Other policies steer patients to a specific panel of physicians by minimizing out-of-pocket expenditures for care received under preferred providers.

Although physicians are free to set their own prices, the dominance of third-party payers – both public and private – leaves most physicians in the position of accepting payment rates negotiated with insurers. As the largest third-party payer in the US health system, Medicare holds significant monopsony power over physicians and other providers, and Medicare payment rates greatly influence the contract rates offered by private insurers. Furthermore, the insurance industry has consolidated in recent years, leaving only one or two major insurers in many markets. Thus, while physician payment rates for privately insured patients are "negotiated" between the physician and the insurance company, and physicians can opt out of Medicare, many physicians are effectively limited in the rates they receive for their services.

Coverage. The US offers virtually universal health insurance to individuals 65 and over through the Medicare program. Among the non-elderly, approximately 62% receive insurance through their employers, and another 6 - 7% obtain individual market coverage (EBRI, 2005). Low-income individuals who meet certain eligibility requirements receive government-sponsored care through Medicaid, and children from low income families are eligible to receive coverage through SCHIP. Approximately 16% of the population is uninsured.

Several studies have demonstrated that being uninsured in the US results in poorer health outcomes and increased incidence of delayed or neglected treatment for health conditions. However, the US has identified a number of mechanisms through which to provide at least limited access to care for uninsured Americans who are unable to afford care. Free clinics, emergency room care, with treatment mandated through EMTALA, and charity care delivered on an individual basis by hospitals and physicians are all ways that the "system" has stretched to accommodate individuals without health insurance.

It should be noted, however, that the continued reliance on utilizing charity care to fill in the gaps of insurance coverage results in significant costs, both economic and social, for the US. Council on Medical Service Report 8 (A-05) provided an in-depth analysis of the costs associated with "uncompensated care" (which includes bad debt in addition to freely given charity care), and the ways in which high levels of uncompensated care are correlated with high health care costs overall due to cost shifting. According to the report, physicians provided more than $39 billion in uncompensated care in 2001, a figure which likely underestimates the true costs associated with the delivery of such care, and which likely has grown significantly in the past five years.

Key Elements of the British Health Care System

The British health care system has been operating under the same basic structure since 1948. At that time, the National Health Service (NHS) was created to facilitate the "collective responsibility by the state for a comprehensive health service, which was to be available to the entire population free at the point of use. Freedom from user charges was a key feature of this approach which placed heavy emphasis on equality of access" (European Observatory on Health Care Systems, 1999). Over the years, there have been significant legislative reforms affecting the operation of the NHS, but the core features have remained intact.

In 2002, total health spending in the United Kingdom accounted for 7.7% of GDP, significantly below the 11% average of the five countries presented in this report. Per capita health expenditure in the UK was $2,231, with a growth rate of 5.7% between 1998 and 2002 (OECD, 2005).

Financing. The vast majority of health care in the UK is financed though general taxpayer funds, and is coordinated by the NHS. Government funding accounts for 83% of national health expenditures (OECD, 2005). There is no patient cost-sharing for "basic" services, which include physician visits, hospital, and diagnostic services. Additional health-related costs, including pharmaceutical costs, are generally paid for by the patient, although at significantly reduced rates. Approximately 11% of UK residents have private health insurance, which essentially duplicates coverage under the NHS, but offers freedom from inconveniences associated with the NHS, such as long wait times for specialist appointments or hospital procedures (British Medical Association, 2004).

Delivery. The actual structure of the NHS varies within the four nations comprising the UK (England, Northern Ireland, Scotland and Wales). For the purpose of this report, the Council focused on the way health care is delivered in England under the NHS. Although recent reforms have decentralized NHS authority, overall expenditure and service delivery guidelines are still set at the national level (European Observatory on Health Care Systems, 1999). The authority for local service delivery, however, has been delegated to more than 300 Primary Care Trusts (PCTs). PCTs have been in operation since 2002, and receive approximately 80% of the total NHS budget.

Each trust is independently organized, with separate boards, staff, and budgets, and is responsible for the planning and provision of primary (e.g., general practitioner) and secondary (e.g., specialist and hospital-based) health care services for the local community (National Health Service, 2005).

To meet these responsibilities, the PCTs contract with individual physicians to provide primary care services, and with NHS Trusts, which run hospitals and provide secondary health care services (NHS, 2005). General practitioners (GPs) are independent physicians who contract with the NHS for services. Terms of GP contracts are negotiated centrally between the NHS and physician organizations. (European Observatory on Health Care Systems, 1999).

Each person covered under the NHS registers with a local GP, who then serves as the primary point of contact for all health-related issues. Individuals can choose any GP within their given region, and although they can change physicians, they rarely do unless they move to a different geographical boundary (European Observatory, 1999). Except in the case of emergency care, referrals are generally required for specialist or hospital services. This gatekeeping feature is one of the cost control measures built in to the NHS system (European Observatory, 1999). When appropriate, GPs make referrals to specialists or for hospital admissions. Individuals who choose to go outside the NHS for care, either by paying out-of-pocket or by utilizing private insurance, may have access to a wider range of services, in many cases bypassing the waits associated with scheduling NHS specialist appointments or hospital stays. Most physicians who treat patients outside the NHS also practice as part of the NHS system (British Medical Association, 2005).

Recently the NHS has established walk-in centers, staffed by nurses, to handle minor issues and injuries. The NHS also operates the NHS Direct Hotline, and NHS Direct Online, which are designed to answer basic "point of entry" questions about how and when to access NHS services (NHS, 2005).

Coverage. According to the British Department of Health, every "ordinary resident" of the UK is eligible for services under the NHS. An ordinary resident has traditionally been defined as anyone "living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has sufficient degree of continuity to be properly described as 'settled'." As noted above, although there is some private insurance coverage, most of it duplicates, rather than supplements, NHS services.

Covered services are not explicitly defined by the NHS, so individual health authorities have some discretion in determining what services are covered (European Observatory, 1999). In an effort to improve patient satisfaction and increase transparency of coverage determinations, PCTs are encouraged to gather community input regarding new coverage decisions. In some cases, services are restricted based on resident populations, or circumstances of individual patients; however, most "rationing" of care occurs via wait lists or use of the gatekeeper model limiting the use of specialists without appropriate referrals (European Observatory, 1999).

Key Elements of the Canadian Health Care System

Similar to Britain's National Health Service, the structure of Canada's health care system is designed to ensure "universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay." Foreshadowing the large role currently played by

the provinces in the delivery of health care, the public financing of Canadian health care was instituted province by province over a period of about 25 years. By 1972, each province was sharing the cost of providing hospital and physician services to its residents with the federal government (European Observatory, 2005). The Canada Health Act was passed in 1984, and established a set of principles to which health plans must adhere.

In 2003, total health spending in Canada accounted for 9.9% of GDP. Per capita health expenditure in Canada was $3,003, with a growth rate of 4.2% between 1998 and 2003 (OECD, 2005).

Financing. Modeled after the NHS, Canada's health care system offers publicly funded (through general taxation) health insurance to all Canadian residents. Unlike the NHS, however, funding responsibility is shared between the federal and provincial governments. Estimates of 2005 – 2006 government health system expenditures indicate federal contributions of 36%, and provincial contributions of 64% (European Observatory, 2005). Public funds (federal and provincial) account for about 70% of all health expenditures (OECD, 2005). Some provinces also impose taxes specifically to support the provincial health plan, although these account for only a small portion of the revenues. The balance is funded through supplemental insurance or out-of-pocket costs for uncovered services. Private health insurance accounts for a significant portion of spending on vision and dental care, and prescription drug costs, services which are not generally covered under the government health system. Cost-sharing (i.e., deductibles, co-payments) for covered services is prohibited under the Canada Health Act.

Delivery. As previously noted, the Canadian health care system is quite decentralized, with the provinces and territories assuming significant responsibility for directing and funding the health insurance plan in their region. The Health Canada Web site refers to Canada's "national health insurance program, which is achieved through a series of thirteen interlocking provincial and territorial health insurance plans" (Health Canada, 2005). Under the Canada Health Act, provincial governments must establish plans that are publicly administered, comprehensive, universal, portable, and accessible.

Implementation of the Canada Health Act is left up to the provinces, each of which has separate legislation governing the administration of a single-payer system for universal hospital and medical expenses (European Observatory, 2005). Although most health care services in Canada are paid for by public funds, most physicians are private practitioners. Doctors generally work on a fee-for-service basis, and submit claims to the provincial health plan. Fees are negotiated between the provincial governments and provincial medical societies (European Observatory, 2005).

Primary care physicians account for over 50% of all doctors in Canada and, like the United Kingdom, these physicians are the primary entry point into the health care system (National Coalition on Health Care, 2005). Individuals work with their primary care physicians to obtain appropriate referrals to specialists and hospitals. Provinces generally require patients to formally register with the government plan in order to receive treatment.

Coverage. Although all Canadian residents are essentially eligible for public insurance, individual provinces can set eligibility requirements for certain groups such as new residents, non-Canadian spouses, or part-time residents. Individual provinces may choose to cover services not otherwise covered in the Canada Health Act, such as prescription drugs, or extended services for children.

Individuals may obtain private coverage as a supplement to the government insurance. However, private insurance "is prohibited or discouraged" for services covered under the provincial plan (European Observatory, 2005).

Canada is unique in its strong opposition to allowing private insurance to duplicate public coverage. Some Canadian residents believe that obtaining private insurance would be one way to circumvent problems inherent in the Canadian system, such as excessive wait times for specialist care. In 2005, the Supreme Court of Canada ruled that the prohibition of private health insurance to cover services included in the provincial health plan in Quebec was in conflict with Quebec's charter of Human Rights and Freedoms. Quebec was given one year in which to modify its provincial health plan to correct the inconsistency. Although the ruling applied only to Quebec, other provinces are reviewing their legislation to see what implications the ruling could have on their insurance policies (European Observatory, 2005).

Key Elements of the German Health Care System

In 1883, the German parliament passed legislation making health insurance mandatory for certain employees. The cost of the "statutory" insurance was to be paid for by individuals and their employers (European Observatory, 2004). Germany's social insurance system also includes work-related and accident insurance, and old age and disability insurance. In 1994, long-term care insurance was added to the system. Although there have been changes in the details of the German health care system, it essentially follows the model established in the late 19th century.

In 2003, total health spending in Germany accounted for 11.1% of GDP, very near the average of the five countries presented in this staff note. Per capita health expenditure in Germany was $2,996, with a growth rate of 1.8% between 1998 and 2003 (OECD, 2005).

Financing. In 2002, public funds accounted for approximately 79% of health expenditures in Germany (WHO, 2005). Unlike Canada and the United Kingdom which use general tax revenues to fund their health care systems, the German system relies primarily on mandatory enrollment in one of the country's statutory health insurance funds. Employees are automatically and compulsorily insured if their incomes are below a certain annual limit. Premium contributions are based on income, not risk, and employees and employers are each required to pay approximately one-half of the health insurance premiums (German Federal Minister of Health and Social Security, 2005). Unemployed family members are covered under the employed member's health insurance at no additional charge. The average total cost of health insurance in 2004 was about 14% of an individual's gross earnings, shared equally between employer and employee (European Observatory, 2004). Individuals earning more than the annual income limit can choose to obtain private insurance, or buy in to one of the state plans (in which case the employers must also contribute). Germany has established an upper limit on premium contributions into the state plans, so even higher-income employees have some level of protection against high insurance costs. Most individuals choose to be insured under the state plan.

In 2004, Germany instituted a system of cost-sharing to encourage more "responsible" use of health care services. With some exceptions, enrollees in the state health plan are subject to certain co-insurance requirements for covered services. However, in order to limit the burden of these out-of-pocket costs, the overall contribution limit cannot exceed 2% of gross disposable income (German Federal Minister, 2005).

Individuals who are not employees or family members of workers, are also covered under the state system. This includes students, the elderly, some disabled individuals, and people receiving unemployment benefits, among others.

Delivery. The German health care system is a partnership among the federal government, the *Lander* (state or regional) governments, and the private sector, which operates the sickness funds and provides health care services. The federal government establishes most of the rules for providing and financing of health care, including regulating the insurance funds. The *Lander* governments maintain the hospital infrastructure. The health insurers remain relatively autonomous, within the parameters set by federal legislation, and each sickness fund determines contribution rates, and negotiates contracts with physicians and other providers delivering services under the fund. The European Observatory on Health Systems and Policies notes that the sickness funds are "private in formal ownership, but public in their responsibilities and liabilities." Unlike Canada and Great Britain where the "gatekeeper" approach is strong, Germans have open access to most services covered by their sickness plan (European Observatory, 2004). Germans can choose which of the many state health plans they want to join, and are free to choose among each plan's participating physicians. Although each plan covers the same range of services, the German Minister of Health and Social Security notes that, "it often pays to compare their rates." Most ambulatory care is delivered by private physicians who are paid on a fee-for-service basis, which is negotiated centrally.

Coverage. As of January 2004, there were 292 statutory funds and 49 private insurance companies operating in Germany. Approximately 88% of the German population is covered under the statutory health plan – 77% compulsorily based on income, and 10% voluntarily. An additional 2% is covered under other, sector-specific governmental plans (e.g., military or police), and 10% choose to be insured privately. Less than 0.2% of Germans are without insurance (European Observatory, 2004).

Key Elements of the Swiss Health Care System

In the early 20th century, the Swiss government passed legislation aimed at coordinating health insurance at the federal level. At that time, health insurance funds were required to register with the Federal Office of Social Insurance and provide a defined benefits package in order to receive federal subsidies. It was not until 1996, however, that the purchase of health insurance became mandatory for all residents of Switzerland (European Observatory, 2000).

In 2003, total health spending in Switzerland accounted for 11.5% of GDP. Per capita health expenditure in Switzerland was $3,781, with a growth rate of 2.8% between 1998 and 2003 (OECD, 2005).

Financing. Switzerland's health care system relies on substantial funding from the private sector. Only 58.5% of total health expenditures come from public funds (OECD, 2005). Under the Swiss system, individuals are responsible for purchasing private "social sickness" insurance directly from one of several private non-profit insurers who meet the specific legislative requirements for the provision of health insurance. Premiums for social sickness insurance vary based on cost-sharing requirements, but coverage levels are mandated by the Swiss government. Since 1996, premiums have been community-rated; prior to 1996 premiums were risk-related which resulted in significant gaps in available and affordable coverage for groups such as the chronically ill and the elderly

(European Observatory, 2000). All individuals must pay some share of their medical costs, in addition to their premiums. The government determines minimum and maximum cost-sharing levels.

Each sickness plan is free to set its own premiums, with market competition within each canton being relied upon to ensure appropriate pricing. Individual cantons offer needs-based subsidies to individuals who cannot afford the full cost of insurance. Within guidelines set by the federal government, the cantons are able to define the criteria and levels of subsidies, and can set the budgets for available subsidies for the region (European Observatory, 2000). Subsidies are given directly to individuals to apply toward purchase of insurance.

Delivery. The benefits offered under social sickness insurance are mandated, and insurers cannot offer additional benefits under the compulsory plan. Individuals wishing to expand their insurance coverage must purchase a separate, complementary plan. Competition among health plans is based primarily on premium cost. The health plans offered in Switzerland are similar to those in the US, in that their cost varies depending on cost-sharing requirements and the flexibility of obtaining services. HMO-type plans, where access to specialists is tightly controlled, are available, along with PPO-type plans where individuals have more freedom in selecting their provider, but pay higher premiums and possibly higher out-of-pocket costs. Individuals can change insurers twice a year (European Observatory, 2000).

Approximately 56% of Switzerland's doctors practice in private, office-based settings (European Observatory, 2000). Physician fees are based on a federally-negotiated relative value scale. Specific prices are negotiated at the cantonal level for services delivered under the compulsory plans. If physicians and insurers cannot agree on the terms of the fee schedule, the cantonal government will set the fee level. Hospitals are supported by a mix of public and private funding, and private hospitals may be for-profit or non-profit. The higher rates charged at private hospitals are often covered by supplementary insurance plans.

Coverage. According to the Swiss Federal Office of Public Health, "all persons domiciled in Switzerland must take out sickness insurance. Every family member is insured individually, regardless of age." In addition, individuals moving to Switzerland must obtain insurance within three months. Surcharges are levied against individuals who fail to obtain insurance within the required time, and individuals may be forcibly assigned to a health insurer (European Observatory, 2000). Because coverage is mandated and subsidies are available to ensure coverage is affordable, virtually everyone in Switzerland has insurance.

DISCUSSION

In developing this report it was the intent of the Council to compare and contrast the health care systems of countries that have at least some economic and societal values similar to those of the United States. The US, the United Kingdom, Canada, Germany, and Switzerland represent several points on the spectrum of publicly and privately controlled health care delivery. Each country struggles in some way with balancing costs, coverage, convenience, and equity. Although not addressed in this report, the ability of a health care system to produce and maintain quality health care services and positive health outcomes is another key feature that must be balanced against other factors.

Much national and international attention is focused on the high number of uninsured residents in the United States. As noted, nearly 16% of the US population lacks health insurance. Every other country featured in this report, and indeed the majority of OECD member countries, has relatively few uninsured residents. The United Kingdom and Canada place such a priority on making health care coverage available to all residents regardless of financial barriers that they have chosen to create and maintain universal, tax-payer funded systems of health insurance.

Within the context of this comparison, however, the Council believes it is extremely important to distinguish between *coverage* (i.e., participation in some health insurance plan), and *access* (i.e., being able to receive appropriate health care services in a timely manner). For the 84% of US residents with health insurance coverage – either private or through a government program such as Medicare – access to covered services is remarkably good. Most individuals are able to schedule appointments relatively quickly and receive needed health care services with minimal difficulties. Even among the uninsured, timely access to care is possible through various charity care avenues. In the US, the private market has been able to adapt to the demand for various levels and types of health care services. Instances where access to care may be in jeopardy (e.g., physicians accepting new Medicare and Medicaid patients) are frequently the result of de-facto price controls imposed by the government through physician payment rates.

In contrast to the US, the government-controlled insurance systems in the United Kingdom and Canada have severe access problems. Excessive wait times for surgeries or specialist appointments in both countries are the most frequent complaint. Because the systems utilize price controls to keep services affordable, demand continues to exceed supply for many health care services. Lengthy wait times have almost become institutionalized in the NHS. Notably, the official NHS web site has a page dedicated to searching wait times (http://www.18weeks.nhs.uk/endwaiting/). According to NHS Direct Online, "the waiting time for outpatients should be no longer than 26 weeks," and more than 70% of patients are seen within 13 weeks of referral. Furthermore, "inpatients should expect to wait no longer than 18 months for a bed, but more than three out of four inpatients are admitted to [a] hospital within three months of referral."

Similar to the United Kingdom, the wait times for accessing covered services under the Canadian health system are also often excessive, and several individual provinces maintain web sites that allow patients to search wait times. In 2005, the median wait time across Canada was nearly 18 weeks from the time of referral to actual treatment by a specialist. Similarly, the wait time for diagnostic procedures (e.g. MRI or CT scan) ranged from three weeks to three months (Fraser Institute, 2005). Although cost is not typically a barrier for individuals trying to obtaining health care services in these countries, they often are unable to gain access to the services they really need. Excessive wait times for a covered diagnostic exam or specialist visit can be just as dangerous as being unable to access those services without outside financial assistance.

In addition to excessive wait times for accessing covered care, government efforts to control health care spending have resulted in policies that compromise access to and quality of health care available to their citizens. For example, Great Britain has chosen to increase available funding for preventive services by restricting other services provided under the NHS. Specifically, tobacco smokers are not eligible to receive coronary bypass surgery, and kidney dialysis is denied for individuals over age 65 (Rohack and Einboden, 2006). Similarly, governments have often restricted the purchase of of new medical technologies (e.g., diagnostic equipment) in order to

"stretch" the resources available for other covered health care services (European Observatory, 2005).

The German system has more flexibility because, within given parameters, each social health insurance plan can operate and charge premiums according to its membership needs. However, a primary concern for the German government is the limited revenue base for its health care system. The ability to finance health care (through the sickness funds) is very dependent on individual incomes and national employment rates, since the majority of funding for the statutory health insurance plans comes from workers and their employers. The lack of plurality in Germany's financing structure presents unique risks, since changes in the employment sector of the economy alone could significantly affect the ability of the country to provide health care services.

Although the Swiss health care system utilizes price controls, which may ultimately strain health care resources, the system's emphasis on individual responsibility to obtain private insurance, coupled with means-tested subsidies provided by the government, is similar to what the AMA has advocated in its health insurance reform proposals. As outlined in several previous Council reports (most recently Council on Medical Service Report 1, I-05), the AMA strongly supports adoption of a health insurance system that relies on individually-owned health insurance, purchased through the use of refundable, advanceable, and income related tax credits. Although the Swiss system is still new relative to the other countries featured in this report, it appears to have achieved considerable success with respect to the provision of comprehensive and affordable health insurance coverage through the use of the private sector and means-tested public subsidies. The House of Delegates will also be considering Council on Medical Service Report 3 (A-06), "Individual Responsibility to Obtain Health Insurance," at this meeting, which includes an analysis of the advantages and disadvantages of utilizing an individual requirement to faciliate expanded health insurance coverage.

Expanding coverage for the uninsured and increasing access to care remains one of the AMA's top advocacy agenda items for 2006. Recognizing that there are many trade-offs associated with ensuring adequate access to health care for everyone, the Council believes that it will be critical to maintain a pluralistic health care system that emphasizes patient choice. Although the government plays a key role in the AMA's health insurance reform proposal through the authorization of tax credits and implementation of insurance market reforms, the Council believes it will continue to be in the best interests of patients and physicians to advocate for long-term health system reforms that are primarily based on consumer-driven and market-based principles.

References for this report are available from the AMA Division of Socioeconomic Policy Development.

APPENDIX

INTERNATIONAL HEALTH SYSTEM FEATURES BY COUNTRY

	Key Features of Health Care System	Total Health Spending as a % GDP (2003)	Average Annual Growth Rate 1998 - 2003	% Funding from Public Sources	Socioeconomic Issues/Challenges
United States	Private-public financing of services that are primarily delivered through the private sector. Employment-based insurance still dominates market.	15%	4.6%	45%	16% uninsured. Presents access problems for uninsured individuals, which results in cost-shifting and contributes to overall higher system costs.
United Kingdom	Centralized, publicly financed and controlled system. All UK residents are eligible for health insurance under NHS.	7.7% (2002)	5.7%	83%	Government control over health care system and resources limits supply/demand equilibrium. “Rationing” to manage costs and accommodate overwhelming demand results in denial of access to some services, and excessive wait times.
Canada	Publicly financed health care system, implemented by individual provinces or territories. All Canadian residents are eligible for health insurance.	9.9%	4.2%	70%	Provincial governments are being overwhelmed by increasing health care costs. Unresponsiveness of publicly funded system results in excessive wait times for some covered services.
Germany	Employers and employees share responsibility for funding statutory health insurance plans, which provide mandatory coverage for most Germans. Health plans are private entities required to carry out publicly defined responsibilities.	11.1%	1.8%	78%	Overly dependent on individual incomes and national employement rates. Focus on limiting premium contributions as a portion of employee income.
Switzerland	Private health insurance mandatory for all residents. Needs-based subsidies available to individuals for whom cost would be a barrier. Compulsory insurance plans have defined benefits package, and are subject to guaranteed issue and community rating requirements.	11.5%	2.8%	58.5%	The centrally determined minimum benefit package, guaranteed issue and strict community rating requirements, and centrally negotiated fee schedules may limit the flexibility of the system and eventually have adverse effects as has been seen in the US.