
Annexure to Chapter 1

Universal Health Care Systems Worldwide: 16 International Case Studies

Compiled by

Priya Balasubramaniam, Hilary Bartlett, Vikas Yadav and Katyayni Seth

HLEG Secretariat

at Public Health Foundation of India

2011

Table of contents

		Page No.
Introduction		57-58
Low-income economies	Bangladesh	59
	Kenya	60
Lower-middle-income economies	Indonesia	62
	Philippines	64
	Sri Lanka	66
Upper-middle income economies	Brazil	68
	China	70
	Malaysia	72
	Thailand	74
High-income economies	Canada	76
	Germany	78
	New Zealand	80
	Norway	82
	Sweden	84
	Taiwan	86
	United Kingdom	88
References		90

Introduction

The India Vision document compiled by the Planning Commission in 2002 envisions that “by 2020, the people of India will be more numerous, better educated, healthier and more prosperous than at any time in our long history.”¹ Although the country has made measurable progress in public health since independence, the achievements so far have been too few and too slow when compared to the country’s planned goals and pace of economic growth. India needs an actionable plan to implement a health system with Universal Health Coverage (UHC) in order to realize its health goals. In its 2003 report, the Institute of Medicine described a public health system as “a complex network of individuals and organizations that...work together towards a health goal.” The health systems of other Asian and European countries with universal or near-universal health coverage provide useful models as India works to achieve its own system of UHC.

Many developing nations have experienced sustained economic growth of late, which made UHC financially feasible for the first time. Spurred by economic success, the citizenry of many low and middle income countries increasingly made strong demands for an improved health system. Governments, in an effort to meet those demands, made political commitments to achieving universal coverage and have, in some cases, formalized UHC legislation in their respective constitutions. The experiences of Brazil, Taiwan and Thailand highlight the importance of political leadership and of making the most of economic and political windows of opportunity. India today finds itself in a promising economic and political position to achieve UHC. The government has committed itself to improving India’s public health care system and is refreshingly open to the mounting health advocacy campaigns of various Civil Society

Organizations. In addition to social pressure for UHC, India’s rapid economic growth over the past 20 years makes financing UHC a real possibility.

In charting their respective paths towards universal health, many developing countries placed special emphasis on reaching the rural and urban poor as part of their larger effort to ensure that coverage is truly universal for all population sectors. Brazil’s Family Health Programme is a central part of its Unified Health System and sends teams of community health workers into the country’s most isolated regions to dispense health care to the poor. Today more than 97 million Brazilians receive care through the Family Health Programme. Another helpful example is Sri Lanka, which managed to achieve universal health coverage when its annual per capita GDP was still below US\$ 500—less than half of India’s per capita GDP today. Sri Lanka’s method prioritized reaching the rural poor by removing financial and social barriers to care as well as improving health infrastructure in rural communities. In fact, the Sri Lankan government aimed to ensure that all citizens had a health clinic within two kilometers of their place of residence. Today roughly 96% of Sri Lankans are born in hospitals and immunization rates are close to 100%. Whereas many developing and developed countries alike face health capacity shortages in rural areas, Sri Lanka’s example serves to show that adequate health infrastructure and access throughout a country are important precursors to achieving truly universal care. The argument that Sri Lanka is a much smaller country than India and, therefore does not brook comparison will not hold if we develop models of decentralized district level planning and delivery of health services.

Though the rural poor can be a difficult group to enroll, the experiences of Kenya and the Philippines provide important insight about the additional

¹ Gupta, S.P. 2004. India Vision 2020. Report of the Committee on India 2020. Planning Commission, Government of India, Delhi.

difficulties of incorporating a large informal sector into a UHC scheme. In a country such as India, where individuals working in the informal sector make up a significant portion of the population, the government will need to develop an effective strategy for collecting adequate contributions from this group. Even if India adopts a tax-based rather than a premium-based health care system, accounting for a large informal sector is crucial for any government-run universal health care scheme to be sustainable in the long term. These 16 international country case studies additionally show that a well-functioning UHC system must align the economic incentives of health care providers with the goals of the system. Both China and Taiwan demonstrate how misaligned economic incentives can encourage behaviors that threaten a high quality of care. In China, government block grants often do not fully cover the actual operating costs of local health institutions. Because those institutions are encouraged to make up the marginal difference, physician-induced demand for unnecessary services and other profit-seeking behaviors have become huge concerns. In Taiwan and the Philippines, fee-for-service mechanisms also encourage supplier-induced demand for services that may not be medically needed. Because Taiwan permits hospitals to sell drugs for prices beyond their acquisition cost, the profitability of prescribing drugs gives providers yet another economic incentive to over-medicate patients. It is crucial for any UHC scheme to incorporate economic incentives and provider payment mechanisms that encourage principles of quality, efficiency, cost-effectiveness and safety.

Within the developed world a wide variety of health care systems are currently in place, which, though largely successful, reveal that developed countries are also struggling to achieve universal access to health care. Although health indicators in Canada, Norway, Sweden, the UK, and Germany are generally very good, these countries face challenges with their government-run health insurance programs going forward. With high rates of coverage, many health systems in developed countries are experiencing rising costs as their respective populations age. To deal with this increasing health burden on government budgets, countries like Canada and Sweden have introduced health care rationing and waiting lists for certain procedures and treatments. As patient satisfaction with the government health system drops, citizens increasingly elect to obtain private health insurance for expensive but timely care or, in the case of Norway, look abroad for faster treatment. In the UK where waiting times are long and a shortage of providers has introduced new concerns about care quality, disparities in health outcomes are wider today than they were during the Great Depression. To protect against the sky-rocketing demand and overuse of subsidized health services that many developed countries are currently experiencing, India ought to emphasize preventive and primary care services in its UHC plan.

What follows is a series of profiles of health systems in a range of different countries around the world. Lists of potential lessons and challenges for these systems provide important insight as India considers its own plan to achieve UHC. The countries reflected here have been arranged according to the World Bank classification of countries by income. (low income economies, lower-middle income economies, upper-middle income economies, and high-income economies).

Bangladesh

The government of Bangladesh aspires to achieve “health for all” through its Revitalized Primary Health Care initiative but it does not have a full-fledged UHC system as yet.² Currently health care services are available from both the public and private sectors, although the public sector mainly handles in-patient and preventive care while the private sector is largely used for out-patient care. In answer to the growing demands of its population, the government is using pilot projects to explore the possibility of a comprehensive health insurance system. While public coverage is high for a few essential public health interventions, particularly immunizations, financial protection is very limited for secondary and tertiary care.³ Today less than 1% of the population is covered by formal insurance, and high out-of-pocket costs push countless citizens into poverty annually.⁴ In part due to 90% vaccine coverage since 1995,⁵ however, Bangladesh has seen steadily improving health indicators over the last few decades, including a marked increase in life expectancy at birth and a decline in infant, maternal, and child mortality rates.⁶ These averages hide the inequalities that nevertheless persist between different social groups and geographical regions.

Potential Lessons⁷

- The government appears increasingly committed to improving health outcomes.

- Life expectancy has improved from 40 years in 1960 to 64 years in 2005.
- Vastly improved immunization coverage, from less than 10% in the 1980s to 90% since 1995, has led to substantial gains in child health and a decline in total fertility rate from 6.3 in the 1970s to 2.7 in 2007.
- Bangladesh has burgeoning private for-profit and not-for-profit health sectors.

Challenges⁸

- A lack of skilled birth attendants has prevented any improvement in the percentage of underweight children in Bangladesh, which has stood at 45% since the mid-1990s.
- Bangladesh faces severe drug, facility, and physician shortages. There is a current shortfall of 60,000 physicians, which will only increase as the population grows. Shortages are particularly acute in rural areas.
- Because of resource shortages and poor care quality, only 25% of the population uses the publicly funded health care system.
- Disparities in access to health services, particularly antenatal care; treatment for acute respiratory infection, malnutrition, and anemia during pregnancy; and complete vaccinations for children are widening.

² World Health Organization, Health System in Bangladesh, 2008, http://www.whoban.org/health_system_bangladesh.html (accessed June 14, 2011).

³ Ibid.

⁴ Coordinator, Timothy G. Evans. Centre of Excellence Timothy G. Evans, “Centre of Excellence on Universal Health Coverage,” James P. Grant School of Public Health, BRAC University, http://www.bracuniversity.net/I&S/sph/centres_initiatives/uhc.htm (accessed June 14, 2011).

⁵ World Health Organization.

⁶ Ibid.

⁷ Anwar Islam, Bangladesh Health System in Transition: Selected Articles, Monograph Series (Dhaka, Bangladesh: James P. Grant School of Public Health, 2008).

⁸ Ibid.

Kenya

Kenya is currently in the process of introducing a nation-wide social health insurance scheme that aims to achieve universal public health coverage after a transition period. Since 1994, reform of Kenya's health sector has been guided by the Kenya Health Policy Framework Paper (KHPFP), which envisions "quality health care that is acceptable, affordable and accessible to all," and the National Health Sector Strategic Plan (NHSSP).⁹ The government has decentralized control of the public health sector as its strategy for implementation and management. Health care in Kenya is provided currently through both the public and private sectors, with the private sector contributing approximately 40% of health services. According to the 2001-2002 National Health Accounts, Kenya spends 5.1% of its GDP on health and only about US\$6.2 per capita, which is far below the WHO recommended amount of US\$34 per capita. The government contributes 30% of total health expenditure, households pay 51% in out-of-pocket costs, donors cover 16%, and the statutory National Hospital Insurance Fund (NHIF) and private sources contribute the rest.¹⁰

A new public health insurance scheme, the National Social Health Insurance Fund (NSHIF), was proposed in 2004 and will be financed through income-rated contributions with the government contributing on behalf of the poor. The government expects that enrolling formal sector employees will take roughly five years and the self-employed informal sector will take nearly ten. Contribution rates and the definition of "poor" have not yet been set, mostly because of the challenge of raising enough funds to cover the large population of objectively poor people. The

government has said that contributions will be set high enough to allow a comprehensive benefit package in all public facilities and most private ones.¹¹ The NSHIF bill will cover in-patient and out-patient hospital care, including surgical, medical, and dental procedures; laboratory and diagnostic tests; drugs and medical equipment, physiotherapy; doctors' fees; and room and board.¹²

Potential Lessons¹³

- The NSHIF is expected to provide greater financial protection than Kenya's current system.
- The NSHIF will operate as a single risk pool to avoid fragmented, unequal risk pooling.
- Proposed provider payment mechanisms aim to incentivize high-quality care at low cost—a flat rate of remuneration per in-patient day and a flat fee per out-patient visit have both been suggested.
- A transition period for roughly a decade has been acknowledged as politically, economically and organizationally necessary before the program is fully implemented.

Challenges¹⁴

- Only 22% of the NHIF's money is used to pay for health coverage. 25% is lost to administrative costs and the remaining 53% is spent on arguably unnecessary investments, such as a lavish new headquarters. Earning the trust of the people it serves will be crucial for the new NSHIF; voluntary compliance rates will fall if contributors continue to sense their money is being siphoned away.¹⁵

⁹ Richard G. Wamai, "The Kenya Health System--Analysis of the situation and enduring challenges," *Japan Medical Association Journal*, 2009: 134-140.

¹⁰ Richard Muga, Paul Kizito, Michael Mbayah and Terry Gakuruh, "Overview of the Health System in Kenya," *Demographic and Health Surveys*, <http://www.measuredhs.com/pubs/pdf/SPA8/02Chapter2.pdf> (accessed June 16, 2011).

¹¹ Guy Carrin et al., "Health financing reform in Kenya--assessing the social health insurance proposal," *South African Medical Journal*, 2006: 130-135.

¹² William C. Hsiao, R. Paul Shaw, Andrew Fraker, and the World Bank. *Social Health Insurance for Developing Nations*. (Washington, D.C.: The World Bank, 2007), 43-59.

¹³ Carrin, et al.

-
- After a coalition government was formed in 2008, the Ministry of Health was split into the Ministry of Public Health and the Ministry of Medical Services to allow for power sharing in the government coalition. Duplication of work and competition for resources, control, and influence will likely slow health system reforms and create management disagreements.
 - Health facilities are unevenly distributed across Kenya's seven provinces and Nairobi.
 - Cost remains a great barrier to health care. One survey showed that only 77.2% of Kenya's ill population actually sought health care in 2003.¹⁶
 - Because poor people and informal sector workers make up a substantial percentage of Kenya's population, achieving a UHC system that is financially sustainable will be a difficult task. High contribution rates from the formal sector will likely be necessary to cross-subsidize the nonpaying informal sector and the poor.¹⁷

¹⁴ Richard G. Wamai, "The Kenya Health System--Analysis of the situation and enduring challenges," *Japan Medical Association Journal*, 2009: 134-140.

¹⁵ Hsiao, et al.

¹⁶ Ministry of Health, "Kenya Household Health Expenditure and Utilization Survey," cited in Richard G. Wamai, "The Kenya Health System--Analysis of the situation and enduring challenges," *Japan Medical Association Journal*, 2009: 134-140.

¹⁷ Hsiao, et al.

Indonesia

Indonesia has recently experienced several major health reforms, including the decentralization reform of 2001, and the National Social Security Law (SJSN) of 2004 that mandated social health insurance for the entire population.¹⁸ Askeskin emerged as the mandatory public insurance system for the poor. Askeskin reimbursed providers in two ways: (i) a capitation payment provided to health centers based on the number of registered poor; and (ii) a fee-for-service payment through a state-owned insurer, called P.T. Askes, based on the number of third-class hospital beds used. In 2008, the Askeskin program expanded into Jamkesmas, a public insurance program for the poor run by the Ministry of Health. Many other district-based programs have tried to replicate the Jamkesmas design, but for other segments of the population. Today roughly 46% of the Indonesian population has health care coverage—up from 10% in 2004—either through Jamkesmas and other public programs for different sectors of the population, or through private schemes. Askes targets active civil servants and retired civil servants and veterans; Taspen targets military workers and police; Jamsostek targets the employees of private sector firms with ten or more employees; private insurance targets the private sector; and community-based health insurance targets students and the self-employed. Where beneficiaries obtain care and how providers are paid vary between schemes.¹⁹

Jamkesmas is financed entirely through general government revenues; there are no required contributions from beneficiaries. Jamkesmas covers a comprehensive package of care, including in-patient and out-patient care as well as maternal and preventive health services. Unlike Askeskin,

Jamkesmas contracts with many private hospitals in addition to public providers. Though the government of Indonesia partially finances Jamkesmas, provincial and district governments are responsible for most of the program's operating decisions. As of January 2010, the Jamkesmas program is being implemented actively throughout the country as part of the Indonesian government's goal to achieve universal coverage by 2014.²⁰

Potential Lessons

- The decentralization reform gives substantial funds and authority to local governments, many of which can reach urban and rural sectors more effectively than the central government.
- Government data suggests that the strategy to target the poor has reached 76 million poor and near-poor enrollees. The rates of service use between the most affluent and the poorest have nearly equalized.²¹
- Though Jamkesmas is intended specifically for the poor, it does not offer a substandard health insurance package. In fact, free access to many providers, both public and private, and a full package of benefits makes Jamkesmas the most attractive insurance scheme—more attractive even than Askes and Jamsostek.

Challenges²²

- Contract mechanisms do not use reimbursement or payment policies strategically to drive improvements in quality or efficiency. In fact, Jamkesmas' current reimbursement system sets

¹⁸ Indonesia Delegation, "Moving Toward Universal Health Coverage: Indonesia," *Joint Learning Workshop*, http://jlw.drupalgardens.com/sites/jlw.drupalgardens.com/files/Indonesia_case_study_2-24-10%20FINAL.pdf (accessed June 16, 2011).

¹⁹ The Joint Learning Network for Universal Health Coverage, *Indonesia*, 2011, <http://www.jointlearningnetwork.org/content/indonesia> (accessed June 16, 2011).

²⁰ *Ibid.*

²¹ Indonesia Delegation.

up harmful incentives—for example, a hospital receives full reimbursement for a referral, which discourages midwives from bringing patients with complications to the hospital because they lose income.

- Jamkesmas and other public programs could be useful tools for promoting certain care practices, but unfortunately payment mechanisms have not been used to drive forward public health priorities such as preventive medicine or long-term family planning methods.
- Concerns abound about the solvency of the Jamkesmas program because increasing utilization of services is going to increase the cost of health insurance.
- Though the central government provides some financing for public health programs, local governments are responsible for filling the gap between what it actually costs to insure their whole population and what the central government pays. This responsibility is particularly burdensome for the poorest states.
- Jamsostek and Askes beneficiaries pay high out-of-pocket costs if they select private care.

²² Indonesia Delegation, “Moving Toward Universal Health Coverage: Indonesia,” Joint Learning Workshop, http://jlw.drupalgardens.com/sites/jlw.drupalgardens.com/files/Indonesia_case_study_2-24-10%20FINAL.pdf (accessed June 16, 2011).

Philippines²³

The Philippines initiated social health insurance nearly 35 years ago with the establishment of its Medicare program, which targeted workers in regular employment in both the public and private sectors. Though Medicare succeeded in enrolling a large portion of the country's employed population, it failed to reach many informal sector workers and the poor. As a result of these gaps, local health insurance schemes, operated by local governments and Non-Governmental Organizations (NGOs), took hold in the 1980s and early 1990s, and a flourishing private health insurance market provided supplementary coverage to the middle class. In 1991, the ownership of rural health units was transferred to local chief executives as part of a decentralization process.

In 1995, the Philippine Health Corporation, or PhilHealth, was established to revitalize the push for universal health coverage. Since PhilHealth was created, some progress has been made in extending coverage to the informal sector and the poor. PhilHealth membership is broken down into four separate categories: the Employed Program, which is compulsory for all government and private sector employees, the Indigent Program, the Individual Program for those not eligible for the Employed or Indigent Programs, and the Nonpaying Program. Contributions for those in the Employed Program are income-based, although there is a salary cap beyond which contributions do not increase, and employers and employees share the cost of contributions equally. For the Indigent Program, local governments are responsible for identifying indigents, enrolling them in PhilHealth, and paying their premiums. Currently approximately 83% of the population is covered through PhilHealth.²⁴ In 2000 and 2005, the

government introduced a series of reforms, which included the creation of local health delivery and planning units, an expanded government subsidy for the poor, and an expanded regulatory role for the Department of Health (DoH).

Today Filipinos receive care from a mix of public and private providers, who receive payment mostly on a fee-for-service basis. PhilHealth's benefit package is principally related to in-patient care, although this trend is slowly changing. The scope of benefits includes in-patient hospital care, some out-patient care, health education packages, emergency and transfer services, and other non-specific services that PhilHealth deems appropriate and cost-effective. Fifth and subsequent normal obstetrical deliveries, nonprescription drugs and devices, substance abuse treatment, cosmetic surgery, optometric services, and non cost-effective services are not included in the PhilHealth benefit package. Health expenditure in the Philippines makes up only 3.2% of GDP, an amount among the lowest levels in its region. In 2004, the government made up less than half of total health expenditure, and out-of-pocket payments accounted for 44.3%.

Potential Lessons

- PhilHealth introduced two new benefits in 2003: a maternity package for normal spontaneous delivery, and a directly observed treatment short-course (DOTS) package for tuberculosis. These two additions exemplify PhilHealth's gradual shift from only paying retrospectively for in-patient care towards increasingly investing in public health and preventive care to try to avoid expensive in-patient care altogether.

²³ William C. Hsiao, R. Paul Shaw, Andrew Fraker, and the World Bank. *Social Health Insurance for Developing Nations*. (Washington, D.C.: The World Bank, 2007), 81-104.

²⁴ The Joint Learning Network for Universal Health Coverage, *Philippines*, 2011, <http://www.jointlearningnetwork.org/content/philippines> (accessed June 20, 2011).

- To maintain financial stability, PhilHealth makes only low-risk investments and is required to keep two years of projected annual benefit payments on reserve. To contain costs, PhilHealth puts limits on levels of benefit payments.
- PhilHealth Regional Offices (PRO) can alter benefits packages to their local area, provided that the overall value to the patient does not change.
- Enrollment of the informal sector in the Individual Program has been particularly difficult, and the voluntary enrollment process for this group has led to problems with adverse selection. PhilHealth is currently experimenting with an initiative that would reward informal organizations if a minimum of 70% of their employees are enrolled.
- The Indigent Program was closely associated with President Gloria Macapagal Arroyo, who initially launched it in 2004, and has struggled to maintain funds ever since she came out of office. To deal with local governments who fail to make their full contributions to the program, PhilHealth has proposed deducting the contributions at source from internal revenue allotments to local governments. New legislation alternatively proposes earmarking 4% of recently increased value added tax receipts to make up the difference.

Challenges

- The move towards a public health function for PhilHealth has created an overlap with the duties of the Department of Health.
- The fee-for-service method for provider payment likely creates problems of supplier-induced demand.
- The Nonpaying Program, which targets those Filipinos who have reached the age of retirement and have paid at least 120 monthly premium contributions to PhilHealth, is a growing financial risk. Neither the government nor those enrolled in the program make any contributions on this high-risk group's behalf.
- Fraud, particularly in the form of claims for treatment that was never provided, poses a problem for the long-term sustainability of PhilHealth. The Office of the Actuary estimates that between 10 and 20 % of claims are fraudulent.

Sri Lanka²⁵

By relying on tax-financed and government-operated health services, Sri Lanka achieved universal health coverage while its per capita GDP was still below US\$500 annually.²⁶ In 2005, total expenditure on health in Sri Lanka accounted for 4.2 % of GDP and neared Rs. 100 billion (US\$1 billion). Government spending accounts for 46% and private financing—mostly household out-of-pocket payments—covers the rest. All in-patient, out-patient, and community health services are free to all Sri Lankans, with very few exceptions. Today roughly 96% of all childbirths occur in hospitals, and the country has close to 100% immunization coverage.²⁷

Sri Lanka realized universal coverage by ensuring that the rural poor had access to hospital services and by removing financial and social barriers to care. Sri Lanka's health system is public hospital-dominated, and the government budget has prioritized establishing rural hospitals since the 1950s. The government financed the construction of a high-density but low-cost network of rural facilities to make sure that almost all citizens live within one or two kilometers of a clinic. Sri Lanka's system successfully protects the poor from the catastrophic financial risk associated with illness—according to an EQUITAP study, only 0.3 % of households in Sri Lanka drop below the international poverty due to health expenditure.

In prioritizing access above all else, Sri Lanka's system encourages richer patients to choose private care, which opens up facilities for the poor and reduces the burden on the government. Because the wealthiest voluntarily opt out of the government

health system, all public hospitals are able to accept all patients without restriction, and no referral system is enforced. Interestingly, however, most private doctors are typically government medical employees who are permitted to practice privately during their free time.

Potential Lessons

- Sri Lanka has strong health infrastructure in rural areas, which has encouraged usage of health services by the poor. Ever since 1951, when user charges were abolished, the poor have gradually become more familiar with health resources. Today utilization rates of government health facilities are actually higher among the poorest households than among the richest.²⁸
- Though the system is hospital-based, an expensive definition of what constitutes a hospital means that the focus on hospitals does not come at the expense of primary care. Sri Lanka has found that well-run government hospitals are actually an efficient way of delivering primary care.
- Sri Lanka's rates of in-patient admission and out-patient visits are comparable to OECD countries.
- In offering a full range of services instead of a more restricted one, Sri Lanka's health system has prioritized risk protection over cost-effectiveness and has won public support and confidence.
- Sri Lanka's system is efficient in terms of high patient throughput—average bed-turnover rate is high and average length of stay is short—and high labor productivity.

²⁵ Ravi P. Rannan-Eliya and Lankani Sikurajapathy, Sri Lanka: "Good Practice" in Expanding Health Care Coverage, Research Studies Series 3 (Colombo: The Institute for Health Policy, 2009).

²⁶ United Nations Publications, "Chapter IV: Towards Universal Health Care Coverage in the Asia-Pacific Region," United Nations Economic and Social Commission for Asia and the Pacific, http://www.unescap.org/esid/hds/pubs/2449/2449_ch4.pdf (accessed June 17, 2011).

²⁷ Ibid.

²⁸ Ibid.

- To contain costs, the health system bulk-purchases only generic drugs. A national formulary of drugs approves drugs for use in government hospitals.
- Through internal purchasing and investment decisions, the Ministry of Health implicitly rations care and deliberately restricts the availability of certain services it considers too expensive. For example, X-rays are not present in most lower-level facilities, and not every medicine is available in every hospital. Though patients can go to whatever hospital they choose and public transportation is cheap, most high-level facilities and services are available only in urban areas.

Challenges

- The main challenge for the provision of health care services in Sri Lanka relates to the government's ability to continue to provide health services free at the point of delivery. The government cannot increase the budget without raising taxes substantially. Lack of funding prevents the adoption of certain modern medical methods, such as the management of chronic, non-communicable diseases.
- As the rich increasingly turn to the private sector, this shift may undermine political support for a tax-financed government health system.

Brazil²⁹

Two decades after Brazil's landmark health reform in 1988 established the country's Unified Health System, also known as Sistema Único de Saúde (SUS), more than 75% of Brazil's population relies exclusively on public health care for coverage. Covering some 97 million of Brazil's rural poor, the Family Health Programme is a central part of the Unified Health System, and employs teams of community health care workers to reach Brazil's especially isolated regions. The Unified Health System, which is financed through income and sales taxes, provides free primary health care, basic dental care, and a range of hospital services including diagnostics and surgeries through a network of public and private providers. Through the public health sector, Brazil also has a robust vaccination program and subsidizes 90% of the cost of many essential drugs. Despite such large network of public health services, however, private insurance still exists in Brazil, largely for Brazilians trying to avoid some of the delays and frustrations of what is, unfortunately, a vastly underfunded public system.

Potential Lessons

- Legislation in 1996 effectively decentralized much of the health financing and decision-making of the Unified Health System. Through health councils, communities are actively involved in developing budgetary priorities and initiatives.
- The Family Health Programme addresses health inequities directly by prioritizing the rural poor. In 2007, the difference in life expectancy at birth between the wealthier south and the poorer northeast narrowed from eight years in 1990 to only five.

- The Unified Health System emphasizes primary care but offers a full set of other benefits, including dental care, hospital care, and financial protection against costly drugs.
- Automatic transfers of federal funding to the municipalities keeps the system afloat.
- Brazil is a single national buyer of drugs so it can negotiate low drug prices with pharmaceutical companies.

Challenges

- Despite responsible accounting in many municipalities, more than half of the 26 states fail to meet the required 12% funding target.
- At the state level, a broad conception of health concerns causes overspending and the misdirection of funds. Some states have used money allocated specifically for the Unified Health System to improve sanitation or offer additional health insurance for civil servants. While these factors certainly affect the health of the population, there is need to define health expenditure more precisely.
- The federal government simply does not adequately support the public health sector. The 1988 constitutional reform committed the government to set aside 30% of the social security budget for health care, but in 1993, social security stopped providing resources to the health sector. The Unified Health System began to depend exclusively on the national budget and has suffered chronic funding shortages ever since.
- Under funding is linked to inadequacies in basic health infrastructure and shortages of hospital

²⁹ World Health Organization, "Brazil's March Towards Universal Coverage," *Bulletin of the World Health Organization*, September 2010, <http://www.who.int/bulletin/volumes/88/9/10-020910/en/> (accessed June 15, 2011).

staff. Access to public hospitals varies widely between municipalities. A recent paper finds robust evidence of a positive relationship between income and doctor visits.³⁰

- Many Brazilian taxpayers pay twice for their healthcare—once when they pay income and sales taxes, and once when they buy private health insurance.³¹

China

China's rapid economic growth over the past 25 years improved standards of living for millions of Chinese but was not coupled with better health or health care. China proclaimed its 'open door policy' in 1978, which called for the country's transition from a social-planning economy to a market-based one. As part of this transition, the burden of health care shifted from largely successful state-owned enterprises, such as 'barefoot' doctors and the Cooperate Medical Scheme that previously covered about 85% of China's rural population, to the private sector.^{32,33} Health care reforms in the 1980s encouraged localities to raise their own tax revenues to offset decreased central government financing, instated price controls on a catalogue of essential health services to safeguard basic health care, and permitted local health institutes to generate additional revenue by pricing non-essential health services above cost recovery. With this new incentive structure, physician-induced demand for unnecessary healthcare has become a major problem in China. As the market responded to the inadequacies of the 1980s reforms with an increasing number of private health insurance schemes, the free-market response exacerbated the inequities in China's health system.³⁴ Market-based health services left more than 500 million Chinese unable to find affordable medical treatment.³⁵

China is currently involved in a 'second generation' of reforms, whose priorities include strengthening the government role, increasing government investment, increasing health insurance coverage,

no longer rewarding doctors based on the revenue they generate, and strengthening primary care, community health care, and disease prevention. One of the reforms dictates an expansion in the list of price-capped essential health care services. Previously, catastrophic illness could impoverish families if the necessary treatment was not on the list of price-controlled essential services. Though this measure is projected to generate annual savings of 4.3 billion RMB, some experts explain that the cost-saving of those additional price caps will likely be offset by compensatory overprescribing, alteration of drug names by manufacturers, purposeful ignoring of the price caps, and simply turning down low cost drugs altogether.³⁶

Potential Lessons

- China has a history of successful state-owned health facilities and state-funded doctors, particularly through barefoot doctors and the Cooperative Medical Scheme, from before the reforms of the 1980s.
- Improving health services has become a recent priority for the Chinese government. Over the past ten years, China has allocated more funds to improve public health and rural health services, emphasized controlling healthcare costs, implemented initiatives to improve hospital management to raise quality of patient care, and developed plans to establish and build a national health infrastructure.³⁷

³² Charles Tsai, Regulatory Reform in China's Health Sector, Policy Brief, Groupe d'Economie Mondiale (Sciences Po, 2010).

³³ Jin Ma, Mingshan Lu and Hude Quan, "From A National, Centrally Planned Health System to A System Based On The Market: Lessons from China," Health Affairs, 2008: 937-948.

³⁴ Ibid.

³⁵ Chee Hew, Healthcare in China: Toward greater access, efficiency, and quality, (Somers, NY: IBM Corporation, 2006).

³⁶ Ibid.

- China's government has acknowledged the failure of the series of reforms in the 1980s and has sought international expertise to assist in developing an improved system that focuses on "health for all" and the government's responsibility to public health and insurance coverage.
- A medical arms race has caused the centralization of physicians and an abundant supply of high-tech and expensive medical equipment and facilities in metropolitan areas to serve a small proportion of the population who can afford such expensive services. At the same time, health resources are lacking in rural areas, where more than half of the population resides.

Challenges³⁸

- A majority of the population no longer has access to health care because of financial barriers. High costs explain how an increase in national health expenditure was accompanied by a decline in the use of health services. Unless the economic incentives of providers are changed, a catalogue of subsidized drugs cannot be fully effective at restraining costs.
- Inequalities in health care access are increasing, and rural residents, children, seniors, and low-income families are particularly vulnerable.
- Pressured to make up funds from inadequate government block grants, hospitals compete for paying patients by recruiting well-known physicians, prescribing multiple comprehensive tests, and encouraging patients to stay at luxury facilities.
- Economic incentives have driven profit-seeking motives and physician-induced demand. Preventive medicine, public education and infectious disease monitoring are unprofitable and therefore largely ignored.
- In 2003, some form of community-financed health care covered some 9.5% of the rural population, down from a peak of about 85% in 1975. From 1993 to 2003, health insurance coverage in urban areas dropped from around 70% to 55%.³⁹

³⁷ Chee Hew, *Healthcare in China: Toward greater access, efficiency, and quality*, (Somers, NY: IBM Corporation, 2006).

³⁸ Jin Ma, Mingshan Lu and Hude Quan, "From A National, Centrally Planned Health System to A System Based On The Market: Lessons from China," *Health Affairs*, 2008: 937-948.

³⁹ Center for Health Statistics and Information, *Ministry of Health of China*, cited in Jin Ma, Mingshan Lu and Hude Quan, "From A National, Centrally Planned Health System to A System Based On The Market: Lessons from China," *Health Affairs*, 2008: 937-948.

Malaysia

Malaysia has achieved close to universal health coverage through a predominantly tax-financed system that makes health services at all levels free for the entire population with some minimum co-payment. Though Malaysia has a high level of formal sector employment, it has not established a social health insurance scheme. The country reports 100% coverage through its tax-funded system, although high out-of-pocket payments, which make up 40.7% of total health expenditure and are mostly spent on secondary and tertiary private services, suggest actual coverage is below 100%.⁴⁰ Total health expenditure per capita is below the minimum US\$49-54 recommended to achieve Millennium Development Goals. Malaysia is one of a few Southeast Asian countries with a private sector presence between 5.6 and 7.8 %, and such relatively low percentages suggest that private insurance plays a supplemental, mainly out-patient role. In the Malaysian arrangement, the presence of the private sector actually attracts richer patients to private facilities and gives poorer patients greater access to government facilities.⁴¹

Though the government has proposed to establish a National Health Financing Scheme that pools resources from public and private sources to provide universal financial risk protection based on principles of social health insurance, the proposal has been met with resistance. Formal sector workers oppose the change, which would require additional mandatory contributions from the formal sector on top of personal

income taxes. Private health insurance operators and the Ministry of Health are both threatened by the proposed arrangement, which would likely delegate all budgetary decisions to a National Health Financing Authority.⁴²

Potential Lessons

- Free healthcare facilities in rural areas have made equal access a reality for the poor.⁴³
- In Malaysia women and men have equal access to preventive and curative care.⁴⁴ Primary care services focus on maternal and child health, which may further explain good health outcomes for women.
- Health services are free for all citizens at primary, secondary and tertiary levels with minimum co-payment, ranging from 1 RM (US\$0.31) to 3 RM (US\$0.94) per admission day.⁴⁵

Challenges

- The fiscal cost of Malaysia's health system is the greatest concern. By international standards, Malaysia's public expenditure on health is low.⁴⁶
- In 2001, 47% of the Ministry of Health's funds went towards curative medical care and only 18% went towards prevention and primary care. Reforms are needed to emphasize prevention and primary care, and to maximize the resources and skills of those delivering public health services.⁴⁷

⁴⁰ Viroj Tangcharoensathien, et al., "Health-financing reforms in southeast Asia: challenges in achieving universal coverage," *The Lancet*, 2011: 863-873.

⁴¹ United Nations Publications, "Chapter IV: Towards Universal Health Care Coverage in the Asia-Pacific Region," *United Nations Economic and Social Commission for Asia and the Pacific*, http://www.unescap.org/esid/hds/pubs/2449/2449_ch4.pdf (accessed June 17, 2011).

⁴² Ibid.

⁴³ United Nations Publications.

⁴⁴ Ibid.

⁴⁵ Tangcharoensathien, et al.

⁴⁶ United Nations Publications.

- Malaysia's system needs to be reformed to encourage allocative and technical efficiency. Performance measurements should track the quality and quantity of results, and compensation should be adjusted to reward improvements.⁴⁸
- Patients report long waiting times for procedures in public hospitals.⁴⁹

⁴⁷ Ibid.

⁴⁸ Ibid.

⁴⁹ Tangcharoensathien, et al.

Thailand⁵⁰

In 2001, Thailand introduced the National Health Security Act, which laid the groundwork for a new, robust Universal Coverage Scheme (UCS). Before 2001, Thailand had four voluntary public risk-protection schemes with widely differing benefits and contribution levels. These schemes protected roughly 75% of Thailand's population, but left 18.5 million people paying costly out-of-pocket fees for health care on a case-by-case basis. Today the UCS covers 74.6% of the population, according to estimates from 2007, and offers a comprehensive package of curative and preventive care, as well as universal access to anti-retroviral drugs. Since 1975 the Thai government has experimented with financial incentives to bring doctors to rural areas. As of 2004 and 2005, a new medical graduate in a remote rural district can earn a salary equivalent to what a senior doctor in a central district makes after 25 years of work experience.⁵¹

The UCS used to require a 30 baht fee for each admission but is now completely free. The program is financed through government taxes and pays providers on a capitation basis. Public hospitals with primary care facilities are the main providers and serve more than 95% of UCS beneficiaries. 60 private hospitals serve around 4% of UCS beneficiaries.

The UCS works alongside two other public health insurance programs: the Compulsory Social Security Scheme (SSS), which was created for government employees and dependents and covers 13% of the population; and the Civil Servant Medical Benefit Scheme (CSMBS), which serves private employees and temporary public employees and covers 8% of the population. All together, the UCS, SSS and CSMBS

represent a strong government-run health insurance system that covers nearly 100% of Thailand's population. Private health insurance companies remain only in a supplemental role for high-income groups.

Potential Lessons⁵²

- Public health advocates are present in the senior levels of Thailand's bureaucracy; they are positioned to translate political imperative into action.
- UCS beneficiaries choose public or private hospitals, which receive annual capitation payments based on the number of UCS beneficiaries that choose them. Freedom of provider choice encourages the development of competing provider networks, and the capitation payment approach helps contain costs and promote efficiency.
- The capitation payment system incentivizes health care providers to reach out and enroll the uninsured—only 2% of the population was still uninsured in 2007. The more people who are registered, the more diverse the risk pool and the more income for each hospital.
- The UCS represents a marked shift towards primary care.
- More than 85% of respondents to a UCS satisfaction survey said they were happy with the quality of care they received.
- An effective administrative system registered 45 million previously uninsured citizens in only

⁵⁰ Thailand Delegation, "Moving Toward Universal Health Coverage: Thailand," *Joint Learning Workshop*, http://jlw.drupalgardens.com/sites/jlw.drupalgardens.com/files/Thailand_Case_Study_2-24-10%20FINAL.pdf (accessed June 16, 2011).

⁵¹ Cha-Aim Pachanee and Suwit Wibulpolprasert, "Incoherent policies of universal coverage of health insurance and promotion of international trade in health services in Thailand," *Oxford Journal on Health Policy and Planning*, 2006: 310-318.

⁵² Adrian Towse, Anne Mills and Viroj Tangcharoensathien, "Learning from Thailand's health reforms," *BMJ*, January 2004: 103-105.

four months, and infrastructure was developed in rural areas to reach the two-thirds of Thailand's population that lives there.

- The Thai government offers attractive salaries to new medical graduates who agree to work in isolated rural districts. Other non-financial incentives include more opportunities for continuing education and social recognition through annual awards for outstanding rural health personnel.⁵³

Challenges

- The new emphasis on primary care caused a shortage of doctors to staff primary care units and left many hospitals with large deficits. The shortage of primary care providers necessitated using hospital doctors in the primary care rotation and also diverted attention away from health promotion services.⁵⁴
- Thailand faces an imbalanced distribution of human resources in terms of both geographical

location and speciality.⁵⁵

- Thailand faces uncertainty about appropriate capitation rates because compliance—the extent to which patients use their registered provider rather than another, in which they pay out-of-pocket—is low. Experts speculate that compliance is low because UCS may not give people access to their preferred providers. Building greater confidence in primary care may be required to encourage higher rates of compliance.⁵⁶
- Because the UCS depends on general revenue financing through the government's annual budget, it is vulnerable to budget cuts. Future budgets may not fully cover the UCS' actual operating costs, which may increase as the population ages.
- Rural residents have little provider choice simply because of low capacity and large distances between health care facilities.
- Thailand aggressively supports medical tourism and international trade in health services, which can divert resources from the poor and from rural areas.⁵⁷

⁵³ Pachanee, et al.

⁵⁴ Adrian Towse, Anne Mills and Viroj Tangcharoensathien, "Learning from Thailand's health reforms," *BMJ*, January 2004: 103-105.

⁵⁵ Pachanee, et al.

⁵⁶ Towse, et al.

⁵⁷ Pachanee, et al.

Canada

Canada has a publicly financed and privately run health care system called Medicare that provides free universal coverage to all its citizens. The system is characterized by local control, doctor autonomy and consumer choice. The Canadian province of Saskatchewan first introduced universal hospital insurance in 1944, and in 1956, the federal government offered an open-ended 50-50 cost sharing arrangement for hospital insurance in all the provinces. By 1958, all provinces had adopted universal hospital coverage. In 1971, the federal government extended the 50-50 cost sharing arrangement to all essential medical services, and Canada's system of universal public health coverage was born. Low government compensation rates drove most doctors to opt out of the system and simply bill patients themselves at their old rates. The Canadian Health Act of 1984 forbids practitioners from billing beyond provincially mandated fee schedules and aims to ensure a one-tiered service.

Today, Canada's system is based on private providers who receive payment from federal and provincial budgets. Physicians are remunerated on a fee-for-service basis (with an imposed cap to prevent excessive utilization and costs) by the provincial health plan. The system is primarily tax-funded through federal transfers to the provinces, but provinces may levy their own taxes to help defray costs. Canada's private health sector is limited to offering insurance and supplemental services not included in the essential public package. Dental care, eye care, prescription drugs, ambulance services, medical devices, upgraded hospital rooms and travel insurance are all outside the scope of Medicare.

Primary care physicians are the forefront of Canadian health care and provide basic medical treatments and preventative care. Typically primary care providers refer patients to specialists for services outside the scope of primary care. Today Canada's ten provincial governments are the constitutionally designated key providers of health care, and have responsibility for planning, financing, and evaluating the provision of hospital care, negotiating salaries of health professionals and negotiating fees for physician service.⁵⁸

Potential Lessons

- Because primary care physicians are the main Medicare providers, Canada has a strong primary care base. More than 63% of all physicians in Canada are primary care providers.
- Consumer choice preserves competition and quality despite mandatory fee schedules.
- Mandatory fee schedules help contain costs.
- Coverage is 'portable' so residents retain their health benefits wherever they move.
- The provincial governments are able to set and enforce overall budgetary limits.
- Prohibiting private insurance for care covered under Medicare ensures a broad-based risk pool. Risk sharing is effective.

⁵⁸ Benedict Irvine, Shannon Ferguson and Ben Cackett, "Background Briefing: The Canadian Health Care System," Civitas: The Institute for the Study of Civil Society, 2005, <http://www.civitas.org.uk/pdf/Canada.pdf> (accessed June 15, 2011).

Challenges

- As Canada struggles with limitless demand, an ageing population, and increasingly costly medical technology, the Canadian Coordinating Office for Health Technology Assessment is tasked with rationing the most expensive new treatments, pharmaceuticals and diagnostic tests.⁵⁹
- Canada's system faces all the challenges of a government-run, single-payer monopoly: limited information, little transparency, poor accountability, politicized decision-making, and lack of innovation.⁶⁰
- A survey of physicians in 2005 revealed that median waiting times in every queried category of care exceed what is 'clinically reasonable'.⁶¹
- Despite the Canadian Health Act of 1984, and probably as a result of long waiting times, the private health sector still operates illegally on the fringe and provides unregulated services that are also included in the public package.

⁵⁹ J. Frogue, D. Gratzler, T. Evans and R. Teske, "Buyer Beware: The Failure of Single-Payer Health Care," *The Heritage Foundation*, 2001.

⁶⁰ Ibid.

⁶¹ D. Gratzler, *Better Medicine, Reforming Canadian Health Care* (Ontario: ECW Press, 2002).

Germany

Germany has a long-standing tradition of public social insurance, and universal health care is rooted in an 1883 parliament decision that made nationwide health insurance mandatory. Currently government-funded Social Health Insurance (SHI) is compulsory for citizens with annual incomes up to €48,000. Those with incomes above the threshold can elect the SHI system, which covers about 88% of the population, or can choose to purchase private insurance. Less than 1% of the German population has no coverage at all. The SHI covers preventive services, in-patient and out-patient hospital care, physician services, mental health and dental care, medical aids, rehabilitation and sick leave compensation. Since 1995, long-term care has been provided as part of a separate mandatory insurance scheme. Out-of-pocket expenditure from co-payments accounted for 13.8% of total health expenditure in 2005. Cost sharing is generally limited to 2% of household income.

The SHI scheme is operated by more than 200 competing Sickness Funds (SFs), which are self-governing, nonprofit, non-governmental organizations, and funded by compulsory wage-based contributions, matched by employers, up to €43,000 per year. In 2005 public insurance accounted for 77.2% of total health expenditure. Private health insurance covers the two groups excluded from SHI—civil servants and the self-employed—and any wealthy citizens who opt out of the public scheme. Those with private insurance pay risk-related premiums for themselves and their dependents, and risk is assessed upon entry only. Private insurance also plays a minor supplemental role with SHI by adding certain benefits such as better amenities and coverage for some co-payments and

dental care. Private insurance made up 9.1% of total health expenditure in 2005.⁶²

Potential Lessons⁶³

- Primary care doctors have no formal gatekeeper function, but in 2004, SFs were required to provide bonuses to enrollees who complied with a “family physician care model.”
- Out-patient physicians are paid in a mix of per time period and per procedure rates, and aggregate payments are negotiated annually to avoid runaway costs. Fees are pro-rated downward when budget ceilings are approached. Collective prescription caps for physicians on a regional basis further contain costs.
- Legislation in 2002, created Disease Management Programs (DMPs) for patients with chronic illnesses. To give SFs an incentive to care for the chronically ill, SFs receive higher per-capita allocations for DMP patients than they do for non-DMP participants. As a result, SFs with higher shares of DMP patients receive higher compensation.
- The German government delegates regulation and governance to the SFs and medical providers’ associations. The Federal Joint Committee was created in 2004, to increase efficacy and compliance.
- Patients have freedom of choice between SFs and providers. Both providers and funds have an obligation to contract and treat a person who has chosen them.

⁶² Reinhard Busse, “The German Health Care System,” *The Commonwealth Fund*, http://www.commonwealthfund.org/~media/Files/Resources/2008/Health%20Care%20System%20Profiles/Germany_Country_Profile_2008_2%20pdf.pdf (accessed June 16, 2011).

⁶³ Ibid.

- Beginning in 2007, all acute care hospitals began publishing 30 quality indicators in mandatory annual reports.
- The Institute for Quality and Efficiency enforces other quality control mechanisms such as mandatory continuous medical education for providers and required health technology assessments for drugs and certain procedures.
- The Institute also evaluates the cost-effectiveness of drugs, which are subject to reference prices unless they can demonstrate an added medical benefit beyond the reference price.
- In addition to price freezes, compulsory bulk discounts on drugs for health insurance funds was raised from 6% to 16% in 2009.⁶⁴
- There is a need to increase the role of general practitioners vis-à-vis office-based specialists by improving their training and by educating patients to use general practitioners as gatekeepers who guide patients through the health care system.
- Ambulatory care and hospital care are structured separately, and there is no coordination between them. This results in long hospital stays because hospital physicians do all the follow up before patients are released. No incentives are in place in fee schedules to shorten lengths of stay.
- Physicians prescribe almost three times more drugs in Germany than they do in the US, and drug prices are higher in Germany than in other countries.
- While the 1993 Health Care Structure Act introduced free choice of SFs for enrollees, true market competition is not possible because SFs have to offer the same benefits for the same contribution rate. Most SFs also have the same range of providers because providers collectively contract with SFs. The “better” SFs are increasingly demanding greater flexibility and the selective contracting of providers to allow for differentiation between SFs.

Challenges⁶⁵

- High levels of unemployment threaten the financial basis of the social insurance system.
- Some antiquated reimbursement mechanisms currently favor unnecessary or excessive treatments.
- Fragmentation of SHI and long-term care causes duplication of services and uncoordinated care, which is exacerbated by the fact that general practitioners do not currently act as formal gatekeepers.

⁶⁴ Rob Hyde, “German Health Reform Compromise Under Attack,” *The Lancet*, 2010: 759-760.

⁶⁵ Reinhard Busse and Annette Riesberg, *Health Care Systems in Transition: Germany*, (European Observatory on Health Care Systems, 2000).

New Zealand

The New Zealand health system provides residents with access to a broad range of health services with substantial government funding. The system gives its beneficiaries the choice of their independent general practitioner, and covers preventive and promotional services, in-patient and out-patient hospital care, primary health care services, prescription drugs, mental health care, dental care for school children, and disability support services. Patient out-of-pocket co-payments for general practitioners, non-hospital prescription drugs, some private hospital or specialist care, and adult dental care account for 16% of total health expenditures.⁶⁶

The system receives most of its funds from general taxation, which supports about 78.3% of health care expenditures. The government sets an annual global budget for health care and distributes funds to District Health Boards (DHBs). DHBs offer general health services at government-owned facilities and buy other services from private providers, such as general practitioners. General practitioners are generally grouped into Primary Health Organizations (PHOs), which have recently received additional government subsidies to increase access to primary care for low-income residents. As of 2005, 92% of the New Zealand population was linked to a PHO to receive a range of clinical and non-clinical care. PHOs are funded partly by capitation rates and partly by fee-for-service.⁶⁷

About one-third of New Zealand's population has some form of private insurance to help cover co-payments, elective surgery and specialist consultations.

Private insurance makes up 6% of health expenses. Recent cutbacks in public funding for the health care system have resulted in fairly long lines for elective procedures and have encouraged the emergence of a two-tier health care system.⁶⁸

Potential Lessons

- New Zealanders report far shorter waiting times for appointments and far lower out-of-pocket costs than patients in the United States and Canada.⁶⁹
- PHARMAC is a government agency that determines which prescription drugs will receive full or partial government subsidy. PHARMAC is a global pioneer in negotiating for low-cost prescription drugs, in part because it acts as a monopoly purchaser and has strong bargaining power. In negotiations, the drug company is responsible for establishing the clinical- and cost- effectiveness of the drug.⁷⁰

Challenges

- Under-funding has led to increasingly long waiting lines for a variety of elective procedures.⁷¹
- Long waiting lists for some treatments in public facilities have led to growth in the private insurance market. The emergence of a two-tiered system may complicate care coordination for patients that use both public and private facilities.
- Independent general practitioners and PHOs often require some kind of co-payment, which represents a cost barrier to the most basic forms

⁶⁶ The Commonwealth Fund, "Descriptions of Health Care Systems: Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States," *Alliance for Health Reform*, 2005, [http://www.allhealth.org/briefingmaterials/DescriptionsofHealthCareSystems_2005\(2\)-348.pdf](http://www.allhealth.org/briefingmaterials/DescriptionsofHealthCareSystems_2005(2)-348.pdf) (accessed June 17, 2011).

⁶⁷ Ibid.

⁶⁸ Stuart Bramhall, "The New Zealand Health Care System," *Physicians for a National Health Program*, January 9, 2003, http://www.pnhp.org/news/2003/january/the_new_zealand_heal.php (accessed June 17, 2011).

⁶⁹ Mary Mahon, "New Commonwealth Fund Survey Spotlights Strengths and Gaps of Health Systems in U.S., Canada, the U.K. and Other Nations," *The Commonwealth Fund*, October 28, 2004, <http://www.commonwealthfund.org/Content/News/News-Releases/2004/Oct/New-Commonwealth-Fund-Survey-Spotlights-Strengths-and-Gaps-of-Health-Care-Systems-in-U-S---Canada--t.aspx> (accessed June 17, 2011).

⁷⁰ Bramhall.

of care. Evidence suggests that the government's efforts to increase access to primary care have not equalized utilization rates among patients of all income levels.⁷²

- New Zealanders have considerable anxiety about their ability to receive health care. In a recent

survey by The Commonwealth Fund, 42% of residents were afraid they could not afford medical care, 38% were anxious about the possibility of wait times for non-emergent care, and 38% feared they would not get advanced care if they became very sick.⁷³

⁷¹ Bramhall.

⁷² Ross Barnett and Pauline Barnett, "Primary Health Care in New Zealand: Problems and Policy Approaches," Ministry of Social Development, March 2004, <http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj21/21-primary-health-care-in-new-zealand-pages49-66.html> (accessed June 17, 2011).

⁷³ The Commonwealth Fund.

Norway

All Norwegian citizens and residents have health care coverage under the National Insurance Scheme (NIS). Norway's system is a tax-funded, single-payer arrangement. The system is financed through general revenue from taxes, and among industrialized countries, only Sweden has a higher tax burden than Norway. Benefits under the NIS are extensive, and include in-patient and out-patient care, diagnostic services, specialist care, maternity services, preventive medicine, palliative care, and prescription drugs. Most notably, the NIS provides sick pay and disability benefits. Small co-payments are due for out-patient treatment and for treatment by a general practitioner, psychologist, or psychiatrist. To limit overall health expenditures and capital investment, the government sets a global budget annually. Some Norwegians opt out of the government health system and pay out-of-pocket for care. Because of insufficient capacity to meet the strong demand for health services, Norwegians face long waiting times for many procedures. Many Norwegians who can afford to pay out-of-pocket travel abroad for medical treatment.⁷⁴

The central government, through the Ministry of Health and Care Services, has overall authority over the system, although management and funding responsibilities have been delegated to regional and municipal governments. Municipal governments are additionally responsible for primary health care, regional governments are also responsible for specialist care, and the central government has full control over all public hospitals. Private facilities for plastic surgery, substance abuse, and dental care complement

publicly funded services. Municipalities can levy proportional income taxes, but regional authorities rely on transfers from the national government. Public sector spending on health accounts for roughly 84% of the total. Most health care personnel are salaried government employees, although some specialists work on a contract basis and receive annual grants and fee-for-service payments.⁷⁵

Potential Lessons

- The Norwegian health system achieves a reasonable balance of local and national governance. A centralized vision guides a decentralized network of regional and municipal governments, which encourage inhabitants to take part in local politics.
- Municipal and regional councils are all popularly elected, which increases accountability.⁷⁶
- An annual global budget is set by the central government to restrain costs.
- Norway's public health providers are in the process of adopting electronic patient records to improve teamwork between municipal health and social services, specialist health care and general practitioner services.⁷⁷
- In 1997, Norway introduced 'activity-based funding' that tied provider payments to the number of patients each provider treated in a certain diagnosis group. This payment mechanism was followed by an increase in the number of cases treated and a reduction in waiting times.⁷⁸

⁷⁴ Healthcare Economist, "Health Care Around the World: Norway," *Healthcare Economist*, April 18, 2008, <http://healthcare-economist.com/2008/04/18/health-care-around-the-world-norway/> (accessed June 17, 2011).

⁷⁵ Michael Tanner, "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World," *The Cato Institute*, March 18, 2008, <http://www.cato.org/pubs/pas/pa-613.pdf> (accessed June 17, 2011).

⁷⁶ Jan Roth Johnson, "Health Systems in Transition: Norway," *World Health Organization on behalf of the European Observatory on Health Systems and Policies*, 2006, http://www.euro.who.int/_data/assets/pdf_file/0005/95144/E88821.pdf (accessed June 17, 2011).

⁷⁷ Ibid.

⁷⁸ Johnson.

Challenges

- Significant wait time for many procedures is the biggest problem Norway's health system faces. Norwegians who can afford to pay out-of-pocket fees look abroad for timely care, but low-income citizens are forced to wait months for non-emergent care.⁷⁹ In 2000, the Norwegian government committed Nkr 1 billion to purchase medical treatment abroad.⁸⁰
- Because of a scarcity of resources relative to demand, treatment can be denied to sick patients if it is not deemed to be cost-effective.⁸¹
- Patient choice of physicians is constrained to a government list of general practitioners. Patients may switch general practitioners, but only twice a year and only if their preferred general practitioner has no waiting list to be seen.⁸²

⁷⁹ Healthcare Economist.

⁸⁰ Johnson.

⁸¹ Tanner.

⁸² Ibid.

Sweden

Sweden has a universal healthcare delivery system with decentralized decision-making and implementation under the stewardship of the national government. Although legislation and regulation of the national health system occurs at the national level, the financing and provision of health care is the responsibility of 21 county councils and 289 municipalities.⁸³ County councils raise tax revenue, determine fee schedules, and organize and dispense health care. While county councils cover most forms of health care, municipalities are responsible for nursing homes, long-term care for the elderly with somatic and psychiatric diseases, and institutional housing and care facilities for mentally retarded patients. Provider payment mechanisms vary among county councils, but global budgets and per-capita payments are the most common.⁸⁴

In 2001, 85.2% of Sweden's total health expenditure came from public sources, while only 14.8% came from private sources. Because Sweden has a heavily socialized, single-payer system, Sweden has charged minimal user fees for primary physician (US\$14) and specialist (US\$35) visits to try to prevent overuse and abuse. These user fees accounted for only 2% of total health expenditure. Sweden sets a maximum annual co-payment at \$US128, after which an individual receives a card that authorizes free care for a year. The government withholds unnecessary benefits such as vaccines for foreign travel and flu shots for low-risk people to contain costs.⁸⁵

In recent years Sweden has undertaken several health system reforms to increase competition, efficiency, marketization, and privatization. In a series of reforms collectively called the Stockholm Revolution, the Swedish health care system introduced patient choice of care providers and separated purchaser and provider functions.⁸⁶ This system has been shown to encourage competition for public contracts, decrease waiting times, increase efficiency, and cut costs.⁸⁷ A degree of privatization and market-based reform in Sweden's health system may threaten truly universal access in the future, however.

Potential Lessons

- A National Pharmaceutical Benefits Board performs analyses of the cost-effectiveness of certain drugs to determine which drugs should be included in the public benefit package, and at what price. The Swedish Council on Technology Assessment in Health Care performs similar cost-effective analyses for health care technologies.⁸⁸
- The Swedish system provides for clear distinctions in the responsibilities of the government, the county councils, and the municipalities. Such decentralization allows for greater flexibility and encourages innovative practices to improve efficiency.

⁸³ D. Brad Wright, "Universal Access to Healthcare: Lessons from Sweden for the United States," *University of North Carolina School of Public Health*, November 17, 2004, <http://www.unc.edu/~wedavid/web/Comparative%20HC%20Systems%20Paper.pdf> (accessed June 17, 2011).

⁸⁴ Bengt Ahgren, "Competition and integration in Swedish health care," *Nordic School of Public Health*, 2010: 91-97.

⁸⁵ Wright.

⁸⁶ Sara M. Glasgow, "What Goes Up: The Genesis and Context of Health Reform in Sweden," *Global Health Governance*, 2009: 1-18.

⁸⁷ Johan Hjertqvist, "Meeting the Challenges to European Healthcare: Lessons Learned from the 'Stockholm Revolution,'" *Pharmacoeconomics*, 2002: 47-53.

⁸⁸ Anna H. Glennard, Frida Hjalte, Marianne Svensson, Anders Anell and Vaida Bankauskaite, *Health Systems in Transition: Sweden*, (Copenhagen, Denmark: WHO Regional Office for Europe on behalf of The European Observatory on Health Systems and Policies, 2005).

- Patient choice increases the responsiveness of the health care sector to needs and wishes of patients, and drives improvements by encouraging competition between providers. The Stockholm Revolution reforms also seem to address many of the common problems with a single-payer health system—inefficiency and increasing costs.

Challenges⁸⁹

- Like other nations with a single-payer system and an aging population, Sweden has had to deal with the problem of ever-growing health care expenses. To deal with this burden, Sweden has begun rationing care, in part by instituting waiting lists for medical appointments and surgery. These long waiting lists are a problem, and may explain why Swedes are increasingly opting for voluntary private health insurance.
- Access to primary care can be difficult in Sweden. Opening hours are inconvenient, and getting an appointment is not easy. Consequently, half of all patients go straight to a hospital for their primary care.
- Future reforms should focus on improving coordination of care, particularly for the elderly and for patients with multiple diagnoses. Though the division of responsibility into three separate levels of governance allows for decentralization, it also permits fragmentation that makes care coordination, particularly for the elderly and the mentally retarded, very difficult.
- Budget-governed health care does not reward curious, innovative physicians. New knowledge and technologies are not welcomed as progress, but are considered disturbances that may increase costs. Budgetary surplus is the primary goal, rather than improving care quality.⁹⁰
- The market-based reforms of the Stockholm Revolution may threaten the system's universality in the future.

⁸⁹ Ibid.

⁹⁰ Sven R. Larson, "Lessons from Sweden's Universal Health System: Tales from the Health-care Crypt," *Journal of American Physicians and Surgeons*, 2008: 21-22.

Taiwan⁹¹

Before 1995, a patchwork of ten different social health insurance schemes covered only 59% of Taiwan's population. The uninsured 41% were predominantly children under age 14 and adults older than 65, who need health care the most. In 1995, the National Health Insurance (NHI) program was established as a government-run, single-payer national health insurance scheme under the direction of the Bureau of National Health Insurance (BNHI). With mandatory enrollment to ensure a broad-based collection of funds and adequate risk pooling, the NHI increased health insurance coverage in Taiwan from 57% to more than 96%. The program is financed through a mix of premiums and taxes, which compensate a mix of public and private providers on a fee-for-service basis. Individual families, employers, and the government all pay a share of the premiums, and the share that each group owes differs within six categories of population subgroups. For military personnel and the poor, the government pays the entire premium. In 2000, 32.15% of the NHI's total premium revenue came from employers, 38.08 % from individuals, and 29.77% from government.

Though some health facilities in Taiwan are public, the majority is privately owned, and more than 90% of all hospital facilities contract with the BNHI. The NHI pays providers on a classic fee-for-service basis at uniform, national fee schedules. The NHI accounts for 55% of Taiwan's national health expenditure while 30% comes from out-of-pocket payments. The NHI health care package covers in-patient care, ambulatory care, laboratory tests, diagnostic imaging, prescription and certain over the counter drugs, dental care, traditional Chinese medicine, day care for the mentally

ill, limited home health care, and certain preventive medicines. Most notably, HIV/AIDS treatment and organ transplants are covered. Households must pay out-of-pocket for services not covered by the NHI, such as orthodontics, prosthodontics, lab tests that are not medically necessary, extra charges for non-NHI beds, requests for nurses or physicians not assigned by the hospital, long-term care, and nursing home care. Out-of-pocket spending also includes "user fees" levied by certain providers and co-payments for NHI-covered ambulatory care, in-patient care, and pharmaceuticals.

Potential Lessons

- Introduced in 2002, Taiwan's IC-Card functions as a communication tool between the NHI and providers, and allows for the transferring of a patient's electronic medical records between providers. The IC-Card also helps protect against fraud.
- Implementation of the NHI significantly increased life expectancy for those most at risk, typically the uninsured, before the NHI scheme.⁹²
- The capacity of Taiwan's health infrastructure has increased since the NHI's inception—the supply of health professionals, for example, increased by 39.6 %.
- Only 2.2% of the NHI's total budget is spent on administration because all claims are processed electronically.
- The NHI offers complete freedom of choice among providers, and there is no rationing of care, or lines for care.

⁹¹ Tsung-Mei Cheng, "Taiwan's New National Health Insurance Program: Genesis and Experience So Far," *Health Affairs*, 2003: 61-76.

⁹² K. Davis and A.T. Huang, "Learning from Taiwan: Experience with Universal Health Insurance," *Annals of Internal Medicine*, February 2008: 313-314.

- Under the NHI the utilization rate of services among the previously uninsured jumped to match the utilization rate of those who were insured prior to the NHI. Essentially, the NHI successfully removed financial barriers to care.
- Global budgets have succeeded somewhat in controlling costs.
- A series of quality monitoring programs using health information technology and payment incentives move physicians towards greater accountability for good health outcomes. The government is considering a fee-for-outcomes (FFO) approach to replace traditional fee-for-service.
- Hospital quality indicators have been introduced to aggregate data on re-hospitalizations and repeated visits to emergency rooms to help hospitals improve quality.

Challenges

- A primary weakness is uncertainty about the long-run sustainability of Taiwan's health insurance system, particularly because of budget cuts and a mounting national debt.⁹³
- Inappropriate physician payment incentives affect how medical trainees choose their specialties. Trainees disproportionately choose specialties that have simpler payment processes under the NHI, such as dermatology, or that are not covered by the NHI at all. These specialties, such as cosmetic surgery, bring in higher, out-of-pocket payments. Specialties covered by the NHI with lower reimbursement rates, such as obstetrics and gynecology, are rarely chosen.⁹⁴
- Critics claim that the fee-for-service payment mechanism encourages supplier-induced demand for services that may not be necessary. This tendency to overmedicate or overprescribe is made worse by excess capacity. Additionally, Taiwan permits hospitals to sell drugs for prices beyond their acquisition cost—the marginal profit is known as the 'drug price black hole.' The profitability of selling drugs creates an additional incentive for hospitals to overmedicate their patients.
- Fee-for-service payments also encourage doctors to increase their volume of services rendered, most often by decreasing the quality of each service. For example, Taiwan's fee schedule is thought to encourage the 'three-minute patient visit.'
- Health capacity is unevenly distributed, not only by specialty, but also geographically. In 2001, the overall ratio of physicians per 1,000 people was 1.37, but in the mountainous areas and offshore islands it was only 0.8.
- Excess health capacity in certain areas of Taiwan engenders fierce competition among hospitals for patients, who are increasingly being viewed merely as "biological structures yielding cash."⁹⁵

⁹³ Davis and Huang.

⁹⁴ Ibid.

⁹⁵ Yeh, , quoted in Tsung-Mei Cheng, "Taiwan's New National Health Insurance Program: Genesis and Experience So Far," *Health Affairs*, 2003: 61-76.

United Kingdom

Since its launch in 1948, the National Health Service (NHS) has grown to become the world's largest publicly funded health service. With the exception of charges for some prescription drugs and optical and dental services, the NHS offers free primary care, preventive care, mental health care and hospital use for anyone who is a resident of the United Kingdom (UK). Children, the elderly, pregnant women, and people with disabilities or certain mental conditions are exempt from any co-payments. Roughly 11.5% of residents purchase supplemental private insurance to avoid wait times, have a higher standard of comfort, or choose their specialist. The NHS is funded largely by general taxation, and government health expenditures make up roughly 15.6% of total government expenditures in the UK. Notable features of the NHS are the combination of universal coverage and access, very little cost sharing, and tight cost containment. Providers are incentivized under the UK's system to promote preventive and curative care. Each country in the UK has a health department that is responsible for its own policy decisions and health budget, and the purchasing and provision of services are delegated further to regional bodies and local public providers, respectively.⁹⁶

Potential Lessons

- The total expenditure of the NHS is relatively low and health outcomes are on par with other developed countries.
- England has had success in reducing wait times by increasing hospital capacity and staff, setting

shorter maximum wait targets and strictly monitoring the performance of physicians.

- England introduced a quasi-market arrangement that rewards providers with greater patient satisfaction.
- The National Institute for Health and Clinical Excellence (NICE) was recently established to assess evidence for the clinical- and cost- effectiveness of certain drugs and medical procedures in an effort to improve the responsiveness of the system.
- The Commission for Health Improvement (CHI) is a regulatory body established to inspect the performance of NHS institutions and to ensure a high quality of care.

Challenges

- A shortage of both primary care providers and specialists has led to concerns with wait times and care quality, particularly for the elderly who require round-the-clock care.
- Reporting of serious failures in health care is patchy and incomplete; the NHS has very few mechanisms in place to identify and respond to those failures. Improvements in the organizational culture of the NHS and in its reporting systems as well as a new emphasis on evidence-based practices are necessary for the NHS to take an active role in addressing its weaknesses.
- The NHS suffers from a lack of local flexibility.
- The NHS has never consistently and systematically measured changes in its patients' health. It is difficult to measure the efficiency of the NHS as a health care system.

⁹⁶ The Kaiser Family Foundation, *United Kingdom Background Brief*, <http://www.kaiseredu.org/Issue-Modules/International-Health-Systems/UK.aspx> (accessed June 15, 2011).

⁹⁷ Dennis Campbell, "NHS Failing in Basic Care of Some Elderly Patients, Warns Watchdog," *The Guardian*, May 26, 2011.

⁹⁸ Department of Health, "An Organization with Memory," *Publications, Policy and Guidance*, 2000, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4098184 (accessed June 16, 2011).

- According to the British Medical Journal, health inequalities in Britain are greater currently than they were during the post-World War I slump and the Great Depression. Though health outcomes across all segments of the population have improved over the last decade, the disparity of health outcomes between the wealthiest and the poorest has widened over the past 20 years.⁹⁹

⁹⁹ Nick Triggle, "Health gap 'wider than in Great Depression,'" BBC News, July 24, 2010.

References

- Ahgren, Bengt. "Competition and integration in Swedish health care." *Nordic School of Public Health*, 2010: 91-97.
- Barnett, Ross, and Pauline Barnett. "Primary Health Care in New Zealand: Problems and Policy Approaches." Ministry of Social Development. March 2004. <http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj21/21-primary-health-care-in-new-zealand-pages49-66.html> (accessed June 17, 2011).
- Bhore Committee. "Report of the Health Survey and Development Committee." From Bhore Committee to National Rural Health Mission: A Critical Review. 1946. <http://nihfw.org/NDC/DocumentationServices/Reports/bhore%20Committee%20Report%20VOL-1%20.pdf> (accessed June 14, 2011).
- Blount, Jeb, Health Care in Brazil on \$300 a Year, August 9, 2010, <http://www.worldpolicy.org/blog/health-care-brazil-300-year> (accessed June 23, 2011).
- Bramhall, Stuart. "The New Zealand Health Care System." Physicians for a National Health Program. January 9, 2003. http://www.pnhp.org/news/2003/january/the_new_zealand_heal.php (accessed June 17, 2011).
- Busse, Reinhard. "The German Health Care System." The Commonwealth Fund. http://www.commonwealthfund.org/~media/Files/Resources/2008/Health%20Care%20System%20Profiles/Germany_Country_Profile_2008_2%20.pdf.pdf (accessed June 16, 2011).
- Busse, Reinhard, and Annette Riesberg. *Health Care Systems in Transition: Germany*. European Observatory on Health Care Systems, 2000.
- Campbell, Dennis. "NHS Failing in Basic Care of Some Elderly Patients, Warns Watchdog." *The Guardian*, May 26, 2011.
- Carrin, Guy, and et al. "Health financing reform in Kenya--assessing the social health insurance proposal." *South African Medical Journal*, 2006: 130-135.
- Cataife, Guido and Charles J. Courtemanche, *Is Universal Health Care in Brazil Really Universal?*, Working Paper (Cambridge, MA: National Bureau of Economic Research, 2011).
- Cheng, Tsung-Mei. "Taiwan's New National Health Insurance Program: Genesis and Experience So Far." *Health Affairs*, 2003: 61-76.
- Davis, K., and A.T. Huang. "Learning from Taiwan: Experience with Universal Health Insurance." *Annals of Internal Medicine*, February 2008: 313-314.
- Department of Health. "An Organization with Memory." Publications, Policy and Guidance. 2000. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4098184 (accessed June 16, 2011).
- Evans, Timothy G. "Centre of Excellence on Universal Health Coverage." James P. Grant School of Public Health, BRAC University. http://www.bracuniversity.net/I&S/sph/centres_initiatives/uhc.htm (accessed June 14, 2011).
- Frogue, J., D. Gratzler, T. Evans, and R. Teske. "Buyer Beware: The Failure of Single-Payer Health Care." The Heritage Foundation, 2001.
- Glasgow, Sara M. "What Goes Up: The Genesis and Context of Health Reform in Sweden." *Global Health Governance*, 2009: 1-18.
- Glennard, Anna H., Frida Hjalte, Marianne Svensson, Anders Anell, and Vaida Bankauskaite. *Health Systems in Transition: Sweden*. Copenhagen, Denmark: WHO Regional Office for Europe on behalf of The European Observatory on Health Systems and Policies, 2005.
- Gratzler, D. *Better Medicine, Reforming Canadian Health Care*. Ontario: ECW Press, 2002.
- Healthcare Economist. "Health Care Around the World: Norway." *Healthcare Economist*. April 18, 2008. <http://healthcare-economist.com/2008/04/18/health-care-around-the-world-norway/> (accessed June 17, 2011).
- Hew, Chee. *Healthcare in China: Toward greater access, efficiency, and quality*. Somers, NY: IBM Corporation, 2006.
- Hjertqvist, Johan. "Meeting the Challenges to European Healthcare: Lessons Learned from the 'Stockholm Revolution.'" *Pharmacoeconomics*, 2002: 47-53.
- Hsiao, William C., R. Paul Shaw, Andrew Fraker, and the World Bank. *Social Health Insurance for Developing Nations*. (Washington, D.C.: The World Bank, 2007), 43-59, 81-104.
- Hyde, Rob. "German Health Reform Compromise Under Attack." *The Lancet*, 2010: 759-760.
- Indonesia Delegation. "Moving Toward Universal Health Coverage: Indonesia." Joint Learning Workshop. http://jlw.drupalgardens.com/sites/jlw.drupalgardens.com/files/Indonesia_case_study_2-24-10%20FINAL.pdf (accessed June 16, 2011).
- Irvine, Benedict, Shannon Ferguson, and Ben Cackett. "Background Briefing: The Canadian Health Care System." *Civitas: The Institute for the Study of Civil Society*. 2005. <http://www.civitas.org.uk/pdf/Canada.pdf> (accessed June 15, 2011).
- Islam, Anwar. *Bangladesh Health System in Transition: Selected Articles*. Monograph Series, Dhaka, Bangladesh: James P. Grant School of Public Health, 2008.
- Johnson, Jan Roth. "Health Systems in Transition: Norway." World Health Organization on behalf of the European Observatory on Health Systems and Policies. 2006. http://www.euro.who.int/___data/assets/pdf_file/0005/95144/E88821.pdf (accessed June 17, 2011).

- Larson, Sven R. "Lessons from Sweden's Universal Health System: Tales from the Health-care Crypt." *Journal of American Physicians and Surgeons*, 2008: 21-22.
- Ma, Jin, Mingshan Lu, and Hude Quan. "From A National, Centrally Planned Health System to A System Based On The Market: Lessons from China." *Health Affairs*, 2008: 937-948.
- Mahon, Mary. "New Commonwealth Fund Survey Spotlights Strengths and Gaps of Health Systems in U.S., Canada, the U.K. and Other Nations." The Commonwealth Fund. October 28, 2004. <http://www.commonwealthfund.org/Content/News/News-Releases/2004/Oct/New-Commonwealth-Fund-Survey-Spotlights-Strengths-and-Gaps-of-Health-Care-Systems-in-U-S---Canada-t.aspx> (accessed June 17, 2011).
- Muga, Richard, Paul Kizito, Michael Mbayah, and Terry Gakuruh. "Overview of the Health System in Kenya." *Demographic and Health Surveys*. <http://www.measuredhs.com/pubs/pdf/SPA8/02Chapter2.pdf> (accessed June 16, 2011).
- Pachanee, Cha-Aim, and Suwit Wibulpolprasert. "Incoherent policies of universal coverage of health insurance and promotion of international trade in health services in Thailand." *Oxford Journal on Health Policy and Planning*, 2006: 310-318.
- Rannan-Eliya, Ravi P. and Lankani Sikurajapathy, Sri Lanka: "Good Practice" in Expanding Health Care Coverage, Research Studies Series 3 (Colombo: The Institute for Health Policy, 2009).
- Shepard, Donald S., William Savedoff, and Phua Kai Hong. "Health Care Reform Initiatives in Malaysia." *World Health Organization*. October 16, 2002. http://www.who.int/health_financing/countries/en/malaysia.pdf (accessed June 17, 2011).
- Socialist Health Association. "Evidence to the Health Select Committee." *Tackling Inequalities through the NHS*. November 16, 2009. <http://www.sochealth.co.uk/Policy/inequalityNHS.htm> (accessed June 16, 2011).
- Tangcharoensathien, Viroj, et al. "Health-financing reforms in southeast Asia: challenges in achieving universal coverage." *The Lancet*, 2011: 863-873.
- Tanner, Michael. "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World." The Cato Institute. March 18, 2008. <http://www.cato.org/pubs/pas/pa-613.pdf> (accessed June 17, 2011).
- Thailand Delegation. "Moving Toward Universal Health Coverage: Thailand." Joint Learning Workshop. http://jlw.drupalgardens.com/sites/jlw.drupalgardens.com/files/Thailand_Case_Study_2-24-10%20FINAL.pdf (accessed June 16, 2011).
- The Commonwealth Fund. "Descriptions of Health Care Systems: Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States." Alliance for Health Reform. 2005. [http://www.allhealth.org/briefingmaterials/DescriptionsofHealthCareSystems_2005\(2\)-348.pdf](http://www.allhealth.org/briefingmaterials/DescriptionsofHealthCareSystems_2005(2)-348.pdf) (accessed June 17, 2011).
- The Joint Learning Network for Universal Health Coverage. Indonesia. 2011. <http://www.jointlearningnetwork.org/content/indonesia> (accessed June 16, 2011).
- . Philippines. 2011. <http://www.jointlearningnetwork.org/content/philippines> (accessed June 20, 2011).
- The Kaiser Family Foundation. United Kingdom Background Brief. <http://www.kaiseredu.org/Issue-Modules/International-Health-Systems/UK.aspx> (accessed June 15, 2011).
- Towse, Adrian, Anne Mills, and Viroj Tangcharoensathien. "Learning from Thailand's health reforms." *BMJ*, January 2004: 103-105.
- Triggle, Nick. "Health gap 'wider than in Great Depression.'" *BBC News*, July 24, 2010.
- Tsai, Charles. Regulatory Reform in China's Health Sector. Policy Brief, Groupe d'Economie Mondiale, Sciences Po, 2010.
- United Nations Publications. "Chapter IV: Towards Universal Health Care Coverage in the Asia-Pacific Region." United Nations Economic and Social Commission for Asia and the Pacific. http://www.unescap.org/esid/hds/pubs/2449/2449_ch4.pdf (accessed June 17, 2011).
- Wamai, Richard G. "The Kenya Health System--Analysis of the situation and enduring challenges." *Japan Medical Association Journal*, 2009: 134-140.
- WHO. "Country Statistics." Global Health Observatory Data Repository. 2011. <http://apps.who.int/ghodata/?vid=10400&theme=country> (accessed June 14, 2011).
- World Health Organization. "Brazil's March Towards Universal Coverage." *Bulletin of the World Health Organization*. September 2010. <http://www.who.int/bulletin/volumes/88/9/10-020910/en/> (accessed June 15, 2011).
- . Health System in Bangladesh. 2008. http://www.whoban.org/health_system_bangladesh.html (accessed June 14, 2011).
- Wright, D. Brad. "Universal Access to Healthcare: Lessons from Sweden for the United States." University of North Carolina School of Public Health. November 17, 2004. <http://www.unc.edu/~wedavid/web/Comparative%20HC%20Systems%20Paper.pdf> (accessed June 17, 2011).