

# Policy Analysis

No. 613

March 18, 2008

Routing


## *The Grass Is Not Always Greener* *A Look at National Health Care Systems Around the World*

by Michael Tanner

### Executive Summary

Critics of the U.S. health care system frequently point to other countries as models for reform. They point out that many countries spend far less on health care than the United States yet seem to enjoy better health outcomes. The United States should follow the lead of those countries, the critics say, and adopt a government-run, national health care system.

However, a closer look shows that nearly all health care systems worldwide are wrestling with problems of rising costs and lack of access to care. There is no single international model for national health care, of course. Countries vary dramatically in the degree of central control, regulation, and cost sharing they impose, and in the role of private insurance. Still, overall trends from national health care systems around the world suggest the following:

- Health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have long waiting lists for treatment.
- Rising health care costs are not a uniquely American phenomenon. Although other countries spend considerably less than the United States on health care, both as a per-

centage of GDP and per capita, costs are rising almost everywhere, leading to budget deficits, tax increases, and benefit reductions.

- In countries weighted heavily toward government control, people are most likely to face waiting lists, rationing, restrictions on physician choice, and other obstacles to care.
- Countries with more effective national health care systems are successful to the degree that they incorporate market mechanisms such as competition, cost sharing, market prices, and consumer choice, and eschew centralized government control.

Although no country with a national health care system is contemplating abandoning universal coverage, the broad and growing trend is to move away from centralized government control and to introduce more market-oriented features.

The answer then to America's health care problems lies not in heading down the road to national health care but in learning from the experiences of other countries, which demonstrate the failure of centralized command and control and the benefits of increasing consumer incentives and choice.

---

*Michael Tanner is director of health and welfare studies at the Cato Institute and coauthor of Healthy Competition: What's Holding Back Health Care and How to Free It (second edition, 2007).*

CATO  
INSTITUTE

**To a large degree, America spends money on health care because it is a wealthy nation and chooses to do so.**

## Introduction

In his movie *Sicko*, Michael Moore explores problems with the U.S. health care system and advocates the adoption of a government-run, single-payer system.<sup>1</sup> Moore compares the U.S. system unfavorably with those of Canada, Great Britain, and France. Economist and *New York Times* columnist Paul Krugman also thinks the health care systems of France, Britain, and Canada are better than that of the United States.<sup>2</sup> Physicians for a National Health Program points out that the United States is the “only industrialized country without national health care.”<sup>3</sup>

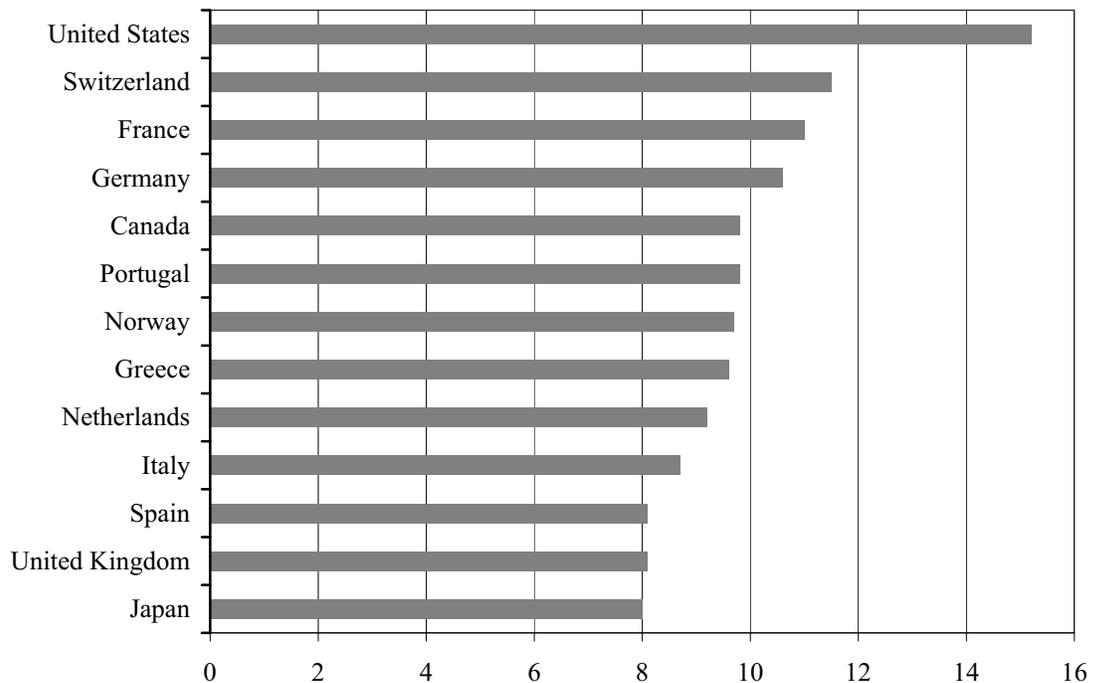
These and other critics of the U.S. health care system note that countries with such systems spend far less per capita on health care than the United States does and, by some measures, seem to have better health outcomes. These critics contend that by adopting a similar system the United States could solve many

of the problems that currently afflict its health care system. As Krugman says, “The obvious way to make the U.S. health care system more efficient is to make it more like the systems of other advanced countries.”<sup>4</sup>

There is no doubt that the United States spends far more on health care than any other country, whether measured as a percentage of gross domestic product (GDP) or by expenditure per capita. As Figure 1 shows, the United States now spends close to 16 percent of GDP on health care, nearly 6.1 percent more than the average for other industrialized countries.<sup>5</sup> Overall health care costs are rising faster than GDP growth and now total more than \$1.8 trillion, more than Americans spend on housing, food, national defense, or automobiles.<sup>6</sup>

Health care spending is not necessarily bad. To a large degree, America spends money on health care because it is a wealthy nation and chooses to do so. Economists consider health care a “normal good,” meaning that spending

**Figure 1**  
**Total Expenditure on Health Care as a Percentage of GDP**



Source: Organisation for Economic Co-operation and Development, “OECD Health Data 2007: Statistics and Indicators for 30 Countries,” (Paris: OECD, July 2007); 2004 data.

is positively correlated with income. As incomes rise, people want more of that good. Because we are a wealthy nation, we can and do demand more health care.<sup>7</sup>

But because of the way health care costs are distributed, they have become an increasing burden on consumers and businesses alike. On average, health insurance now costs \$4,479 for an individual and \$12,106 for a family per year. Health insurance premiums rose by a little more than 6 percent in 2007, faster on average than wages.<sup>8</sup>

Moreover, government health care programs, particularly Medicare and Medicaid, are piling up enormous burdens of debt for future generations. Medicare's unfunded liabilities now top \$50 trillion. Unchecked, Medicaid spending will increase fourfold as a percentage of federal outlays over the next century.<sup>10</sup>

At the same time, too many Americans remain uninsured. Although the number of uninsured Americans is often exaggerated by critics of the system, approximately 47 million Americans are without health insurance at any given time.<sup>11</sup> Many are already eligible for government programs; many are young and healthy; many are uninsured for only a short time.<sup>12</sup> Yet there is no denying that a lack of insurance can pose a hardship for many Americans.<sup>13</sup>

Finally, although the U.S. health care system can provide the world's highest quality of care, that quality is often uneven. The Institute of Medicine estimates that some 44,000–90,000 annual deaths are due to medical errors,<sup>14</sup> while a study in *The New England Journal of Medicine* suggests that only a little more than half of American hospital patients receive the clinical standard of care.<sup>15</sup> Similarly, a RAND Corporation study found serious gaps in the quality of care received by American children.<sup>16</sup>

Many critics of U.S. health care suggest that the answers to these problems lie in a single-payer, national health care system.<sup>17</sup> Under such a system, health care would be financed through taxes rather than consumer payments or private insurance. Direct charges to patients would be prohibited or severely restricted. Private insurance, if allowed at all, would be

limited to a few supplemental services not covered by the government plan. The government would control costs by setting an overall national health care budget and reimbursement levels.

However, a closer look at countries with national health care systems shows that those countries have serious problems of their own, including rising costs, rationing of care, lack of access to modern medical technology, and poor health outcomes. Countries whose national health systems avoid the worst of these problems are successful precisely because they incorporate market mechanisms and reject centralized government control. In other words, socialized medicine works—as long as it isn't socialized medicine.

## Measuring the Quality of Health Care across Countries

Numerous studies have attempted to compare the quality of health care systems. In most of these surveys, the United States fares poorly, finishing well behind other industrialized countries. This has led critics of the U.S. health care system to suggest that Americans pay more for health care but receive less.

There are several reasons to be skeptical of these rankings. First, many choose areas of comparison based on the results they wish to achieve, or according to the values of the comparer. For example, *SiCKO* cites a 2000 World Health Organization study that ranks the U.S. health care system 37th in the world, “slightly better than Slovenia.”<sup>18</sup> (See Table 1.)

This study bases its conclusions on such highly subjective measures as “fairness” and criteria that are not strictly related to a country's health care system, such as “tobacco control.” For example, the WHO report penalizes the United States for not having a sufficiently progressive tax system, not providing all citizens with health insurance, and having a general paucity of social welfare programs. Indeed, much of the poor performance of the United

**A closer look at countries with national health care systems shows that those countries have serious problems of their own.**

**When you compare the outcomes for specific diseases, the United States clearly outperforms the rest of the world.**

**Table 1  
WHO Health Care Rankings**

Country	Rank	Country	Rank
France	1	Switzerland	20
Italy	2	Belgium	21
San Marino	3	Colombia	22
Andorra	4	Sweden	23
Malta	5	Cyprus	24
Singapore	6	Germany	25
Spain	7	Saudi Arabia	26
Oman	8	United Arab Emirates	27
Austria	9	Israel	28
Japan	10	Morocco	29
Norway	11	Canada	30
Portugal	12	Finland	31
Monaco	13	Australia	32
Greece	14	Chile	33
Iceland	15	Denmark	34
Luxemburg	16	Dominica	35
Netherlands	17	Costa Rica	36
United Kingdom	18	United States	37
Ireland	19	Slovenia	38

Source: World Health Organization, "The World Health Report 2000" (Geneva: WHO, 2000).

States is due to its ranking of 54th in the category of fairness. The United States is actually penalized for adopting Health Savings Accounts and because, according to the WHO, patients pay too much out of pocket.<sup>19</sup> Such judgments clearly reflect a particular political point of view, rather than a neutral measure of health care quality. Notably, the WHO report ranks the United States number one in the world in responsiveness to patients' needs in choice of provider, dignity, autonomy, timely care, and confidentiality.<sup>20</sup>

Difficulties even arise when using more neutral categories of comparison. Nearly all cross-country rankings use life expectancy as one measure. In reality though, life expectancy is a poor measure of a health care system. Life expectancies are affected by exogenous factors such as violent crime, poverty, obesity, tobacco and drug use, and other issues unrelated to health care. As the Organisation for Economic Co-operation and Development explains, "It is difficult to estimate the relative contribution of the numerous nonmed-

ical and medical factors that might affect variations in life expectancy across countries and over time."<sup>21</sup> Consider the nearly three-year disparity in life expectancy between Utah (78.7 years) and Nevada (75.9 years), despite the fact that the two states have essentially the same health care systems.<sup>22</sup> In fact, a study by Robert Ohsfeldt and John Schneider for the American Enterprise Institute found that those exogenous factors are so distorting that if you correct for homicides and accidents, the United States rises to the top of the list for life expectancy.<sup>23</sup>

Similarly, infant mortality, a common measure in cross-country comparisons, is highly problematic. In the United States, very low birth-weight infants have a much greater chance of being brought to term with the latest medical technologies. Some of those low birth-weight babies die soon after birth, which boosts our infant mortality rate, but in many other Western countries, those high-risk, low birth-weight infants are not included when infant mortality is calculated.<sup>24</sup> In addition,

many countries use abortion to eliminate problem pregnancies. For example, Michael Moore cites low infant mortality rates in Cuba, yet that country has one of the world's highest abortion rates, meaning that many babies with health problems that could lead to early deaths are never brought to term.<sup>25</sup>

When you compare the outcomes for specific diseases, the United States clearly outperforms the rest of the world. Whether the disease is cancer, pneumonia, heart disease, or AIDS, the chances of a patient surviving are far higher in the United States than in other countries. For example, according to a study published in the British medical journal *The Lancet*, the United States is at the top of the charts when it comes to surviving cancer. Among men, roughly 62.9 percent of those diagnosed with cancer survive for at least five years. The news is even better for women: the five year-survival rate is 66.3 percent, or two-thirds. The countries with the next best results are Iceland for men (61.8 percent) and Sweden for women (60.3 percent). Most countries with national health care fare far worse. For example, in Italy, 59.7 percent of men and 49.8 percent of women survive five years. In Spain, just 59 percent of men and 49.5 percent of women do. And in Great Britain, a dismal 44.8 percent of men and only a slightly better 52.7 percent of women live for five years after diagnosis.<sup>26</sup>

Notably, when former Italian prime minister Silvio Berlusconi needed heart surgery last year, he didn't go to a French, Canadian, Cuban, or even Italian hospital—he went to the Cleveland Clinic in Ohio.<sup>27</sup> Likewise, Canadian MP Belinda Stronach had surgery for her breast cancer at a California hospital.<sup>28</sup> Berlusconi and Stronach were following in the footsteps of tens of thousands of patients from around the world who come to the United States for treatment every year.<sup>29</sup> One U.S. hospital alone, the Mayo Clinic, treats roughly 7,200 foreigners every year. Johns Hopkins University Medical Center treats more than 6,000, and the Cleveland Clinic more than 5,000. One out of every three Canadian physicians sends a patient to the United States for treatment each year,<sup>30</sup> and those patients along with the

Canadian government spend more than \$1 billion annually on health care in this country.<sup>31</sup>

Moreover, the United States drives much of the innovation and research on health care worldwide. Eighteen of the last 25 winners of the Nobel Prize in Medicine are either U.S. citizens or individuals working here.<sup>32</sup> U.S. companies have developed half of all new major medicines introduced worldwide over the past 20 years.<sup>33</sup> In fact, Americans played a key role in 80 percent of the most important medical advances of the past 30 years.<sup>34</sup> As shown in Figure 2, advanced medical technology is far more available in the United States than in nearly any other country.<sup>35</sup>

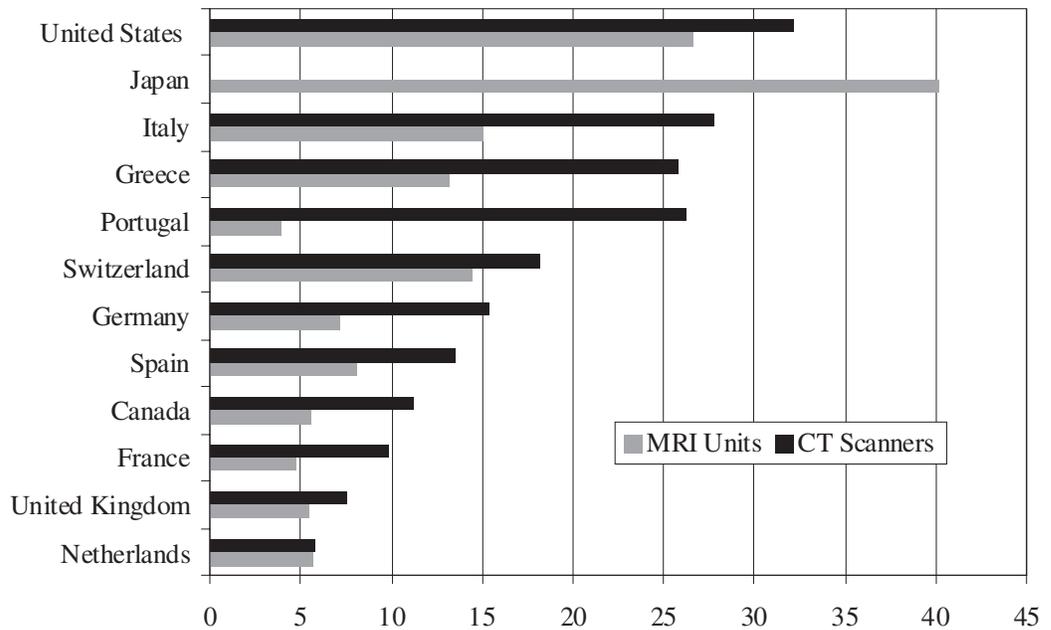
The same is true for prescription drugs. For example, 44 percent of Americans who could benefit from statins, lipid-lowering medication that reduces cholesterol and protects against heart disease, take the drug. That number seems low until compared with the 26 percent of Germans, 23 percent of Britons, and 17 percent of Italians who could both benefit from the drug and receive it.<sup>36</sup> Similarly, 60 percent of Americans taking anti-psychotic medication for the treatment of schizophrenia or other mental illnesses are taking the most recent generation of drugs, which have fewer side effects. But just 20 percent of Spanish patients and 10 percent of Germans receive the most recent drugs.<sup>37</sup>

Of course, it is a matter of hot debate whether other countries have too little medical technology or the United States has too much.<sup>38</sup> Some countries, such as Japan, have similar access to technology. Regardless, there is no dispute that more health care technology is invented and produced in the United States than anywhere else.<sup>39</sup> Even when the original research is done in other countries, the work necessary to convert the idea into viable commercial products is most often done in the United States.<sup>40</sup>

By the same token, not only do thousands of foreign-born doctors come to the United States to practice medicine, but foreign pharmaceutical companies fleeing taxes, regulation, and price controls are increasingly relocating to the United States.<sup>41</sup> In many ways, the rest of the world piggybacks on the U.S. system.

**The United States drives much of the innovation and research on health care worldwide.**

**Figure 2**  
**Number of MRI Units and CT Scanners per Million People**



Source: Organisation for Co-operation and Development, “OECD Health Data, 2007 Statistics and Indicators for 30 Countries” (Paris: OECD, July 2007).

Note: U.S. Data from 2003.

Obviously there are problems with the U.S. system. Too many Americans lack health insurance and/or are unable to afford the best care. More must be done to lower health care costs and increase access to care. Both patients and providers need better and more useful information. The system is riddled with waste, and quality of care is uneven. Government health care programs like Medicare and Medicaid threaten future generations with an enormous burden of debt and taxes.

Health care reform should be guided by the Hippocratic Oath: First, do no harm. Therefore, before going down the road to national health care, we should look more closely at foreign health care systems and examine both their advantages and their problems.

Many of the countries with health systems ranked in the top 20 by the World Health Organization, such as San Marino, Malta, and Andorra, are too small to permit proper evaluation, or their circumstances clearly limit the

applicability to the U.S. health care system. Accordingly, this study will look at 12 countries that appear to hold lessons for U.S. health care reforms: 10 ranked in the top 20 by the WHO and 2 others frequently cited as potential models for U.S. health care reform.

## Types of National Health Care Systems

National health care, or universal health care, is a broad concept and has been implemented in many different ways. There is no single model that the rest of the world follows. Each country’s system is the product of its unique conditions, history, politics, and national character, and many are undergoing significant reform.

### Single-Payer Systems

Under a single-payer health care system, the government pays for the health care of all citi-

**Health care reform should be guided by the Hippocratic Oath: First, do no harm.**

zens. It collects taxes, administers the supply of health care, and pays providers directly. In effect, this replaces private insurance with a single government entity. Typically, the government establishes a global budget, deciding how much of the nation's resources should be allocated to health care, and sets prices or reimbursement rates for providers. In some cases, providers may be salaried government employees. In others, they may remain independent and be reimbursed according to the services and procedures they provide. In the strictest single-payer systems, private insurance and other ways to "opt out" of the system are prohibited. This is the type of system advocated by Michael Moore, Paul Krugman, Dennis Kucinich, and Physicians for a National Health Program, among others.

### Employment-Based Systems

Countries with employment-based systems require that employers provide workers with health insurance, often through quasi-private "sickness funds." These insurance funds may operate within or across industry sectors, with benefits and premiums set by the government. Often premiums are simply a form of payroll tax paid directly to the fund. Providers remain independent and reimbursement rates are negotiated with the funds, sometimes individually, sometimes on a national level. Germany has long been the model for an employment-based system.

### Managed Competition

Managed competition leaves the provision of health care in private hands but within an artificial marketplace run under strict government control and regulation.<sup>42</sup> In most cases, the government mandates that individuals purchase insurance, though this is often paired with a requirement for employers to provide insurance to their workers. Individuals have a choice of insurers within the regulated marketplace and a choice of providers. Although the government sets a standard benefits package, insurers may compete on price, cost sharing, and additional benefits. Switzerland is the clearest example of a managed-competition

approach to universal coverage, although the Netherlands has also recently adopted a similar system. The 1993 Clinton health plan, the 2006 Massachusetts health care reform, and most of the proposals advocated by the current Democratic presidential candidates are variations of managed competition.<sup>43</sup>

Within these broad categories are significant differences. Some countries, such as France and Japan, impose significant cost sharing on consumers in an effort to discourage overutilization and to control costs. Other countries strictly limit the amount that consumers must pay out of pocket. Some countries permit free choice of providers, while others limit it. In some countries there is widespread purchase of alternative or supplemental private insurance, whereas in others, private insurance is prohibited or used very little. Resource allocation and prioritization vary greatly. Japan spends heavily on technology but limits reimbursement for surgery, while France has exceptionally high levels of prescription drug use.

Outcomes also vary significantly. Canada, Great Britain, Norway, and Spain all heavily ration health care or have long waiting lists for care, while France and Switzerland have generally avoided waiting lists. At the same time, France, Italy, and Germany are struggling with rising health care costs and budget strain, compared with Canada and Great Britain which have done better at containing growth in expenditures. And some countries such as Greece have fallen far short of claims of universal coverage.

With all of that in mind, consider the following prominent national health care systems.

## France

Some of the most thoughtful proponents of national health care look to France as a model of how such a program could work. Jonathan Cohn of the *New Republic* has written that "the best showcase for what universal health care can achieve may be France."<sup>44</sup> Ezra Klein of the *American Prospect* calls France "the closest thing to a model structure out there."<sup>45</sup>

**Some countries, such as France and Japan, impose significant cost sharing on consumers in an effort to discourage overutilization and to control costs.**

**The health care system is the largest single factor driving France's overall budget deficit.**

The French system ranks at or near the top of most cross-country comparisons and is ranked number one by the WHO.<sup>46</sup>

Although the French system is facing looming budgetary pressures, it does provide at least some level of universal coverage and manages to avoid many of the problems that afflict other national health care systems. However, it does so in large part by adopting market-oriented approaches, including consumer cost sharing. Other aspects of the system appear to reflect French customs and political attitudes in such a way that would make it difficult to import the system to the United States.

France provides a basic level of universal health insurance through a series of mandatory, largely occupation-based, health insurance funds. These funds are ostensibly private entities but are heavily regulated and supervised by the French government. Premiums (funded primarily through payroll taxes), benefits, and provider reimbursement rates are all set by the government. In these ways the funds are similar to public utilities in the United States.

The largest fund, the General National Health Insurance Scheme, covers most non-agricultural workers and their dependents, about 83 percent of French residents. Separate insurance plans cover agricultural workers, the self-employed, and certain special occupations like miners, transportation workers, artists, clergy, and notaries public. Another fund covers the unemployed. These larger insurance schemes are broken down into smaller pools based on geographic region. Overall, about 99 percent of French citizens are covered by national health insurance.

The French health care system is the world's third most expensive, costing roughly 11 percent of GDP, behind only the United States (17 percent) and Switzerland (11.5 percent). Payroll taxes provide the largest source of funding. Employers must pay 12.8 percent of wages for every employee, while employees contribute an additional 0.75 percent of wages, for a total payroll tax of 13.55 percent. In addition, there is a 5.25 general social contribution tax on income (reduced to 3.95 percent on pension income and unemployment benefits). Thus, most French

workers are effectively paying 18.8 percent of their income for health insurance. Finally, dedicated taxes are assessed on tobacco, alcohol, and pharmaceutical company revenues.<sup>47</sup>

In theory, the system should be supported by these dedicated revenues. In reality, they have not been sufficient to keep the program's finances balanced. The National Health Authority sets a global budget for national health care spending, but actual spending has consistently exceeded those targets.<sup>48</sup>

In 2006, the health care system ran a €10.3 billion deficit. This actually shows improvement over 2005, when the system ran an €11.6 billion deficit.<sup>49</sup> The health care system is the largest single factor driving France's overall budget deficit, which has grown to €49.6 billion, or 2.5 percent of GDP, threatening France's ability to meet the Maastricht criteria for participation in the Eurozone.<sup>50</sup> This may be just the tip of the iceberg. Some government projections suggest the deficit in the health care system alone could top €29 billion by 2010 and €66 billion by 2020.<sup>51</sup>

In general, the funds provide coverage for inpatient and outpatient care, physician and specialist services, diagnostic testing, prescription drugs, and home care services. In most cases, the services covered are explicitly specified in regulation. However, some "implicit" benefit guarantees occasionally result in conflicts over what benefits are and are not fully covered.<sup>52</sup>

Most services require substantial copayments, ranging from 10 to 40 percent of the cost. As a result, French consumers pay for roughly 13 percent of health care out of pocket, roughly the same percentage as U.S. consumers.<sup>53</sup> Moreover, because many health care services are not covered, and because many of the best providers refuse to accept the fee schedules imposed by the insurance funds, more than 92 percent of French residents purchase complementary private insurance.<sup>54</sup> In fact, private insurance now makes up roughly 12.7 percent of all health care spending in France, a percentage exceeded only by the Netherlands (15.2 percent) and the United States (35 percent) among industrialized countries.<sup>55</sup>

The combination of out-of-pocket and

insurance payments means that nongovernment sources account for roughly 20 percent of all health care spending, less than half the amount spent in the United States but still more than most countries with national health care systems.<sup>56</sup>

The private insurance market in France is in many ways less regulated than the U.S. market. For example, while 20 U.S. states require some form of community rating or put limits on health insurance premiums, private health insurance in France is largely experience rated. No regulations specify what benefits must be included in coverage or mandate “guaranteed issue”; and pre-existing conditions may be excluded. The only significant restriction requires “guaranteed renewability” after two years of coverage.<sup>57</sup> More than 118 carriers currently offer some form of private health insurance coverage.<sup>58</sup>

In general, French patients pay up front for treatment and are then reimbursed by their government health insurance fund and/or private insurance. The amount of reimbursement, minus the copayment, is based on a fee schedule negotiated between health care providers and the national health insurance funds. These fee schedules operate similarly to the diagnostic-related groups (DRGs) under the U.S. system.

Although reimbursement levels are set by the government, the amount physicians charge is not. The French system permits providers to charge more than the reimbursement schedule, and approximately one-third of French physicians do so.<sup>59</sup> In some areas, such as Paris, the percentage of physicians who bill above reimbursement schedules runs as high as 80 percent.<sup>60</sup> In general, however, competition prevents most physicians from billing too far outside negotiated rates; and physicians employed by hospitals, as opposed to those in private practice, do not have the same ability to charge more than the negotiated rate.

The government also sets reimbursement rates for both public and private hospitals, which are generally not allowed to bill beyond the negotiated fee schedules. While fees are restricted, private hospitals (called *cliniques*),

which account for 37 percent of all short-stay hospital beds and half of all surgical beds, control their own budgets, whereas public hospitals operate under global annual budgets imposed by the Ministry of Health.

Health care technology that the National Health Authority has categorized as “insufficient medical service rendered” cannot be purchased by public hospitals, and its use at *cliniques* is not reimbursable through national insurance schemes.<sup>61</sup> Yet in denying reimbursement for such technology, the French government admits that when a product with an insufficient medical service rendered is de-listed from reimbursement, this does not imply that it is not efficient for a given pathology, but simply that the government prefers to commit its resources to other reimbursements which it deems more useful from a collective point of view.<sup>62</sup>

In general, the quality of French health care is high, but there are problem areas. Until very recently, the French have generally had quick access to their primary care physician of choice. Now, a growing problem, *nomadisme medical*, wherein patients go from one doctor to another until they find one whose diagnosis they prefer, is driving up costs to the system.<sup>63</sup> The government has responded by increasing copayments and attempting to limit physician reimbursements.

Much of the burden for cost containment in the French system appears to have fallen on physicians. The average French doctor earns just €40,000 per year (\$55,000), compared to \$146,000 for primary care physicians and \$271,000 for specialists in the United States. This is not necessarily bad (there is no “right” income for physicians) and is partially offset by two benefits: 1) tuition at French medical schools is paid by the government, meaning French doctors do not graduate with the debt burden carried by U.S. physicians, and 2) the French legal system is tort-averse, significantly reducing the cost of malpractice insurance.<sup>64</sup> The French government also attempts to limit the total number of practicing physicians, imposing stringent limits on the number of students admitted to the second year of medical school.<sup>65</sup>

**The private insurance market in France is in many ways less regulated than the U.S. market.**

**Global budgets and fee restrictions for hospitals have led to a recurring lack of capital investment, resulting in a shortage of medical technology and lack of access to the most advanced care.**

However, French physicians have shown growing resistance to efforts at limiting physician reimbursement with several recent strikes and protests.<sup>66</sup> In the face of growing budgetary problems, future conflict may well be brewing.

More significantly, the government has recently begun imposing restrictions on access to physicians. A 2004 study by the High Council on the Future of Health Insurance raised questions about “the legitimacy of the complete freedom enjoyed by health professionals in setting up their private practice.”<sup>67</sup> And in 2005, the government adopted a system of “coordinated care pathways.” Under the new system, which operates very much like managed care in the United States, patients are encouraged to choose a “preferred doctor” and to follow the “pathway” suggested by that doctor. The effect is both to lock patients into a choice of primary care physician and to establish a “gatekeeper” who limits access to specialists, tests, and some advanced treatment options.<sup>68</sup>

So far, the new system has been more of a gentle push than a mandate. If the new system is not used, copayments may be slightly higher or reimbursements slightly lower, much like going “out of network” in the United States. But if costs continue to rise, the new system may be extended and made more rigorous.

Of more immediate concern, global budgets and fee restrictions for hospitals have led to a recurring lack of capital investment, resulting in a shortage of medical technology and lack of access to the most advanced care. For example, the United States has eight times as many MRI units per million people and four times as many CT scanners as France.<sup>69</sup> This partially reflects the more technology-reliant way of practicing medicine in the United States, but it has also meant delays in treatment for some French patients. Also, strong disparities are evident in the geographic distribution of health care resources, making access to care easier in some regions than others.<sup>70</sup> Thus, while the French system has generally avoided the waiting lists associated with other national health care systems, limited queues do exist for some specialized treatments and

technologies. In some cases, hospitals in danger of exceeding their budgets have pushed patients to other facilities to save money.<sup>71</sup>

Finally, the government has tried to curtail the use of prescription drugs. The French have long had an extremely high level of drug consumption. French general practitioners (GPs) prescribe on average €260,000 worth of drugs a year.<sup>72</sup> However, the National Health Authority has begun de-listing drugs from its reimbursement formulary.<sup>73</sup> Many French patients have responded by switching to similar, reimbursable drugs, but some patients may not be getting the medicine they need. For example, one study found that nearly 90 percent of French asthma patients are not receiving drugs that might improve their condition.<sup>74</sup>

Government regulation and bureaucracy have also been blamed for rigidity in the French system, preventing it from reacting quickly to changing circumstances. For example, mismanagement and the inability of the system to cope with emergencies were blamed in part for the deaths of 15,000 elderly individuals in the summer of 2003 during the European heat wave; and a shortage of hospital beds occurred in 2004 when a nationwide flu and bronchitis epidemic broke out.<sup>75</sup>

Although the changes made so far do not amount to rationing, 62 percent of French citizens report that they “have felt the effects” of the new restrictions.<sup>76</sup> Slightly less than half consider the waiting time between diagnosis and treatment to be acceptable.<sup>77</sup>

Valentin Petkantchin, a scholar with the Institut Economique Molinari, warns that France is in danger “of joining the group of countries [such as] the UK and Canada, where the existence of rationing of health care and waiting lists raises serious questions of access to treatments by those who need them.”<sup>78</sup> And some French health professionals have suggested that waiting times for care have begun to lengthen.<sup>79</sup>

The impact of all these cost containment measures is alleviated to some degree by the ability of French patients to privately contract for care outside the public system. If a drug is removed from the national formulary, patients

may still purchase it if they are willing to pay for it themselves. The same is true for technology. Likewise, patients may ignore the “coordinated care pathway” and accept higher prices, paying more for immediate access.

In addition, the added resources from payments by private insurance have increased the supply of health care technology and services. By increasing the overall amount of capital available for investment above and beyond the restrictions imposed by the government system, private insurance payments increase the number of hospital beds and the amount of technology available within the system. The capital infused through private insurance may also increase the number and training of physicians.<sup>80</sup>

In essence, the French system avoids widespread rationing because, unlike true single-payer systems, it employs market forces. Even the OECD says that the “proportion of the population with private health insurance” and the degree of cost sharing are key determinants of how severe waiting lists will be:

Waiting lists for elective surgery generally tend to be found in countries which combine public health insurance (with zero or low patient cost sharing) and constraints on surgical capacity. Public health insurance removes from patients the financial barriers to access leading to high potential demand. Constraints on capacity . . . prevent supply from matching this demand. Under such circumstances, non-price rationing, in the form of waiting lists, takes over from price rationing as a means of equilibrating supply and demand.<sup>81</sup>

And Ezra Klein praises the French because

[France’s ability to hold down health care costs] is abetted by the French system’s innovative response to one of the trickier problems bedeviling health-policy experts: an economic concept called “moral hazard.” Moral hazard describes people’s tendency to overuse goods or

services that offer more marginal benefit without a proportionate marginal cost. Translated into English, you eat more at a buffet because the refills are free, and you use more health care because insurers generally make you pay up front in premiums, rather than at the point of care. The obvious solution is to shift more of the cost away from premiums and into co-pays or deductibles, thus increasing the sensitivity of consumers to the real cost of each unit of care they purchase.<sup>82</sup>

However, the benefits of private insurance are not equally distributed. The wealthy are more likely to be able to pay privately to escape the government system, creating in essence a two-tier system. That has resulted in a disparity in health outcomes based on income.<sup>84</sup> While this is certainly the case in the United States and elsewhere—and there is nothing wrong with the wealthy being able to pay more to receive better care—it demonstrates that the professed goal of entirely equal access is largely unattainable even under this government-run health system.

A 2004 poll showed that the French had the highest level of satisfaction with their health care system among all European countries. This is partly because their hybrid system has avoided many of the biggest problems of other national health care systems. Yet it also stems from French social character. For example, by a three-to-one margin, the French believe the quality of care they receive is less important than everyone having equal access to that care.<sup>85</sup> This means the French experience may not be easily transferable to the United States, which has a far less egalitarian ethic.

While satisfied with their care today, the French do express concern about the future. In particular, they acknowledge the need for greater cost control. This leads to the standard contradiction inherent in government services: most people are opposed to paying more (either through higher taxes or out of pocket), yet they worry that cost-control measures will lead to a deterioration of care

**The new French government has made a crackdown on health care spending one of its top priorities.**

**Although Italy spends a relatively low percentage of GDP on health care, expenditures have been rising rapidly in recent years and have consistently exceeded government forecasts.**

in the future. There is no consensus on what French health care reform would look like. Still, some 65 percent of French adults believe that reform is “urgent,” and another 20 percent believe reform is “desirable.”<sup>86</sup>

Moreover there is growing dissatisfaction with the French welfare state—of which the health care system is a significant part—and the level of taxes necessary to support it. The recent election of French president Nicolas Sarkozy is widely regarded as a reflection of this new attitude.<sup>87</sup> Indeed, the new French government has made a crackdown on health care spending one of its top priorities.<sup>88</sup>

To sum up: the French health care system clearly works better than most national health care systems. Despite some problems, France has generally avoided the rationing inherent in other systems. However, the program is threatened by increasing costs and may be forced to resort to rationing in the future.

The French system works in part because it has incorporated many of the characteristics that Michael Moore and other supporters of national health care dislike most about the U.S. system. France imposes substantial cost sharing on patients in order to discourage over-utilization, relies heavily on a relatively unregulated private insurance market to fill gaps in coverage, and allows consumers to pay extra for better or additional care, creating a two-tier system.

This is clearly not the commonly portrayed style of national health care.

## Italy

Italy’s national health care system is rated second in the world by the WHO.<sup>89</sup> Yet a closer examination shows the system to be deeply troubled, plagued with crippling bureaucracy, mismanagement and general disorganization, spiraling costs, and long waiting lists.

Generally, the Italian system is similar to the British National Health Service but enjoys more decentralization. The central government sets goals on how money should be spent, monitors the overall health status of the

nation, and negotiates the labor contracts of medical staff. The Italian Constitution was changed in 2001 such that the national government now sets the “essential levels of care” regions must meet, but regional governments still control their own autonomous budgets and distribute resources to the local level.

In theory, under the “fiscal federalist” provisions of this reform, discretionary central transfers should have dropped sharply, local tax bases and tax sharing should have increased, and “equalizing” transfers should have been standardized and linked to objectives for controlling costs and increasing quality. However, poorer regions and powerful special interests have strongly resisted these changes. Reform therefore remains incomplete, and financial transfers from the central government are still based on historical spending patterns.<sup>90</sup>

Thus, while the national Ministry of Health continues to outline funding needs based on weighted capitation and past spending, recent reforms have shifted more and more power and responsibility to regional governments who set their own budgets. The regions establish one or more Local Health Authorities, which are responsible for the provision of care either through government-run hospitals and clinics or by contracting with private providers.<sup>91</sup> It should be noted that governance in Italy is often as much art as science, and regions frequently fail to implement rules, guidelines, reimbursement schedules, and budgets set by the central government.<sup>92</sup>

Financing comes from both payroll taxes and general revenues. Payroll taxes have a regressive structure, starting at 10.6 percent of the first €20,660 of gross income and decreasing to 4.6 percent of income between €20,661 and €77,480. The remainder of funding comes from both federal and regional general taxation, including income and value-added taxes.<sup>93</sup> The central government redistributes resources to compensate to some degree for inequalities among regions. Even so, most regional health authorities run significant deficits. Overall, regional deficits top 1.8 percent of GDP.<sup>94</sup>

Inpatient care and primary care are free at the point of treatment. However, copayments are required for diagnostic procedures, specialists, and prescription drugs.<sup>95</sup> The size of such copayments has crept steadily upward over the past decade and now runs as high as 30 percent for some services.<sup>96</sup> Several attempts have been made to impose copayments for a broad range of services, including primary care, but have collapsed in the face of public protests.<sup>97</sup> In addition, nearly 40 percent of the population (the elderly, pregnant women, and children) are exempt from copayments.<sup>98</sup>

Italians have limited choice of physician. They must register with a general practitioner within their LHA. They may choose any GP in the LHA but may not go outside it. Except for emergency care, a referral from a GP is required for diagnostic services, hospitalization, and treatment by a specialist. Despite these limits, Italians enjoy more choice of physician than do the British or Spanish.

Most physicians are reimbursed on a capitated basis (i.e., according to the number of patients served over a given time period rather than the services actually provided), although some hospital physicians receive a monthly salary. Hospitals are generally reimbursed according to DRGs, with rates set by the central government—though regions sometimes disregard those rates and set their own.

Private health insurance is available in Italy but is not widespread. Where offered, it is usually provided by employers. About 10 percent of Italians have private health insurance, below the percentage in most OECD countries. According to the insurance industry, this is partly because it is not possible to opt out of the National Health System and because health insurance premiums are not tax deductible.<sup>99</sup> Private health insurance allows free choice of doctors, including specialists, and treatment in private hospitals. Even without private insurance, however, many Italians use private health resources (and presumably pay out of pocket). Estimates suggest that as much as 35 percent of the population uses at least some private health services.<sup>100</sup>

Although Italy spends a relatively low per-

centage of GDP on health care, expenditures have been rising rapidly in recent years and have consistently exceeded government forecasts.<sup>101</sup> Between 1995 and 2003, total health care spending rose by 68 percent.<sup>102</sup> The Italian government has taken various steps to try to control costs, such as reducing reimbursement rates, increasing copayments, reducing capital expenditures, contracting with private providers, and limiting prescription drugs. All of these measures have met with protests, including physician strikes, and many have been repealed after only a short time.<sup>103</sup>

The Italian government does not provide official information on waiting lists, but numerous studies have shown them to be widespread and growing, particularly for diagnostic tests. For example, the average wait for a mammogram is 70 days; for endoscopy, 74 days; for a sonogram, 23 days.<sup>104</sup> Undoubtedly, this is due in part to a shortage of modern medical technology. The United States has twice as many MRI units per million people and 25 percent more CT scanners.<sup>105</sup> Ironically, the best-equipped hospitals in northern Italy have even longer waiting lists since they draw patients from the poorer southern regions as well.<sup>106</sup>

If delays become excessive, patients may seek permission from the regional government to obtain treatment from private doctors or hospitals at NHS expense. A recent court decision allows patients whose life would be endangered by delays under the NHS to seek treatment in private hospitals even without prior permission from the regional government.

Italy has imposed a relatively strict drug formulary as well as price controls, and has thereby succeeded in reducing pharmaceutical spending, long considered a problem for the Italian health care system. In 2006, Italian drug prices fell (or were pushed) 5 percent, even as drug prices rose in the United States and much of the rest of the world. However, the savings came at a cost: the introduction of many of the newest and most innovative drugs was blocked.<sup>107</sup>

Conditions in public hospitals are consid-

**Conditions in Italy's public hospitals are considered substandard, particularly in the south. They lack not just modern technology, but basic goods and services; and overcrowding is widespread.**

**Spanish patients cannot choose their physicians, either primary care or specialists.**

ered substandard, particularly in the south. They lack not just modern technology, but basic goods and services; and overcrowding is widespread. Conditions are frequently unsanitary. For example, one of the largest public hospitals in Rome was recently found to have garbage piled in the hallways, unguarded radioactive materials, abandoned medical records, and staff smoking next to patients.<sup>108</sup> Private hospitals are considered much better and some regions have contracted with private hospitals to treat NHS patients.

Dissatisfaction with the Italian health care system is extremely high, by some measures the highest in Europe.<sup>109</sup> In polls, Italians say that their health care system is much worse than that of other countries and give it poor marks for meeting their needs. Roughly 60 percent of Italians believe that health care reform is “urgent,” and another 24 percent believe it is “desirable.” In general, Italians believe that such reform should incorporate market-based solutions. More than two-thirds (69 percent) believe that giving patients more control over health care spending will improve the system’s quality. And 55 percent believe that it should be easier for patients to spend their own money on health care.<sup>110</sup>

However, given the general dysfunction of the Italian political system, and the entrenched opposition of special interest groups, substantial reform is not likely anytime soon.

## Spain

Spain’s national health care system operates on a highly decentralized basis, giving primary responsibility to the country’s 17 regions. The Spanish Constitution guarantees all citizens the “right” to health care, including equal access to preventive, curative, and rehabilitative services; but responsibility for implementing the country’s universal system is being devolved to regional governments. The degree and speed of devolution is uneven, however, with some regions only recently achieving maximum autonomy.<sup>111</sup>

Coverage under the Spanish system is near-

ly universal, estimated at 98.7 percent of the population. The system provides primary health care, including general health and pediatric care, outpatient and inpatient surgery, emergency and acute care, long-term disease management, and prescription drugs (although some drugs may require a copayment). Many mental health services, particularly outpatient services, are excluded, as is cosmetic surgery.<sup>112</sup>

The federal government provides each region with a block grant. The money is not earmarked: the region decides how to use it. The block grant itself is based primarily on a region’s population with some consideration given to other factors such as the population’s demographics. Regions may use their own funds to supplement federal monies.

Not surprisingly, health care spending varies widely from region to region. The differences in expenditures, as well as in spending priorities, lead to considerable variance in the availability of health resources. For example, Catalonia has more than 4.5 hospital beds per 1,000 residents, while Valencia has just 2.8.<sup>113</sup>

Spanish patients cannot choose their physicians, either primary care or specialists. Rather, they are assigned a primary care doctor from a list of physicians in their local community. If more specialized care is needed, the primary care physician refers patients to a network of specialists. Unlike U.S. managed care, it is not possible to go “out of network” unless the patient has private health insurance (see below). This has sparked an interesting phenomenon whereby sick Spaniards move in order to change physicians or find networks with shorter waiting lists.

Waiting lists vary from region to region but are a significant problem everywhere. On average, Spaniards wait 65 days to see a specialist, and in some regions the wait can be much longer. For instance, the wait for a specialist in the Canary Islands is 140 days. Even on the mainland, in Galicia, the wait can be as long as 81 days. For some specialties the problem is far worse, with a national average of 71 days for a gynecologist and 81 days for a neurologist.<sup>114</sup> Waits for specific procedures are also lengthy.

The mean waiting time for a proctectomy is 62 days; for hip replacement surgery, 123 days.<sup>115</sup>

Some health services that U.S. citizens take for granted are almost totally unavailable. For example, rehabilitation, convalescence, and care for those with terminal illness are usually left to the patient's relatives. There are very few public nursing and retirement homes, and few hospices and convalescence homes.<sup>116</sup>

As with most other national health care systems, the waiting lists and quality problems have led to the development of a growing private insurance alternative. About 12 percent of the population currently has private health insurance. (This amounts to double coverage since opting out of the government system is not allowed.<sup>117</sup>) In larger cities such as Madrid and Barcelona, the number of privately insured reaches as high as 25 percent. Overall, private insurance payments account for 21 percent of total health care expenditures.<sup>118</sup> More commonly, Spaniards pay for care outside of the national health care system out of pocket. In fact, nearly 24 percent of health care spending in Spain is out of pocket, more than any European country except Greece and Switzerland, and even more than the United States.<sup>119</sup>

Here again, a two-tier system has developed, with the wealthy able to buy their way around the defects of the national health care system, and the poor consigned to substandard services.<sup>120</sup>

There are also shortages of modern medical technologies. Spain has one-third as many MRI units per million people as the United States, just over one-third as many CT units, and fewer lithotripters.<sup>121</sup> Again, there is wide variation by region. For example, two regions, Ceuta and Melilla, do not have a single MRI unit.<sup>122</sup> The regional variation is important because Spaniards face bureaucratic barriers in trying to go to another region for treatment.

All hospital-based physicians and approximately 75 percent of all other physicians are considered quasi-civil servants and are paid a salary rather than receiving payment based on services provided. Compensation is based on years of practice or the attainment of certain professional credentials, with across-the-

board annual increases unrelated to merit, performance, or patient satisfaction.<sup>123</sup>

As a result, Spain has fewer physicians and fewer nurses per capita than most European countries and the United States. The lack of primary care physicians is particularly acute.<sup>124</sup>

Even so, Spaniards are generally happy with their system. Nearly 60 percent describe their system as good, the second highest favorability rating in Europe. (France was first.)<sup>125</sup> Accordingly, health care reform does not rank high on the average Spaniard's political agenda. One observer described health care as "conspicuous by its absence as a major issue" in recent elections.<sup>126</sup> Only about 46 percent of Spaniards describe the need for reform as "urgent," while 35 percent see reform as "desirable." And Spaniards are less inclined toward market-based reforms than most other European countries. Only 42 percent of Spaniards believe that it should be easier for patients to spend their own money on health care, and only 58 percent believe that giving patients more control over spending will improve quality. However, Spaniards do want more choice of doctors and hospitals, and they want the government to do a better job of dealing with waiting lists.<sup>127</sup>

## Japan

Japan has a universal health insurance system centered primarily around mandatory, employment-based insurance. On the surface, Japan's national health insurance program defies easy description, comprising some 2,000 private insurers and more than 3,000 government units. However, in a broader sense, the system encompasses four principal insurance schemes.

The Employee Health Insurance Program requires companies with 700 or more employees to provide workers with health insurance from among some 1,800 "society-managed insurance" plans. Nearly 85 percent of these plans cover a single company and can be thought of as similar to the self-insurance plans operated by many large U.S. com-

**Spain has fewer physicians and fewer nurses per capita than most European countries and the United States. The lack of primary care physicians is particularly acute.**

**The reimbursement schedule for physicians creates an incentive for them to see as many patients as possible. The result is assembly line medicine.**

panies. Most of the rest are industry-based. About 26 percent of the population participates in these plans.<sup>128</sup>

Such plans are financed through mandatory employer and employee contributions, effectively a payroll tax. The total contribution averages around 8.5 percent of wages. It is generally split evenly between employer and employee, although some companies assume slightly more than half the contribution. As a result, workers contribute about 45 percent of payments overall.<sup>129</sup> It should be noted that studies have found that the majority of the burden of the employer's contribution to health insurance is borne by the employees in the form of reduced wages.<sup>130</sup>

These contributions are frequently insufficient to operate the insurance plans. In 2003, more than half lost money.<sup>131</sup> A number of companies have responded by dissolving their individual plans and entering larger industry-based plans. However, growing costs continue to pressure many businesses.

Workers in businesses with fewer than 700 workers must enroll in the government-run, small-business national health insurance program. This plan covers about 30 percent of the population and is funded primarily through mandatory contributions, around 8.2 percent of wages, and supplemented by government funds.<sup>132</sup>

The self-employed and retirees are covered under the Citizens Insurance Program administered by municipal governments. Funding comes primarily from a self-employment tax, but additional revenues come from an assessment on the society-managed insurance programs discussed above and the small business program. General revenue contributions from the national government are used to plug shortfalls.

Finally, the elderly are covered through a fund financed by contributions from the other three schemes, as well as contributions from the central government. The elderly do not pay directly into this plan, known as the *Roken*, but contribute to the plan they were enrolled in while employed. The *Roken* is simply a cost-sharing mechanism.<sup>134</sup>

A number of small programs exist to handle special populations such as farmers, fishermen, and government workers. The unemployed remain under their former employers' plan, although they are not required to continue contributing. Private supplemental insurance exists, but very few Japanese carry it. Private health insurance pays for less than 1 percent of total Japanese health care spending.

Benefits under all four schemes are extremely generous, including hospital and physician care, as well as dental care, maternity care, prescription drugs, and even some transportation costs. There are no restrictions on hospital or physician choice and generally no preauthorization or gatekeeper requirements. Significant copayments accompany most services, ranging from 10 percent to, more commonly, 30 percent (capped at \$677 per month for a middle-income family). As a result, the average Japanese household pays about \$2,300 per year out of pocket.<sup>135</sup> Overall out-of-pocket expenditures amount to roughly 17 percent of total health care spending.

The vast majority of hospitals and clinics in Japan are privately owned, but because the government sets all fee schedules, the distinction between privately and publicly owned is irrelevant for patients. Reimbursement for both hospitals and clinics is on a fee-for-service basis, with the government setting fees and prescription prices.

The fee schedule is identical for inpatient and outpatient treatment. Because hospitals must absorb both physician and capital costs from the same level of reimbursement, the tendency has been to shift patients to outpatient services.<sup>136</sup> Recently, some attempts have been made to introduce alternate reimbursement mechanisms for hospitals, including DRGs and Diagnosis and Procedure Combinations—classification systems that tie reimbursements more closely to the resources that a particular patient consumes. But the medical establishment has resisted, and only about 80 hospitals participate in the experiment.<sup>137</sup>

Hospital physicians are salaried employees. Nonhospital physicians work in the private sector, and the government sets their reim-

bursement schedules. Generally, reimbursement is on a fee-for-service basis, although recently some chronic conditions have been “price bundled” into a single fee. Reimbursement schedules are set within the context of an overall global budget on health spending, but the division of resources is the subject of extensive negotiation with providers.

The fee schedule reflects both the Japanese style of medicine and attempts to contain costs. For example, because of a strong cultural bias against invasive procedures, surgery tends to be reimbursed at a much lower rate than nonsurgical procedures.<sup>138</sup>

The fee-setting system has had serious corruption problems. Because the fees for each of more than 3,000 procedures or services are set individually and adjusted every two years on an individual basis, it is possible to manipulate particular fees without attracting much attention.<sup>139</sup> In 2004, a group of dentists was indicted for bribing the fee-setting board.<sup>140</sup>

In addition, the reimbursement schedule for physicians creates an incentive for them to see as many patients as possible. The result is assembly line medicine. Two-thirds of patients spend less than 10 minutes with their doctor; 18 percent spend less than 3 minutes.<sup>141</sup>

On the other hand, the Japanese, like Americans, practice a very technology-intensive style of medicine. Capital investment in technology has been given high priority, and the Japanese have at least as much access to technology such as MRI units, CT scanners, and lithotripters as patients in the United States.<sup>142</sup> Because the government imposes uniform fee schedules on hospitals, there is no price competition. Instead, hospitals attempt to lure patients by having the best technology. While this can benefit patients, it has also led to queues at the best hospitals and a black market with “under the table” payments for faster access.<sup>143</sup>

Some restrictions have been added in the last few years, capping the number of diagnostic imaging procedures that a hospital can perform in a calendar month, as well as reducing the fees for those services.<sup>144</sup> These changes have not led to visible rationing yet

but could in the future.

To date, Japan has done a fairly good job of controlling costs without resorting to the rationing common in many universal care systems. This is due in part to factors outside the health care system, such as generally healthy lifestyles, low vehicle accident rates, low crime rates, low rates of drug abuse, and other cultural factors.<sup>145</sup> One study estimated that 25 percent of the difference in health care spending between the United States and Japan is attributable to a lower incidence of disease and 15 percent to less aggressive practice styles.<sup>146</sup> But rationing has also been avoided through the management of the health care system and the imposition of significant consumer cost sharing.

Nonetheless, spending is beginning to escalate, especially in government-managed programs such as the *Roken*, where there has been less of an attempt at cost sharing and cost containment. As one observer explained:

We Japanese have a tendency to go to the hospital even when we have only minor ailments such as the flu, headaches, or stomach aches. If medical expenses are not high and we do not feel well, then why not go see a doctor and get some medication. . . . The result, of course, is that waiting rooms of clinics and hospitals are full of people. Everyone is welcome and there are, in fact, regular customers. Sometimes elderly people come to see a friend and the hospital waiting room becomes a sort of salon.<sup>147</sup>

This problem is aggravated by the demographics of a rapidly aging society. By some estimates, the elderly are responsible for 90 percent of the aggregate increase in Japan’s health care costs.<sup>148</sup> If current trends continue, Japan will almost triple its government spending on health care in the next 20 years.<sup>149</sup> And the situation will only grow less stable with time. Japan is expected to lose 35 million workers by 2050, with 35 percent of its population in retirement.<sup>150</sup> This raises questions of how a system that relies on payroll taxes for funding

**Rationing has also been avoided through the management of the health care system and the imposition of significant consumer cost sharing.**

can continue to fund rising costs even as its payroll base shrinks.

## Norway

Norway has a universal, tax-funded, single-payer, national health system. All Norwegian citizens, as well as anyone living or working in Norway, are covered under the National Insurance Scheme. Norwegians can, however, opt out of the government system by paying out of pocket. In addition, many Norwegians go abroad for treatment to avoid the waiting lists endemic under the government program.<sup>151</sup>

The system is financed through general tax revenues, with no earmarked or dedicated tax for health care.<sup>152</sup> Thus, health care becomes one large contributor to a tax burden that consumes 45 percent of GDP. Among industrialized countries, only Sweden has a higher tax burden.<sup>154</sup>

Benefits are extensive and include inpatient and outpatient care, diagnostic services, specialist care, maternity services, preventive medicine, palliative care, and prescription drugs. At public hospitals, there are no charges for stays or treatment, including drugs. However, small copayments may be charged for outpatient treatment and for treatment by a general practitioner, psychologist, or psychiatrist. The program also provides “sick pay” and disability benefits.<sup>155</sup> As Michael Moore has noted, the Norwegian system will even pay for “spa treatments” in some cases.<sup>156</sup>

Although the central government retains overall responsibility for and authority over the system, some management and funding responsibilities have devolved to regional and municipal governments. In general, municipal governments are responsible for primary health care, while four regional health authorities are responsible for specialist care.<sup>157</sup> Prior to 2002, public hospitals were run by local or county governments. In the face of chronic problems, notably long waiting lists and rising costs, the central government took direct control of all public hospitals in January 2002.<sup>158</sup> A

small number of private hospitals do exist outside the public system.

The government sets a global budget limiting overall health expenditures, and setting capital investment expenditures for hospitals. Most general practitioners and physician specialists outside hospitals receive a fixed salary, although some specialists working on a contract basis receive both an annual grant and fee-for-service payments. Reimbursement rates are set by the government and balance-billing is prohibited. Most other health care personnel are salaried government employees.<sup>159</sup>

Patient choice of physician is constrained. All Norwegian citizens must choose a general practitioner from a government list. The GP acts as a gatekeeper for other services and providers. Patients may switch GPs, but no more than twice per year and only if there is no waiting list for the requested GP.<sup>160</sup> Specialists may only be seen with a referral from the GP.

The Norwegian health care system has experienced serious problems with long and growing waiting lists.<sup>161</sup> Approximately 280,000 Norwegians are estimated to be waiting for care on any given day (out of a population of just 4.6 million).<sup>162</sup> The average wait for hip replacement surgery is more than four months; for a prostatectomy, close to three months; and for a hysterectomy, more than two months.<sup>163</sup> Approximately 23 percent of all patients referred for hospital admission have to wait longer than three months for admission.<sup>164</sup>

The Norwegian government has responded by repeatedly and unsuccessfully attempting to legislate waiting lists out of existence. For example, under the 1990 Patients’ Rights Act, patients with a condition that would lead to “catastrophic or very serious consequences” have a right to treatment *within six months*, if the treatment is available.<sup>165</sup> In 2001, after several government reports had documented repeated violations of this policy, the government passed a new mandate requiring that a patient’s medical condition be at least “assessed” within 30 days.<sup>166</sup> Despite these paper guarantees, waiting lists have not been substantially reduced.<sup>167</sup>

Moreover, such delays may represent only the tip of the iceberg when it comes to

**The Norwegian health care system has experienced serious problems with long and growing waiting lists.**

rationing care in Norway. In some cases, care may be denied altogether if it is judged not to be cost-effective. As Knut Erik Tranoy, Professor Emeritus at the Centre for Medical Ethics of the University of Oslo and an original member of the government's Health Care Priorities Commission, explains:

It is important to see (a) that, in a public health service of the Nordic type, any given amount of resources always has alternative uses. And (b) it is neither medically nor morally defensible to put scarce resources to uses which will foreseeably yield less favorable outcomes than other uses—save fewer lives, cure fewer patients.<sup>168</sup>

Tranoy differentiates between Norwegian-style systems of national health care and “a health care system where patients buy services in a market, and where justice means equality of opportunity to buy what you need. Decisions about alternative use are then (largely) patients' decisions.”<sup>169</sup>

While Norwegians generally report that they are “fairly satisfied” with the way their health care system is run, there has been growing discontent over such issues as the ability to choose a health care provider, involvement in decisions regarding care or treatment, and waiting times—which has been an ongoing issue in Norwegian politics.<sup>170</sup> However, at this time there doesn't appear to be any widespread movement for larger reform.

## Portugal

The Portuguese health care system is a classic, universal, centrally run National Health System, a single-payer system funded through taxes with comprehensive benefits provided free or with little cost at the point of service.<sup>171</sup> Also, a number of occupation-related health insurance schemes—originally intended to be integrated into the NHS—now coexist with it.

The primary source of care is the NHS, which is funded primarily through general tax

revenues, accounting for approximately 13 percent of all government expenditures.<sup>172</sup> In theory, the NHS operates within an annual global budget for health care spending. In reality, it regularly exceeds this budget by a wide margin, necessitating supplemental funding. Portugal is one of the few OECD countries where public health care spending has been rising as a proportion of total health spending, up more than four percentage points since 1997.<sup>173</sup>

Theoretically, benefits under the NHS include all necessary inpatient and outpatient health care services including specialists, diagnostic tests, mother and child care, and prescription drugs. On paper, no health-related expense is specifically excluded from coverage by the NHS, though in reality services such as dental care and rehabilitation therapy are seldom provided.<sup>174</sup> Copayments are required for diagnostic tests, hospital admissions, consultations with specialists, and prescription drugs, where copayments can run to 40 percent or higher.<sup>175</sup>

Primary care physicians and hospital-based physicians are public employees, paid directly by the NHS. However, NHS doctors are permitted to practice privately as well, and roughly half do so.<sup>176</sup> Specialists are often in private practice and are reimbursed by the NHS on a contractual basis.

About 25 percent of the population, mostly government workers, military, telecommunication workers, and their families, remain under a series of industry or occupation-based insurance schemes, known collectively as “subsystems,” which are a legacy of the country's pre-NHS health care system.<sup>177</sup> These plans were originally intended to be incorporated into the NHS, but their powerful constituencies have prevented that from occurring. Participants in the subsystems pay a premium equal to approximately 1 percent of their salary. Benefits are generally superior to those offered through the NHS.<sup>178</sup> Not surprisingly, premiums fall far short of what is needed to finance benefits. The resulting shortfall is shifted to the NHS.

In addition, approximately 10 percent of the population has private insurance, usually

**Waiting lists are so long and so prevalent that the European Observatory on Health Systems says that they veer toward “de facto rationing.”**

**Despite overlapping health plans, the Greek system falls short of universal coverage.**

through their employer.<sup>179</sup> Private insurance generally pays for hospital and specialty care but not for primary care physicians. Policies are medically underwritten and have no requirement for renewability, meaning insurers can raise premiums or drop customers with extremely high claims.<sup>180</sup>

Choice of provider is heavily constrained under the NHS. Every citizen must choose a primary care physician from a list of those available within a specified geographic area. This area is usually based on the person's area of residence but may be based on the area of employment. The average general practitioner serves as many as 1,500 people, though some may have more than 2,000 patients, leading to long waits and difficulties in getting appointments. People may change GPs only by applying in writing to the NHS and explaining their reasons.<sup>181</sup>

Access to specialists or hospital care, except in emergencies, requires referral from the patient's GP. Since this is often difficult to secure in a timely manner, patients often seek care through hospital emergency rooms. By some estimates, at least 25 percent of emergency room patients do not need immediate treatment.<sup>182</sup>

Despite guarantees of "universal coverage," access to care remains a serious problem. Waiting lists are so long and so prevalent that the European Observatory on Health Systems says that they veer toward "de facto rationing."<sup>183</sup> Currently, more than 150,000 Portuguese are on waiting lists for surgery, out of a population of just 10.6 million.<sup>184</sup> However, that may understate the problem in poorer and rural areas, which have fewer health resources and less access to care.<sup>185</sup> Modern health technology is far less available than in the United States. The United States has almost seven times more MRI units per million people, and 20 percent more CT scanners.<sup>186</sup>

To avoid waiting lists, Portuguese patients frequently pay out of pocket to see physicians in private practice. In some cases, Portuguese patients have crossed the border to receive treatment in Spain.<sup>187</sup>

While there appears to be a consensus in

Portugal that the system needs some kind of reform, weak governments and strong structural interest groups have combined to prevent the development of any consensus over the direction reform should take.<sup>188</sup> For the moment, Portugal drifts.

## Greece

Although ostensibly an employer-based system, the Greek system operates more like a single-payer system in that it is highly centralized and regulated. Virtually every aspect of health care financing and provision is strictly controlled by the Ministry of Social Health and Cohesion.<sup>189</sup> Some attempts have been made to decentralize decisionmaking, with 17 regional organizations having some responsibility for implementing policy and managing the delivery of health care, but most power remains with the central government.

Greek employers must enroll their workers in one of 35 "social insurance funds," funded in part through a payroll tax and in part through general tax revenues. Unlike Germany, where employers have a choice among competing sickness funds, Greek social insurance funds are specific to industry sectors. The range of benefits offered by each fund, the contribution rates, and the types of providers that the insured can access are all determined by the Ministry of Social Health and Cohesion.<sup>190</sup>

Certain funds known as "noble funds," primarily used by government workers, the banking sector, and public utility workers, offer more extensive benefits and require smaller worker contributions. The powerful unions representing workers from these sectors have consistently blocked attempts to merge these funds with other social insurance funds or to allow buy-ins from other industry sectors.<sup>191</sup>

Social insurance funds reimburse doctors in two ways. Some providers are employed directly by the funds at fund-operated clinics and are effectively salaried employees. Others practice privately but contract with funds to provide care. Contract physicians are reimbursed on a

fee-for-service basis, but reimbursement rates are extremely low. Balance-billing is prohibited.

In theory, funds provide first-dollar coverage, with no deductibles and low copayments for only a few services. However, as discussed below, most physicians demand “informal” payments in exchange for treatment.

In addition to the social insurance funds, the National Health Service employs physicians and operates hospitals. The NHS operates parallel to the social insurance funds, acting essentially as a back-up mechanism, although it may be the principal provider of health services in some rural areas. It also provides health care for the uninsured and the elderly.

In addition to NHS hospitals, other public hospitals contract with the social insurance funds. In both cases, the Ministry of Social Health and Cohesion determines not only the hospital’s budget, but the number of personnel, the specialties of the personnel, salary levels, number of beds, and the purchase of technology. Budgets are rigidly monitored and hospital administrators have little leeway.<sup>192</sup> Hospitals are reimbursed on a per diem payment system, a type of a fixed charge.<sup>193</sup>

NHS hospitals in particular are considered substandard. Most suffer from severe staffing shortages caused by low pay and poor living conditions in rural areas. It has been estimated that less than half of authorized medical positions are actually filled.<sup>194</sup> Low salaries have also led to personnel shortages in public hospitals associated with social insurance funds.<sup>195</sup>

A series of reforms implemented in 2005 imposed a referral requirement for hospital admissions. Patients seeking free treatment in a public NHS hospital must have a referral from a general practitioner, who acts as a gatekeeper. Private practice physicians may not make referrals to public or NHS hospitals.<sup>196</sup> Unfortunately, general practitioners are in severely short supply. Greece needs an estimated 5,000 general practitioners to meet demand. In actuality it has only around 600.<sup>197</sup>

Despite overlapping health plans, the Greek system falls short of universal coverage. About 83 percent of the population is covered for primary care (on par with the United States), and

about 97 percent for hospital care.<sup>198</sup> In theory, the uninsured can always receive treatment by walking into an NHS clinic or hospital. Only about 8 percent of Greeks have private supplemental health insurance, although this percentage has risen substantially in the past few years and further growth is predicted.<sup>199</sup>

Accurate information on waiting lists is difficult to come by. According to the WHO, “although ‘patient registries’ at the hospital level do exist, there is no systematic data processing available at any level of care,” to provide adequate analysis.<sup>200</sup> However, most observers agree that waiting lists are a severe problem at almost every level of care, and particularly bad at both NHS and public hospitals. An examination of waiting lists at Athens hospitals by the *Ta Nea* newspaper found the wait for surgery was as long as six months; for an outpatient appointment with either the hypertension or neurology departments, 150 days. Even simple blood tests required a month-long wait.<sup>201</sup>

The Greek system has developed a level of endemic corruption as patients have sought ways around the system’s rationing, bureaucracy, and inefficiencies. For example, Greeks routinely provide physicians with “informal” payments for seeing a patient from a sickness fund that has not contracted with the doctor, for moving a patient up in the queue, or for providing treatment outside government guidelines. In addition, physicians actively attempt to persuade patients to move from a doctor’s sickness fund contract to the doctor’s private practice. Patients who switch pay out of pocket but receive faster and better care. Even NHS physicians see private patients on the side. (This practice was illegal until 2002 but went on despite the prohibition).<sup>202</sup> Physicians also receive payments for referrals to private hospitals or diagnostic centers. Such informal out-of-pocket payments made up 42 percent of total health expenditures in 2002, fully 4.5 percent of GDP.<sup>203</sup> Essentially, the Greek health care system is funded through payroll taxes, general tax revenue, and bribery.

In addition, the health care bureaucracy has become highly politicized. Every staff appoint-

**Essentially, the Greek health care system is funded through payroll taxes, general tax revenue, and bribery.**

**Aside from Switzerland, the Netherlands has perhaps the most market-oriented national health care system in Europe.**

ment in the public health sector must be approved at the ministry level. All hospital administrators and other health officials are appointed on the basis of political affiliation with the governing party, often with little regard for relevant training or other qualifications.<sup>204</sup>

Not surprisingly, Greece has far less modern health care technology than the United States. The United States has more than twice as many MRI units per million people and 20 percent more CT scanners.<sup>205</sup> Much of the state-of-the-art equipment that does exist is clustered in the country's small number of private clinics and hospitals. Indeed, the vast majority of high technology biomedical tests are performed by the private sector.<sup>206</sup>

One study summed up the problems with the Greek health care system this way:

The Greek health system does not yet offer universal coverage and has fragmented funding and delivery. Funding is regressive, with a reliance on informal payments, and there are inequities in access, supply and quality of services. Inefficiencies arise from an over reliance on relatively expensive inputs, as evidenced by the oversupply of specialists and undersupply of nurses. Resource allocation mechanisms are historical and political with no relation to performance or output; therefore providers have little incentive to improve productivity.<sup>207</sup>

That would appear to be a fairly accurate summary.

## **Netherlands**

Aside from Switzerland, the Netherlands has perhaps the most market-oriented national health care system in Europe. That was the case even before 2006, when a series of reforms introduced even more market mechanisms.

The old pre-2006 Dutch system resembled Germany's. Dutch workers with incomes below €32,600 were required to enroll in one of 30 government-controlled "sickness funds."

Those with higher incomes had the option of enrolling in the funds if they wished, or opting out of the government system and purchasing private insurance. Sickness funds were financed through a payroll tax and a flat-rate, per-capita premium.<sup>208</sup>

The funds provided a uniform package of benefits including physician and hospital care, specialist care, diagnostic tests, prescription drugs, and dental care for children.<sup>209</sup> While consumers could switch funds annually, there was little competition between funds and few consumers actually switched.

The new Dutch system operates on the theory of managed competition like Switzerland (see below). Both the social health insurance program and the alternative private health insurance option were replaced by a requirement that all Dutch citizens purchase a basic health insurance plan from one of 41 private insurance companies. Although a fine may be imposed for failure to comply, there is no comprehensive system for identifying citizens who do not meet the mandate. An estimated 1.5 to 2 percent of the population is currently uninsured.<sup>210</sup>

The required plan, which covers minimum benefits set by the government, includes general practitioner and specialist care, hospital stays, some dental care, prenatal care, some medicines, and travel expenses. In one interesting innovation, most of the required benefits are specified in terms of "functions of care" rather than by provider category. Thus, "rehabilitation care" is required, but no particular type of rehabilitation provider is mandated.<sup>211</sup> This may mean that the benefits package will be less susceptible to manipulation by provider interest groups, but it is much too early to tell.

The Health Ministry sets premiums, which average around €100 per month for an individual. Insurance companies can offer varying deductibles, ranging from €150 to €1,000 per year, allowing for a small level of price competition. Policies can also offer rebates of up to €225 if a policyholder uses no health services in a given year beyond seeing a primary care physician.<sup>212</sup> About 90 percent of the popula-

tion also buys supplemental insurance covering services over and above the required standard benefits package.<sup>213</sup>

Employers generally pay half of insurance premiums, with individual workers picking up the other half.<sup>214</sup> Individual premiums are tax deductible.<sup>215</sup> Subsidies, or care allowances, that help low- and middle-income workers purchase the basic insurance plan are extensive and reach well into the middle class. Currently, 5 million Dutch citizens qualify for some level of subsidy on a sliding scale based on income.<sup>216</sup> Those subsidies are financed through a tax on salaried workers. Because of the high levels of subsidy, the Dutch government remains a large source of health spending, one area of significant difference with the Swiss system.<sup>217</sup>

Insurers negotiate quality, quantity, and price of services with providers. Notably, many insurers require providers to document the quality of the care they provide, frequently relying on evidence-based guidelines and performance metrics.<sup>218</sup>

Some insurers provide care directly, using their own staffs and their own facilities, such as primary care centers and pharmacies. Other insurers contract with a network of providers similar to U.S. preferred provider organizations (PPOs). Patients can go out of network but will receive only partial reimbursement. Most insurers require a referral from a primary care provider before a patient can see a specialist.<sup>219</sup> Pharmaceutical prices are capped nationwide at the average price of medicines in a therapeutic class. Individuals may choose more expensive drugs but must pay the difference out of pocket.<sup>220</sup>

The new system has been in place for only two years, which is not enough time to permit a thorough evaluation. However, preliminary indications suggest that it is an improvement over the pre-2006 system.<sup>221</sup>

Dutch consumers appear to have embraced the reforms. Consumer organizations are participating in negotiations with providers, insurers, and lawmakers. The system is becoming more transparent, with far greater information available regarding both price and quality. Consumers seem willing to make

decisions and change insurers on the basis of price and quality.

Price competition under the new system has increased significantly and at least 20 percent of Dutch consumers have switched insurers.<sup>222</sup> When the system was initiated, the Dutch government predicted premiums would cost €1,106 on average. However, competition has forced the average premium down to €1,028, 097.6 percent below the prediction.<sup>223</sup> Overall, the new system is estimated to have increased the purchasing power of Dutch households by as much as 1.5 percent.<sup>224</sup> However, not everyone has been a winner. The community rating requirement has resulted in steep increases in premiums for younger workers who were more heavily subsidized under the old system.<sup>225</sup>

Under the old system, waiting lists were widespread—for example, more than three months for a hip replacement and two months for a prostatectomy or hysterectomy.<sup>226</sup> One study estimated that at least 100 heart patients died each year while on waiting lists.<sup>227</sup> Early evidence suggests that some improvement has come as a result of the 2006 reforms.<sup>228</sup>

Hospitals are beginning to compete by expanding services such as neurosurgery and radiation therapy.<sup>229</sup> Although some experts have expressed concern that smaller hospitals offering these services may not have sufficient utilization rates to ensure quality and efficacy, the expanded availability of services will likely increase access to care and reduce queues.<sup>230</sup>

The new system may even be having a positive impact on health care costs. Since the new system took effect, health care costs have been growing at an annual rate of just 3 percent, compared to more than 4.5 percent in the year before the reforms.<sup>231</sup>

The jury is still out, and the Dutch system still falls well short of a true free market, but the Netherlands appears to have taken a big step in the right direction.

## Great Britain

Almost no one disputes that Britain's National Health Service faces severe prob-

**As many as 750,000 Britons are currently awaiting admission to NHS hospitals.**

**Explicit rationing also exists for some types of care, notably kidney dialysis, open heart surgery, and some other expensive procedures and technologies.**

lems, and few serious national health care advocates look to it as a model. Yet it appears in Moore's movie *SiCKO* as an example of how a national health care system should work, so it is worth examining.

The NHS is a highly centralized version of a single-payer system. The government pays directly for health care and finances the system through general tax revenues. Except for small copayments for prescription drugs, dental care, and optician services, there are no direct charges to patients. Unlike many other single-payer systems such as those in Canada and Norway, most physicians and nurses are government employees.

For years, British health policy has focused on controlling spending and in general has been quite successful, with the system spending just 7.5 percent of GDP on health care.<sup>232</sup> Yet the system continues to face serious financial strains. In fiscal year 2006, the NHS faced a deficit of £700 million, according to government figures, and as much as £1 billion, according to outside observers.<sup>233</sup> This comes despite a £43 billion increase in the NHS annual budget over the past five years.<sup>234</sup> By some estimates, NHS spending will have to nearly triple by 2025 just to maintain the current level of services.<sup>235</sup>

And that level of services leaves much to be desired. Waiting lists are a major problem. As many as 750,000 Britons are currently awaiting admission to NHS hospitals. These waits are not insubstantial and can impose significant risks on patients. For example, by some estimates, cancer patients can wait as long as eight months for treatment.<sup>236</sup> Delays in receiving treatment are often so long that nearly 20 percent of colon cancer patients considered treatable when first diagnosed are incurable by the time treatment is finally offered.<sup>237</sup>

In some cases, to prevent hospitals from using their resources too quickly, mandatory minimum waiting times have been imposed. The fear is that patients will flock to the most efficient hospitals or those with smaller backlogs. Thus a top-flight hospital like Suffolk East PCT was ordered to impose a minimum waiting time of at least 122 days before

patients could be treated or the hospital would lose a portion of its funding.<sup>238</sup> As the *Daily Telegraph* explained:

In a real competitive market, increased demand can allow prices to rise, thus increasing profits, which allow the market to grow. Efficient producers can then reduce their unit costs and their prices, and so give a better deal to the consumer. The prevailing logic is that the more customers who are served—or products that are sold—in a given period of time, the better the business does.

But PCTs have budgets that are predetermined by Whitehall spending limits, and there is no way for them to conjure extra revenue out of the air or to grow their market. As a result, the hospitals that are most successful in providing prompt treatment are running through the finite resources of their PCTs at an unacceptably rapid rate.<sup>239</sup>

The problem affects not only hospitals. There are also lengthy waits to see physicians, particularly specialists. In 2004, as a cost-cutting measure, the government negotiated low salaries for general practitioners in exchange for allowing them to cut back the hours they practice. Few are now available nights or weekends.<sup>240</sup> Problems with specialists are even more acute. For example, roughly 40 percent of cancer patients never get to see an oncology specialist.<sup>241</sup>

The government's official target for diagnostic testing is a wait of no more than 18 weeks by 2008. In reality, it doesn't come close.<sup>242</sup> The latest estimates suggest that for most specialties, only 30 to 50 percent of patients are treated within 18 weeks. For trauma and orthopedics patients, the figure is only 20 percent. Overall, more than half of British patients wait more than 18 weeks for care.<sup>243</sup>

Explicit rationing also exists for some types of care, notably kidney dialysis, open heart surgery, and some other expensive procedures and technologies.<sup>244</sup> Patients judged

too ill or aged for the procedures to be cost-effective may be denied treatment altogether.

Recently, the British government introduced some tiny steps toward market-based reforms. Under the experimental London Patient Choice Project, patients who have been waiting longer than six months for treatment are offered a choice of up to four alternate providers. This experiment has been extended nationwide for coronary heart patients who have been waiting longer than six months.<sup>245</sup>

Some proposed solutions are far more radical. David Cameron, leader of the Conservative Party, has proposed that the NHS be allowed to refuse treatment to individuals who don't practice healthy lifestyles, for example, who smoke or are overweight. Then again, he has also proposed that the government pay for gym memberships and subsidize the purchase of fresh fruit and vegetables.<sup>246</sup>

A small but growing private health care system has emerged in the UK. About 10 percent of Britons have private health insurance. Some receive it through their employer, while others purchase it individually. In general, the insurance replicates care provided through the NHS and is purchased to gain access to a wider choice of providers or to avoid waiting lists.<sup>247</sup> Private health insurance is lightly regulated and risk-rating is allowed. The British government treats health insurance more or less the same as other types of insurance.<sup>248</sup>

The British public is well aware of the need for reform. Nearly two-thirds of Britons (63 percent) say that the need for reform is "urgent," while another 24 percent believe it is "desirable." Fully 60 percent of Britons believe that making it easier for patients to spend their own money on health care would improve quality.<sup>249</sup> Yet Britons are also extremely proud of their health care system and wary of any reforms that would "Americanize" it.

## Switzerland

Of all the countries with universal health care, Switzerland has one of the most market-oriented systems. Indeed, the Swiss gov-

ernment actually pays for a smaller amount of total health care expenditures than the U.S. government, 24.9 percent versus 44.7 percent.<sup>250</sup> (See Figure 3.)

The Swiss system is based on the idea of managed competition, the same concept that underlay the 1993 Clinton health care plan and Mitt Romney's reforms in Massachusetts.<sup>251</sup> Managed competition leaves the provision of health care and health insurance in private hands but creates a highly regulated artificial marketplace as a framework within which the health care industry operates.<sup>252</sup>

Swiss law requires all citizens to purchase a basic package of health insurance, an individual mandate. Coverage is close to universal, estimated at 99.5 percent.<sup>253</sup> This level of compliance is due in part to the Swiss national character and may not be replicable in the United States where the record of complying with mandates is much more mixed (even if such a mandate were desirable).<sup>254</sup> For example, nearly 100 percent of Swiss drivers comply with their country's mandate for automobile insurance, compared with only 83 percent of U.S. drivers.<sup>255</sup>

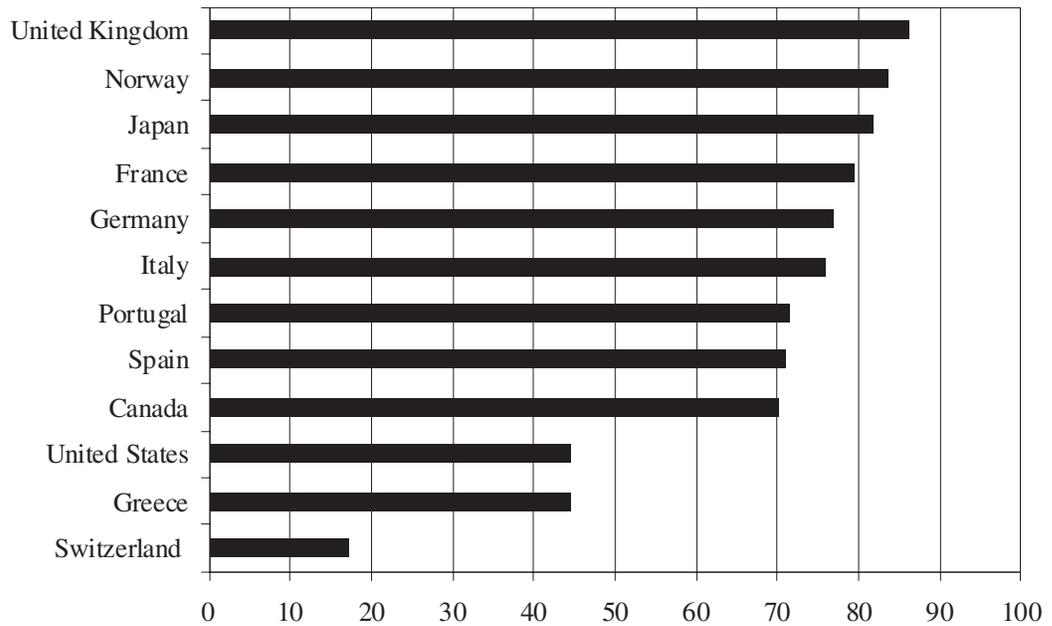
The term "basic benefits package" is somewhat misleading since the required benefits are quite extensive, including inpatient and outpatient care, care for the elderly and the physically and mentally handicapped, long-term nursing home care, diagnostic tests, prescription drugs, and even complementary and alternative therapies.<sup>256</sup>

Insurance is generally purchased on an individual basis. Few employers contribute to the purchase or provide insurance.<sup>257</sup> The policies are provided by private insurers. Currently, some 93 insurers operate in Switzerland, although not every insurer operates in every canton, or region.<sup>258</sup> Originally, insurers were required to be nonprofit entities, but that restriction was eliminated in 2002.

Insurers cannot reject an applicant on the basis of health status, and all policies are community rated within a geographic area, meaning that the healthier pay higher premiums to subsidize the less healthy. One exception to community rating is for nonsmokers, who can receive premiums as much as 20 percent lower

**Waiting lists are a major problem under the Canadian system.**

**Figure 3**  
**Percentage of Total Health Spending Paid by Government**



Source: OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries." Organisation for Economic Co-operation and Development, July 2007; 2004 data.

Note: Switzerland excludes mandatory insurance premiums.

than smokers. A formula adjusts premiums based on sex and age.<sup>259</sup> The geographic variation can be significant, with premiums differing as much as 50 percent between cantons.<sup>260</sup>

Unable to compete on the basis of managing and pricing risk, and required to offer nearly identical basic benefits packages, insurers compete primarily on price. Since they cannot reduce costs by risk management or benefit design, they generally manage prices by varying the level of deductibles and copayments. Individuals can purchase expensive policies with very low deductibles and copayments, or far less expensive policies with high deductibles or extensive copayments. Thus, premiums vary according to their cost-sharing attributes and plan type, running from \$1,428 per year for a plan with a deductible of approximately \$2,000 to \$2,388 for a plan with a \$250 deductible.<sup>261</sup>

Because employers do not pay for workers' health insurance, the Swiss are exposed to the full cost of their insurance purchases. As a result, many Swiss have opted for high-deductible

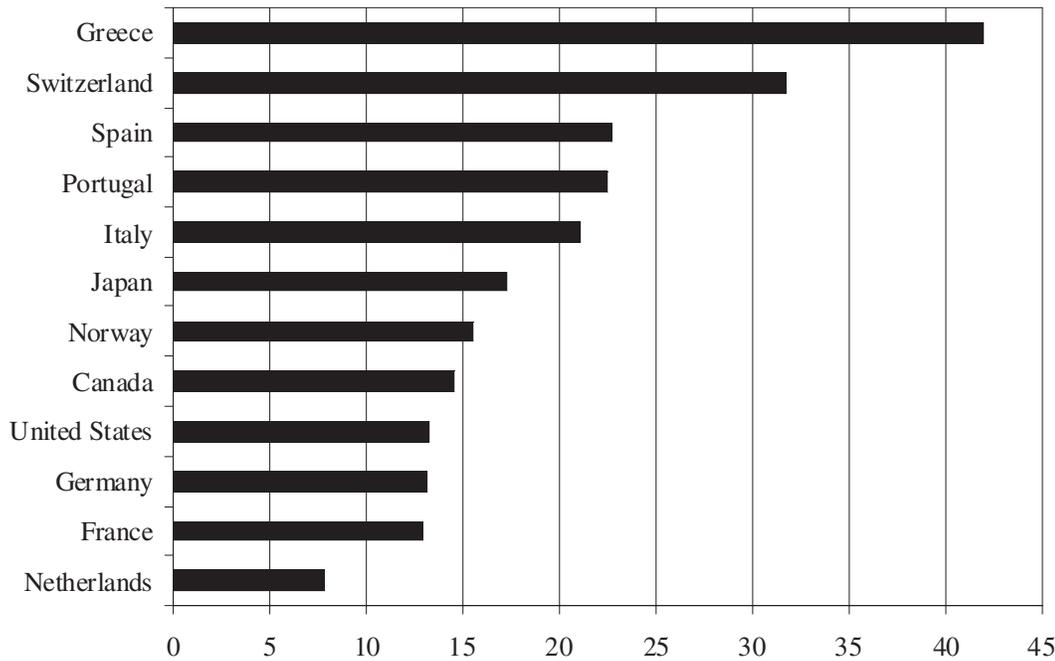
insurance. Thus, with high deductibles and extensive copayments, the Swiss pay out of pocket for 31.5 percent of health care, twice as much as in the United States.<sup>262</sup> (See Figure 4.)

Recently, there has also been a growing market in managed care plans that, like those in the United States, offer lower premiums in exchange for limitations on access to specialists and other services. Premiums for such plans run around \$1,900 per year.<sup>263</sup>

The Swiss government offers subsidies to low-income citizens to help them purchase a policy. Subsidies are based on both income and assets, and the maximum available subsidy covers the cost of an average premium in the individual's canton. These subsidies are designed to prevent any individual from having to pay more than 10 percent of income on insurance. They do not, however, pay the entire cost of insurance because the Swiss do not want to create an incentive for subsidized individuals to choose the most expensive plan with the lowest deductibles and copayments.<sup>264</sup> Roughly one-third of Swiss citizens

**Insurance is generally purchased on an individual basis. Few employers contribute to the purchase or provide insurance.**

**Figure 4**  
**Percentage of Total Health Spending Out of Pocket**



Source: OECD, “OECD Health Data 2007: Statistics and Indicators for 30 Countries.”  
 Data for France from Simone Sandier, Valerie Paris, and Dominique Polton, *Health Care Systems in Transition: France* (Copenhagen: European Observatory on Health Systems and Policies, 2004).  
 Data for Greece from the World Health Organization.

receive some form of subsidy, and approximately 19 percent of all health insurance premiums are paid with government funds.<sup>265</sup>

Swiss insurers operate as cartels to negotiate provider reimbursements on a cantonal basis. Providers must accept the negotiated payment, and balance-billing is prohibited. If insurers and providers are unable to reach agreement on a fee schedule, canton governments are empowered to step in and impose an agreement. There are no restrictions on where physicians may set up practice, so to some degree providers can vote with their feet, moving to cantons that offer higher reimbursements, a practice that has led to physician shortages in some areas.<sup>267</sup>

The system includes both public and private hospitals.<sup>268</sup> Private hospitals negotiate reimbursement with insurance cartels and physicians in the same manner. Public hospitals are operated by cantons, which negotiate reimbursement rates with insurers and provide subsidies to the hospitals. In some can-

tons, individuals with only the basic insurance plan must use public hospitals; supplementary insurance (see below) is required for admission to private hospitals.

Recently some providers have begun operating outside the negotiated fee schedules. A separate supplemental insurance market is starting to develop to cover the cost of these providers, which are presumed to offer higher quality or more advanced services. Supplementary insurance also allows access to private hospitals in those cantons that do not permit access under the basic insurance plan. Even within public hospitals, supplementary insurance can be used to pay for services such as private rooms that are not covered under the basic plan. By some estimates as many as 40 percent of Swiss citizens have purchased supplemental insurance.<sup>269</sup>

The Swiss do not impose a global budget on their health care system and have therefore avoided the waiting lists common in other sys-

**Because employers do not pay for workers’ health insurance, the Swiss are exposed to the full cost of their insurance purchases. As a result, many Swiss have opted for high-deductible insurance.**

**Strong evidence suggests that the exposure of Swiss consumers to the cost consequences of their health care decisions has made them more conscious consumers.**

tems. In addition, the Swiss have a high degree of access to modern medical technology, but it has come at a cost. The Swiss spend 11.5 percent of GDP on health care, second only to the United States.<sup>270</sup>

Since Swiss health care consumers are exposed to the cost consequences of their health care decisions, this trade-off between access and cost can be presumed to reflect the desires of Swiss patients. They have chosen high quality care even though it costs them more. Given that economists consider health care to be a “normal good”—that is, consumption rises along with income—and Switzerland is a wealthy nation, such a decision seems entirely reasonable.<sup>271</sup>

At the same time, it is notable that Swiss health care spending remains below that of the United States for nearly comparable care. Strong evidence suggests that the exposure of Swiss consumers to the cost consequences of their health care decisions has made them more conscious consumers and helped limit overall health care costs. As Regina Herzlinger and Ramin Parsa-Parsi of Harvard have concluded, “Cost control may be attributed to the Swiss consumer’s significant role in health care payments and the resulting cost transparency.”<sup>272</sup>

The transparency of the system also makes it responsive to consumer preferences. The WHO survey ranked Switzerland second only to the United States in terms of responsiveness to patients’ needs for choice of provider, dignity, autonomy, timely care, and confidentiality.<sup>273</sup>

The Swiss generally seem pleased with their system. Earlier this year, Swiss voters overwhelmingly rejected a proposal to replace the current system with a single-payer plan; more than 71 percent of Swiss voters turned down the proposal in a nationwide referendum.<sup>274</sup>

Nonetheless, the Swiss system has its own problems, most of them predictable outgrowths of the individual mandate and the regulation inherent in managed competition. In most markets, consumers impose a certain discipline on prices because they can refuse to buy a product if it costs too much. The individual mandate removes this power since consumers must purchase the product (in this case, insurance) even if

they believe the cost outweighs the value. Moreover, the establishment of a government-defined benefits package is an open-ended invitation to special interests representing various health care providers and disease constituencies, who can certainly be expected to lobby for the inclusion of additional services or coverage.<sup>275</sup>

Public choice dynamics are such that providers (who would make money from the increased demand for their services) and disease constituencies (whose members naturally have an urgent desire for coverage of their illness or condition) will always have a strong incentive to lobby legislators for inclusion under any minimum benefits package. The public at large will likely be unaware of the debate or see resisting the small premium increase caused by any particular additional benefit as unworthy of a similar effort—a simple case of concentrated benefits and diffused costs.<sup>276</sup>

That is exactly what has happened in Switzerland, leading to a growing expansion of the basic benefits package. In particular, a powerful hospital and physician lobbying coalition known as the “Blue Front” was able to demand a significant expansion in covered benefits in exchange for a relaxation of “any willing provider” laws so as to permit managed-care contracts.<sup>277</sup>

The expansion of benefits has driven up the cost of insurance, a cost only partially offset by larger deductibles. Although the proportion of health expenditures paid out of pocket remains high, it has decreased by roughly 10 percent in the past decade.<sup>278</sup>

Moreover, the growth in covered benefits has helped drive up costs for the system as a whole, as the Swiss become more insulated from the costs of their health care purchasing decisions. If that trend continues, it could undermine the cost transparency that is at the heart of the Swiss system.” As Uwe Reinhardt has noted, “Over time, the growth in compulsory benefits has absorbed an increasing fraction of the consumers’ payment, thus compromising the consumer-driven aspects of the Swiss system.”<sup>279</sup>

Evidence shows that the community rating requirements are creating distortions within

the Swiss market, leading to the over provision of care to the healthy and the under provision of care to the sick.<sup>280</sup> In addition, the prohibition on risk management discourages the development of new and innovative products. Peter Zweifel of the University of Zurich, a member of the Swiss Competitive Committee which oversees insurance regulation, believes that a return to some degree of risk-rating is essential to the long-term success of the Swiss system.<sup>281</sup> As Zweifel puts it, “Let competition work its magic. Let those who are bad risks get the message that they need to become better risks, if possible. If not possible, [they would] still get a subsidy which [keeps their costs] down to little more than 8–10 percent of taxable income.”<sup>282</sup>

Third, the cartel structure for negotiating reimbursement schedules can create a number of distortions. Effectively monopsony purchasers, the cartels have enormous leverage when it comes to negotiations. Not surprisingly, physicians have tended to set up practice in cantons with the highest levels of reimbursement, leading to shortages in other areas. Reimbursement rates have reportedly created wasteful incentives—for example, hospitals shifting patients from outpatient to inpatient care.<sup>283</sup> And the combination of increased demand and low reimbursement has led to the first signs of queues for the most complex surgeries.<sup>284</sup>

In addition, the negotiations freeze in place a pricing structure that inhibits the development of innovative approaches that do not tie payments to specific benefits. This includes both managed care approaches and health services integration.<sup>285</sup>

Finally, Switzerland has some of Europe’s strongest regulation of nonphysician health care professionals.<sup>286</sup> As a result, patients are often forced to use more expensive providers where a less expensive professional would do.

All of the above combine to undermine the consumer-driven nature of Switzerland’s health system. Despite these problems, the Swiss system provides a useful lesson for the United States about the value of consumer-directed health care. In particular, we can see

that when the cost of insurance becomes more transparent, consumers shift their purchasing preferences toward true insurance (spreading catastrophic risk), rather than purchasing prepayment for routine, low-cost services. That gives consumers an overall incentive to make cost-versus-value decisions when purchasing health care, resulting in reduced costs while maintaining individual choice and quality care.

## Germany

Germany ranked 25th in the WHO ratings.<sup>287</sup> Despite that low ranking, however, the country is worth examining because it is frequently cited as a model by advocates of national health care.

National health insurance in Germany is part of a social insurance system that dates back to Bismarck. All German citizens with incomes under €46,300 (roughly \$60,000) are required to enroll in one of approximately 250 statutory “sickness funds.” Those with higher incomes may enroll in the funds if they wish, or may opt out of the government system and purchase private insurance.<sup>288</sup> About three-quarters of workers with incomes above the statutory limit choose to remain in the sickness funds, which currently cover approximately 90 percent of the population. Overall, insurance coverage is nearly universal. However, the number of uninsured has been rising, roughly tripling in the last 10 years to 300,000 people.<sup>289</sup> About 9 percent of the population purchases supplemental insurance to cover items that are not included in the standard benefits package.<sup>290</sup>

Sickness funds are financed through a payroll tax split equally between the employer and employee. The size of the tax varies depending on which fund the worker has chosen, but averages around 15 percent of wages.<sup>291</sup> Sickness funds are supposed to be solvent and self-supporting, but in reality the system ran a €7 billion deficit in 2006.<sup>292</sup> The German government has proposed a 1 percent increase in the payroll tax, split evenly between employer and

**The Swiss system provides a useful lesson for the United States about the value of consumer-directed health care.**

**Although Germany spends less on health care than the United States, expenditures have been rising at an alarming rate in recent years.**

employee, starting next year.<sup>293</sup> In addition, general tax revenues finance capital costs for acute care hospitals and many rehabilitative services, especially for retirees.

Benefits are extensive, covering physicians, hospital and chronic care, diagnostic tests, preventive care, prescription drugs, and part of dental care. In addition to the medical benefits, sickness funds provide sick pay to those who cannot work due to illness, ranging from 70 to 90 percent of the patient's last gross salary, for up to 78 weeks.<sup>294</sup>

The central government and state governments split the regulation of the health care system. The central government establishes the national global budget for health care spending, defines any new medical procedures to be included in benefit packages, and sets reimbursement rates for physicians. Some of this is accomplished through legislation, while the rest is handled through negotiations between the National Association of Sickness Funds and the National Association of Physicians. At the state level, state associations of sickness funds and physicians negotiate overall health budgets, reimbursement contracts for physicians, procedures for monitoring physicians, and reference standards for prescription drugs.<sup>295</sup> The bargaining power in these negotiations clearly lies with the sickness funds backed by the government, allowing them to effectively impose fee schedules and other restrictions on providers. The purchasing power of a German physician's wages is now about 20 percent that of a U.S. physician.<sup>296</sup> This has led to physician strikes as recently as 2005.<sup>297</sup>

Although Germany spends less on health care than the United States, both as a percentage of GDP and per capita, expenditures have been rising at an alarming rate in recent years. Friedrich Breyer, an economist from Konstanz University, estimates that health care spending could reach 30 percent of GDP by 2020 unless significant changes are made.<sup>298</sup>

The German government has responded by beginning to cut back on benefits. In 2004, sickness funds stopped covering eyeglasses, lifestyle medications, and all over-the-counter

drugs. Copayments were imposed for the first time, such that Germans now pay €10 per quarter to see a general practitioner, €10 per day of hospital stay, €10 per prescription, and for certain specialty services.<sup>299</sup> The highest copayments are 10 percent for prescription drugs. Overall, Germans pay out of pocket for about 13 percent of total health care spending, only slightly less than Americans.<sup>300</sup> Preliminary evidence suggests that the introduction of cost sharing has slightly reduced utilization and spending.<sup>301</sup>

In 2006, Chancellor Angela Merkel proposed a sweeping set of health care reforms that included creating a centralized health fund, shifting financing in part from payroll taxes to general revenues, trimming benefits, imposing greater cost sharing, and making the system more transparent. She was forced to abandon the package in the face of public and political opposition.<sup>302</sup>

The degree of health care rationing in Germany is the subject of considerable debate. Unlike many OECD countries, the German government does not compile data on waiting lists.<sup>303</sup> One frequently cited study suggests that Germans are no more likely than Americans to wait more than four weeks to see a specialist.<sup>304</sup> The WHO says, "Waiting lists and explicit rationing decisions are virtually unknown."<sup>305</sup>

However, at least one study concludes that rationing is occurring for the elderly and those with terminal illness, and concludes that "the question remains as to whether lives at advanced ages could be saved if age rationing were discontinued and maximum medical treatment were to be applied to everyone, irrespective of their age."<sup>306</sup> In addition, a survey of German hospitals reported that "waiting times were prolonged" due to both a lack of capacity and hospital target budgets that make the treatment of sickness fund patients with serious conditions financially unattractive.<sup>307</sup>

Also, Germans have less access to modern medical technology than Americans. The United States has four times as many MRI units per million people and twice as many CT scanners.<sup>308</sup> The situation would undoubt-

edly be worse without the existence of the small private insurance sector. Although small as a proportion of total health spending, private insurance puts competitive pressure on sickness funds, pushing them to expand their quality and services. At one time, CT scanners were even rarer in the public system, available only under exceptional circumstances and after long waits, yet relatively common in the private sector. Competition forced the public sector to add more CT scanners.<sup>309</sup>

Some analysts blame price restrictions and reimbursement rates for increasing bureaucratic interference in how German physicians practice medicine. Physicians trying to work within the maze of reimbursement caps and budget restrictions have no financial incentive to provide more than the minimally necessary care. That has led to questions of quality assurance, and the government has responded with ever greater micromanagement of practice standards. The result has been a huge increase in red tape for physicians and a general loss of innovation.<sup>310</sup>

Germans seem aware of the need to reform their health care system. In a 2004 poll, 76 percent of Germans thought health care reform was “urgent,” while an additional 14 percent thought it was “desirable.” However, Germans are split nearly down the middle about what that reform should be. Roughly 47 percent would like to see an increase in private health care spending, whereas 49 percent would not. Similarly, 45 percent of Germans believe that more patient choice would improve health care quality, whereas 50 percent do not. The reluctance to fully embrace market reforms undoubtedly stems from a long-standing German belief in social solidarity. By a margin of 81 to 18 percent, Germans believe that equal access to the same quality of care for everyone is more important than their own access to the best possible care.<sup>311</sup>

Costs and demographics will eventually force changes in the German system. However, given the failure of Chancellor

Merkel’s reforms, change is unlikely in the near future.

## A Few Thoughts on Canada

Canada is another country that did not make the top 20 health care systems in the WHO rankings (it finished 30th), and few serious advocates of universal health care look to it as a model. As Jonathan Cohn puts it, “Nobody in the United States seriously proposes recreating the British and Canadian system here—in part because, as critics charge . . . they really do have waiting lines.”<sup>312</sup> However, since the press still frequently cites it as an example, it is worth briefly examining.

Although Canada is frequently referred to as having a “national health system,” the system is actually decentralized with considerable responsibility devolved to Canada’s 10 provinces and 2 territories. It is financed jointly by the provinces and the federal government, similar to the U.S. Medicaid program. In order to qualify for federal funds, each provincial program must meet five criteria: 1) universality—available to all provincial residents on uniform terms and conditions; 2) comprehensiveness—covering all medically necessary hospital and physician services; 3) portability—allowing residents to remain covered when moving from province to province; 4) accessibility—having no financial barriers to access such as deductibles or copayments; and 5) public administration—administered by a nonprofit authority accountable to the provincial government.

Federal financing comes from general tax revenue. The federal government provides a block grant to each province which amounts to around 16 percent of health care spending. However, most funding comes from provincial taxes, primarily personal and corporate income taxes. Some provinces also use funds from other financial sources like sales taxes and lottery proceeds. And some (British Columbia, Alberta, and Ontario) charge premiums, although health services cannot be denied because of inability to pay. The health

**Some analysts blame price restrictions and reimbursement rates for increasing bureaucratic interference in how German physicians practice medicine.**

**U.S. patients are actually more likely than Canadians to receive preventive care for chronic or serious health conditions.**

care system is an enormous part of the Canadian welfare state. On the provincial level, the health care system amounts to between one-third and one-half of all social welfare spending.<sup>313</sup>

Provinces must provide certain benefits, including primary care doctors, specialists, hospitals, and dental surgery. Other benefits, such as routine dental care, physiotherapy, and prescription drugs, are optional. Some provinces offer substantial coverage for these services, some cover them only partially, and some do not cover them at all. Except for emergencies, treatment by specialists or hospital admission requires a referral from a primary care physician.

Provider reimbursement is set by each province, and some provinces restrict overall physician income. In general, however, reimbursement is on a fee-for-service basis. Hospitals are paid a specific pre-set amount to cover all noncapital costs. Capital expenditures must be approved on a case-by-case basis.

An increasing number of Canadians also carry private insurance, most often provided through their employer. Originally this insurance was designed to cover those few services not covered by the national health care system. At one time, all provinces prohibited private insurance from covering any service or procedure provided under the government program. But in 2005, the Canadian Supreme Court struck down Quebec's prohibition on private insurance contracting.<sup>314</sup> Litigation to permit private contracting is now pending in several other provinces.

In addition to the public hospitals covered by the government, many private clinics now operate, offering specialized services. Although private clinics are legally barred from providing services covered by the Canada Health Act, many do offer such services in a black market. The biggest advantage of private clinics is that they typically offer services with reduced wait times compared to the public health care system. Obtaining an MRI scan in a hospital could require a wait of months, whereas it could be obtained much faster in a private clinic.

Waiting lists are a major problem under the Canadian system. No accurate government data exists, but provincial reports do show at least moderate waiting lists. The best information may come from a survey of Canadian physicians by the Fraser Institute, which suggests that as many as 800,000 Canadians are waiting for treatment at any given time. According to this survey, treatment time from initial referral by a GP through consultation with a specialist, to final treatment, across all specialties and all procedures (emergency, nonurgent, and elective), averaged 17.7 weeks in 2005.<sup>315</sup> And that doesn't include waiting to see the GP in the first place.

Defenders of national health care have attempted to discount these waiting lists, suggesting that the waits are shorter than commonly portrayed or that most of those on the waiting list are seeking elective surgery. A look at specialties with especially long waits shows that the longest waits are for procedures such as hip or knee replacement and cataract surgery, which could arguably be considered elective. However, fields that could have significant impact on a patient's health, such as neurosurgery, also have significant waiting times.<sup>316</sup> In such cases, the delays could be life threatening. A study in the *Canadian Medical Association Journal* found that at least 50 patients in Ontario alone have died while on the waiting list for cardiac catheterization.<sup>317</sup> Data from the Joint Canada-United States Survey of Health (a project of Statistics Canada and the National Center for Health Statistics) revealed that "thirty-three percent of Canadians who say they have an unmet medical need reported being in pain that limits their daily activities."<sup>318</sup> In a 2005 decision striking down part of Quebec's universal care law, Canadian Supreme Court Chief Justice Beverly McLachlin wrote that it was undisputed that many Canadians waiting for treatment suffer chronic pain and that "patients die while on the waiting list."<sup>319</sup>

Clearly there is limited access to modern medical technology in Canada. The United States has five times as many MRI units per million people and three times as many CT

scanners.<sup>320</sup> Indeed, there are more CT scanners in the city of Seattle than in the entire province of British Columbia.<sup>321</sup>

Physicians are also in short supply. Canada has roughly 2.1 practicing physicians per 1,000 people, far less than the OECD average. Worse, the number of physicians per 1,000 people has not grown at all since 1990. And while the number of nurses per 1,000 people remains near the OECD average, that number has been declining since 1990.<sup>322</sup>

In addition, although national health care systems are frequently touted as doing a better job of providing preventive care, U.S. patients are actually more likely than Canadians to receive preventive care for chronic or serious health conditions. In particular, Americans are more likely to get screened for common cancers, including cancers of the breast, cervix, prostate, and colon.<sup>323</sup>

Canada has been relatively effective at controlling spending. The country spends about 9 percent of GDP on health care, a percentage that has risen only slightly over the last decade. Relative to average OECD expenditures, Canadian health expenditures have declined by 4 percent since 1997.<sup>324</sup> That cost control, however, has clearly come at the expense of access to care.

Canadians' dissatisfaction with the problems in their system has been growing for some time. One survey showed that some 59 percent of Canadians believe that their system requires "fundamental changes," and another 18 percent believe the system needs to be scrapped and totally rebuilt.<sup>325</sup> Still, Canadians are reluctant to embrace market reforms that are associated with the U.S. health care system—a system that Canadians disdainfully reject. As one observer put it:

Anxiety about Americanization and the constantly reinforced strain of national pride in Canadian health care coexist[s] with considerable uneasiness about the actual state of that care. It is as if, when Canadians look south across the border they swell with pride, but when they look within they shrink back, seeing

many problems and feeling uncertainty about the future.

Canadians may jealously guard their system and resist "Americanizing" it, but even advocates of universal health care are coming to recognize that it does not provide a valid model for U.S. health care reform.

## Conclusion

The U.S. health care system clearly has problems. Costs are rising and are distributed in a way that makes it difficult for some people to afford the care they want or need. Moreover, although the number of uninsured Americans is often exaggerated, far too many Americans go without health insurance. And while the U.S. provides the world's highest quality health care, that quality is uneven, and too often Americans don't receive the standard of care that they should. But the experiences of other countries with national health care systems show that the answer to these problems lies with more pro-market reform, not more government control.

Of course, there is no single model for national health care systems in other countries. Indeed, the differences from country to country are so great that the terms "national health care" or "universal coverage" can be misleading—as if one collective model shows how other countries deal with health care and health insurance. Each country's system is the product of its unique conditions, history, politics, and national character. Those systems range from the managed competition approach of the Netherlands and Switzerland to the more rigid single-payer systems of Great Britain, Canada and Norway, with many variations in between.

Some countries have a true single-payer system, prohibiting private insurance and even restricting the ability of patients to spend their own money on health care. Others are multi-payer systems, with private competing insurers and varying degrees of government subsidy and regulation. Some countries base their sys-

**Universal health insurance does not mean universal access to health care.**

**The broad and growing trend in countries with national health care systems is to move away from centralized government control and introduce more market-oriented features.**

tems around employment, while others have completely divorced work from insurance. Some require consumers to share a significant portion of health care costs through either high deductibles or high copayments. Others subsidize virtually first-dollar coverage. Some allow unfettered choice of physicians. Others allow a choice of primary care physicians but require referrals for specialists. Still others restrict even the choice of primary care doctors.

In fact, about the only system one cannot find is the type of system described by Michael Moore, Physicians for a National Health Program, and other national health care advocates—a system that provides unlimited care with no premiums, deductibles, or copayments, from the physician of one’s choice. For example, in *SiCKO*, Moore lambastes American insurers for denying coverage for rare and experimental treatments.<sup>327</sup> And, during the New Hampshire primary, John Edwards ran television advertisements highlighting the tragic death of a teenage girl whose liver transplant was rejected by her father’s insurer.<sup>328</sup> These stories play effectively on the emotions and drive a desire for change. Yet one searches in vain for a national health care system anywhere that regularly pays for experimental and untested procedures.

Likewise, advocates for national health care tap into the anger many patients (and doctors) feel for the gatekeepers and prior approval required under American managed care. But many if not most foreign systems require similar gatekeepers. Moreover, copayments and other forms of cost sharing are commonplace.

It is also important to realize that no country’s system would translate directly to the United States. Americans are unlikely to accept the rationing or restrictions on care and technology that many countries use to control costs. Nor are U.S. physicians likely to accept a cut in income to the levels seen in countries like France or Germany. The politics, economics, and national cultures of other countries often vary significantly from those of the United States. Their citizens are far more likely to have faith in government actions and to be suspicious of free markets. And polling suggests

that citizens of many countries put social solidarity and equality ahead of quality and choice when it comes to health policy.<sup>329</sup> American attitudes are quite different. As pollster Bill McInturff notes, “Never, in my years of work, have I found someone who said, ‘I will reduce the quality of the health care I get, so that all Americans can get something.’”<sup>330</sup>

Even so, some important lessons can be drawn from the experiences of other countries:

- Universal health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have extremely long waiting lists for treatment. Nor does a national health care system necessarily mean universal coverage. Some countries with ostensibly universal systems actually fall far short of universal coverage, and most leave at least a small remnant (1–2 percent of the population) uncovered. Although this is certainly wider coverage than the United States provides, it shows the difficulty of achieving either truly universal coverage or universal access to care.
- Rising health care spending is not a uniquely American phenomenon. Other countries spend considerably less than the United States on health care, both as a percentage of GDP and per capita, often because they begin with a lower base of expenditures. Nonetheless, their costs are still rising, leading to budget deficits, tax increases, and/or benefit cuts. In 2004, the last year for which data is available, the average annual increase for per capita health spending in the countries discussed in this study was 5.55 percent, only slightly lower than the United States’ 6.21 percent.<sup>331</sup> As the *Wall Street Journal* notes, “Europeans . . . face steeper medical bills in the future in their cash-strapped governments.”<sup>332</sup> In short, there is no free lunch.
- Those countries that have single-payer systems or systems heavily weighted toward government control are the most

likely to face waiting lists, rationing, restrictions on the choice of physician, and other barriers to care. Those countries with national health care systems that work better, such as France, the Netherlands, and Switzerland, are successful to the degree that they incorporate market mechanisms such as competition, cost-consciousness, market prices, and consumer choice, and eschew centralized government control.

- Dissatisfaction and discontent with a nation's health care system seems to be universal. Undoubtedly, Americans are unhappy with the current state of our health care system. According to the most recent Commonwealth Fund survey, an astounding 82 percent of Americans believe that our system either requires fundamental change or needs to be completely rebuilt.<sup>333</sup> Not surprisingly, polls suggest health care reform is the top domestic policy issue in the upcoming presidential election.<sup>334</sup> Yet, that same Commonwealth Fund study shows large majorities in every country, ranging from 58 percent in the Netherlands to 78 percent in Germany calling for fundamental reform or complete rebuilding of their health care systems.<sup>335</sup> Earlier polling by the Stockholm Network found similar levels of unhappiness.<sup>336</sup> Not as bad as in the United States, perhaps, but certainly no ringing endorsement of their systems.
- Although no country with universal coverage is contemplating abandoning a universal system, the broad and growing trend in countries with national health care systems is to move away from centralized government control and introduce more market-oriented features. As Richard Saltman and Josep Figueras of the World Health Organization put it, "The presumption of public primacy is being reassessed."<sup>337</sup> Alan Jacobs of Harvard points out that despite significant differences in goals, content, and strategies, European nations are general-

ly converging toward market practices in health care.<sup>338</sup> Thus, even as Americans debate adopting a government-run system, countries with those systems are debating how to make their systems look more like that of the United States.

Looking at other countries and their experiences, then, can provide guidance to Americans as we debate how to reform our health care system. National health care is not a monolithic idea, nor is it as disastrous as U.S. critics sometimes portray. Some national health care systems do *some* things well.

Yet, those systems do have serious problems. In most cases, national health care systems have successfully expanded insurance coverage to the vast majority, if not quite all, of the population. But they have not solved the universal and seemingly intractable problem of rising health care costs. In many cases, attempts to control costs through governmental fiat have led to problems with access to care, either delays in receiving care or outright rationing.

In wrestling with this dilemma, many countries are loosening government controls and injecting market mechanisms, particularly cost sharing by patients, market pricing of goods and services, and increased competition among insurers and providers. As Pat Cox, former president of the European Parliament, put it in a report to the European Commission, "We should start to explore the power of the market as a way of achieving much better value for money."<sup>339</sup>

Moreover, the growth of the government share of health care spending, which had increased steadily from the end of World War II until the mid-1980s, has stopped, and in many countries the private share has begun to increase, in some cases substantially. Some evidence shows a growing shift from public to private provision of health care.<sup>340</sup> If the trend in the United States over the last several years has been toward a more European-style system, the trend in Europe is toward a system that looks more like America's.

Therefore, if U.S. policymakers can take one

**The United States can increase coverage and access to care, improve quality, and control costs without importing the problems of national health care.**

lesson from national health care systems around the world, it is not to follow the road to government-run national health care, but to increase consumer incentives and control. The United States can increase coverage and access to care, improve quality, and control costs without importing the problems of national health care. In doing so, we should learn from the successes—and the failures—of systems in other countries.

## Notes

The author wishes to thank Pierre Bessard of the Institut Constant de Rebecque; Valentin Petkantchin of the Institut Economique Molinari; Alberto Mingardi of the Instituto Bruno Leoni; and Regina Herzlinger of Harvard University for their assistance. The author would also like to offer special thanks to Jonathan Cohn of the *New Republic* and author of *Sick: The Untold Story of America's Health Care Crisis—and the People Who Pay the Price*, for his willingness to review and comment on this paper despite disagreeing with my conclusions.

1. *SiCKO*, Dog Eat Dog Films, 2007.
2. Paul Krugman, "The Waiting Game," *New York Times*, July 16, 2007.
3. Physicians for a National Health Program, "Insurance CEOs Fattened on the Suffering of Many," [http://www.pnhp.org/news/2006/april/the\\_health\\_care\\_tipp.php](http://www.pnhp.org/news/2006/april/the_health_care_tipp.php).
4. Paul Krugman and Robin Wells, "The Health Care Crisis and What to Do about It," *New York Review of Books*, March 23, 2006.
5. Organisation for Economic Co-operation and Development, "OECD Health Data 2007: Statistics and Indicators for 30 Countries" (Paris: OECD, 2007).
6. Christine Borger et al., "Health Spending Projections through 2015: Changes on the Horizon," *Health Affairs* 25, no. 2 (2006): w61-w73, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w61>.
7. Uwe Reinhardt of Princeton University, for example, estimates that nearly half of the difference in spending between the United States and other industrial nations is due to America's higher GDP. Uwe Reinhardt, Peter Hussey, and Gerard Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs* 23, no. 3 (2004): 11-12.
8. Kaiser Family Foundation, "Employer Health Benefits 2007 Annual Survey," Kaiser Family Foundation, September 11, 2007.
9. *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds* (Washington: Government Printing Office, 2007).
10. Jagadeesh Gokhale, "Medicaid's Soaring Costs: Time to Step on the Brakes," Cato Institute Policy Analysis no. 597, July 19, 2007.
11. Carmen DeNavas-Walt et al., "Income, Poverty and Health Insurance in the United States: 2005," *Current Population Reports* (Washington: U.S. Census Bureau, 2006). This number should be approached with a great deal of caution, however. A study for the Department of Health and Human Services suggests that the Current Population Survey "appears to overstate the uninsured substantially compared to other surveys." Cathy Callahan and James Mays, "Working Paper: Estimating the Number of Individuals in the United States without Health Insurance," Actuarial Research Service, prepared for the Department of Health and Human Services (Washington: U.S. Department of Health and Human Services, 2005), p. 22. Other studies put the actual number of uninsured at 21-31 million. Congressional Budget Office, "How Many People Lack Health Insurance and for How Long?" (Washington: Congressional Budget Office, 2003). Moreover, all those estimates include people who could obtain coverage. For example, as many as one-third of Americans without health insurance are eligible for existing government programs such as Medicaid or the State Children's Health Insurance Program but have failed to sign up for the program. BlueCross BlueShield Association, "The Uninsured in America," January 2005, [www.coverageforall.org/pdf/BC-BS\\_Uninsured-America.pdf](http://www.coverageforall.org/pdf/BC-BS_Uninsured-America.pdf). Roughly another third live in households with annual incomes above \$50,000, suggesting that many could reasonably afford to purchase insurance if they chose to do so. Devon Herrick, "Crisis of the Uninsured: 2007," National Center for Policy Analysis Brief Analysis no. 595, September 28, 2007.
12. "Overview of the Uninsured in the United States: An Analysis of the 2005 Current Population Survey" (Washington: U.S. Department of Health and Human Services, 2005).
13. This is not to say that *universal* coverage should be the goal of health care reform, and certainly not the primary goal. Universal insurance coverage does not necessarily translate into access to care. And, while some evidence indicates that uninsured Americans have somewhat worse health outcomes than insured Americans, the evidence of a direct link between health insurance and health is weak. Nor is expanding insurance

coverage necessarily the best or most efficient use of resources for improving health. Helen Levy and David Meltzer, "What Do We Really Know about Whether Health Insurance Affects Health," Economic Research Initiative on the Uninsured Working Paper no. 6, December 2001. Moreover, in many cases, expanding insurance coverage will exacerbate the problems of third-party payment.

14. Cited in Tamar Nordenberg, "Make No Mistake: Medical Errors Can Be Serious," *FDA Consumer Magazine* 34, no. 5 (2000).

15. Elizabeth McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348 (2003): 2635–45.

16. Rita Mangione-Smith et al., "The Quality of Ambulatory Care Delivered to Children in the United States," *New England Journal of Medicine* 357 (2007): 1515–23.

17. See, for example, <http://www.michaelmoore.com/sicko/health-care-proposal/> and <http://www.pnhp.org>.

18. World Health Organization, "The World Health Report 2000" (Geneva: WHO 2000); *SiCKO*, Dog Eat Dog Films, 2007. For a critical look at the WHO study, see Glen Whitman, "WHO Do You Think You're Fooling: The World Health Organization's Problematic Ranking of Health Care Systems," Cato Institute Briefing Paper, February 28, 2008; Twila Brase, "WHO's Hidden Agenda," *Ideas on Liberty*, Foundation for Economic Education, October 2000.

19. World Health Organization.

20. *Ibid.*

21. OECD, "Health at a Glance: OECD Indicators, 2005" (Paris: OECD Publishing, 2005), p.11.

22. Census Bureau, *2000 Census* (Washington: U.S. Census Bureau).

23. Robert L. Ohsfeldt and John E. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington: American Enterprise Institute Press, 2006).

24. In Austria and Germany, fetal weight must be at least 500 grams (1 pound) to count as a live birth; in other parts of Europe, such as Switzerland, the fetus must be at least 30 centimeters (12 inches) long. In Belgium and France, births at less than 26 weeks gestation are registered as lifeless. And some countries don't reliably register babies who die within the first 24 hours after birth. For a full discussion of the issue, see

Miranda Mugford, "A Comparison of Reported Differences in Definitions of Vital Events and Statistics," *World Health Statistics Quarterly* 36 (1983), cited in Nicholas Eberstadt, *The Tyranny of Numbers: Measurements and Misrule* (Washington: AEI Press, 1995), p. 50. Some, but not all, countries are beginning to standardize figures, and future data may be more reliable.

25. Anthony DePalma, "SiCKO, Castro, and the 120 Year Club," *New York Times*, May 27, 2007.

26. Arduino Verdecchia et al., "Recent Cancer Survival in Europe: A 2000–02 Period Analysis of EUROCARE-4 Data," *The Lancet Oncology* 8, no. 9 (2007): 784–96, <http://www.thelancet.com/journals/lanonc/article/PIIS1470204507702462/abstract>; Nicole Martin, "UK Cancer Survival Rate Lowest in Europe," *Daily Telegraph*, August 24, 2007. Of course, some argue that these figures are skewed by aggressive U.S. testing and diagnostic procedures. In the United States, doctors catch many cancers that would go undetected in other countries. These cancers may be small or slow growing and might not kill the person. That these cancers are diagnosed in the United States but not in other countries makes our survival rate look higher. Jonathan Cohn, "What Jacques Chirac Could Teach Us about Health Care," *New Republic*, April 10, 2007. That theory is worth considering; increased screening likely does affect the figures for slow growing cancers such as prostate cancer (the source of much controversy since Rudy Giuliani raised the issue in his campaign). "Rudy Wrong on Cancer Survival Chances," *Washington Post*, October 31, 2007; David Gratzler, "Rudy Is Right in Data Duel about Cancer," *Investors Business Daily*, November 6, 2007.

As Robert Ohsfeldt and John Schneider concede in their book, *The Business of Health*, "[Many] cancer survival rate estimates . . . do not adjust for cancer stage at diagnosis. This could result in survivor time bias—those with cancers detected at an earlier stage would exhibit longer post diagnosis survival times, even for cancers that are essentially untreatable." Robert Ohsfeldt and John Schneider, *The Business of Health* (Washington: AEI, 2007), pp. 23–24. However, survivor time bias is not as big an issue for cancers that have faster metastasizing times or that strike younger patients. As Ohsfeldt and Schneider go on to note:

Survivor time bias, however, should not be a significant concern for cancers that respond well to treatment if detected early. For such cancers, early detection makes a substantive contribution to survival time—the longer survival time associated with early detection thus is not a spurious effect of early detection. An example is thyroid cancer. In the United States, virtually all females with thyroid cancer survive for at least five years. The lower survival rates for

thyroid cancer in European countries suggest some underperformance in either early detection or post diagnosis management in these countries. In contrast, the differences in survivor rates are less pronounced for cancers that are more difficult to treat, such as lung cancers.

The United States' advantage holds for other cancers, too, including breast, colon, and thyroid cancer among others. Moreover, the benefits of early detection and treatment go well beyond survival rates. Even for prostate cancer, early treatment can significantly affect quality of life. And the United States might simply have more cases of prostate cancer than other countries. (For example, diet could play a significant role. Kyung Song, "Study Links Diet to Prostate Cancer," *Seattle Times*, October 11, 2007.)

Finally, one of the most common arguments for socialized medicine is its capacity to increase screening and preventive care. Indeed, John Edwards actually wants to make testing mandatory for all Americans. "Edwards Backs Mandatory Preventive Care," Associated Press, September 2, 2007.

27. "World Briefing: Berlusconi Has Heart Surgery in US," *New York Times*, December 19, 2006.

28. "Stronach Went to US for Cancer Treatments: Report," CTV, September 14, 2007, [http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070914/belinda\\_Stronach\\_070914/20070914](http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070914/belinda_Stronach_070914/20070914).

29. Steve Findlay, "U.S. Hospitals Attracting Patients from Abroad," *USA Today*, July 22, 1997.

30. The two principal reasons for sending a patient abroad were the lack of availability of services in Canada (40 percent) and the length of the wait for certain treatments (19 percent). Robert J. Blendon et al., "Physicians' Perspectives on Caring for Patients in the United States, Canada, and West Germany," *New England Journal of Medicine* 328, no. 14 (1993): 1011–16.

31. John Goodman, "Moore's SiCKO Could Put Lives at Risk," *The Michael Moore Chronicles*, National Center for Policy Analysis, 2007, <http://sicko.ncpa.org/moores-sicko-could-put-lives-at-risk>.

32. "Nobel Prize in Physiology or Medicine Winners 2007–1901," The Nobel Prize Internet Archive, <http://almaz.com/nobel/medicine/medicine.html>.

33. Pharmaceutical Research and Manufacturing of America, "R&D Spending by U.S. Biopharmaceutical Companies Reaches a Record \$55.2 Billion in 2006," February 12, 2007.

34. *Economic Report of the President* (Washington:

Government Printing Office, 2004), p. 192.

35. Gerard Anderson et al., "It's the Prices Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (2003): 99.

36. Oliver Schoffski, "Diffusion of Medicines in Europe," paper prepared for the European Federation of Pharmaceutical Industries and Associations, 2002, cited in Daniel Kessler, "The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature," submitted to the U.S. International Trade Commission.

37. Ibid.

38. For example, some evidence seems to indicate that overuse of CT scans in the United States, especially in children, may actually be increasing the incidence of some cancers. David Brenner and Eric Hall, "Computed Tomography—An Increasing Source of Radiation Exposure," *New England Journal of Medicine* 357, no. 22 (2007): 2277–84. Yet, other evidence suggests that increased use of CT scans may reduce deaths from other cancers such as lung cancer. International Early Lung Cancer Investigators, "Survival of Patients with Stage I Lung Cancer Detected on CT Screening," *New England Journal of Medicine* 355, no. 17 (2006): 1763–71. Robin Hanson of George Mason University has argued that much of U.S. health care spending provides no benefit at all. Indeed, Hanson believes that we could cut health care spending by 50 percent without affecting health outcomes. Robin Hanson, "Cut Medicine in Half," *Cato Unbound*, September 10, 2007, <http://www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-in-half/>. In contrast, Mark McClellan of Harvard University and economist David Cutler argue that the benefits of increased health care technology vastly overwhelm their costs. David Cutler and Mark McClellan, "Is Technological Change in Medicine Worth It?" *Health Affairs* 20 (2001): 11–29.

39. Ohsfeldt and Schneider, *The Business of Health*. It is true, as Jonathan Cohn points out, that much, though by no means all, of the basic research on health care is funded by the National Institutes of Health. Jonathan Cohn, "Creative Destruction: The Best Case against National Health Care," *The New Republic*, November 12, 2007. However, the vast majority of applied research is funded by the private sector. Overall, roughly 57 percent of all biomedical research spending comes from private industry. From 1989 to 2002, four times as much money was invested in private biotechnology companies in America as in all of Europe. Tyler Cowen, "Poor U.S. Scores in Health Care Don't Measure Nobels or Innovation," *New York Times*, October 5, 2006.

40. Cowen, "Poor U.S. Scores in Health Care Don't Measure Nobels or Innovation."
41. "The Novartis Warning," *Wall Street Journal*, May 8, 2002.
42. See Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs* 12, suppl. 1 (1993): 24–48.
43. Michael Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work," Cato Institute Briefing Paper no. 97, June 6, 2006.
44. Jonathan Cohn, *Sick: The Untold Story of America's Health Care Crisis—And the People Who Pay the Price* (New York: HarperCollins, 2007), p. 226.
45. Ezra Klein, "Health Care Wrap Up," [www.ezralein.com](http://www.ezralein.com), April 25, 2005; [http://www.prospect.org/csnc/blogs/ezraklein\\_archive?month=04&year=2005&base\\_name=health\\_care\\_wrapup](http://www.prospect.org/csnc/blogs/ezraklein_archive?month=04&year=2005&base_name=health_care_wrapup).
46. Mattke et al., "Health Care Quality Indicators Project."
47. Victor Rodwin, "The Health Care System under French National Health Insurance: Lessons for Health Reform in the United States," *American Journal of Public Health* 93, no. 1 (2003): 34. Note that the total tax burden is higher than the health care system's percentage of GDP because of the costs associated with the non-working population—that is, children, the elderly, and the unemployed.
48. Philippe Manière et al., "Perspectives on the European Health Care Systems: Some Lessons for America," Heritage Foundation Lecture no. 711, July 9, 2001.
49. "French Health Insurance System to Post 10.3-Billion-Euro Deficit," *EU Business*, August 6, 2006.
50. "Deficit-Saddled France under Fire over Budget," Reuters, July 5, 2007. Members of the Eurozone are required to keep budget deficits below 3 percent of GDP.
51. "French Health Care Is Badly Run," *BBC News*, August 8, 2006.
52. Martine Bellanger, Veneta Cherilova, and Valerie Paris, "The Health Benefit Package in France," *European Journal of Health Economics* 6, suppl. 1 (2005): 24–29.
53. Simone Sandier et al., "France," in *Health Care Systems in Transition*, eds. Sarah Thomson and Elias Mossialos (Brussels: The European Observatory on Health Care Systems, 2004).
54. Thomas Buchmueller and Agnes Couffinhal, "Private Health Insurance in France," OECD Health Working Paper no. 12, 2004. In this sense at least, French physicians may have more freedom than American physicians under Medicare, which prohibits balance-billing.
55. Francesca Columbo and Nicole Tapay, "Private Health Insurance in the OECD Countries: The Benefits and Costs for Individuals and Health Systems," OECD Health Working Paper no. 15, 2004.
56. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."
57. Buchmueller and Couffinhal, "Private Health Insurance in France." It is important to note, however, that this deregulated insurance is *supplemental coverage*. No one can be disqualified for health reasons from basic coverage.
58. Ibid.
59. Rodwin, "The Health Care System under French National Health Insurance."
60. Ibid.
61. Valentin Petkantchin, "Pernicious Myths about Public Health Insurance in France," *Economic Note* (Brussels: Institut Economique Molinari, 2007), <http://www.institutmolinari.org/pubs/note20071.pdf>.
62. "La Securite Social," Report of the French Court of Audit, September 2006.
63. Manière et al., "Perspectives on the European Health Care Systems."
64. Paul Dutton, "Health Care in France and the United States: Learning from Each Other," Brookings Institution, July 2002.
65. Rodwin, "The Health Care System under French National Health Insurance."
66. Alexander Dorozynski, "French Health Staff Strike over Budget Cuts," *British Medical Journal* 320 (February 2000): 333; Alexander Dorozynski, "French Medical System Beset by Strikes," *British Medical Journal* 324 (February 2002): 258.
67. High Council for the Future of Health Insurance, "L'Avenir de l'Assurance Maladie: L'Urgence d'un Redressement par la Qualité" (Paris, Ministry of Health, 2004).
68. Valentin Petkantchin, "The Ineffectiveness of Health Cost Containment Policies in France," *Economic Note* (Brussels: Institut Economique

- Molinari, 2007); <http://www.institutmolinari.org/pubs/note20073.pdf>.
69. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."
70. Rodwin, "The Health Care System under French National Health Insurance."
71. Petkantchin, "The Ineffectiveness of Health Cost Containment Policies in France."
72. Norman Ho, "A Long, Hot Summer," *Harvard International Review* 26 (Summer 2004); "French Health Care Is Badly Run," BBC News, January 23, 2004.
73. Valentin Petkantchin, "Bureaucratic Drug Delisting: The French Example," *EU Reporter*, January-February 2007.
74. Schoffski, "Diffusion of Medicines in Europe."
75. "French Health Care Is Badly Run," BBC News, January 23, 2004.
76. D. Benamouzig and R. Launois, "Rationing Health Care in Europe-France," in *Rationing Health Care in Europe: An Empirical Study*, eds. J. Matthais Graf von der Schulenburg and Michael Blanke (Amsterdam: IOS Press, 2004), p. 16.
77. Helen Disney et al., *Impatient for Change: European Attitudes to Healthcare Reform* (London: Stockholm Network, 2004), pp. 69–86.
78. Institut Economique Molinari, "Health Myths in France—More Competition, Not Cost Containment Is the Solution According to the French Institut Economique Molinari," news release, January 7, 2007, [www.institutmolinari.org/pubs/pr20071.pdf](http://www.institutmolinari.org/pubs/pr20071.pdf).
79. Dorozynski, "French Health Staff Strike over Budget Cuts."
80. Columbo and Tapay, "Private Health Insurance in the OECD Countries."
81. Hurst and Luigi Siciliani, "Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries," OECD Health Working Paper no. 6, July 2003.
82. Ezra Klein, "The Health of Nations—Here's How Canada, France, Britain, Germany, and our Own Veterans Health Administration Manage to Cover Everybody at Less Cost and with Better Care than We Do," *American Prospect*, April 24, 2007.
83. E. van Doorslaer et al., "Income-Related Inequality in the Use of Medical Care in 21 OECD Countries," in *Towards High Performing Health Systems: Policy Studies from the OECD Health Project* (Paris: OECD, 2004).
84. Rodwin, "The Health Care System under French National Health Insurance."
85. Disney et al., *Impatient for Change*, pp. 69–86.
86. Ibid.
87. "Sarkozy's Election Reflects Europe's Right Turn," National Public Radio, May 7, 2007.
88. "Budget 2008: Tighter Controls on Healthcare Spending as French Conservatives Crack Down on Social Security Deficit," Global Insight, 2007, <http://www.globalinsight.com/SDA/SDADetail10740.htm>.
89. Mattke et al., "Health Care Quality Indicators Project."
90. Alexandra Bibbee and Benoît Bellone, "Economic Survey of Italy, 2007" (Paris: OECD, 2007).
91. Andrea Donatini et al., *Health Care Systems in Transition: Italy* (Copenhagen: European Observatory on Health Systems and Policies, 2001).
92. Franco Reviglio, "Health Care and Its Financing in Italy: Issues and Reform Options," IMF Working Paper 00-166, October 2000.
93. Donatini et al., *Health Care Systems in Transition: Italy*.
94. Reviglio, "Health Care and Its Financing in Italy".
95. Depending on regions and election cycles. Copayments for prescription drugs are frequently introduced only to be repealed shortly before elections.
96. Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006), p. 98.
97. Donatini et al., *Health Care Systems in Transition: Italy*.
98. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*, p. 93.
99. Vincenzo Atella and Federico Spandanaro, "Private Health Insurance in Italy: Where We Stand Now," *Euro Observer*, Spring 2004.
100. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*, p. 97.
101. George France, Francesco Taroni, and Andrea Donatini, "The Italian Health Care System," *Health*

- Economics* 14 (September 2005): 185–202.
102. Alberto Mingardi, “A Drug Price Path to Avoid,” *Washington Post*, November 12, 2006.
103. See, for example, “Italy Hit by Double Strike,” BBC News, February 9, 2004.
104. Reviglio, “Health Care and Its Financing in Italy.”
105. OECD, “OECD Health Data 2007: Statistics and Indicators for 30 Countries.”
106. Donatini et al., “Health Care Systems in Transition: Italy.”
107. Mingardi, “A Drug Price Path to Avoid.”
108. Ariel David, “Italian Police Units Inspect Hospitals,” *Washington Post*, January 8, 2007.
109. Vittorio Maio and Lamberto Manzoli, “The Italian Health Care System: WHO Ranking versus Public Perception,” *PLoS Medicine* 6 (June 2002): 301–03.
110. Disney et al., *Impatient for Change*, pp. 111–19.
111. Guillem Lopez-Casasnovas, Joan Coasta-Font, and Ivan Planas, “Diversity and Regional Inequalities: Assessing the Outcomes of the Spanish System of Health Care Services,” UPF Working Paper no. 745, April 2004.
112. Antonio Duran, Juan Lara, and Michelle van Waveren, “Spain: Health System Review,” *Health Systems in Transition* 8, no. 4 (Copenhagen: European Observatory on Health Systems and Policies, 2006).
113. Ibid.
114. “Waiting to Be Seen: How the Health Service Varies across Spain,” *Expatica*, June 26, 2007.
115. Emilio Cerda, Laura de Pablos, and Maria Rodriguez, “Waiting Lists for Surgery,” in *Patient Flow: Reducing Delay in Healthcare Delivery* (Hoboken, NJ: Springer, 2006).
116. Xavier Bosch, “Spain: The Old Frequently Live with Their Families,” *British Medical Journal* 324 (June 29, 2002): 1543.
117. There is one exception. Central government civil servants can opt out of the public system and have the government pay for their private insurance. Roughly 91 percent of civil servants choose private insurance. Noah Clarke, “Government Health Care: A Universal Failure,” *Today’s News*, Goldwater Institute, May 10, 2007.
118. Mario Rodriguez, Richard Scheffler, and Jonathan Agnew, “An Update on Spain’s Health Care System: Is It Time for Managed Competition?” *Health Policy* 51 (2000): 109–31.
119. Columbo and Tapay, “Private Health Insurance in the OECD Countries.”
120. Luis Rajmil et al., “The Quality of Care and Influence of Double Health Care Coverage in Catalonia (Spain),” *Archive of Disease in Childhood* 83 (September 2000): 211–14.
121. OECD, “OECD Health Data 2007: Statistics and Indicators for 30 Countries.”
122. Duran, Lara, and van Waveren, “Spain: Health Systems Review.”
123. Rodriguez, Scheffler, and Agnew, “An Update on Spain’s Health Care System.”
124. Duran, Lara, and van Waveren, “Spain: Health Systems Review.”
125. Disney et al., *Impatient for Change*, pp. 151–60.
126. Alastair Kilmarnock, “Spain: Commentary,” in *Impatient for Change: European Attitudes to Healthcare Reform*, eds. Disney et al. (London: Stockholm Network, 2004), p. 161.
127. Disney et al., *Impatient for Change*, pp. 151–60.
128. Tetsuo Fukawa, “Public Health Insurance in Japan,” World Bank Institute Working Paper no. 37201 (2002).
129. Ibid.
130. Kohei Komamura and Atsuhiko Yamada, “Who Bears the Burden of Social Insurance? Evidence from Japanese Health and Long-Term Care Insurance Data,” *Journal of Japanese and International Economics* 18 (December 2004): 565–81.
131. “Japanese Health Insurance Industry Faces Winnowing Out,” *Medical Insurance News*, March 21, 2004.
132. Noriyuki Takayama, “Japan’s Never-Ending Social Security Reforms,” *International Social Security Review* 55 (2002): 11–22.
133. Ibid.
134. Adam Wagstaff, “Health Systems in East Asia: What Can Developing Countries Learn from Japan and the Asian Tigers?” *Health Care Economist*, April 18, 2007.

135. Shikha Dalmia, "The UAW's Health-Care Dreams," *Wall Street Journal*, July 27, 2007.
136. M. Ryan Baker, "Japan and Massachusetts: A Comparison of Universal Health Care Systems," Missouri Foundation for Health, Spring 2006.
137. Naoki Ikagami and John Campbell, "Japan's Health Care System: Containing Costs and Attempting Reform," *Health Affairs* 23 (2004): 29–34.
138. Naoki Ikagami and John Campbell, "Health Care Reform in Japan: The Virtues of Muddling Through," *Health Affairs* 18 (Fall 1999): 56–75.
139. Ibid.
140. "The Doctor's Dilemma," *The Economist*, June 10, 2004.
141. Jeong Hyoung-Sun and Jeremy Hurst, "An Assessment of the Performance of the Japanese Health Care System," OECD Labour Market and Social Policy Occasional Paper no. 56, 2001.
142. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."
143. Aki Yoshikawa and Jayanata Bhattacharya, "Japan," in *World Health Systems: Challenges and Perspectives*, eds. Bruce Fried and Laura Gaydos (Chicago: Health Administration Press, 2002).
144. Ikagami and Campbell, "Health Care Reform in Japan: The Virtues of Muddling Through."
145. Bill Ross et al., "International Approaches to Funding Health Care," [Australia] Commonwealth Department of Health and Ageing Occasional Papers, Health Financing Series no. 2, 1999.
146. W. C. Hsiao, "Afterward Costs—The Macro Perspective," *Containing Health Care Costs in Japan* (Ann Arbor: The University of Michigan Press, 1999), pp. 45–52. While this study uses dated data, the general conclusions have been endorsed by more recent authors: Ikagami and Campbell, "Health Care Reform in Japan: The Virtues of Muddling Through"; Ross et al., "International Approaches to Funding Health Care."
147. Rihito Kimura, "Bioethics and Japanese Health Care," *Washington-Japan Journal* 3 (1994): 2.
148. Takayama, "Japan's Never-Ending Social Security Reforms."
149. Christian Hagist and Laurence J. Kotlikoff, "Health Care Spending: What the Future Will Look Like," National Center for Policy Analysis, Study no. 286, June 28, 2006.
150. Booyeon Lee, "Help Wanted: Is Immigration the Answer to the Shrinking Labor Force," *Ashai Shimbum*, December 23, 2003.
151. Waiting lists and rationing in Norway have become sufficiently bad that, in 2000, the government launched the Patient Bridge Project to facilitate the treatment of Norwegian patients in private hospitals in neighboring countries. G. Bottom, S. Grepperud, and S. M. Neiland, "Trading Practices: Lessons from Scandinavia," *Health Affairs* 69 (2004): 317–27.
152. Jan Roth Johnsen, *Health Systems in Transition: Norway* 8, no. 1 (Copenhagen: European Observatory on Health Systems and Policies, 2006).
153. "Tax Revenues on the Rise in Many OECD Countries, OECD Report Shows," *FinFacts*, October 11, 2006; [http://www.finfacts.com/irelandbusiness/news/publish/article\\_10007581.shtml](http://www.finfacts.com/irelandbusiness/news/publish/article_10007581.shtml).
154. Ibid.
155. Johnsen, *Health Systems in Transition: Norway*.
156. Michael Moore, Remarks before the Washington, D.C., premiere of *SiCKO*, June 20, 2007.
157. Johnsen, *Health Care Systems in Transition: Norway*.
158. Terje Hagen and Oddvar Kaarboe, "The Norwegian Hospital Reform of 2002: Central Government Takes Over Ownership of Public Hospitals," Health Organization Research Norway (HORN) Working Paper no. 1 (2004).
159. Paul van den Noord, Terje Hagen, and Tor Iversen, "The Norwegian Health Care System," OECD Economics Department Working Paper no. 198, 1998.
160. Johnsen, *Health Care Systems in Transition: Norway*.
161. H. Piene, P. Nyen, and H. Hauge, "Waiting Lists and Hospital Capacity—Analyses Based on Theoretical Queue Models and Empirical Data," Paper presented to the Annual Meeting of the International Society for Technological Assessment of Health Care, Unimed, Norway, 1997.
162. Christine Furuholmen and Jon Magnussen, *Health Care Systems in Transition: Norway* (Copenhagen: European Observatory on Health Care Systems, 2000).
163. Luigi Siciliani and Jeremy Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries," OECD Health Working Paper no. 7, October 2003.
164. M. Hoel and E. Saether, "Private Health Care

- as a Supplement to a Public Health System with Waiting Time for Treatment,” Ragnar Frisch Center for Economic Research, Oslo, 2000.
165. Quoted in Soren Holm, “Goodbye to the Simple Solutions: The Second Phase of Priority Setting in Health Care,” *British Medical Journal* 317 (October 1998): 1000–02.
166. Hagen and Kaarboe, “The Norwegian Hospital Reform of 2002: Central Government Takes Over Ownership of Public Hospitals.”
167. Ibid.
168. Knut Erik Tranoy, “Ethical Principles in Public Health Care” in “Scandinavia: With a Remark about Relativism and the Cultural Foundations of Health Care Ethics,” in *Bioethics for the People by the People*, ed. Darryl R. J. Macer (Bangkok, Thailand: Eubios Ethics Institute, 1994), p. 57.
169. Ibid.
170. Hagen and Kaarboe, “The Norwegian Hospital Reform of 2002: Central Government Takes Over Ownership of Public Hospitals.”
171. Catarina Diogo, “The Reform of the NHS in Portugal,” University of York, Department of Management, Working Paper no. 5, 2005.
172. Directorate-General of Health, “National Health Plan, 2004–2010” (Lisbon: Ministry of Health, July 2004).
173. OECD, “Health at a Glance: OECD Indicators, 2005” (Paris: OECD, 2005).
174. Margarida Bentes et al., *Health Care Systems in Transition: Portugal* (Copenhagen: European Observatory on Health Systems and Policies, 2004).
175. Bentes et al., *Health Care Systems in Transition: Portugal*.
176. Paul Ferrinho, “Dual Practice in the Health Sector: Review of the Evidence,” *Human Resources for Health* 2 (2004).
177. Bentes et al., *Health Care Systems in Transition: Portugal*.
178. Ibid.
179. Ibid.
180. Columbo and Tapay, “Private Health Insurance in OECD Countries.”
181. Bentes et al.
182. Ibid.
183. Ibid.
184. Catarina Diogo, “The Reform of the NHS in Portugal,” University of York, Department of Management, Working Paper no. 5, 2005.
185. Monica Duarte Oliveira and Gwyn Bevan, “Measuring Geographic Inequalities in the Portuguese Health Care System: An Estimation of Hospital Care Needs,” *Health Policy* 66 (March 2003): 277–93.
186. OECD, “OECD Health Data 2007: Statistics and Indicators for 30 Countries.”
187. Mario de Queiroz, “Living in Portugal, Giving Birth in Spain,” *InterPress Service*, March 29, 2005.
188. Monica Duarte Oliviera, Jose Magone, and Joao Periera, “Nondecision Making and Inertia in Portuguese Health Policy,” *Journal of Health Politics, Policy and Law* 30 (January–February 2005): 211–30.
189. Josep Figueras et al., *Health Care Systems in Transition: Greece* (Copenhagen: World Health Organization, 1996).
190. Figueras et al., *Health Care Systems in Transition: Greece*.
191. Konstantina Davaki and Elias Mossialos, “Plus Ca Change: Health Sector Reforms in Greece,” *Journal of Health Politics, Policy, and Law* 30 (February–April 2005): 143–67.
192. Figueras et al., *Health Care Systems in Transition: Greece*.
193. Mary Geitona, “Cost Containment Policies in the Public Sector,” Paper presented at International Training Program on Health Economics, Athens, December 2003, <http://www.nsph.gr/ecoman/word/costconainmentpolicies.doc>
194. Davaki and Mossialos, “Plus Ca Change.”
195. Ibid.
196. “Greece Healthcare: Coming under Great Pressure,” *The Economist*, June 24, 2005.
197. Figueras et al., *Health Care Systems in Transition: Greece*.
198. WHO, “Highlights on Health: Greece 2004” (Copenhagen: WHO Regional Office for Europe, 2005.)
199. Columbo and Tapay, “Private Health Insurance

- in OECD Countries”; WHO, “Highlights on Health: Greece 2004.”
200. Theodora Zachariadou et al., “The Demolition of Waiting Lists Project,” PowerPoint presentation, 2005; [http://www.hope.be/04\\_exchange/programme\\_2006/presentations\\_participants/greece\\_2006.pdf](http://www.hope.be/04_exchange/programme_2006/presentations_participants/greece_2006.pdf).
201. Cited in Zachariadou et al., “The Demolition of Waiting Lists Project.”
202. Davaki and Mossialos, “Plus Ca Change.”
203. WHO, “Highlights on Health: Greece 2004.”
204. Figueras et al., *Health Care Systems in Transition: Greece*.
205. OECD, “OECD Health Data 2007: Statistics and Indicators for 30 Countries.”
206. Geitona, “Cost Containment Policies in the Public Sector.”
207. Elias Mossialos, Sara Allin, and Konstantina Davaki, “Analyzing the Greek Health System: A Tale of Fragmentation and Inertia,” *Health Economics* S1 (2005): S151.
208. Jessica Hohman, “International Healthcare Systems: A Primer,” American Medical Student Association, 2007.
209. Andre den Exter et al., *Health Care Systems in Transition: Netherlands* (Copenhagen: European Observatory on Health Systems and Policies, 2004).
210. G. P. Westert and H. Verkleij, eds., *Dutch Health Care Performance Report 2006* (Bilthoven, The Netherlands: Center for Prevention and Health Services Research, National Institute for Public Health and the Environment, 2006.) A government-run system remains in place to cover long-term care, mental health care, and mental health hospitalization of longer than one year. Kaiser Permanente International, “Selected European Countries’ Health Systems,” Prepared for a conference on European Systems of Universal Health Care, Washington, October 31, 2007.
211. “Alain Enthoven and Wynand van den Ven, “Going Dutch—Managed-Competition Health Insurance in the Netherlands,” *New England Journal of Medicine* 357 (2007): 2421–23.
212. Stefan Greb, Maral Manougian, and Jurgen Wasem, “Health Insurance in the Netherlands,” CESifo DICE Report, January 2007.
213. Kaiser Permanente International, “Selected European Countries’ Health Care Systems.”
214. Willem van Duin, “The Role of Private Insurers in Dutch Health Care: The Vision of Eureko,” Paper presented at a conference on European Systems of Universal Health Care, Washington, October 31, 2007.
215. Ibid.
216. “The New Care System in the Netherlands,” Ministry of Health, Welfare and Sport, The Netherlands Embassy, May 2006, [www.mivws.nl/images/boekje-zorgstelsel—engels\\_tem20-107939.pdf](http://www.mivws.nl/images/boekje-zorgstelsel—engels_tem20-107939.pdf).
217. “Health Insurance System,” Ministry of Health, Welfare and Sport, The Royal Netherlands Embassy, 2006, [www.minvws.nl/en/themes/health-insurance-system/](http://www.minvws.nl/en/themes/health-insurance-system/).
218. J. Andre Knottnerus and Gabriel ten Velden, “Dutch Doctors and Patients—Effects of Health Care Reform in the Netherlands,” *New England Journal of Medicine* 357 (2007): 2424–26.
219. Van Duin, “The Role of Private Insurers in Dutch Health Care: The Vision of Eureko.”
220. Ibid.
221. Knottnerus and ten Velden, “Dutch Doctors and Patients—Effects of Health Care Reform in the Netherlands.”
222. Greb, Manougian, and Wasem, “Health Insurance in the Netherlands.”
223. Gautam Naik, “Dutch Treatment: In Holland, Some See Model for U.S. Health-Care System,” *Wall Street Journal*, September 6, 2007.
224. Greb, Manougian, and Wasem, “Health Insurance in the Netherlands.”
225. Ibid.
226. Siciliani and Hurst, “Explaining Waiting Times Variations for Elective Surgery across OECD Countries.”
227. J. Plomp et al., “Death on the Waiting List for Cardiac Surgery in the Netherlands in 1994 and 1995,” *Heart* 81 (1999) 593–97.
228. Paul Belien, “Two Months of Competition in Dutch Healthcare,” *Brussels Journal*, October 23, 2006.
229. Knottnerus and ten Velden, “Dutch Doctors and Patients—Effects of Health Care Reform in the Netherlands.”

230. Ibid.
231. Gautam Naik, "Dutch Treatment: In Holland, Some See Model for U.S. Health-Care System," *Wall Street Journal*, September 6, 2007.
232. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."
233. Rudolf Klein, "The Troubled Transformation of Britain's National Health Service," *New England Journal of Medicine* 355 (2006): 409–15.
234. Daniel Martin, "Billions Squandered as NHS Fails to Deliver," *Daily Mail*, September 12, 2007.
235. Ibid.
236. Anthony Browne, "Deadly Rise in Wait for Cancer Care," *London Observer*, March 3, 2002.
237. Anthony Browne, "Cash-Strapped NHS Hospitals Chase Private Patient 'Bonanza,'" *London Observer*, December 16, 2001.
238. "Too Successful: The Hospitals Forced to Introduce Minimum Waiting Times," *Daily Telegraph*, August 7, 2006.
239. Ibid.
240. Martin, "Billions Squandered as NHS Fails to Deliver."
241. John C. Goodman, "Health Care in a Free Society: Rebutting the Myths of National Health Insurance," *Cato Policy Analysis* no. 532, January 27, 2005.
242. Richard Lewis and John Appleby, "Can the English NHS Meet the 18-Week Waiting List Target?" *Journal of the Royal Society of Medicine* 99 (2006): 10–13.
243. David Rose, "Waiting List Crisis as NHS Cuts Costs," *London Times*, June 56, 2007.
244. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*, p. 93.
245. Lewis and Appleby, "Can the English NHS Meet the 18-Week Waiting List Target?"
246. "NHS Should Not Treat Those with Unhealthy Lifestyles, Say Tories," *Evening Standard*, September 4, 2007.
247. Elizabeth Docteur and Howard Oxley, "Health-Care Systems: Lessons from the Reform Experience," OECD Working Paper no. 9, December 5, 2003.
248. Sarah Thomson and Elias Mossialos, "Regulating Private Health Insurance in the European Union: Implications of Single Market Legislation and Competition Policy," European Health Policy Group, September 2004.
249. Disney et al., *Impatient for Change*, pp. 29–38.
250. Civitas, "The Swiss Healthcare System," (London: The Institute for the Study of Civil Society, 2002), <http://www.civitas.org.uk/pdf/Switzerland.pdf>. This number differs from the official OECD percentage because the OECD defines government expenditure on health to include government-mandated insurance premiums, even if they are spent on private insurance. Under this definition, all private insurance purchased in Massachusetts under its new compulsory health care plan would be categorized as a public expenditure on health, for example. The cited number excludes mandatory insurance premiums because, though Swiss citizens are required to purchase a basic insurance plan, that plan comes from privately owned and even "for-profit" insurance companies. Individuals have considerable freedom of choice among insurers. Furthermore, premiums are paid directly to the insurers rather than collected directly by the government. For all those reasons the Swiss system differs significantly from, say, Germany, where I believe it is proper to include payments to sickness funds as a governmental rather than a private expenditure.
251. Michael Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work." However, Regina Herzlinger of Harvard University notes the important distinction that, unlike most systems of managed competition, including both the Clinton and Romney versions, the Swiss system is not employer based (e-mail to author, October 3, 2007).
252. For more on the concept of managed competition, see Enthoven, "The History and Principles of Managed Competition."
253. Association of Swiss Health Insurance Companies and *CIA World Factbook* (Washington: Central Intelligence Agency).
254. Michael Tanner, "Individual Mandates for Health Insurance: Slippery Slope to National Health Care," *Cato Institute Policy Analysis* no. 565, April 5, 2006.
255. E-mail from Sabine Alder, Communications Manager, Association Suisse d'Assurances, to author, October 4, 2007; Greg Kelly, "Can Government Force People to Buy Insurance?" *Issues and Answers* no. 123, Council for Affordable Health Insurance, March 2004, citing data from the Insurance Research Council, [http://www.cahi.org/cahi\\_contents/resources/pdf/n123GovernmentMan date.pdf](http://www.cahi.org/cahi_contents/resources/pdf/n123GovernmentMan date.pdf).

256. Andreas Minder, Hans Schoenholzer, and Marianne Amiet, *Health Care Systems in Transition: Switzerland* (Copenhagen: European Observatory on Health Care Systems, 2000).
257. Jim Landers, "In Switzerland, Everyone Is Insured, and Businesses Don't Pay," *Dallas Morning News*, February 7, 2006.
258. Regina Hertzlinger and Ramin Parsa-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland." *Journal of American Medical Association* 292, no. 10 (2004).
259. Ibid.
260. Ibid.
261. Landers, "In Switzerland Everyone Is Insured, and Businesses Don't Pay."
262. Uwe E. Reinhardt, "The Swiss Health System: Regulated Competition without Managed Care," *Journal of the American Medical Association* 292, no. 10 (2004): 1227–31.
263. Hertzlinger and Parsa-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland."
264. Peter Zweifel, "Competitive Mechanisms in Health Care," in *Reinventing Health Care* (London: Stockholm Network, 2000).
265. Hertzlinger and Parsa-Parsi. "Consumer-Driven Health Care: Lessons from Switzerland."
266. Minder, Schoenholzer, and Amiet, *Health Care Systems in Transition: Switzerland*.
267. Ibid.
268. Civitas, "The Swiss Healthcare System."
269. Ibid.
270. OECD, "Health at a Glance: OECD Indicators, 2005."
271. See Reinhardt, Hussey, and Anderson, "U.S. Health Care Spending in an International Context."
272. Herzlinger and Parsa-Parsi. "Consumer-Driven Health Care: Lessons from Switzerland."
273. Mattke et al., "Health Care Quality Indicators Project."
274. "Swiss Voters Reject Health Insurance Changes," Agence France Presse, March 11, 2007.
275. Tanner, "Individual Mandates for Health Insurance: Slippery Slope to National Health Care."
276. Ibid.
277. Civitas, "The Swiss Healthcare System."
278. Ibid.
279. Reinhardt, "The Swiss Health System: Regulated Competition without Managed Care."
280. Herzlinger and Parsa-Parsi. "Consumer-Driven Health Care: Lessons from Switzerland."
281. Peter Zweifel, "Switzerland," *Journal of Health Politics, Policy, and Law* 25 (2000): 937–44.
282. Zweifel, "Competitive Mechanisms in Health Care."
283. Hertzlinger and Parsa-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland."
284. Alphonse Crespo, "Swiss Health Care: A Clockwork Model That Fails to Keep Its Promise," in *The Dangers of Undermining Patient Choice: Lessons from Europe and Canada*, eds. Merrill Matthews, Grace-Marie Turner, and Julian Morris (Dallas: Institute for Policy Innovations, and Alexandria, VA: Galen Institute, 2006), pp. 16–19.
285. Hertzlinger and Parsa-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland."
286. Minder, Schoenholzer, and Amiet, *Health Care Systems in Transition: Switzerland*.
287. Mattke et al., "Health Care Quality Indicators Project."
288. David Greene and Benedict Irvine, "Health Care in France and Germany: Lessons for the UK" (London: Civitas, The Institute for the Study of Civil Society, 2001).
289. Ulla Schmidt, "Health Policy and Health Economics in Germany," Speech given at the conference, *The American Model and Europe: Past-Present-Future*, Washington, January 27, 2006.
290. Kaiser Permanente International, "Selected European Countries' Health Care Systems."
291. Schmidt, "Health Policy and Health Economics in Germany." Roughly 14.2 percent covers standard health insurance, with an additional 0.9 percent going to cover dentures and sick pay. There is also a separate 1.7 percent tax (1.95 percent for childless couples) to cover long-term care insurance. Kaiser Permanente International, "Selected European Countries' Health Care Systems."

292. Kyle James, "German Health Care Reform: Mission Impossible?" *Deutsche Welle*, March 8, 2006.
293. Ibid.
294. Reinhard Busse and Annette Riesberg, *Health Care Systems in Transition: Germany* (Copenhagen: European Observatory on Health Systems and Policies, 2004).
295. Ibid.
296. Dennis Nowak, "Doctors on Strike—The Crisis in German Health Care Delivery," *New England Journal of Medicine* 355, no. 15 (2006): 1520–22.
297. Ibid.
298. Cited in Annette Tuffs, "Germany at Centre of Rationing Row as Budget in Crisis," *British Medical Journal* 327 (2003): 414.
299. Christian Gericke, Matthias Wismar, and Reinhard Busse, "Cost-Sharing in the German Health Care System," Berlin University of Technology, 2004, <http://www.wv.tu-berlin.de/diskussionspapiere/2004/dp04-2004.pdf>.
300. Kaiser Permanente International, "Selected European Countries' Health Care Systems."
301. Boris Augurzky, Thomas Bauer, and Sandra Schaffner, "Copayments in the German Health Care System: Does It Work?" Institute for the Study of Labor (IZA) Discussion Paper no. 2290, September 2006.
302. "Merkel Announces a Deal, Averts a Crisis," *Der Spiegel*, October 5, 2006.
303. Siciliani and Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries."
304. K. Davis et al., "Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care," The Commonwealth Fund, May 2007.
305. World Health Organization, "Highlights on Health, Germany, 2004, [www.euro.who.int/eprise/main/WHO/Progs?CHHDEU/system/200050311-1](http://www.euro.who.int/eprise/main/WHO/Progs?CHHDEU/system/200050311-1).
306. Hilke Brockmann, "Why Is Less Money Spent on Health Care for the Elderly than for the Rest of the Population? Health Care Rationing in German Hospitals," *Social Science and Medicine* 55 (2002): 593–608
307. Cited in Busse and Riesberg, *Health Care Systems in Transition: Germany*.
308. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."
309. Wilfried Prewo, "Germany: How Not to Organize a Health System," in *The Dangers of Undermining Patient Choice: Lessons from Europe and Canada*, ed. Merrill Matthews, Grace-Marie Turner, and Julian Morris (Dallas: Institute for Policy Innovations, and Alexandria, VA: Galen Institute, 2006).
310. Dieter Braeuning, "Health Policy in Germany: Health Reforms Need a Dose of Market Medicine," Deutsche Bank Research, June 13, 2006.
311. Disney et al., *Impatient for Change*, pp. 89–97.
312. Jonathan Cohn, "Shtiko: It's No Fun to Agree with Michael Moore," *New Republic*, June 22, 2007.
313. Brett J. Skinner, "Paying More, Getting Less 2005: Measuring the Sustainability of Provincial Public Health Expenditure in Canada," Fraser Institute, October 2005.
314. *Chaoulli v. Quebec* (Attorney General), 2005 SCC 35, [2005] 1 S.C.R. 791.
315. Nadeem Esmail, Michael Walker, and Dominika Wrona, "Waiting Our Turn, 16th Edition: Hospital Waiting Lists in Canada," Fraser Institute, 2006.
316. Ibid.
317. Madhu Natarajan et al., "The Risks of Waiting for Cardiac Catheterization: A Prospective Study," *Canadian Medical Association Journal*, November 26, 2002.
318. Cited in June O'Neill and David O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S.," National Bureau of Economic Research Working Paper no. 13429, September 2007.
319. *Chaoulli v. Quebec*.
320. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 Countries."
321. "What President Clinton Can Learn from Canada about Price Controls and Global Budgets," Policy Backgrounder no. 129, National Center for Policy Analysis, October 5, 1993.
322. OECD, "Health at a Glance: OECD Indicators, 2005."
323. O'Neill and O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S."
324. OECD, "Health at a Glance: OECD Indicators, 2005."

325. Cited in Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*, p. 72.
326. *Ibid*, p. 69.
327. *SiCKO*, Dog Eat Dog Films, 2007.
328. "Edwards Campaign Unveils New 'Underdog' Television Ad in New Hampshire," John Edwards 08, news release, January 6, 2008, <http://www.johnewards.com/news/headlines/20080106-underdog-ad/>; Joel Zinberg, "Edwards' Evil Insurance Scam," *New York Post*, January 10, 2008.
329. Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*; Disney et al., *Impatient for Change*.
330. Robin Toner, "Unveiling Health Care 2.0, Again," *New York Times*, September 16, 2007.
331. OECD, "OECD Health Data 2007: Statistics and Indicators for 30 countries."
332. Quoted in Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*, p. 109.
333. Cathy Schoen et al., "Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries, 2007," *Health Affairs*, October 31, 2007.
334. For example, the CBS News poll, October 12–16, 2007, found 25 percent of Americans choosing health care as the most important issue in this campaign, second only to 26 percent choosing the war in Iraq. Similarly, an NBC/*Wall Street Journal* poll, November 1–5, found 16 percent chose health care, second to the 26 percent who chose Iraq, <http://www.pollingreport.com/prioriti.htm>.
335. Schoen et al., "Toward Higher-Performance Health Systems."
336. Disney et al., *Impatient for Change*.
337. Richard Saltman and Josep Figueras, "Analyzing the Evidence on European Health Care Reforms," *Health Affairs*, March–April 1998.
338. Cited in Callahan and Wasunna, *Medicine and the Market: Equity v. Choice*, p. 91.
339. "Cox Report on Financing Sustainable Health-care in Europe Presented to European Commission Today," *Medical News Today*, February 13, 2007.
340. Hans Maarse, "The Privatization of Health Care in Europe: An Eight Country Analysis," *Journal of Health Politics, Policy, and Law* 3He1 (2006): 981–1014.

## STUDIES IN THE POLICY ANALYSIS SERIES

612. **Electronic Employment Eligibility Verification: Franz Kafka's Solution to Illegal Immigration** by Jim Harper (March 5, 2008)
611. **Parting with Illusions: Developing a Realistic Approach to Relations with Russia** by Nikolas Gvosdev (February 29, 2008)
610. **Learning the Right Lessons from Iraq** by Benjamin H. Friedman, Harvey M. Sapolsky, and Christopher Preble (February 13, 2008)
609. **What to Do about Climate Change** by Indur M. Goklany (February 5, 2008)
608. **Cracks in the Foundation: NATO's New Troubles** by Stanley Kober (January 15, 2008)
607. **The Connection between Wage Growth and Social Security's Financial Condition** by Jagadeesh Gokhale (December 10, 2007)