HEALTH CARE FINANCING PRACTICES IN SELECTED COUNTRIES

National Institute of Public Finance and Policy
New Delhi

Preface

The National Institute of Public Finance and Policy (NIPFP) is an autonomous non-profit organisation established for carrying out research, undertaking consultancy work and imparting training in the fields of public finance and policy.

In June 1990, the NIPFP with financial support from the Ford Foundation set up a research unit to study 'Health Economics and Financing in India'. The major research concerns in the Health Economics Unit, since then, have been the problems of financing public health expenditure in India in the light of its persistent low health status. The present studies— the final outputs of the unit— are a set of five studies, of which one is devoted to a database on health expenditure of four states of India. Focused mainly on health and environment, these studies examine various aspects of public health care scenarios in the central, state, and union territory levels, as also in some selected countries of the world.

The titles of the studies are:

1. Health and Environment

2. Health Care Status in India.

3. Health Care Systems in India.

4. Health Care Financing Practices in Selected Countries.

5. Database on Health Expenditure: Four Selected States, Volume I and Volume II

The first study was planned and conducted by A.L. Nagar. He was assisted by Harmeet Singh Maddh, Sharmistha Mukherjee, Anindita Chakroborty, Tauhidur Rehman, Rajeev Kumar Singh and Vikram Singh. The studies at 2, 3 and 4 were undertaken by Charu C. Garg, Harmeet Singh Maddh, Ranita Datta and V. Selvaraju. The database is the outcome of an effort made by Charu C. Garg and V. Selvaraju.

The members of the Governing Body of the Institute are not be responsible for the views expressed in these reports. That responsibility belongs to the authors.

Ashok K. Lahiri
Director

June 1999

HEALTH CARE FINANCING PRACTICES IN SELECTED COUNTRIES

The health care financing and delivery practices among the countries vary considerably according to socio-cultural, economic, behavioural and political characteristics specific to a society. The three common concerns shared by the nations are its *cost, access* and *quality* of health care that is being provided to the people. Nations basically, develop their strategies to achieve a balance between these three important aspects of health care provision and financing. The review of health care practices of different countries can be a study by itself. Nevertheless, an attempt is made here to review the practices in selected developed industrial countries and developing countries and to draw lessons, if any, for India. Different models of health care systems being practised in some developed and developing countries are presented here. This review of financing, organisation and delivery system of health care mechanism in selected countries would help in working out a model for India.

MODELS OF HEALTH CARE SYSTEM

A glance at the health care systems of different countries reveals that their practices of financing vary widely; and no two country's practices are alike. Financing is largely influenced by the organisational and institutional arrangements evolved over a period of time (Hoffmeyer and McCarthy 1994). Broadly speaking, health care systems fall into the following categories: [1]

1. Public financing and public delivery
2. Private financing and private delivery
3. Public financing and private delivery
4. Private financing and public delivery

The first one, public financing and public delivery, is the famous Beverdige model, the National Health Service (NHS) scheme practised in the United Kingdom until, it was reformed in 1989, and to a large extent, still falls within this category. The second one, private financing and

private delivery is the "Private Insurance Model" and is characterised by employer-based or individual purchases of private health insurance coverage on the one hand, and private delivery on the other. The U.S. system falls in this category, if the role played by government in terms of medicare and medicaid [2] is ignored. The third one, public financing and private delivery is the Bismarck Model, idealising the "public/social health insurance scheme". This model being characterised by compulsory universal coverage, financed by individual/employer contributions and having public/private ownership of factors of production, is practised in Germany, France, Japan, Canada and several European countries. The fourth one, private financing and public delivery is not known to be in practice anywhere.

International evidence suggests that the combination of public financing and private delivery, namely, the third one, is superior to other models (Hsiao 1992). The argument in favour of public financing arises from the fact that the single payer systems could tend to have lower costs than what public - private mixed systems could have, for: (a) it may be easier to shift costs than to cut them; (b) there may be a tendency for each funder to attempt to avoid those clients that are, such as to generate high costs (e.g., U.S.A.); and (c) monopsony bargaining power over providers is difficult to achieve under a multiple-payer system, as in the U.S.A.

It may be noted that public financing here is interpreted in a rather general sense, encompassing tax-based funding for National Health Service (NHS) as in UK, Italy, Spain, and National Health Insurance (NHI) as in Canada, mandatory insurance-based funding for (through sickness funds) Social Health Insurance (SHI) as in Germany, France, Netherlands, and Japan, compulsory co-payments for co-operatives as in China, and health insurance plans regulated by the government, which involve none or some co-payment as in Switzerland.[3] Interpreted thus, the Canadian system of public financing of health care scores the highest marks in terms of "satisfaction". In Canada, 56 per cent of its people are satisfied, while in U.S.A. only 10 per cent are satisfied. In comparison, in U.K., 27 per cent of its people are satisfied, in Japan, 29 per cent are satisfied and in Germany 41 per cent are satisfied with their health systems (Hsiao 1992; Hoffmeyer and McCarthy 1994). [4] But, fears are expressed about the veracity of the survey methods used by the authors and results interpreted by them. For example, Hoffmeyer and

McCarthy (1994) pointed out that "it is, such as that people being asked about their satisfaction in different countries have widely differing awareness of the cost to them of the services they are getting." Instead, it is suggested that, to minimise biases, other proxies such as: (a) macro-economic efficiency (measured in terms of Health Care Expenditure (HCE) as percentage of Gross Domestic Product (GDP) or HCE per capita); (b) micro-economic efficiency (measured in terms of "physician visits per head"); (c) social solidarity (measured in terms of percentage of the population covered by public schemes); and (d) aggregate health status (measured in terms of "potential life years lost" or "perinatal mortality") may be used. Table 3.1 and Table 3.2 show the proxies. It is clear that either way, the Canadian system of health care scores the highest points and the American system of health care scores the lowest. It is, therefore, useful to know whether the health insurance systems of these countries notably U.K., Canada, Germany, Japan, and U.S. among developed countries and South Korea, China, and Costa Rica among developing countries — could be examined closely to draw lessons, if any.

COUNTRY EXPERIENCES

The experiences of the health care systems of some developed countries, such as, U.K., Canada, Germany, Japan, and U.S. and developing countries, such as South Korea, China, and Costa Rica can be analysed by looking at two major aspects: (i) financing, and (ii) organisation and delivery mechanism. These have been briefly listed in Table 3.2 and some details are provided below.

The United Kingdom

In United Kingdom, health insurance is in the form of NHS. It is a service provided by the government just like any other service, such as defence, law and order, education. It is financed by the government out of taxes/budgetary resources and is provided through various hospitals owned mainly by the government. The services of doctors, nurses and others are hired by the government. Only a small health insurance market offers supplementary health insurance. As of 1991, only 12

per cent of the population had private medical insurance (Hoffmeyer and McCarthy 1994). The important feature of the NHS is its accessibility. Every one is taken care of.

Financing

a. Total health care expenditure formed about 6.1 per cent of GDP in 1990. Public expenditure on health care formed 5.2 per cent of GDP.

b. Eighty-six per cent of the total health expenditure is public, and only 4 per cent represents out-of-pocket expenditure.

c. The bulk of public expenditure is funded out of general taxation.

d. Fourteen per cent of health care expenditure not funded publicly includes all private sector health care spending plus out-of-pocket co-payments by non-exempt patients (e.g. for optical check-ups and eyeglasses and dental check-up and treatment).

e. The total public budget for health care is determined in the annual round of negotiations among all the spending departments of the government (e.g. defence, environment, education and revenue as well as health) and the treasury.

f. The hospital sector has a cash-limited budget based on age and mortality rates of the particular population.

g. The primary care sector managed by Family Practitioner Committees (FPCs) has an open-ended budget which is demand-based. The FPC budget finances general practitioners (GPs) who are on contract to the NHS and also finances prescription drugs.

h. There are three components under which GPs are reimbursed in the NHS system:
   a. Base salary to cover fixed costs.

b. Salary based on the number of patients on the list, and

c. Fee charged for certain services from patients.

i. The personal social service is sponsored by the local government, whereas it is financed from central government funds.

Organisation and delivery

a. Most of the hospitals in U.K. are run by the government under the responsibility of the district health authorities.

b. Hospital staff of all kinds, including doctors, are salaried.

c. The services are basically provided by the government through the NHS. The mainstay of the system is the general practitioner (GP). Every member of the community is registered with a GP who is the gatekeeper of the system. The GP deals with minor problems locally and refers more complicated cases and difficult diagnoses to a hospital outpatient clinic where the patients may be treated, referred back or scheduled for admission. The GPs are free to refer their patients to any hospital of his or her choice either within or outside the relevant districts. They are also responsible for much of preventive medicine, such as immunisation, family planning, cervical screening, and so on. The GPs are self-employed, independent practitioners. However, most of them work in group practices.

d. Consultants are usually employed in only one hospital (though many are part-time employees who also run private practices). Each senior doctor has junior doctors assigned to him or her and a designated number of beds. He also manages his or her own waiting list. In teaching hospitals, senior doctors may also hold university posts; they are paid at higher rates than other academic staff. Many consultants run their "enterprises" as quasi-feudal ones exercise major control over the hospital's expenditure.

e. Community health care: Along with running the hospitals, the district health authorities co-ordinate community service, such as preventive health, education, health visiting, screening and vaccination, maternity and child welfare clinics, liaison with the local authority, social services especially regarding public health, licensing of private nursing homes and relevant personnel social services.

f. Tight budgetary constraints which resulted in long waiting lists in the government system have led to a significant increase in private medical coverage in Britain. The population covered under private insurance increased from 4 per cent in 1971 to approximately 12 per cent in 1991.

g. The NHS hospitals also have "pay beds" for private patients. Most of the private coverage is provided by the employer. "But, this has been a source of political controversy. On the one hand, it is often claimed that this leads to an inequitable system. On the other hand, most privately practising consultants who are also part time NHS employees are either able to use some NHS beds for private patients or beds in private hospitals. It is argued that they have a direct incentive to manufacture NHS shortages in order to create a demand for private care. There have been clearly identified cases where surgical waiting times seem to have been unduly long, despite the existence of under utilised NHS beds" (Culyer and Meads 1992). In the early nineties there were about 200 private best-equipped hospitals having about 10,500 beds (Meads and Culyer 1992).

In conclusion, one can say that Britain's system of health care is considered as the most centrally financed or managed system in the world. Britain's market-minimised system spends less on health care compared to countries with similar indicators of health status and is also able to provide access to such care to the entire population. However, the expenditure-capped system has not been able to cope adequately with the demand for health service, which has led to its rationing and a long waiting time for some patients. In terms of quality, if measured by people's satisfaction, Britain's health care system fares low. The two-tier system of quality enables those who are willing

to pay out of their own pockets or who have private insurance, to jump the NHS queue for selective surgery; this is widely regarded as inequitable.

Canada

In Canada, the socialised health insurance system is government financed and has a private delivery system. Basically, it is a provincial government health insurance system, wherein, public control is exerted by provincial governments. Each of the provinces runs its own health system under general federal rules and with a fixed federal contribution. The system is financed through general taxation. All legal residents irrespective of income, age and health status are covered. Coverage is portable and not linked to employment. Private insurance is prohibited from covering the same benefits covered by the public system. More than 60 per cent of Canadians are however covered by complementary private policies. Private insurance coverage can be used to meet the cost of a private hospital room.

Financing

1. The amount spent on health care is 9.3 per cent of the GDP. Of this, 7.37 per cent is spent by the public sector and 2 per cent is paid out of pocket by the patient.

2. The provincial governments are the primary payers of health care services. The system is financed through general taxation, income tax, sales tax. Residents in some provinces also pay a monthly-income-based premium or an employer paid pay roll tax. The federal government is largely entitled to raise funds for the programme in any way it chooses including, through premia. But no one can be denied services or even charged for them, for failure to pay the premia (Evans 1992).

Each of the 10 provinces runs its own health system under general federal rules and with a fixed federal contribution. In order to qualify for federal contributions, each provincial plan must conform to the following federal standards:

a. Universability

b. Comprehensiveness

c. Accessibility

d. Portability

e. Non-profit administration

Provincial governments also have extensive taxing power and can regulate health programmes as they wish. Provinces earmark up to 32 per cent of their entire budget to operate health plans (Graig 1993).

4. Hospitals are funded on the basis of global budgets, and physicians in both inpatient and outpatient settings are paid on a negotiated fee-for-service basis.

5. The global budgets for hospitals cover only operating costs. Separate provisional capital budgets are there to cover capital costs, such as new constructions or major purchases. Hospitals do not receive reimbursements for particular items of service. Each hospital negotiates an annual budget with the province reimbursement agency, from which it pays all staff salaries and costs of equipment and supplies. These budgets cover only operating costs; they do not include any allowance for capital costs, either depreciation or interest charges.

Organisations and delivery

- The delivery system in Canada is private, composed largely of non-profit community hospitals and self-employed physicians.

- Only about 5 per cent of Canadian hospitals do not participate in the public insurance programme. Physicians practising in a public system are not allowed to accept private payments. Doctors can not be in both the systems.

- Services are primarily provided by private physicians who are in independent fee-for-service practice and by non-profit hospitals that are "owned" by or are at least under the direction of Boards of Trustees (Evans 1992).

- Every Canadian resident is covered by a provincial plan, and both patient and provider have a free choice. Normally, a patient consults a general practitioner—roughly half of Canadian physicians are general or family practitioners. The general practitioners either provide diagnostic and treatment services themselves or refer the patient to a specialist (Evans 1992). All inpatient hospital services, necessary drugs, supplies and tests are covered.

- The physicians involved, including those who own private diagnostic facilities, are reimbursed according to fee schedules negotiated at periodic intervals — usually annually — between each provincial ministry of health and the corresponding provincial medical association. The schedule in each province is binding on all physicians working in that province, and physicians do not bill their patients additional amounts above these rates. At no point will the patient be required to pay a fee or make any other financial contribution.

- Rationed services in Canada are provided according to needs rather then the ability to pay. "Equal access to all" are the key words in the Canadian health care system.

While concluding, one can say that though the Canadian system provides for egalitarian universal coverage and the costs have also been kept under control, the quality of care in terms of latest technology, is at times deficient. Regulated budgets for hospitals prevent them from investing in the latest medical equipment and technology. In spite of the cost control mechanism, provinces in Canada spend the largest proportion of their budget on health care. These are financed from high income taxes in Canada, the incidence of which falls on individuals.

Germany

The health care system of the Federal Republic of Germany is based on a compulsory insurance scheme. The insurance scheme is highly decentralised and comprises more than 1100 insurance funds or sickness funds. Approximately 90 per cent of its population is insured in one of the compulsory insurance funds and 8 per cent is fully covered by private insurance. The remaining 2 per cent are mainly civil servants for whom the government administers health care. Less than one per cent of the population is not covered by any type of health insurance. They are either very poor and homeless or very rich.

In Germany, health insurance is one of the four branches of social insurance; the other three being: (a) work-related accident insurance (paid exclusively by the employers); (b) pension insurance; and (c) unemployment insurance. Several health care services are free at the point of delivery. Benefits in kind include primary care, inpatient hospital care, dental care, rehabilitation and preventive care, and even stays in health resorts, but not long-term care; benefits in cash include sickness payments and burial allowances. In order to fulfil this obligation, insurance funds may contract directly with individual doctors or they may establish their own provider organisations. The health care in Germany is regulated and supervised by the federal and state ministries (as well as other organisations such as the federal insurance office), financed by private insurance funds and provided by private doctors, and hospitals.

Financing

- The German health care system is financed by self-governing statutory insurance funds or sickness funds. Insurance funds are organised on a local basis, company or national basis.

- Sickness funds reimburse health care providers for a broad range of services. An exception is long-term residents care which is not covered. Sickness funds are largely financed through a proportional — after a minimum threshold — pay roll tax which is levied on income earned in regular employment.

- Both employer and employee contribute equally to health insurance payments. Other sources of insurance funds' revenues include transfers by pension funds, local unemployment office and welfare organisations.

- The amount of contribution in sickness funds is determined individually by each sickness fund, as a certain percentage of the gross income of its members. If, for instance, a sickness fund needs 13 per cent of gross income to finance its current cost, a member with an income of DM 4000 must pay DM 260 to the fund and the employer will pay an additional DM 260.

- The contribution to the statutory sickness funds is unrelated to the size or health status of the employee's family. There is a redistribution within a fund from the young and healthy to the elderly and ill. But since people must stay with one fund once they have enrolled, the redistributional effect is evened out over a person's lifetime. There is also redistribution between a single person and employees with families.

- The contributions are calculated on pay-as-you-go basis; the funds do not accumulate financial reserves. Contribution rates differ among funds and among regions depending on, (i) income level, (ii) the percentage of people covered by the fund, and (iii) the physician– population ratio. The combined contribution of employer and employee varies anywhere between 8 per cent to 16 per cent of gross income. It averaged 12.5 per cent in 1992. The variation in contributions among funds is a source of concern. There is some government subsidy. For instance, funds with a high percentage of retired members receive compensation from a national reserve fund. The unemployed and their dependants are covered by the local sickness funds, which are then reimbursed from statutory unemployment insurance.

- Those who earn above a statutory health insurance scheme limit can buy private insurance. Private insurance appeals to high-income people, particularly those with few or no children. The premia are calculated on an actuarial basis. However, under the Health Insurance Reform Act of 1989, those who opt out in favour of private insurance lose the right to return to the

statutory system.

- Some citizens covered by the sickness fund buy supplementary private health insurance for special services not covered by the funds, such as a private room in a hospital, full coverage for dentures.

- The Hospital Financing Act of 1985 restricts federal funds for capital expenditures to hospitals that have received accreditation (i.e. the hospital meets certain standards and conforms to a hospital need plan. Linking funding to hospital accreditation was intended to achieve two goals: a more equitable regional distribution of hospital facilities and hospital beds and an overall reduction in the number of hospital beds. The federal budget for capital expenditure to hospitals covers construction costs of the hospital and costs of durable equipment.

- Hospital operating costs, including physicians' salaries are covered by per diem payments. The per diem rates are uniform for all patients of a given hospital but differ among hospitals. The rates are negotiated between the sickness funds, and the individual hospitals. Hospitals have the legal right to receive rates that enable them to cover all current costs. The sickness funds in turn have the right to demand economical hospital management. Under the arrangement, it is common for both the sickness funds and hospitals to sue to change the stated rates. The sickness funds and the hospitals also agree on certain quality standards, length of stay and occupancy rates.

- Since hospitals have been paid on a per diem basis with payment rates established prospectively, the hospital may keep any profits (surplus of per diems over operating costs), but also must cover any losses. In either case, the hospital's per diem rate will be adjusted in the following year. However, a per diem basis of payment provides no financial incentive to shorten the length of stay. Patients are frequently hospitalised on Fridays or discharged on Mondays, even when no specific medical care is provided over the weekend.

Organisation and delivery

- There is private ownership and private provision of health care services but public regulation and supervision of the system. Health care is provided through private hospitals and physicians.

- Government sets the overall framework and has strong control over physician's fee, hospital budgets and capital investment.

- Health care is financed and sometimes also delivered through "sickness funds". The funds cover ambulatory hospital, and dental care with very little or no co-payment. The funds also give cash benefits for maternity leave, "cure leave" and compensation for lost wages owing to illness. The fund covers all basic care including drugs' and makes the system equitable and effective.

- The system makes a sharp distinction between hospital care by hospital-based physicians, and ambulatory care which is organised on the basis of office-based private practitioners. Office-based physicians do not ordinarily have hospital privileges, and only the chiefs among hospital–based physicians may see private, insured patients on both an ambulatory and an inpatient basis.

- Office–based physicians play the dominant role of gatekeepers to hospital service in the health care sector. Every patient who is covered by a statutory sickness fund must first consult an office-based physician in order to receive any type of medical care. Only office-based physicians may provide ambulatory care, prescribe drugs and medical appliances and decide who is to be hospitalised. If the case is not an emergency, the hospital requires a referral order by an office-based physician before the patient may be treated.

- The payment of physicians' services is determined by negotiation between the sickness funds and the medical associations. No direct negotiations or contacts take place between an individual physician and the sickness funds. The sickness funds pay the state medical

association, which in turn compensates the physician on a fee-for-service basis. The individual physician must accept the rates of the negotiated fee schedule. The global state budget for physicians' payments are made. These act as an expenditure cap on total physicians' fees.

- Physicians in former East Germany can choose whether to remain on salary or switch over to fee-for-service remuneration. To run a private office-based practice, however, involves capital and experience, which East German physicians lack.

- The ownership of inpatient facilities in Germany is a mix of public and private systems. About half of all beds in West Germany are in publicly owned facilities, mainly municipal hospitals; another 35 per cent are in private, non-profit community hospitals; and the rest are in privately owned, for-profit facilities. There are about 11 hospital beds per 1,000 population, about twice the United States rate and 1.35 hospital-based physicians per 1,000 population.

The objectives of the German health care system are an offshoot of the German social and economic system, the so-called social market economy. The values underlying the health care system are based on the principles of *self-governance, social partnership and social solidarity.* Self-governance means that purchasers and providers of health care should operate as self-managing private organisations with as little interference from the government as possible. Social partnerships rest on the assumption that both employers and employees should share the burden of financing health care. Social solidarity means that the economically stronger members of society should support the weaker members to ensure quality in the provision of health care. First, contributions to sickness funds are fixed as a percentage of income; sickness fund representatives are elected by employees and employers; and funds cover all basic care including drugs. These provisions make the system equitable and effective. Second, all providers' belong to providers' associations, which do not set the price of health care unilaterally, but negotiate for payment with the consumers and payers. The German system of remunerating physicians implies positive incentives of a fee-for-service scheme and guarantees cost containment, so that expenditures do not increase faster than wages. The system combines full coverage of services with a high degree of competition among physicians, and allows physicians clinical freedom. Third, the government sets

common standards and goals for health care and regulates the payment and training of physicians, dentists, and nurses. It also plans for hospital needs and places expenditure caps on hospital capital costs.

Japan

The Japanese social insurance system is derived from the health insurance tradition of Bismarckian Germany. The Japanese health care system is marked by strict governmental regulation. It is employment-based and the employer has mandatorily to provide insurance coverage to its employees and dependants. Patients are allowed their choice of doctor and hospitals and, within narrow limits, may exercise control over the quality of care they receive.

Japan's medical insurance system has basically assumed a social insurance format through compulsory subscription. Medical insurance is broadly divided into three plans:

1. There is an employees ' insurance plan for employees and their dependants which can be sub-divided into following:

   a. Government-managed health insurance for those employed in small companies, which covers 28.9 per cent of population;
   b. Society-managed health insurance for those employed in large companies and covering 25.5 per cent of the population;
   c. Mutual aid associations for government employees and private school employees covering 9.7 per cent of population;
   d. Seamen's insurance which covers 0.4 per cent of the population; and
   e. Day labourers' insurance covering 0.1 per cent of population.

2. There is a system of community-based health insurance to extend protection to the self-employed, unemployed, pensioners and their dependants. This segment of population tends to have a lower income and is at higher medical risk than those covered under the employees' plans. The

principal community-based health insurance plan is the National Health Insurance (NHI) which covers 35.4 per cent of the population.

3. There is the Geriatric Health Act enacted in 1982 which created an insurance pool to cross-subsidise the costs of the elderly and which covers 8 per cent of the population.

Financing

- Society-managed health is financed though employer-employee contribution in the form of pay-roll tax. Some out-of-pocket expenditures for co-payments also have to be made.

- Government-managed health insurance has income-based premia fixed by law. It is also subsidised by the government (varies from 6.6 per cent – 9.1 per cent) and is borne equally by the employee and employer.

- Premia for National Health Insurance are funded by individuals depending on income and size of households. These premia are collected as general tax revenues. Government also finances half of the plans' total cost.

- Financing for the elderly comes from the national government, local governments and employer insurance groups. There is very limited cost sharing by the individuals themselves.

- Government pays the administrative cost of all insurance plans.

- A nation-wide fee schedule is negotiated between the Ministry of Health and Welfare and Central Social Insurance Medical Council (which include representatives of providers, payers and consumers). This helps in controlling costs.

- Providers are reimbursed according to a procedure-based fee schedule. Payers pay the same fee for the same service, regardless of where it was performed (urban/rural) and who (physician)

performed it.

Organisation and delivery

- As in the German system, universal coverage is mandated by the government and achieved through a number of health insurance plans, carefully regulated by the government. The Japanese government plays an active role by providing most of the insurance coverage itself.

- Insurance benefits cover most medical services. In addition, there are direct cash benefits paid to the insured for childbirth, maternity leave, nursing, injury and sickness. Co-insurance is required under all the plans. Under the employees' plans, employees must pay 10 per cent of inpatient and outpatient costs, and employees' dependants must pay 20 per cent and 30 per cent of inpatient and outpatient costs, respectively. Under the NHI plan, both the insured and their dependants must pay 30 per cent of inpatient and outpatient costs. For all patients, however, there is a limit of ¥ 60,000 (about $400) per month to the maximum amount of co-payment which must be paid. In addition, the elderly do not have to make any co-payment.

- Medical care benefits comprise: (a) medical consultation; (b) supply of drugs and other therapeuticall materials; (c) treatment, surgery and other medical care; (d) management of medical treatment at home plus the care and nursing involved; and (e) admission to a hospital or clinic and the care and nursing accompanying the treatment. They are provided as benefits-in-kind and there is no time limit involved. Inpatient meal expenses are also covered.

- Medical care is organised into clinics (with 19 or fewer beds) and hospitals. The majority of outpatient medical services are provided by solo practitioners in clinics. A "closed staff" system of hospitals operates in parallel but it is distinct from the clinics. Each hospital employs its own physicians, who are salaried. There is an overlap of functions between hospitals and clinics, with both offering inpatient and outpatient services. Patients have the freedom to choose where they want to seek services. The two types of institutions compete for market share by offering

as attractive a range of services as possible. Serious surgical procedures, however, tend to be performed only by hospitals. Physicians working in clinics generally have no privileges in hospitals. As a consequence, medical services are largely fragmented and both clinics and hospitals suffer from duplication of service and excess capacity.

- Ownership of facilities is a mix of private and public systems. Over 90 per cent of the clinics are owned by private physicians as are the majority of hospitals. In either public or private owned hospitals, the directors are physicians, as mandated by law, who have the final clinical and administrative responsibilities. Laws restrict investor-owned health care organisations and vertical integration.

- The dominance of the private sector explains the large number of facilities, their small size and regional differences in their distribution. Japan has the highest rate of hospital beds per 1,000 population in the world. Hospitals tend to be small, averaging 166 beds.

- Japanese hospitals and clinics are characterised by a low staffing ratio. They manage to function by maintaining a low-level intensity of care. In some cases where the patient requires greater nursing care, the family or a nursing aid hired by the family assists. However, hospitals and clinics have a wide range of sophisticated medical equipment with the emphasis on diagnostic equipment. The widespread availability of such equipment is due to the competitive nature of the delivery system and the emphasis on diagnosis, (which may stem from the cultural tradition of Chinese medicine).

- The traditional influence can also be seen in a continued emphasis on ambulatory care. Japan has the world's highest rate of outpatient visits, three times that of the U.S., low hospital admission rate (one-third of the U.S.), and a low number of surgical procedures (one-quarter per capita rate of the U.S.).

The Japanese system is mainly employment-based and financed by equal contribution from the employer and the employee. The government plan helps to cover the unemployed and the

elderly population and also subsidies other employment plans. It is mandatory for everyone to take insurance, thus universal coverage is provided. The private delivery system maintains quality to a certain extent only, as providers are paid the same fee for the same service. There are no incentives to guarantee the quality of care. Physicians act as pharmacists also and compensate for fee-control by prescribing more medicines, ordering more tests and necessitating frequent visits. However, costs are contained in the Japanese health care system as it is based on negotiated fees for service and by government regulations. As both employees and employers contribute for costs of health insurance and the government also subsidies it, all have a shared interest in cost containment. Co-payment also helps to keep the insurance premium low and avoids the problem of over utilisation.

U.S.A.

U.S.A. spends 12.1 per cent of its GDP on health care with public health care expenditure comprising only 4.2 per cent of total health expenditure. The U.S. system, characterised by high costs, declining access and a need to provide quality health care has led to a increasing crisis in the U.S. health care system. About 75 per cent of the population is covered by private insurance and 19 per cent is covered by public programmes. Fourteen per cent of the population has no coverage (these percentages total more than 100 per cent because 13 per cent of the population has multiple health insurance coverage, e.g. public and private coverage). The system is largely based on consumer sovereignty and can be called a private insurance model.

Financing

- Financing is a complex mixture of public payers (federal, state, and local governments) and mainly private insurance and individual payments.

- There are more than 1000 private insurance companies.

- Employer-based insurance is tax-subsidised, as health insurance premia are a tax deductible

- There is no health planning at the federal level, and the state planning efforts vary from none to stringent review of hospital and nursing home construction projects.

- In areas without sufficient private providers (e.g. inner cities and remote areas), federal and state fund programmes provide some primary care to the population, not otherwise served by the fee-for-service system.

- Municipal and country public health departments provide limited primary care services through public health clinics. They also regulate the environmental hazards.

- Physicians see their patients in their offices, and admit them to hospitals where they can continue to serve them.

- Two-fifths of the physicians are in solo practice. A relatively small number of physicians are not in the fee-for-service sector, but are employed by the government, corporations, managed care networks or hospitals.

- Recently co-ordinated care arrangements, such as health maintenance organisations (HMOs) and preferred provider organisations (PPOs) have become popular. Individuals who enrol in an HMO receive a comprehensive benefit package available only from a defined network of providers for a fixed payment, usually a monthly or yearly premium.

The U.S. system is characterised by financial constraints, not on the system, but on the individual. Ability to pay is an important factor in determining access and the amount of care. More than 50 per cent of expenditure is from private payments and most of the expenditure goes for private hospital care. The system is characterised by spiralling costs of health care because of the use of expensive, high-technology procedures.

business expense.

- Physicians, providing both ambulatory and inpatient care, are generally reimbursed on a fee-for-service basis. Payment rates vary among the insured.

- Hospitals are paid on the basis of charges, costs, negotiated rates or diagnosis-related groups, depending on the patients' insurer. There are no overall global budgets or expenditure limits.

- Hospitals finance capital purchases through a variety of means including savings, tax-exempt bond issues, and philanthropy. Although federal and state mortgage loan and loan guarantee programmes assist some hospitals to secure financing for construction and renovation projects, it is more common for hospitals to secure private mortgage insurance when floating a construction bond.

- Government pays for the health care coverage of the elderly, poor and disabled through Medicaid and Medicare programmes. At present, 28 per cent of total health expenditure is for these programmes.

Organisation and delivery

- There are about 6,700 hospitals, 340 federal hospitals, 880 special hospitals, 5500 community hospitals.

- Of the community hospitals, 27 per cent are public; 59 per cent are private non-profit; and 14 per cent are private for profit.

- Physicians are generally self-employed professionals.

- Health services are provided by a loosely-structured delivery system organised at the local level.

Hence, the U.S. system can be summarised as high quality, but coupled with high costs, inaccessibility and unaffordability.

Korea

Korea has achieved its objective of universal coverage of compulsory health insurance within 12 years of its introduction in 1976. It has chalked out its health insurance plan from the experiences of the Japanese health insurance system. Its health security consists of the National Health Insurance system and the Medicaid programme. Besides, there is a public assistance programme for medical care financed by the government, an industrial accident-insurance programme for occupational diseases, and the Veterans Relief Scheme for injuries associated with national defence.

Medical care in Korea is generally financed through health insurance and from direct out-of-pocket expenditures and, to a lesser extent, through taxation. The exchange involved is either direct payment upon receipt of services or pre-payment (insurance and taxes).

The health insurance system comprises three different types of systems based on the place of work.

Type I. This type covers all regular employees and employers and their dependants, of firms employing 5 or more persons (excluding civil servants and private school teachers). It cover 36 per cent of population.

Type II. This type covers 11 per cent of population comprising civil servants, all private school teachers, supporting staff, their dependants, military personnel' and their dependants.

Type III. This type covers self-employed persons, and pensioners in urban and rural areas. It covers 34 per cent of the population.

Besides these, 6 per cent of the population (in 1992) was covered under the medical aid programme basically for the poor and the indigent. Economic factors such as income and assets are taken into account by local government administrators while selecting beneficiaries of the medicaid programme. These beneficiaries do not pay premia, and their dependants automatically become benefit recipients. Government subsidy is extended to cover the elderly and indigent.

Financing

- In Type I insurance plan, contribution is generally between 3 per cent and 8 per cent of the monthly salary. Contribution is shared equally by employees and employer.

- In Type II, the contribution of civil servants is 2.3 per cent of monthly salary by the employee and 2.3 per cent by the government, and for private school employees it is 2.3 per cent of salary by the employee and 0.92 per cent by the government and 1.38 per cent by the school.

- For Type I and II only the insured are asked to pay the premium while the family dependants[1] are exempt. The providers are reimbursed on the basis of a fee-for-service schedule which is periodically reviewed. Part of the payment is made from insurance funds and the rest by patients as out-of-pocket payments.

- For Type III, that is, the self employed, the programme levies a fixed amount of premium per household, based on cash income, assets and the number of dependants. In view of the fact that the insured under the regional health insurance programme includes many of the poor, the government gives a subsidy which is committed to provide a matching fund, including administrative cost, equal to one-half of the total cost.

---

[1] Here the dependants includes spouse, parents, grandparents, children grandchildren, father-in-law, mother-in-

- A co-financing programme was started recently by the National Federation of Medical Insurance. One of the main purposes of the programme is to take care of additional financial burdens, such as care of the elderly, and of expensive services using high-technology medical equipment. Contributions are made according to "ability to pay" by each insurance carrier, and the benefits are paid in proportion to actual costs, thus providing a financial transfer mechanism to the poorer insurance societies.

Organisation and delivery

- The health insurance system is still underdeveloped in terms of the delivery of health care. In Korea, hospitals and clinics compete for patients. Patients are free to choose physicians, hospitals or clinics, given the enforced use of the referral system.

- There exists a two-tier system of service charges, that is, for regular care and special care. The former is provided by general practitioners or equivalent medical providers while the latter is provided by patient-designated specialists. If a patient requests hospital specialists by name, he or she can be charged a supplementary fee after treatment, in addition to standard fees.

- Korea's health providers are mostly private seventy-two per cent of physicians and 80 per cent of beds are paid for on-a fee for-service basis. In this system, the provider may be rewarded according to his effort, but it results in unnecessary and excessive treatment, leading to cost inflation.

- Health insurance societies (sickness funds) are formed to act as health insurance carriers. These societies collect insurance premia and use these funds to provide that portion of their bills which are not covered by co-insurance. Each health insurance society is financially independent.

---

law, brothers and sisters of the insured excluding those who make their living independently of the insured.

- Many insurance societies exist, within each type of health insurance programme on the basis of an enterprise or a group of enterprises and regional administrative units. Type II is an exception, with only one insurance society. In 1994, there were about 417 independent insurance funds, with high administrative costs of the order of 10 per cent to 20 per cent of operating costs associated with them.

- Korea has more sophisticated medical equipment per capita as compared to Canada or Germany. Most insurance services in Korea do not cover high-technology-related medical services. In 1989–91, spending on medical devices and diagnostic products grew by more than 20 per cent per year. Prescription pharmaceuticals accounted for more than 36 per cent of health spending coupled, with high administrative costs. Korea's share of GNP on health rose from 3.7 per cent in 1980 to 6.6 per cent in 1990 (spending $377 per capita on health).

The problems of delivery of health care in Korea can be summarised as: long waits to get into hospitals, unfriendly treatment and rapidly by rising costs. High costs for quality care, particularly, makes it inaccessible and unaffordable for most people. The health care system is predominantly private. It is financed basically from high user fees arising from high co-insurance arrangement within the insurance plan, and also full direct payments for services and persons not covered in the insurance plans.

China

Health care delivery in China has a well-organised referral system from the lower level in rural areas to the higher level in urban areas. Medical services in socialist China are not entirely socialised or free to all of the population. It is a costly task for a central government to provide health care services to the entire country. Therefore, the government has strongly emphasised preventive medicine and public health work. It also encourages self-reliance at the local level. There are three types of health care insurance:

- The Public Expenses Medical Insurance, introduced in 1951, covers students and state cadres. About 2 per cent of the population is covered by this scheme, including family dependants.

- Labour Medical Insurance covers the workers and staff members of factories and state -owned firms. Around 10–12 per cent of the population is covered under this scheme, including their dependants. These people are located primarily in urban areas.

- The Co-operative Medical Insurance is for those in rural agricultural areas. About 70 per cent of China's communes have been covered under this programme. Sixty per cent of national health expenditure is allocated to the rural areas.

Financing

- Preventive health care is funded by the governments, and capital expenditure for hospitals is financed by the central and provincial governments. State financing is used mainly for the capital expenditure of local health hospitals, with minor roles in financing health services. The decentralised approach reduces the financial burden of the state.

- A co-operative health security programme is emerging in China. Instead of the collective having to finance health centres, the new self-managed health centres are financed through various channels. The merit of this type of system is that provision and financing of health care are integrated, and ownership and control by community translates into demand for good quality and accountable services. Also, the self-management of finances results in greater efficiency and savings.

- Under the co-operative medical services, payments are made in advance by the users of the medical services and no credits are allowed. The patient then must request for a refund to his commune for his medical expenses.

- The medical expenses of the students and state cadres are fully covered by the government insurance scheme without any contribution by individuals as insurance premium.

- There is some co-insurance. Dependants pay 50 per cent of their medical expenses and only the workers are covered with 100 per cent expenses recoverable. The cost would be around 1.5 per cent of the family's disposable income for people in rural areas. Pilot projects for reforms in financing workers' medical insurance are directed towards greater cost recovery and financing treatment of serious illness, while discouraging over utilisation of services and unnecessary medication.

- Government funds preventive health care. Curative services are financed from the funds partly generated through prepayment by the people.

- An individual contributes 1 per cent and the enterprise contributes 10 per cent to the fund. Of this 11 per cent, five per cent is retained as social co-ordinating fund and the remaining six per cent goes to the individual's account. Funds in the individual account can be accumulated and saved, tax-free. Health expenses are reimbursed initially from the individual account. As the expenses increase, as in cases of serious illness, the contribution from the social co-ordinating fund goes up, even up to 98 per cent of total costs.

- The social co-ordinating fund also finances special health activities for target groups, such as the old and disabled, thus providing social security. Additionally, special control programmes for infectious diseases, occupational diseases and family planning are also funded.

Organisation and delivery

- In China the decentralisation approach is adopted and the structure of the health care delivery system is part of the national administrative system, running from the commune to the country[2]

[2] In rural areas, the sub-provincial political constitute "country".

and the central government.

- China consist of twenty-one provinces, five autonomous regions and three centrally administrated metropolitan areas, Beijing, Shanghai, and Tianjin. Within each of these provincial-level administrative units, a health department operates under guidelines from the Ministry of Health in Beijing, which is primarily responsible for formulating health care policies and supervising health research institutes throughout the People's Republic of China. It does, however, directly manage the local hospitals or health activities. The major task of financing and delivery of health services are left to the local political units.

- The organisational level descends from country to commune to production brigade to production team. A production team shares a barefoot doctor [3] and a number of public health workers.

- In the Chinese urban health care system, each lane has a street doctor and some public health workers. Within each lane is a lane health station and street doctors in charge. Seriously ill patients are referred by street doctors to the district hospitals, who can refer cases to the municipal hospital or specialised hospital, both of which belong to the municipality as a whole.

In China, local control over local services and a strong referral system paves the way for efficient health care financing mechanism. The Chinese medical system is financed by a decentralised insurance package, with the delivery under the control of the state.

Costa rica

The system in Costa Rica is mainly funded by social insurance (Costa Rica Social Security fund, CCSS) with preventive services provided by the Ministry of Health (MoH). The system is very successful and health indicators resemble those of Europe, U.S.A. Canada, even though Costa

[3] A barefoot doctor is a peasant who receives three to six months of medical training and is capable of treating his/her fellow members for minor diseases, minor injuries, and the like.

Rica has a much lower per capita income. The coverage of the population is more or less universal (Normand and Weber 1993).

Financing

- The main sources of financing are:
  - Compulsory contributions to the CCSS by employers, employees and state.
  - Taxes.
  - Income from rent, interest and the hospital lottery.

- One per cent of expenditure comes from fee-for-service from the self-employed.

- Seventeen per cent of expenditure is spent by MoH on disease prevention and environmental health.

- CCSS spends 80 per cent of the total health expenditure to provide curative, rehabilitative services, immunisation and educational services.

Organisation and delivery

- The National Insurance Institute covers treatment, rehabilitation and compensation for illnesses and injuries and also automobile related injuries.

- Most hospitals are owned and operated by the CCSS and all the facilities operated by the CCSS, MoH and INS. The CCSS owns and operates all the country's 29 hospitals, providing 95 per cent of hospital services and 70 per cent of all consultations.

- Patients enter the system through local clinics. They cannot choose their physicians.

- Providers are mainly paid salaries.

The system provides universal coverage at low cost but waiting time is usually long. Patients are generally dissatisfied with the quality of care provided in ambulatory settings, though in-patient services are considered efficient.

CONCLUSION

Health services in different countries and for different levels of the population vary differ. Differences also lie in their financing patterns. On the three broad aspects considered at the outset, that is, quality, access, and costs, it was found that, though the national health insurance systems existing in U.K. can provide universal coverage at lower costs, good quality care cannot be promised. In such a system, normally, excess demand leads to long queues. Germany's mainly private provider system based on fee-for-service and mandated by the government provides universal coverage but has a poor mechanism for cost control. The private-insurance-based U.S. system provides quality care but makes it inaccessible and unaffordable to a large part of the population. The Japanese system has greater government regulation over private doctors who are paid on a negotiated fee for service. The Canadian system has still higher government control and is a socialised insurance system where funding is from the government and provision is by a private provider. Though it does not provide quality care in terms of higher technology, it ranks highest inpatients' satisfaction level. It is low in costs and provides universal coverage. Another social health insurance system exists in Costa Rica which is provided through facilities operated by the social insurance fund and uses contributions by the government, employee, and employer.

All these experiences suggest that countries with higher contribution by the government as compared to private systems have higher access, coverage, and lower costs. In terms of quality, though, they may fare slightly poorer. A government-regulated health care system with private provision can deliver reasonable quality of health care at reasonable costs and also provide universal coverage. Hence, socialised insurance may be a better option to balance cost, quality and access.

TABLE 3.1 : PERFORMANCE OF HEALTH CARE SYSTEMS

Countries	Macro-Performance			Micro-Performance	Social Solidarity	Health Status		Satisfaction
	HCE as a per cent age of GDP (1980)	HCE as a per cent age of GDP (1990)	HCE per capita, PPP[1]S US (1990)	Physician visits per head per year (various years)	Percentage covered by Public Schemes (various years)	PLYL[2] (various years)	Perinatal Mortality[3] (various years)	Percentage of population Generally Satisfied[4]
Canada	7.4	9.0	1795	6.6	100	3977	7.6	56
France	7.6	8.9	1379	7.2	99	4434	8.9	41
Germany	8.4	8.1	1287	11.5	92	4039	6.4	41
Italy	6.8	7.6	1113	11.0	100	4034	11.0	12
Japan	6.4	6.5	1113	12.9	100	2890	5.7	29
Netherlands	8.0	8.1	1182	5.5	69	3499	9.7	47
New Zealand	7.2	7.2	853	N.A.	100	5198	8.5	NA
Spain	5.6	6.6	730	4.0	99	4368	10.0	21
Sweden	9.4	8.7	1421	2.8	100	3375	6.8	32
Switzerland	7.3	7.8	1640	6.0	100	3718	7.1	NA
United Kingdom	5.6	6.1	909	5.7	100	4060	9.0	27
United States	9.3	12.4	2566	5.3	44	5479	9.7	10
Average	7.4	8.1	1304	7.3	96	4123	8.5	32

Source: OECD (1991).

Notes: 1 PPP (purchasing power parity): national exchange rates derived from the price of a representative bundle of goods and services in different countries.

2 PLYL (potential life years lost): the number of deaths under the age of 65 which are "avoidable" given current medical knowledge multiplied by (65 - the age of the deceased), as a rate per 100,000 person years of life, as estimated by the World Health Organisation. This is therefore a weighted measure of premature mortality. The figure quoted is the unweighted average of the male and female PLYL, for the latest year when data was available.

3 Number of stillbirths from the 28th week of pregnancy and of infants dead in the first week of life per 1,000 live and stillbirths.

4 See Blendon, et.al. (1990 & 1991).

NA Not available.

TABLE 3.2

Countries	Doctors Per 1,000 Population 1988–1992[a]	Nurse-to-Doctor Ratio, 1988–1992[a]	Hospital Beds Per 1,000 Population, 1988–1992[a]
Mozambique	0.02	13.1	0.9
Ethiopia	0.03	2.4	0.3
Tanzania	0.03	7.3	1.1
Nepal	0.06	2.7	0.3
Uganda	0.04	8.4	0.8
Bangladesh	0.15	0.8	0.3
Madagascar	0.12	3.5	0.9
India	0.41	1.1	0.7
Kenya	0.14	3.2	1.7
Nigeria	0.15	6.0	1.4
Pakistan	0.34	0.8	0.6
Ghana	0.04	9.1	1.5
China	1.37	0.5	2.6
Sri Lanka	0.14	5.1	2.8
Zimbabwe	0.16	6.1	2.1
Egypt, Arab Rep.	0.77	1.2	1.9
Indonesia	0.14	2.8	0.7
Sudan	0.09	2.7	0.9
Cote d'Ivoire	0.06	4.8	0.8
Philippines	0.12	3.1	1.3
Cameroon	0.08	6.4	2.7
Uzbekistan	3.58	2.9	12.4
Peru	1.03	0.9	1.5
Morocco	0.21	4.5	1.2
Ecuador	1.04	0.3	1.7
Romania	1.79	-	8.9
Colombia	0.87	0.6	1.5
Ukraine	4.40	2.7	13.6

(Table 3.2 contd.)

Algeria	0.26	4.7	2.6
Thailand	0.20	5.5	1.6
Poland	2.06	-	6.6
Turkey	0.74	1.5	2.1
Iran, Islamic Rep.	0.32	1.1	1.5
Russian Federation	4.69	-	13.8
Chile	0.46	0.8	3.3
Syrian Arab Rep.	0.85	1.2	1.1
South Africa	0.61	4.5	4.1
Brazil	1.46	0.1	3.5
Malaysia	0.37	3.9	2.4
Venezuela	1.55	0.5	2.9
Belarus	4.05	-	13.2
Hungary	2.98	1.1	10.1
Mexico	0.54	0.8	1.3
Argentina	2.99	0.2	4.8
Greece	1.73	1.6	5.1
Saudi Arabia	1.52	1.5	2.7
Spain	3.60	1.1	4.8
Australia	2.29	3.8	5.6
United Kingdom	1.40	2.0	6.3
Italy	4.69	0.6	7.5
Netherlands	2.43	3.4	5.9
Canada	2.22	4.7	16.1
Belgium	3.21	0.1	8.3
France	2.89	1.6	9.3
Germany	2.73	1.7	8.7
United States	2.38	2.8	5.3
Japan	1.64	1.8	15.9

Note: Each value refers to one particular but not specified year within the time period denoted.

TABLE 3.3

Country	Financing	Organisation and Delivery	Health expenditure as a % of GDP (1990)		
			Total	Pub. Sec	Pvt. Sec
U.K.	- Govt financial tax funded - Small proportion through private insurance (mostly employer based)	- Services provided through govt. run NHS hospitals - GPs refer the cases to hospitals for specialised treatment - Social and preventive services provided by govt. - Some private fee for service hospitals.	6.1	5.2	0.9
Canada	- Govt. financed though tax revenues-financed by provincial and federal govt. on set budgets - Private insurance cover some complementary benefits not provided by public system.	- Services provided by private doctors fixed fee for services and by non-profit voluntary hospitals on fixed global budget respectively.	9.1	6.8	2.4
Germany	- Five major sources of finance - General taxes (21 per cent) - Pay-roll taxes (employee and employer contribution 60 per cent) to sickness funds - Direct payments - Co-payments and out of pocket - 11 per cent - Private insurance 7 per cent - Federal funds are used to finance capital expenditures of hospitals	Universal coverage - mandated by govt. and achieved through several health insurance plans (statutory sickness funds) regulated by govt. - Office based physicians are generally private paid on negotiated fee for service providers but hospital services are mix of public and private provision.	8.0	5.8	2.2
Japan	- Financed by pay-roll taxes. - Govt. subsidies through employed insurance groups, govt. national health insurance.	- Mostly though private doctors and clinics - Reimbursed on negotiated fee for service basis - Govt. regulated system - Greater role of govt. than in Germany	6.5	4.8	1.6
U.S.A.	- Mainly financed from private, health insurance and direct patient payments. - Government finances are used for financing medicaid and medicare schemes for poor and elderly and military personnel	- Mostly private provision through hospitals and clinics.	12.7	5.6	7.0

(Table 3.3 contd.)

Korea	- Mostly private out of pocket expenditure on fee for service basis or premia to insurance companies. Very small proportion financed by government subsidy.	- Most clinics and hospitals are privately owned. - More than 3/4 of hospital beds are private. - Only 23 per cent of beds are in the public sector.			
China	- Financed mostly by govt. - Insurance packages are decentralised and finance, mostly particular type of population. - For workers insurance package workers contribute a very small proportion, employers contribute some part and rest is paid by state - State financing is used for preventive health care.	- Delivered by state through clinics and hospitals. - There is local control over local services and strong referral system	3.5	2.1	1.4

NOTES

1. Kleczkoswski (1984) classified health care programmes into five groups, (i) national health authority, (ii) health insurance programmes, (iii) other governmental agencies, (iv) non-governmental agencies (voluntary), and (v) independent private sector. Deber Raisa, et.al. (1993) presented health care systems as four models, (i) public financing and public delivery, (ii) private financing and private delivery, (iii) public financing and private delivery, and (iv) private financing and public delivery. Others have suggested factors that should be taken into account while classifying the health care systems. For example, Abel-Smith, Brian (1976) suggested that fourteen questions need to be asked when assessing a health care system, (i) how are doctors and other health care providers paid, (ii) are they allowed private practice? (iii) do patients pay their own bills for health service, (iv) if so, can they claim whole or partial reimbursement from health insurance or social security, (v) does the service or social security agency pay the providers directly, (vi) are charges and fees regulated and if so by whom, (vii) are they regulated to the maximum extent or do they apply only to the level of reimbursement of the patients so that provider is free to charge more, (viii) what proportion of cost of service do the charges come from, (ix) does the patient ultimately pay for other than through taxes and insurance contributions, (x) what taxes are used to finance health programmes, (xi) are they pay-roll or other designated taxes, (xii) if there is insurance, is it compulsory or voluntary, and if it is the latter how is it conditioned for payment, and (xiii) are there any special arrangements made for the lowincome section of the population to provide them with equal access to medical services, Others have classified the health care system from the revenue sources or financing point of view. For example Kleczkoswski, et.al. 1984) in a WHO study identified seven revenue sources (i) public (all levels of government, including ministries of health, health insurance schemes, and other ministries), (ii) employers (industrial and agricultural enterprises), (iii) organised voluntary agencies (charity voluntary insurance, etc.), (iv) local community efforts (financial contributions and unremunerated services), (v) foreign aid (both governmental and philanthropic, the latter often from religious agencies, (vi) private households (both for payment to organised programmes and for pure purchases), and (vii) other possible sources such as lotteries and donations. Applebe (1992) suggested four basic financing methods, (i) direct payment of users, (ii) private health insurance, (iii) social and state insurance, and (iv) direct tax. The methods, in turn vary according to whether funding is central or local, optional or

compulsory and whether there are single or multiple schemes available. However, from the theoretical point of view four alternative models have been proposed.

2. Medicare programme is meant for those of 65 years of age and above. It is a federal programme that covers some 30 million Americans over the age of 65, in addition to certain categories of the disabled, for the cost of physicians services, hospital care, and a limited number of days of skilled nursing facility. Until now, it has not covered prescription drugs, dental care and a variety of other services and it has always-required cost-sharing by the aged through deductible, co-insurance and extra biddings by physicians above the fees allowed by medicare. Eligibility for the programme is strictly age-related and not based on income. It covers less than half of the total health care expenditure incurred by the aged. Another 13 per cent is paid by Medicaid mainly for nursing-home care for the very old and for medicare beneficiaries. The aged themselves cover an average of close to one-third of their health care expenditures with their own resources either through private insurance coverage or out-of-pocket expenditures. As the scheme is not income-related its incidence is highly regressive and constitutes a serious burden on the already high medicare budgets of the low-income elderly.

The medicaid programme is meant for the poor. It is a joint federal - state government programme that currently covers about 24 million low-income Americans of all ages, among them 3.5 million are aged and 3.4 million blind and disabled persons. The federal government pays 56 per cent of total programme cost and the state government pays the remaining. Under federal law, the states participating in the Medicaid programme are mandated to provide coverage for hospital and physicians' services and care in skilled nursing facilities. Many states, however, offer additional benefits including prescription drugs, since inception in 1966. Eligibility for the programme has been closely linked to the eligibility to the states welfare programmes. Because the latter vary enormously among the states, there are vast disparities in the level of income at which entitlement to Medicaid coverage sets in. A further limitation of programme has been the relatively low rates at which the medicaid programme compensate the providers of health care. In most states, the rates of compensation paid by Medicaid or unilaterally set by the state government fall far below the rates paid by medicare, which in turn tends to pay less than do the private insurance carriers. Many providers are reluctant to accept Medicaid patients for treatment, especially if there is an ample supply of better-paying patients.

BIBLIOGRAPHY

Chen, Xiao-ming, Hu Teh-Wei, and Lin Zihua. "The Rise and Decline of the Co-operative Medical System in Rural China." *International Journal of Health Services 23* (1993): 731-742.

Chirmulay, D. " Managing Health Care: Lessons from China." *The Times of India, Pune Plus,* 2 Dec. 1995.

Culyer, A.J., and Andrew Medas. "The United Kingdom: Effective, Efficient, Equitable?" *Journal of Health Politics, Policy and Law.* 17 (1992): 666-687.

De Lew, Nancy, George Greenberg, and Kraig Kinchen. "Layman's Guide to the U.S. Health Care System." *Health Care Financing Review* 14 (1992): 151- 169.

Evans, R.G. "Canada: The Real Issues." *Journal of Health Politics, Policy and Law* 17 (1992): 739-761.

Glaser, William A. "Universal Health Insurance That Really Works: Foreign Lessons for the United States." *Journal of Health Politics, Policy and Law* 18 (1993): 695-721.

Graig, L. "Health of Nations: An International Perspective on U.S. Health Care Reforms." *Congessional Quarterly* Inc. Washington, D.C. 1993.

Hashimoto, Masami. "Health Services in Japan." In *Comparative Health Systems*, edited by Marshall W. Raffel. Pennsylvania: State University Press, 1984.

Hoffmeyer, U.K., and Thomas R. McCarthy, eds. *Financing Health Care.* Vol.1. Boston, London.: Kluwer Academic Publishers, 1994.

Hsiao, W.C. "Comparing Health Care System: What Nations Can Learn from One Another." *Journal of Health Politics, Policy and Law* 17 (1992): 615-635.

Ikegami, Naoki. "Japan: Maintaining Equity through Regulated Fees." *Journal of Health Politics, Policy and Law* 17 (1992): 688-713.

OECD. *The Reform of Health Care: A Comparative Analysis of Seven OECD Countries.* OECD, 1992.

Raffel, M.V. *Comparative Health Systems.* Pennsylvania: State University Press, 1989.

Rapp, R.T., and Shibuya Kyoko. "The Health Care System in Japan. In *Financing Health Care,* edited by U.K. Hoffmeyer and Thomas. R. Mc Carthy. Vol. I. Dordrechi: Kluwer Academic Publishers, 1994.

Reinhardt, U.E. "The United States: Breakthroughs and Waste." *Journal of Health Politics, Policy and Law* 17 (1992): 636-665.

Schieber, J., George, Jean-Pierre Poullier, and Leslie M. Greenwald. "U.S. Health Expenditure Performance: An International Update." *Health Care Financing Review* 13 (1992): 1-15.

Schulenburg, J., and Matthias Graf. "Germany: Solidarity at a Price." *Journal of Health Politics, Policy and Law* 17 (1992): 715-737.

Weiner, J.P., and Gregory de Lissovoy. "Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans." *Journal of Health Politics, Policy and Law* 18 (1993),: 74-103.