Health Policy 201– International comparisons

Ellen Andrews, PhD
CT Health Policy Project
Fall 2011

Connecticut Health Policy Project

four models

- Out of pocket – Third world countries, US uninsured
- Private individual insurance – Switzerland, US individual insurance
- Employer-sponsored insurance – Germany, US ESI
- Government finance – UK, US Medicare and Medicaid

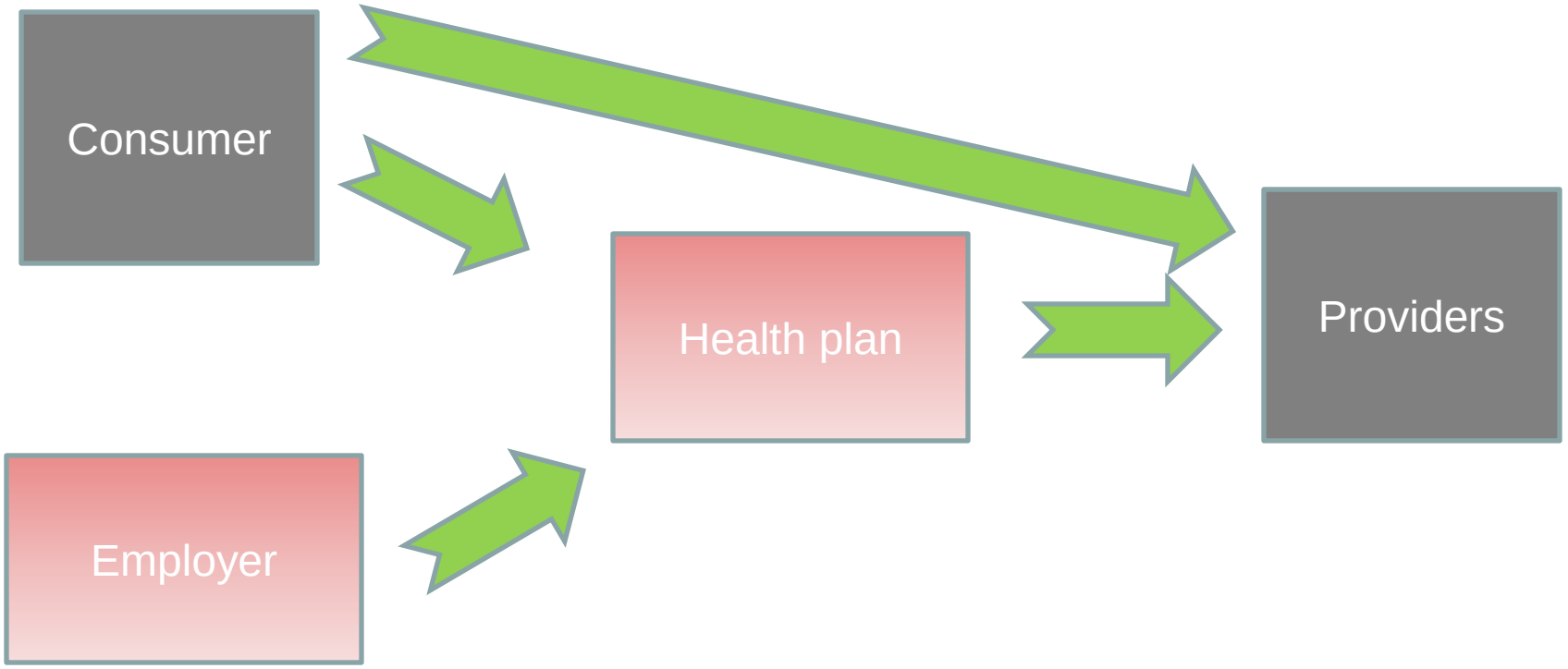
out of pocket

Red box = who bears risk

individual private insurance

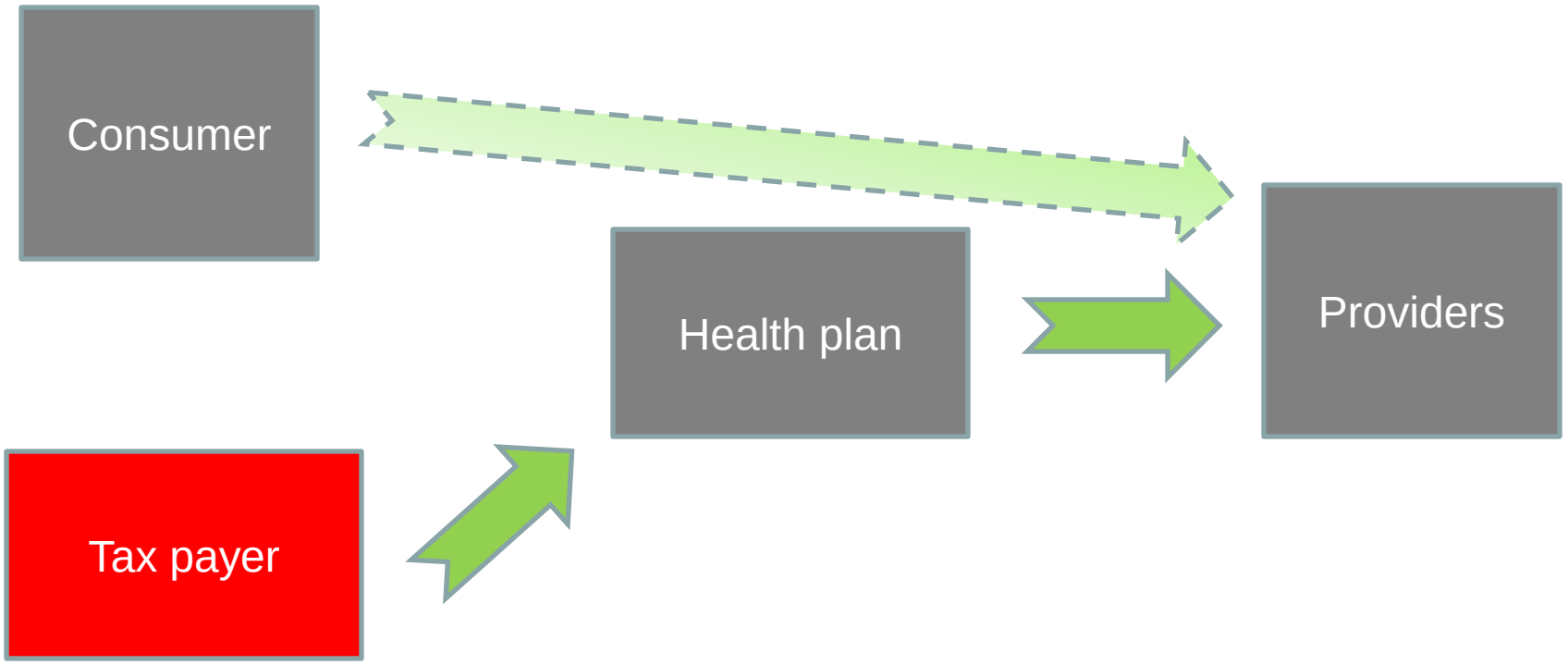
Red box = who bears risk
Green = $$$$

employer sponsored private insurance



Red box = who bears risk, varies in this model
Green = $$$$

single payer



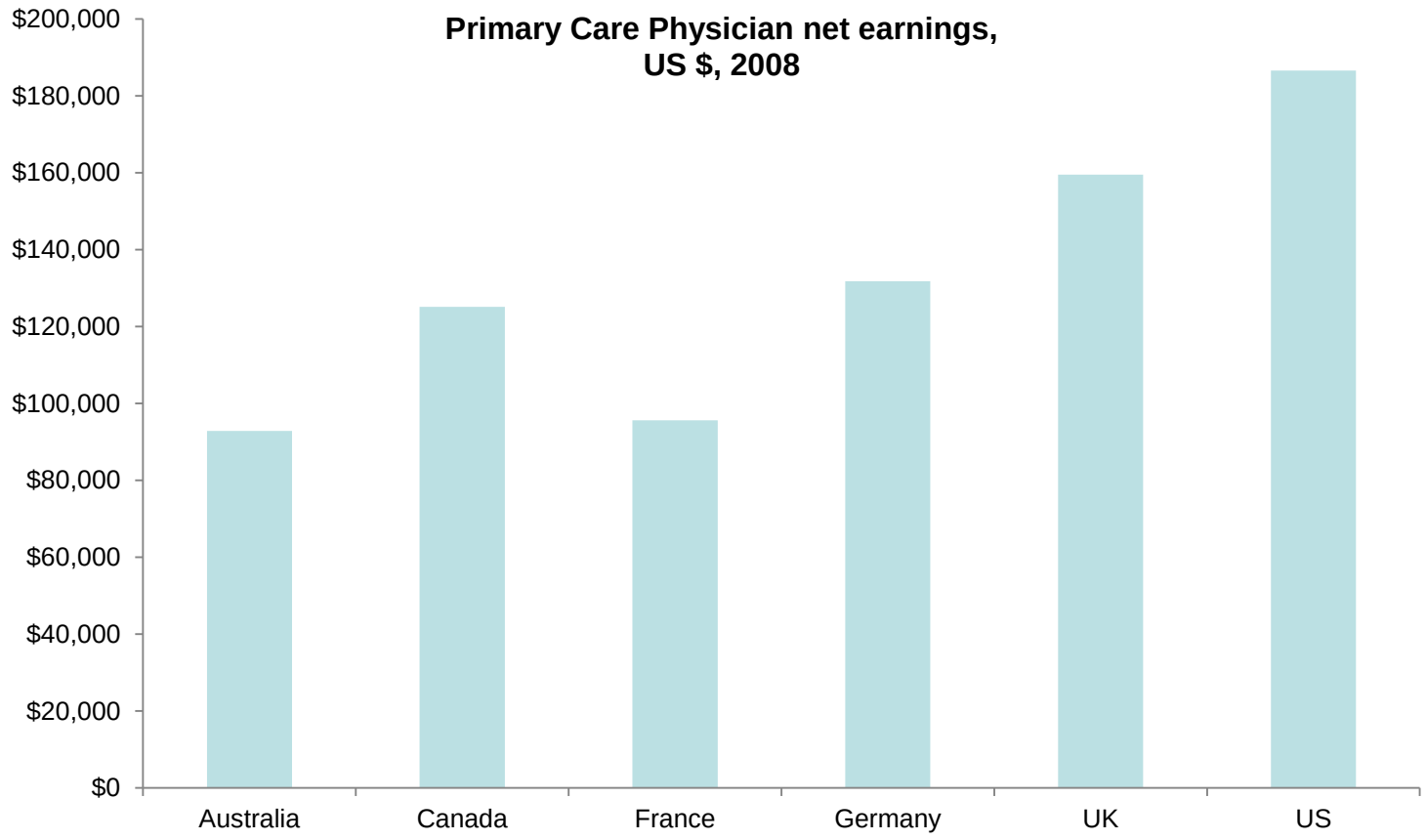
Red box = who bears risk
Green = $$$$

Physician costs

	office visit		hip replacement	
	public	private	public	private
Australia	$34	$45	$1,046	$1,943
Canada	$59		$652	
France	$32	$34	$674	$1,340
Germany	$46	$104	$1,251	
UK	$66	$129	$1,181	$2,160
US	$60	$133	$1,634	$3,996

Source: Laugesen M and S Glied, Health Affairs 30:1647-56, Sept. 2011

Physician earnings



Physician earnings

Explanations

- US has fewer active physicians (2.6) per pop than most other countries (2.3 to 3.9)
- US patients get fewer office visits per capita (3.8) than other countries (5.1 to 7.4)
- US has fewer elderly residents (12.8% over age 65) than other countries (13.3 to 20.3%)
- Higher practice expenses or costs of med school do not explain the differences

Germany

- 0.2% uninsured
- Individual and employer mandates
- Highly regulated insurance and prices
- Sickness funds purchased through employer
- For unemployed, retired government pays employer share
- Little coordination between providers – similar to US

German sickness funds

- About 180
- Nonprofit, quasi-public
- Funded by employer and worker contributions
  - Lower wage workers pay more as % of income
  - Cannot charge more for age or health status
- Standard benefit package
- 1994 reforms
  - Sicker members were concentrating in some plans
  - Allowed people to switch plans
  - Pool funds, redistribute based on costs
  - 2002 incentives to enroll people with chronic conditions

Germany

- Community physicians join regional associations
- Associations paid a global fee based on services provided
  - Payments are now risk adjusted
  - Payments to associations reduced if volume is too high
- Hospitals paid based on bundle system for admissions
  - Physicians in hospitals are paid salaries by hospital
- Little coordination between community care and hospitals
- Fees set by convening group
- Recent cost increases led to drug cost controls

Canada

- Called Medicare, but unlike US covers everyone
- Single payer private system
- Almost all physicians own their own business
- Most hospitals are private, nonprofit
- Funded through taxes – federal and provincial
- Operated by provinces
- Not linked to employment at all
- Same benefits, costs for every Canadian
- Broad benefits, 2/3 carry gap insurance for other services

Canada

- Very high percent of physicians are primary care
- Gatekeeping encouraged with fees
- Hospital and physician care linked
  - EMRs more prevalent than US
- Less high tech treatment
  - 6.7 MRIs/million people vs. 26 US
- Waiting times for elective procedures
  - Similar in many cases to waits in US in our Medicare
  - Provinces have intensive plans to address
  - Tiny number of Canadians cross boarder for care
- More equitable distribution of care

Canada

- Far less time and resources devoted to administration
- Global rates paid to hospitals
  - Negotiated with provincial government
- Physicians paid fee for service
  - Fees negotiated between provincial government and professional associations
- Provinces regulate drug prices, formularies
- Canadians do not receive less services than US patients
- Cost reductions due to lower prices, less administration, less high tech interventions, public health interventions

United Kingdom

- Everyone in the country is covered
- National Health Service (NHS)
- Funded by taxes
- No link to employment
- Everyone gets the same benefit package
  - Hospital, physician services, drugs
- Private companies can sell coverage for same services as NHS
- Everyone must be enrolled with a GP to get care
- Referrals to specialists needed except for emergencies

United Kingdom

- Waiting times an issue for nonemergency surgeries, not other services
- Waiting times for primary care far less than US
- GPs paid flat fee per patient in their panel
  - Plus pay for performance, administrative bonuses, patient satisfaction
  - Can reach $77,000/physician
  - Some extra fees for off hours care, house calls
- Specialists generally work in hospitals, paid by salary
- Most hospitals nationalized, global budget
- GPs do not provide care in hospitals
- P4P drove hiring more nurses, more EMRs, chronic disease management clinics

United Kingdom

- Large increase in funding 1999 to 2004
- Number of physicians up 25%
- Scaled back somewhat since
- Still one of the least expensive in world
  - Single payer limits costs, fragmentation
  - Caps on physician total payments
  - Fewer services provided
- GPs now required to join regional groups to address budget, primary care planning

Switzerland

- Individual mandate, virtually universal coverage
- No link to employment
- All coverage is individual
  - No dependent coverage
- Competing health plans for basic package
- Limits on deductibles, coinsurance caps
- Prenatal and some preventive service exempt from copays
- Premiums can only vary by age (child, young adult, adult), canton and deductible level
- Cantons may cover costs for low income, retirees, 1.6% of Swiss who do not pay

Switzerland

- Insurers are strictly regulated
- Guaranteed issue
- Redistributes excess revenue over medical costs between plans
  - Reduces incentives to exclude costly patients
  - But reimbursement is retroactive
  - Reduces incentives to lower prices, spending
- Generally free access to any provider
- Physician-centered system
- Physicians negotiate fee for service rates with plans individually as in the US
- Many hospitals are public or heavily subsidized, run by cantons
- System is very fragmented by canton, planning and funding

Switzerland

- Early on in quality reforms, due to fragmentation of canton control
- Government is funding health information technology adoption
- Some of highest costs in the world (after the US)
- Moving toward more global payment rates in future